With the assistance of these experienced consultants, the APS approach to dental services will be informed, efficient, and effective in expanding high quality dental services for ACCESS Plus Enrollees. In this section, we explain our approach to achieving this goal.

A. Describe the Offeror's overall approach to coordinating dental services for Enrollees who are eligible for dental benefits –

As with all APS programs, our approach to coordinating dental services for ACCESS Plus Enrollees is one of true partnership with participating dentists in order to reduce disease burden in the population. As reported by the Arc of Pennsylvania "less than 20 percent of the total available dentists in Pennsylvania participate in the Medical Assistance (MA) program. Of this small percentage, even fewer MA-participating dentists agree to treat MA clients on a regular basis" due to issues such as missed appointments, commensurate loss of revenue[1], and the difficulty of providing services to individuals with intellectual or developmental disabilities. Given the rural nature of the State, the declining number of dentists in rural Pennsylvania and the limitations in reimbursement arrangements permitted by the Commonwealth, it is critical that the Department offer care strategies that coordinate health resources with patient needs. Furthermore, with limited communication opportunities, many within the dental community have a sense of isolation from the mainstream of Medicaid, creating significant challenges in their ability to support Medicaid Enrollees in their practices. For this reason, we propose the development of "healthcare neighborhoods" that connect providers to each other, payers, and Enrollees. Through the establishment of the "healthcare neighborhood," our experience indicates that many rural providers experience a significant advantage in positive and proactive administration of their programs serving rural Enrollees.

A focus for our coordination efforts for Enrollees under the age of 21 is to strengthen the relationship between PCPs and Dental Homes for delivery of EPSDT services. To this end, our Enrollee roster listings will also indicate Enrollees who have not had a routine dental checkup in the previous six months. APS Care Coordinators can then assist Enrollees and PCP offices by scheduling appointments with available dentists. One of the most important services we will incorporate into the Dental Home is reminding Enrollees to keep their dental appointments. Just as we will collaborate closely with PCPs to identify Enrollees who miss appointments, we will also work with dentists to provide the same service. In addition, we will also work with dental providers to identify referral limitations for the practice (as with PCPs).

APS knows how important it is for Medicaid Enrollees to have access to a Dental Home, and currently includes reminders about the importance of oral health in our Disease Management newsletters (**Exhibit 12**). Literature indicates that as many as a third of people with diabetes are undiagnosed. In many cases, dentists play a key role in identifying these individuals early as oral health symptoms (e.g., toothaches) can present earlier than other physical health symptoms.

APS will use innovative techniques to promote effective coordination of dental services:

- Identifying **Dental Champions** in each region who represent the interests of the program to their colleagues and assist with recruitment.

[1] Position paper of The Arc of Pennsylvania with Regard to Access to Dental Care for People with Disabilities. April 2008. http://www.thearcpa.org/images/position%20papers/Dental.pdf. Accessed February 6, 2009.

- Integration of dental claims in APS CareConnection® so APS Care Coordinators and PCPs can monitor dental care utilization and reach out to underserved Enrollees.

- Development of consumer incentives to improve oral health for children under 21 (who are covered for teeth cleaning, X-rays, cavity fillings, and crowns), aligned with provider Pay for Performance programs – for dentists **and** PCPs.

- Expansion of the Enrollee Handbook to provide a more detailed discussion of covered services, the importance of oral health, information on how to find an ACCESS Plus dentist, and how to contact an APS Care Coordinator for assistance with access to dental care.

- Including dental offices in the PCP audit. APS has proposed consulting services from local dental experts to assist with the development of an audit approach that is customized for dental offices to support training initiatives and provide positive feedback as well as program support for this valuable resource.

- Adapting the Dentist Locator system developed by the APS Southwest Pennsylvania Healthcare Quality Unit that displays enrolled dentists by county. Information on each provider will include:

    - Cultural competencies (e.g., languages spoken by staff).
    - Cultures that dentists and office staff are sensitive to and familiar with.
    - Clinical capabilities, including an indicator to notify Enrollees if the dentist practices sedation dentistry.

Oral Health as a Predictor of Physical Disease

We know that many conditions have symptoms that manifest through dental and oral health problems including diabetes, eating disorders, cardiovascular disease, and HIV/AIDS to name a few. As a result, we will develop and conduct provider training that incorporates both medical and dental aspects of care. For example, according to the American Heart Association and a recent study conducted by the Harvard School of Public Health, "*A poor oral health diagnosis was a stronger predictor of heart disease than other markers such as high levels of HDL or 'good' cholesterol, or high triglycerides.*" This study concluded that the strongest predictors of heart disease were five common oral health conditions:

- Infection around the third molars.
- The presence of root remnants.
- Missing teeth;
- Gingivitis; and
- Cavities.[2]

This study is one of many that have linked oral health symptoms to physical conditions. Other studies and findings associate oral health characteristics with a variety of conditions:

- **COPD and Respiratory Disease:** Chronic obstructive pulmonary disease, characterized by obstruction of airflow due to chronic bronchitis or emphysema and by recurrent episodes of respiratory infection, has

[2] Position paper of The Arc of Pennsylvania with Regard to Access to Dental Care for People with Disabilities. April 2008. http://www.thearcpa.org/images/position%20papers/Dental.pdf. Accessed February 6, 2009.

been associated with poor oral health status (Hayes et al. 1998, Scannapieco et al. 1998). A positive relationship between periodontal disease and bacterial pneumonia has been shown by Scannapieco and Mylotte (1996).[3]

- **Diabetes:** The first signs and symptoms of diabetes can develop in the mouth. The oral complications of diabetes are related to a person's ability to control blood sugar levels (Glycemic control) and their overall health. Scientific studies have shown that cases of advanced periodontitis are associated with poorly controlled diabetes. Periodontal disease (periodontitis) affects the gums and bone that support the teeth. It is an inflammatory disease, triggered by the bacteria in dental plaque, which results in the infection of gums followed by the destruction of bone. Symptoms include bleeding gums, tooth sensitivity, recession of gums, bad breath (halitosis), swollen gums, itchy gums, and loose teeth.

- **Eating Disorders:** Up to 89 percent of bulimic patients have signs of tooth erosion due to stomach acid. Over time, this loss of tooth enamel can be considerable, and the teeth change in color, shape and length. They can also become brittle, translucent and sensitive to temperature. The salivary glands may swell, causing the jaw to widen and appear squarish. Anorexia can lead to tooth decay due to malnutrition. [4]

- **HIV/AIDS:** The progressive destruction of the body's immune system by HIV leads to oral lesions. Oral candidiasis is rarely seen in previously healthy young adults who have not received prior medical therapy such as chemotherapy or treatment with other immunosuppressive drugs (Klein et al. 1984). Oral candidiasis may be the first sign of HIV infection and often occurs as part of the initial phase of infection—the acute HIV syndrome.[5]

- **Pregnancy:** Periodontal disease may contribute to adverse outcomes of pregnancy as a consequence of a chronic oral inflammatory bacterial infection. Toxins or other products generated by periodontal bacteria in the mother may reach the general circulation, cross the placenta, and harm the fetus. Case-control studies have demonstrated that mothers of low-birth-weight infants born as a result of either preterm labor or premature rupture of membranes tend to have more severe periodontal disease than mothers with normal-birth-weight infants.[6]

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[3] Sources: Hayes C, Sparrow D, Cohen M, Vokonos PS, Garcia RI. The association between alveolar bone loss and pulmonary function: the VA Dental Longitudinal Study. Ann Periodontol 1998 Jul;3(1):257-61.
Scannapieco FA, Papandonatos GD, Dunford RG. Associations between oral conditions and respiratory disease in a national sample survey population. Ann Periodontol 1998 Jul;3(1):251-6.
Scannapieco FA, Mylotte JM. Relationships between periodontal disease and bacterial pneumonia. J Periodontol 1996 Oct;67(10 Suppl):1114-22.
[4] Changes In Mouth Often First Signs Of Eating Disorders, www.medicalnewstoday.com, Oct 25, 2003.
[5] Sources: Tindall B, Carr A, Cooper DA. Primary HIV infection: clinical, immunologic, and serologic aspects. In: Sande MA, Volberding PA, editors. The medical management of AIDS. Philadelphia: W.B. Saunders; 1995. p. 105-29.
Klein RS, Harris CA, Small CB, Moll B, Lesser M, Friedland GH. Oral candidiasis in high-risk patients as the initial manifestation of the acquired immunodeficiency syndrome. N Engl Med J 1984 Aug 9;311(6):354-8.
Oral Health in America: A Report to the Surgeon General, National Institute of Dental and Craniofacial Research, National Institutes for Health, September 2000.
[6] Sources: Oral Health in America: A Report to the Surgeon General, National Institute of Dental and Craniofacial Research, National Institutes for Health, September 2000.
Offenbacher S, Katz V, Fertik G, Collins J, Boyd D, Maynor G, McKaig R, Beck J. Periodontal infection as a possible risk factor for preterm low birth weight. J Periodontol 1996 Oct;67(10 Suppl):1103-13.

- **Additional Health Issues:** Unusual bleeding could indicate liver disease, medication overdoses, or coagulation disorders. A red, smooth tongue can indicate GI problems or diet deficiencies, especially a lack of vitamin B12 or folate; swollen gums can indicate a vitamin C deficiency.[7]

APS will emphasize the importance of dental care and the impact of dental care on Enrollees' overall health. Training will facilitate interactions between local dentists and APS program staff, provide input regarding strategies to improve the dentist/Enrollee relationship, increase access to care, and improve quality of care delivered to Enrollees.

APS will also assist the Department in identification and management of Enrollees who are high volume utilizers of emergency room facilities ("Frequent Emergency Room Users") for the primary purpose of obtaining dental services. Once identified (e.g., through paid claims data, self-referrals, or referrals from providers), APS' Care Coordinators will contact adult Enrollees with dental coverage, and will contact parents/guardians of Enrollees under 21. Our Care Coordinators will arrange *confirmed* referrals to dentists who are able to deliver dental services in a non-emergency setting. If a Care Coordinator discovers through routine interactions with Enrollees that they have visited emergency departments for dental care in the past, the Care Coordinator will provide referrals to dentists. During conversations with the Enrollee, our Care Coordinators will also determine why the Enrollee is using the emergency room to access dental services, record any barriers the Enrollee has experienced in trying to access services from dental offices, and will work with Enrollees, dental providers, PCPs, MATP providers, other transportation systems, and community- and faith-based organizations to help secure access to needed services such as transportation, childcare, or eldercare. We will also provide this information to the Department.

- including the Offeror's approach for:

1. Helping Enrollees find a dentist who is accepting new clients.

Our approach to helping Enrollees find dentists who accept new clients involves obtaining a copy of the Bureau of Fee For Service Programs (BFFSP) zip code list of enrolled MA providers, which may include both active and inactive providers of ACCESS Plus and the Managed Care Organizations. APS' Care Coordinators will then identify dentists located within the Enrollee's region, and make outreach calls to dentists to verify whether they are accepting additional ACCESS patients. APS will then manually enter this information in our Specialist Resource and Referral database to facilitate appropriate referrals from PCPs and Enrollees. We prefer that resources be incorporated into our systems from other electronic databases to improve the accuracy and timeliness of information. If the information is available electronically from the Department and/or other sources, we will upload this information into our Specialist Resource and Referral database so that Enrollees can also access it themselves if preferred.

[7] Source: Abel, Barbara, Dental Symptoms can Expose Health Issues, HealthLink, April 27, 2006.

2. Identifying dentists who will serve MA recipients, including how the Offeror will identify dentists who are willing and able to serve children with special needs.

As we discuss above, we will identify dentists who will serve MA recipients by referring to the BFFSP list of enrolled MA providers. For counties that border the HealthChoices Zones, we will solicit providers who participate in MCO programs but may not accept ACCESS Plus patients. APS will enter the information from the ACCESS Plus Supplemental Provider agreement for dentists completing this document, a process that will allow us to capture the information electronically and populate our listing from this source. This will enable us to maintain an up-to-date database that includes information about their specialty and willingness to serve children with special needs.

APS' Care Coordinators will then confirm directly with dentists if they are willing to accept MA recipients and if they are willing and able to serve children with special needs. Those dentists who are willing to accept MA recipients, including special needs children, will be specifically noted in the Specialist Resource and Referral database in order to facilitate appropriate referrals. Dentists no longer accepting MA recipients will also be noted in the Specialist Resource and Referral database. Additionally, APS will notify the Department of dentists willing to accept MA recipients as well as those no longer accepting MA recipients. We will also forward the reason for discontinuing Medicaid service if the dentist provides a reason.

In Table 11-1 we show the dentist locator screen for the South West Pennsylvania Health Care Quality Unit. For the ACCESS Plus Program, APS will populate the database from the provider file if possible.
The South West Pennsylvania Health Care Quality Unit developed this resource in response to the need to identify dentists who are willing to provide treatment to people with intellectual and developmental disabilities. Entering an address (optional) or a ZIP Code, and indicating the preferred radius of miles returns a list of dentists in that area. Individuals may also specify if they only want to search for dentists who accept Medical Assistance and/or if they only want to search for dentists who provide Sedation Dentistry.

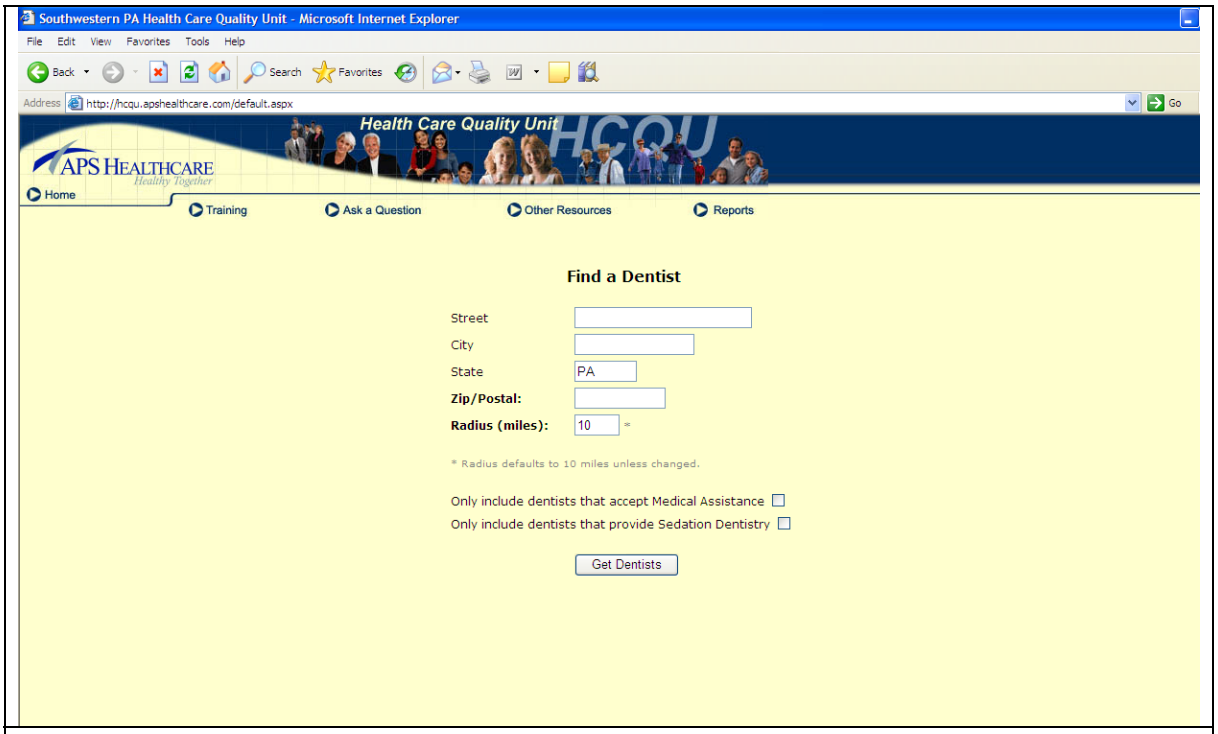

Table 11-1. SW PA HCQA Dentist Locator System

Identifying dentists who are willing and able to treat people with special needs is particularly challenging, as few special needs dental practices exist. Individuals with special needs can present challenges in delivering dental care as their cognitive status, intellectual/developmental disabilities, and/or physical disabilities can interfere with routine dental procedures. As a result, people with special needs, including children, often prefer to have dental services delivered with the assistance of intravenous sedation delivered by a Certified Registered Nurse Anesthetist (CRNA) or general anesthesia.

One aspect of our efforts to identify and engage dentists who will serve children with special needs includes engaging Pennsylvania's Health Care Quality Units (HCQUs) in the ACCESS Plus region. These organizations are contracted to enhance the quality of life of individuals with intellectual and developmental disabilities (I/DD) by leading initiatives that facilitate improvements in the delivery of healthcare and services to this population. APS operates the Southwestern Pennsylvania HCQU that we reference in this section, so we are very familiar with the complexity of this issue. The program provides collaborative, responsive educational support to its eight-county region. Our goal will be to solicit the help of other HCQUs to identify providers already delivering care to this population, and populate the Specialist Resource and Referral database with such providers. With the help of the HCQUs, we may be able to identify dentists who are sympathetic to special needs children and have practices that are able to bring in a CRNA once a month to serve this population. By leveraging the knowledge and resources HCQUs have, we believe we will be able to identify more providers who are willing and able to serve special needs children and make a profound difference in the healthcare and outcomes of this population.

In addition to the efforts described above, we will contact and develop relationships with organizations that advocate for people with special needs, including I/DD; associations advocating for people who are blind, deaf or hard of hearing; and organizations for people with physical and mental disabilities, traumatic and non-

traumatic brain injury, etc. Special effort will be given to identifying organizations that are focused specifically on children with special needs.

By engaging with dental societies and associations in the effort to improve dental care for people with special needs, APS will motivate the special needs community to address this important issue. Just as importantly, we will also actively seek the engagement of community- and faith-based organizations, and local agencies with community welfare roles (e.g., the local Extension offices).

3. Implementing follow-up strategies for confirming appointments have been kept and providing assistance in rescheduling and logistics to assure reasonable optimization of treatment compliance in the event of a missed appointment.

To ensure Enrollees keep their appointments, APS' approach will involve the efforts of our Care Coordinators. For example, if an Enrollee is referred by their PCP for dental services or an Enrollee calls APS for dental services, our Care Coordinators are responsible for checking the Specialist Resource and Referral Database to locate an available dentist, informing the Enrollees of the dentist's appointment availability, and assisting with scheduling an appointment.

Once appointments are made, our Care Coordinators are responsible for reaching out to the Enrollee (and their caregiver if appropriate) to remind him/her of the upcoming appointment, explain the importance of keeping the scheduled appointment, and help the Enrollee overcome any barriers to access to ensure the appointment is kept (e.g., secure transportation to the appointment if requested). Our Care Coordinators will also follow-up with the dental office and the Enrollee's caregiver to verify the appointment was kept, and to assist in rescheduling any missed appointments. If the Enrollee missed the appointment, our Care Coordinators will identify the reason for the missed appointment (e.g., coordinating transportation), reinforce the importance of dental care, update the Enrollee's PCPs through APS CareConnection® and reschedule the missed appointment. This aspect of coordination reaffirms the importance of linking the dental and medical homes to ensure that these primary care resources are closely coordinated and working together to improve the delivery of dental and medical preventive and primary care. By coordinating information between the PCP and the referred dentist, PCPs are informed of the results of their referral, can provide education on the importance of dental care, and further encourage their Enrollees to keep their scheduled appointments.

4. Providing dental services for Enrollees with special needs.

As we discussed in our response to item 2, the first step in providing dental services for Enrollees with special needs is ensuring the availability of dentists who are willing to provide these services to Medicaid Enrollees who have special needs. However, expanding access is only the first step. It is also important to communicate with Enrollees and their parents to ensure they are aware of these resources as well as other supports that make it possible for Enrollees with special needs to use these resources safely and successfully. That effort involves not only helping to identify supports for other needs such as transportation, but also educating Enrollees with special needs and their family members about good dental care "protocol." This includes helping them understand what information is necessary for the dentist to know before the visit, letting offices know of any special accommodations that might be needed ahead of time, being on time for and keeping appointments, and adhering to the dentists' recommendations for home-based dental care. APS will conduct this educational campaign directly with Enrollees by including information in newsletters as well as through

the Regional Ambassador Councils (which should include individuals with special needs), local organizations, the ACCESS Plus website, and through PCPs and other providers delivering services to Enrollees.

In addition, we will encourage dental offices to use APS CareConnection® to document medical co-morbidities issues with adherence to recommended care as well as missed appointments. Dentists will have access to APS CareConnection® in order to be kept appraised of other aspects of the enrollee's plan of care. APS' field-based and office-based Care Coordinators and Health Coaches can then work directly with families to help locate and use services that help promote oral health for all Enrollees.

5. Providing orthodontic care management to Enrollees who are approved for those services.

APS' Care Coordinators will reach out to all Enrollees identified by BFFSP and approved for comprehensive orthodontic treatment to help them comply with prescribed treatment regimens. Our Care Coordinators will be responsible for calling the orthodontist's office that is authorized to perform the treatment to obtain information regarding scheduled appointments for the Enrollee, as well as the caregivers of Enrollees to remind them to keep the scheduled appointments with the orthodontist. As part of our program, APS will track the frequency of orthodontic pre-authorizations with a report of started cases we receive from orthodontists, which indicate the initiation of orthodontic care. For those who were approved and did not have a case start date, Care Coordinators will make follow-up calls to caregivers and Enrollees to determine the barrier to necessary care, encourage them to complete the recommended orthodontic care, as well as provide counseling on the importance of orthodontic care.

Our Care Coordinators will also assist Enrollees with obtaining transportation or managing other logistical issues to help ensure Enrollees keep their scheduled dental appointments, if requested. Lastly, our Care Coordinators will follow-up with the orthodontic office and Enrollee caregivers after scheduled appointments to verify that the appointment was kept, and if not, identify barriers to access (e.g., facilitating transportation) and assist in rescheduling the appointment.

B. Describe additional innovative strategies the Offeror intends to implement for increasing the number of dental Providers that participate in the ACCESS Plus Program and any specific initiatives the Offeror would implement related to dental services.

APS offers the Commonwealth additional strategies for increasing the number of dental providers that participate in ACCESS Plus. Specifically, we propose to implement the following activities based upon the Department's approval:

- APS will identify dental providers who participate with the MCOs but do not participate with Access Plus. Once identified, APS will provide information about fee schedule increases that are available under ACCESS Plus as well as the incentive payments that will be offered within the dental P4P program.

- In regions where there is no MCO penetration, APS' Care Coordinators will perform outreach calls to dentists to encourage them to accept at least a few Medicaid members, many of whom they may have already treated before. For example, given the layoffs experienced by the Pennsylvania mining community, many individuals that may have previously been covered through private insurance or private pay are now receiving benefits through Medicaid. Dentists who decide to accept Medicaid patients can then continue

to see individuals they have already been treating for years, and maintain the relationship with their patients after they return to work.

- APS will identify and utilize dental champions who represent the interests of the program to their colleagues and assist with recruitment. We have found that using well respected practitioners to promote participation can be among the most effective approaches to recruitment.

- APS will develop an **ACCESS Plus Best Practice** initiative to recognize dentists for their achievements in improving dental outcomes for Enrollees. This award will be shared with the community via various media (e.g., published in local newspapers, radio announcements, etc.). We believe that by acknowledging the efforts of our provider partners and showing appreciation, some providers may be more encouraged and willing to participate in ACCESS Plus.

C. Identify potential challenges the Offeror anticipates in ensuring Enrollees, including those with special needs, receive recommended and appropriate dental care and explain how the Offeror will mitigate those challenges.

A number of challenges exist in ensuring Enrollees, including those with special needs. In 2007, the American Dental Association (ADA) House of Delegates authorized a Medicaid Provider Symposium for 2008 to identify specific challenges of providing dental care to Medicaid recipients. The symposium noted the following key challenges:

- "Legislators are not fully aware of the growing oral health needs of the Medicaid population, which requires greater advocacy efforts and collaboration with stakeholders to increase awareness.
- A basic understanding and appreciation of oral health as an integral part of overall health often appears lacking within this target population.
- The current dental school curriculum inadequately prepares dental providers to address the oral health needs of this population, especially young children.
- The administration of state Medicaid dental programs is often inefficient.
- The lack of coordination of the Dental Home with the medical home perpetuates a lack of emphasis on preventive care among Medicaid-eligible children."

Many of these challenges exist in Pennsylvania, including long waits before a patient may be able to get into an office for a dental appointment, the long distance a patient has to travel to for a dental appointment, and missed appointments.

Furthermore, ensuring that those with special needs receive recommended dental care is particularly challenging. For example, the American Academy of Pediatric Dentists (AAPD) notes "that low income children with special health care needs (SHCN) are at greater risk of developing oral health problems than low income "healthy" children. For a number of reasons, when children with SHCN develop oral health problems, they tend to involve more serious health consequences relative to low income "healthy" children."[8] Some of the reasons that oral health issues have a higher prevalence and are likely to be more complex in this population than low income "healthy" children" include:

[8] Mitchell, J. Gaskin, D. *Dental Care Use and Access for Special Needs Children.* March 2007. ftp://ftp.hrsa.gov/mchb/research/documents/finalreports/r40_mc_04296_final_report.pdf. Accessed February 6, 2009.

- "Physical handicap, a developmental problem or serious medical illness that prevents a child from brushing his/her teeth and lack of effective daily hygiene by caregivers.
- Specific behaviors of the child with SHCN that prevent the caregiver from providing thorough hygiene.
- Frequent consumption of carbohydrates, starches and nutritional supplements, including the use of sugars and starches to reward the child with SHCN in school programs and/or at home.
- Frequent use of oral medications that contain sugars or dependence on nursing bottles for feeding rather than age appropriate foods.
- Poor chewing and swallowing that allow the food to remain in the mouth and repeated vomiting so that swallowed foods and/or stomach acids enter the mouth.
- Medications (anti-seizure or behavior control) that may cause dry mouth, ulcers or gum swelling, and any condition that makes mouth tissues sensitive (cold sores or ulcers).
- Crowded teeth which make oral cleaning more difficult, excessive drooling, self-abusive behaviors, and birth defects that make feeding difficult."[9]

APS CareConnection® is the infrastructure of the healthcare neighborhood – linking medical and dental homes to pharmacy, lab, and specialty care data.

Poor children are at increased risk for poor oral health and sometimes tragic circumstances are needed to elevate concern to actionable levels. Special needs children are also "more prone to have higher levels of unmet need, yet lower levels of use of dental services than healthy children."[10] Key barriers to delivering dental care to this population include "office limitations to accommodate a special needs child, scheduling complications, inadequate reimbursement, children's behavioral problems, few dentists with appropriate training, burdensome paperwork, and managed care."[11]

In order to mitigate these challenges, APS' approach will be to implement a Dental Home campaign to encourage Enrollees to identify a local dentist with whom they can establish a relationship. The Dental Home concept encourages a positive relationship between provider and Enrollee as both parties will have the opportunity to develop trust and rapport with one another. If Enrollees feel more comfortable with their dentist, they are more apt to keep their scheduled appointments, accept valuable education regarding the importance of oral healthcare and comply with the dentist's recommended treatment regime. At the same time, dentists will feel more comfortable with Enrollees and willing to accept more Medicaid Enrollees.
To mitigate challenges associated with treating special needs children, APS proposes to identify special needs practices with the help from Pennsylvania's HCQUs to ultimately provide caregivers more dentist selection.

[9] Mitchell, J. Gaskin, D. *Dental Care Use and Access for Special Needs Children.* March 2007.
[10] Mitchell, J. Gaskin, D. *Dental Care Use and Access for Special Needs Children.* March 2007.
[11] Mitchell, J. Gaskin, D. *Dental Care Use and Access for Special Needs Children.* March 2007.

D. The selected Offeror must make dental outreach calls to new Enrollees who have dental benefits and annual calls to caregivers of Enrollees under the age of twenty-one (21) to remind them to schedule a dental appointment. Describe the extent to which the Offeror, upon Enrollee request, will help Enrollees find a dentist who is accepting new clients. Include the process for identifying dentists who will serve MA recipients. Describe the Offeror's follow-up strategies for confirming appointments have been kept and providing assistance in rescheduling and logistics to assure reasonable optimization of treatment compliance in the event of a missed appointment.

In accordance with **Draft ACCESS Plus Agreement, Section B.13 – Dental Outreach Services**, APS will conduct dental outreach to all new Enrollees who are eligible for dental benefits. Our Care Coordinators will be responsible for making annual calls to caregivers of Enrollees under the age of twenty-one (21) to remind them to schedule an appointment with a dentist. As stated in our responses above, APS will assist Enrollees in obtaining necessary dental care whether they are referred by their PCP, call APS directly for assistance, or proactively reach out to. We see our role as the Enrollee Advocate and will do what is necessary to work with providers and enrollees to ensure that enrollees obtain necessary oral health services. This outreach effort includes:

- Assisting Enrollees in identifying dentists who are accepting new patients – APS' Care Coordinators will check the BFFSP list of enrolled MA providers to identify dentists within their area as well as the Specialist Resource and Referral database. If a new enrollee has an established relationship with a dentist, APS will reach out to that dentist to engage them in becoming a Medicaid provider if they do not already participate. Once a dentist is identified, the Care Coordinator will then call the dentist's office to verify whether they are accepting new patients. The Care Coordinator can then assist the Enrollee is scheduling an appointment as well as coordinating transportation if necessary. If the dentist is not accepting new patients, the Care Coordinator will exhaust all avenues to locate a dentist who accepts new patients, including contacting the Department.

- Assisting Enrollees in scheduling appointments - If Enrollees are referred by their PCP for dental services or an Enrollee calls APS for dental services, our Care Coordinators are responsible for checking the Specialist Resource and Referral Database to locate an available dentist, informing the Enrollees (or the Enrollee's caregiver) of the dentist's appointment availability, and assisting with scheduling an appointment.

- Establishing follow-up strategies to ensure appointment and treatment compliance – APS will improve appointment and treatment adherence through communication and interventions from Care Coordinators and Health Coaches. Once appointments are made, Care Coordinators will reach out to Enrollees (and their caregivers if appropriate) to remind them of their upcoming appointment, explain the importance of keeping their scheduled appointment, and help Enrollees overcome any barriers to access to ensure appointments are kept (e.g., secure transportation to the appointment if requested). Care Coordinators will also follow-up with the dental office and Enrollees' caregivers to verify the appointment was kept, and to assist in rescheduling any missed appointments. If an Enrollee missed his/her appointment, our Care Coordinators are responsible for identifying the reason for the missed appointment (e.g., coordinating transportation), reinforcing the importance of dental care, and documenting appointments in APS CareConnection®. This information will alert the PCP office to educate Enrollees on the importance of dental care and further encourage them to keep their scheduled dental appointments.

E. Describe how the Offeror will provide orthodontic care management to Enrollees who are approved for those services.

APS' approach to providing orthodontic care management to Enrollees will be part of our Dental Home campaign. This campaign will encourage Enrollees to choose a dentist with whom they can build a relationship based on trust and respect, and who can manage all their oral health needs including orthodontist care. By creating a new provider and patient relationship, we hope to foster more informed Enrollees who understand the connection between medical and dental healthcare, who comply with recommended treatment regimes from dentists that they believe in, and who keep scheduled appointments with orthodontists referred by their Dental Home.

APS' Care Coordinators will also reach out to all Enrollees identified by BFFSP and approved for comprehensive orthodontic treatment to help them comply with prescribed treatment regimens. Specifically, our Care Coordinators will be tasked with reaching out to the orthodontist office authorized to perform the treatment to obtain information regarding scheduled appointments for the Enrollee, as well as the caregivers of Enrollees, to remind them to keep the scheduled orthodontist appointments. APS will track the frequency of orthodontic pre-authorizations with the case start reports we receive from orthodontists. For those who were approved and did not have a case start date, Care Coordinators will make follow-up calls to caregivers and Enrollees to encourage them to complete the care as well as to provide education on the value of completing the orthodontic care that has been approved.

Lastly, our Care Coordinators will follow-up with the orthodontic office and Enrollee caregivers after scheduled appointments to verify that the appointment was kept. If an Enrollee was unable to keep their appointment, the Care Coordinator will identify barriers to access and assist the Enrollee in managing logistical issues (e.g., facilitating transportation) to help ensure scheduled dental appointments are kept, and to optimize treatment compliance.

II-3 Work Statement

12. TRANSPORTATION

A. The selected Offeror must assist Enrollees with arranging non-emergency transportation for appointments and Disease Management Services. Describe how the Offeror will coordinate with the Medical Assistance Transportation Program (MATP) and what type of alternative transportation methods, if any, the Offeror will use to coordinate Enrollee services.

APS has a wealth of experience assisting Enrollees with arranging non-emergency transportation for appointments and disease management services, and will do the same for Enrollees of the ACCESS Plus Program. We prescribe to an Enrollee-centered model for disease management which reflects the holistic nature of our care management paradigm. Our *model* is active in several state Medicaid disease management programs including [redacted], [redacted], [redacted] and [redacted]. Within our model, we view Enrollees and their families within the context of their ability to access and utilize services, their community, and their treatment needs. Our Health Coaches-- nurses trained in chronic illness management and behavior modification-- and Care Coordinators-- individuals specially trained in locating social support systems and resources – work with program Enrollees to obtain specific information on access and preferences, including transportation resources. They work with Enrollees to find resources as needed, including transportation to office visits, food, clothing, etc. For example, we provide Enrollees with the Persons with Disabilities Rural Shared-Ride Transportation Program (PwD) Fact Sheet, which we have included as **Exhibit 10.** As part of our assessment, APS Care Coordinators and Health Coaches document information on Enrollees' barriers to care that may pose a risk for non-adherence such as transportation, functional limitations, financial, educational, psychosocial, language/cultural or social isolation issues; and functional and psychosocial status and lifestyle risk factors, co-morbidities, etc. APS is also familiar with Pennsylvania's Medicaid Policies and Procedures on non-emergency transportation vendors and will coordinate with the Medical Assistance Transportation Program (MATP). Point of contact information for each transportation vendor, with information about regions served, hours of operation, and requirements for advance notice, will be accessible through our information system, APS CareConnection®. Health Coaches and PCP offices will be able to identify the relevant MATP provider for each Enrollee and contact that vendor on behalf of the Enrollee to schedule transportation.

During implementation, APS will meet with MATP providers to develop procedures APS will use to interact with providers at the county level, including service maps or routes, formal points of contact for problem-solving, and agreements concerning scheduling transportation on behalf of Enrollees. When requested by Enrollees and/or PCPs and other providers, APS will then be able to access MATP on behalf of enrollees, and arrange for transportation for the Enrollee. If MATP transportation is not available, APS will work to schedule alternative transportation consistent with Appendix A of the RFP, including contacting community organizations that provide transportation support. APS will also distribute any MATP materials the Department generates to all Enrollees as well as PCPs to help ensure that Enrollees are familiar with transportation options.

APS also documents other available transportation in APS CareConnection®, such as public bus routes and taxi services that may be available to Enrollees. We understand that with the rural character of most ACCESS Plus counties, public transportation will be limited, and MATP vendors will be the primary source of transportation. At the county level, other resources may exist that are offered privately. We will collect information about formal and informal transportation resources, such as community- and faith-based organizations that offer subsidized/low cost/free transportation and document this information in APS CareConnection® and the ACCESS Plus website.

II-3 Work Statement

14. PCP SELECTION

A. Describe the orientation process for Enrollees newly eligible for PCCM, Enrollees newly eligible for both PCCM and Disease Management, Enrollees who are reassigned to ACCESS Plus after losing and regaining eligibility, and Enrollees transitioning from another delivery system (e.g., FFS or voluntary managed care).

New ACCESS Plus Enrollee Orientation

APS recognizes the importance of the communication that fully orients ACCESS Plus Enrollees on their program benefits, including the PCP selection process. One of our most important strengths, cited by stakeholders in the policy, consumer and provider communities, is the systems and processes we put in place to share information about our program. We work both hard and smart to serve our customers by using breakthrough technology and creating mechanisms to track contacts that drive informed communications and minimize confusion. We do this by ensuring that appropriate parties have access to the information they need. Every interaction APS has with an Enrollee of our program is captured electronically and stored for easy retrieval.

One of the most important APS strengths, cited by stakeholders in the policy, consumer and provider communities, is the systems and processes we put in place to share our program.

Please note that APS will comply with the requirements stated in the **Draft ACCESS Plus Agreement, Section C.1 PCP Selection**. As part of the orientation process, APS will provide Enrollees who are newly eligible for PCCM services with a variety of information materials that provide an overview of ACCESS Plus, including the PCP selection process. Enrollees can also call the ACCESS Plus 24/7 toll-free number to receive information from our staff about the PCP selection process. However, all Enrollees seeking counseling on the selection of specific PCPs will be directed to the EAP Contractor. APS will hold Consumer Orientation Forums during implementation that will be led by APS' Medical Director, Field Care Coordinators, and Health Coaches. At the Consumer Orientation Forums they will distribute an Enrollee Handbook with program information regarding access, services, support, PCP selection and other procedures. Also during implementation and periodically afterwards, APS will distribute an orientation mailing to all PCCM Enrollees with comprehensive information on the program, a new Enrollee Handbook, pamphlets explaining EPSDT services, and information that specifically addresses the selection of PCPs. On an annual basis we will repeat the forums at the regional level to help ensure that Enrollees understand the PCP selection process and overall ACCESS Plus benefits.

APS will hold Consumer Orientation Forums to distribute an Enrollee Handbook with program information regarding access, services, support, PCP selection and other procedures.

As part of the communications and orientation process for all Enrollees who are transitioning into ACCESS Plus, APS will provide the following information:

- An Enrollee can voluntarily select a PCP through the EAP Contractor. APS will provide the telephone number for the EAP Contractor, and will also work with the EAP Contractor during implementation to establish warm transfer protocols.
- An Enrollee who does not voluntarily select a PCP within fourteen (14) days of his/her ACCESS Plus enrollment effective date will be auto-assigned to a PCP by APS. APS will implement the auto assignment

logic as directed by the Department in the RFP and will review the auto assignment logic annually with the department or as needed. (Please note that APS will notify the Enrollee by telephone or in writing of his or her auto-assigned PCP name, location and office telephone number within five (5) Business Days of the auto-assignment.)

- APS will also explain that Enrollees can obtain information regarding the selection of PCPs through the EAP Contractor, in the Enrollee Handbook, and through the APS Call Center.

Enrollees Who Lose/Gain Eligibility

APS will issue a written notice to Enrollees who are reassigned to ACCESS Plus after losing and regaining eligibility within five (5) business days of receiving the update file from the Department. This notice will inform Enrollees that they have been re-enrolled in ACCESS Plus and assigned to their previous PCP of record. APS will also explain the process that Enrollees can use to change their PCP. The letter will explain how Enrollees can contact the EAP Contractor, and what services are available through the EAP Contractor. APS will also explain that Enrollees can contact APS for a new Enrollee Handbook and what to do if they have a chronic condition that is included in the DM program.

When Enrollees call the 24/7 toll-free number for information about re-enrollment, the APS Call Center representatives will explain that they are re-enrolled in ACCESS Plus and their previously selected PCP has been assigned to them. If at that time the Enrollee requests a PCP transfer, the Call Center representative will offer to transfer him/her to the EAP Contractor. As part of this process the Call Center representative will stay on the line until the EAP representative answers. We will then introduce Enrollees, explain the reason for the call, and ensure that Enrollees are comfortable continuing the discussion before we disconnect from the call.
If the call occurs after the EAP Contractor's hours of operation, our Call Center staff will provide the EAP Contractor's telephone number and hours of operation to the Enrollee. If the Enrollee is not able to call the EAP Contractor during hours of operation, for any reason, the APS Call Center representative will assist with the call and arrange for the EAP Contractor to call the Enrollee.

Please note that APS will re-assign the Enrollee to his/her previously-assigned PCP within twenty-four (24) hours of regaining eligibility unless: the Enrollee wishes to change to a different PCP, the PCP is no longer accepting ACCESS Plus Enrollees, or the Enrollee or PCP has moved to a different location. Since we maintain Enrollee records in APS CareConnection® for the duration of the contract, we can ensure continuity of information for Enrollee Plans of Care, and will update the Enrollee record when a new eligibility record is updated to APS CareConnection®. We will then send an update to the PCP. This process will be used when Enrollees leave the program and when they rejoin.

Enrollees Transitioning from Another Payment System

For Enrollees who are newly eligible for Medicaid or are transitioning from a Fee for Service basis, we will use the standard orientation process that we describe in this section to ensure that Enrollees are aware of ACCESS Plus benefits and requirements.

For these Enrollees, the eligibility files and any available claims history will be used to populate APS CareConnection® so that the PCP can use this information to develop a Plan of Care. For newly eligible Enrollees, the claims data may not be available and only eligibility data will be available in APS CareConnection®.

Enrollees who are transitioning from a managed care organization (MCO) represent a slightly different circumstance. These Enrollees will most likely have PCPs. We will work with the EAP Contractor, the PCPs, and Enrollees to help ensure that Enrollees are able to maintain their PCPs through the transition. This process will also help to address the fact that there may not be claims data for the Enrollee since the MCO will have encounter data for capitated Enrollees. A new PCP would not be aware, for example, of services previously received by Enrollees, their medications, or upcoming immunizations. Without claims data to assist in building a Plan of Care the new PCP might have to rely on hardcopy medical records, notes from the MCO, or information from Enrollees. APS will also work carefully with the MCOs and PCPs to help ensure that the health and treatment history for Enrollees making this transition has been updated to APS CareConnection®, either directly by the MCOs, by the PCP office, or by an APS Health Coach.

In particular, we will highlight the role of the PCP in coordinating services, since this requirement may not have applied to the Enrollee prior to membership in ACCESS Plus. A common problem for Enrollees and providers is the difficulty of obtaining care that requires a PCP referral and the PCP has not provided it. This problem can be avoided for Enrollees new to the PCCM environment by carefully explaining the referral process. APS understands this issue, and will work with PCPs and other providers to facilitate appropriate referrals when Enrollees attempt to access care without them.

Working with the Department's EAP Contractor

In accordance with **Draft ACCESS Plus Agreement**, **Section C.1 PCP Selection**, APS will seamlessly coordinate with the Department's EAP Contractor to assist eligible Enrollees with the PCP selection process. This approach includes developing and following written policies and procedures that clearly identify APS' role in the PCP selection process, including new enrollments, auto-assignment and changes to PCP selections. APS will provide these policies and procedures to the Department's EAP Contractor.

APS will use the weekly enrollment file sent by the EAP Contractor to determine those Enrollees who need to be auto-assigned to a PCP. Please note that APS will comply with the Department's auto-assignment rules including requirements related to the Department's Recipient Restriction (Lock-in) Program when auto-assigning an Enrollee. Specifically, APS will use the following auto-assignment rules:

- If the Enrollee had a claim paid to a participating ACCESS Plus PCP within the past six (6) months, APS will assign the Enrollee to that PCP.
- If not, APS will determine if a family member is already assigned to an ACCESS Plus PCP. If so, we will assign the Enrollee to that PCP.
- If no family member is already assigned to an ACCESS Plus PCP, we will assign the Enrollee to the PCP with an open panel closest to the Enrollee's home. If the Enrollee is under the age of twenty-one (21), we will make every effort to assign the Enrollee to the closest pediatrician. If multiple PCPs meet this criterion, our auto-assignment algorithm will rotate through the PCPs using random assignment.

APS will work with the Department to review the auto-assignment algorithm at least annually, or upon Department request.

B. Enrollees may request a Specialist to serve as the Enrollee's PCP. If Provider enrollment does not occur prior to the Enrollee's assignment to ACCESS Plus, describe how the Offeror will coordinate the Enrollee's care until the Provider's enrollment is effective.

For some Enrollees a Specialist may be the most appropriate PCP. For example, women may choose an OB/GYN Specialist as their PCP; Enrollees with diabetes may need a Specialist as their PCP and Enrollees who have cardiac conditions or who previously underwent heart surgery may request that a cardiac Specialist serve as their PCP. If the provider has not previously enrolled in ACCESS Plus, APS will assist the provider with enrollment, including having a Provider Representative visit the office to assist the provider in accurately completing and signing the Supplemental Agreement so that enrollment can be expedited.

APS will comply with the requirements regarding the selection of Specialists as Enrollees' PCPs as detailed in **Draft ACCESS Plus Agreement, Section C.1 PCP Selection**. Part of this process is to explain how the Enrollee must either voluntarily select a PCP or be auto-assigned prior to being assigned to a Specialist to allow time for the provider enrollment process to occur. Our call center staff will then connect them with the Commonwealth's EAP Contractor so that they may begin the PCP selection process.

However, if provider enrollment does not occur prior to the Enrollee's assignment to ACCESS Plus, APS' Health Coaches will work with the Enrollee's selected PCP to coordinate care until the Specialist's enrollment is effective. For example, our community-based Health Coaches may coordinate referrals to other programs available to the Enrollee (e.g., Behavioral MCOs, Dentists, etc.) and work with the provider and Enrollee to enroll him/her in the ACCESS Plus Disease Management Program if applicable. APS will also notify the Enrollee upon completion of the Specialist's provider enrollment and change the Enrollee's PCP to the Specialist. Subject to approval by the Department, APS will also authorize the Specialist to use APS CareConnection® while enrollment is in process. Access to the Enrollees' Plans of Care, claims and pharmacy history, Health Coach notes and interventions, as well as the ability to exchange information with the PCP, will help to ensure that an Enrollee's Plan of Care remains consistent between Specialist and PCP until enrollment is complete.

APS can authorize Specialists to use APS CareConnection® while enrollment is in process. Access to Enrollees' Plans of Care, claims and pharmacy histories, Health Coach notes and interventions and the ability to exchange information with the PCP will help to ensure that Enrollees' Plans of Care remain consistent between Specialist and PCP until enrollment is complete.

The APS Health Coach will work with both the Specialist and the PCP to ensure that the Plan of Care is appropriate, complete, and updated.

The benefit of APS' information system in this context is dramatic. Far from having to rely on copies of paper records requested from the Specialist, the PCP will have an organized, well-documented Plan of Care and can also reference previous services received by the Enrollee. The PCP can set alerts for the Health Coach, interact with the Specialist either directly or through the Health Coach, and can ensure that questions and concerns receive priority attention.

Via APS CareConnection®, PCPs have access to organized, well-documented Plans of Care, can reference previous services received by the Enrollee, set alerts for the Health Coach, interact with the Specialist either directly or through the Health Coach, and ensure that questions and concerns receive priority attention.

When Enrollees then transition to the newly enrolled Specialist PCP, the Plan of Care remains current and accessible to the PCP. The Specialist can also interact with the former PCP for continuity of services initiated by the former PCP to ensure that ordered services and prescriptions continue seamlessly through the transition.

We understand that not all PCP offices in the ACCESS Plus region may have adequate access to the Internet to take best advantage of APS CareConnection®. In these instances, the APS Health Coach is available to facilitate the relationship between Enrollees and their new PCPs through the Call Center or directly with Enrollees, PCPs, and Specialists. The Health Coach will maintain the APS CareConnection® Plan of Care, which can also be printed and faxed to the PCP office and Specialist to ensure that documentation is current and accurate.

II-3 Work Statement

15. COMMUNICATION STANDARDS AND ALTERNATIVE LANGUAGE REQUIREMENTS

A. Describe how the Offeror will assist non-English speaking Enrollees during the orientation process.

A key component of our program is effectively addressing the needs of non-English speaking Enrollees. As part of the ACCESS Plus Program's orientation process, we will assist Enrollees who are not fluent in English by helping them understand the scope of the program, the program's benefits, how to access services, how to obtain appropriate materials, how to select a PCP, etc. We will accomplish this assistance using a variety of strategies that include the use of interpreters and the production of written materials in different languages. Our goal is to provide a supportive atmosphere that allows for successful outreach, engagement, education and care management with Enrollees whose primary language is not English. Please note that APS complies with all requirements detailed in **Draft ACCESS Plus Agreement, Section C.2 Communication Standards and Alternative Language Requirements**.

APS is deeply committed to ensuring linguistic access for its Enrollees, and to bridging gaps posed by language, culture, and/or disability. We understand that the success of our efforts depends greatly upon our ability to communicate with our Enrollees, as well as our Enrollees' ability to communicate with their providers and support systems. Our policies regarding linguistic access ensure that Enrollees are informed about the availability of linguistic services through written materials and other means, interpreter services are provided at no charge for Enrollees when accessing services, and that Enrollees may not use friends or family members as interpreters unless specifically requested by the Enrollee. Our policies also ensure that face-to-face or telephone interpreter services are available, particularly for discussions of detailed medical information such as diagnoses of complex conditions and accompanying treatment options, or explanations of more detailed plans of care or discussions of complex procedures. They further ensure that informing documents are available to Enrollees in all threshold languages and that Enrollees may file a complaint or grievance if their linguistic needs are not met.

As APS will store each Enrollee's primary language in APS CareConnection®, we can ensure translator services are available to meet the language requirements of the Enrollee and will automatically send program materials in their primary language, if it is a prevalent language.

To meet the specific requirements of the program, our staff will always attempt to identify Enrollees who speak a language other than English, as their first language, during program welcome calls as well as during the orientation process. To streamline communications initiated by APS and for tracking purposes, we will then maintain a record of each Enrollee's primary language in APS CareConnection®, which has already been configured to accommodate this documentation. This documentation will enable us to ensure translator services are available to meet all language requirements of the ACCESS Plus Program membership. It will also enable APS to automatically send program materials in the Enrollee's primary language, if it is a prevalent language.

Furthermore, when delivering educational services via the telephone, APS will first rely on the Omni Network Language Line for individuals who do not speak English. If this resource is not satisfactory, APS will use an interpreter. Because this program will be served by a dedicated clinical team including Case Managers and Health Coaches, APS will make it a priority to hire staff members who are also

bilingual and/or bicultural. We understand that these capabilities, however, may not take the place of certification as an interpreter. Our staff receives ongoing training in both cultural and disability competency, which enables them to better assist Enrollees with limited English skills and Enrollees with disabilities in managing their own care.

Additionally, APS will make all written materials disseminated to English speaking Enrollees available in prevalent languages. Our written materials will be prepared at the fifth (5th) grade reading level and will be translated into Spanish. In addition, directions on requesting materials in other languages will be included with all materials in each of the prevalent languages (as is currently done).

B. Describe how the Offeror will provide and educate Enrollees regarding alternative methods of communication for Enrollees who are visually or hearing impaired or require alternative speech devices.

With APS' experience supporting programs that serve individuals with physical, intellectual, and developmental disabilities, we are aware that the best approach reaches multiple, alternative stakeholders through multiple, alternative notifications.

During implementation, APS will conduct extensive outreach to advocate organizations to help ensure they are aware of alternative communication methods and will help promote this awareness throughout their membership. All provider information will include a special notice that outlines methods for alternative communications. The Enrollee Handbook and the ACCESS Plus website will include a notice to Enrollees with the 800 number for TTY service as well as directions for accessing services for Enrollees who are visually or hearing impaired. APS will also emphasize policies and procedures for staff using TTY/TDD services so as to ensure ease of communication with this service. For Enrollees who are visually impaired, written materials will also be available in alternative formats, including Braille, large size print, and audio format. To help ensure that Enrollees are aware of assistive approaches for visually impaired individuals, we will also create an audio announcement to accompany the ACCESS Plus website that provides the toll-free number so Enrollees can request alternative visual formats.

As part of the communication process, APS will also inform Enrollees and PCPs of these services via telephonic scripts, mailings and in-person interactions of field-based Care Coordinators and Health Coaches. These communications will include directions on how to receive assistance with accessing desired materials in an alternate language or format. Additionally, APS will capture information during orientation on Enrollees' alternative methods of communication (e.g., Braille, etc.) to ensure APS sends materials that accommodate their special needs.

II-3 Work Statement

16. ENROLLEE OUTREACH AND EDUCATION ACTIVITIES

A. Submit sample Enrollee materials for the PCCM Program that the Offeror may distribute.

APS will comply with requirements listed in **Draft ACCESS Plus Agreement, Section C.4 – Enrollee Outreach and Education Activities**. We will also develop all Enrollee outreach and educational materials in the form and context required by the Department, in accordance with **Section B.2, Materials Development and Distribution**.

APS maintains a rich library of Enrollee materials, available in print as well as electronically via our State-specific websites (see screen shots in **Exhibit 1**). We customize Enrollee materials for each program. Customization includes program logos and individual state references. As part of the ACCESS Plus Program, Enrollee outreach activities and educational materials will include the following elements, examples of which are included in **Exhibit 9**:

- Enrollee Welcome Packet and Welcome Call for every new Enrollee, including the Enrollee Handbook. The handbook is also accessible on the ACCESS Plus website. APS will send out welcome packets for Enrollees to receive within five (5) Business Days from the effective date of enrollment into ACCESS Plus, but not before ten (10) days prior to the Enrollee's effective ACCESS Plus enrollment date.

- Primary Care Provider (PCP) Directory (hard copy and online via ACCESS Plus website) with information such as PCP names, addresses, telephone numbers, email addresses (when available), PCP hospital affiliations, languages spoken, sites that are wheelchair accessible, office days and hours of operation, offices where signing or other accommodation (i.e., TTY) is available for those who are deaf or hearing impaired, and an indication of which PCPs not accepting new patients, etc.

- Quarterly ACCESS Plus Bulletins/Newsletters on preventive care, access to PCPs and other providers, health literacy, Department initiatives as directed by the Department, and other information that is helpful to Enrollees. Monthly outreach for EPSDT updates and reminders will also be part of our outreach program.

- Literature, including brochures and posters regarding health or wellness promotion programs. Brochures and posters will be distributed to PCP offices, high traffic retail locations, and local hospital systems. In addition, complementary literature will be mailed directly to Enrollees (in Spanish for Enrollees with Spanish indicated as their primary language, and directions to access materials in other languages).

- Information about Quality Improvement Initiatives relevant to ACCESS Plus Enrollees that we initiate or are sponsored by the Department. Information would cover, for example, consumer incentives or an initiative to increase well care visits for adolescents (to address the low score on the HEDIS[1] performance measure, which also declined between 2006 and 2007 from 53.28% to 50.85%).

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance.

- Information about Utilization of Services as described in Exhibit D, Required Vendor Reports, and Exhibit W, Quality Management Performance Measures, and upon Department request.

B. The Offeror is required to identify Enrollees with special needs, particularly individuals who may benefit from Disease Management or a referral to the Department's Intensive Medical Case Management Unit. Describe how the Offeror will identify and outreach to Enrollees with special needs and ensure that the Enrollee's needs are adequately addressed. Include in the description, how the Offeror will educate Enrollees with longterm special needs who are not eligible for Disease Management (e.g., Enrollees with cerebral palsy) about services and benefits that they may need.

APS understands that Enrollees with special needs require extra attention as they:

- Need services of a type or amount that are beyond what is typically required.
- May have been diagnosed with an Autism Spectrum Disorder.
- Require extensive rehabilitative, habilitative or other therapeutic interventions to maintain or improve their level of functioning.
- May require a Specialist to manage primary care due to the nature of their condition.
- May incur higher morbidity without intervention and coordination in the care of the individual.
- Require care and/or services that necessitate coordination and communication with public and private community service organizations.
- Require coordination of care and/or services between acute inpatient settings and other facilities and community providers.
- Require assistance to schedule or arrange for appointments or services, including arranging for transportation to and from appointments.
- Need language, communication or mobility accommodations.
- Need to be accompanied or assisted by an individual who may act on the Enrollee's behalf when seeking or receiving care.

As part of ACCESS Plus, APS will use pertinent claims data and demographic information about the Enrollee (e.g., Special Needs data collected through the EAP Contractor or directly indicated to APS by the Enrollee or a provider) to identify Enrollees with Special Needs.

Once an Enrollee with Special Needs is identified, we will place a Special Needs indicator on the Enrollee's record or file and an APS Care Coordinator will reach out to them to identify his or her Special Need or circumstance. The Care Coordinator will also ask when the Enrollee had his or her last medical appointment and offer assistance in scheduling an appointment if necessary. Our Care Coordinators are responsible for arranging and ensuring that care provided to Special Needs Enrollees meets their needs and is coordinated with other health, education and human service systems. If necessary, the Care Coordinator will also refer the Enrollee to appropriate services including an APS Health Coach for enrollment in our Disease Management program or the Department's Intense Medical Case Management Unit for case management services if the Enrollee is high risk and does not have one or more of the diseases covered under the Disease Management program. To facilitate this process, APS Care Coordinators will be lay educators, Behavioral Health professionals, as well as trained administrative coordinators. A key concern has to do with Special Needs that develop *after* enrollment, and which may not therefore be documented by the EAP Contractor. Our outreach and education for Enrollees will include a focus on what special needs are and how Enrollees can receive assistance through ACCESS Plus. Our PCP outreach and training will include a continuing focus on alerting PCPs

to Special Needs that Enrollees on their rosters may develop, and the need to notify APS so that we can contact Enrollees to provide coordination and assistance.

APS has extensive experience supporting programs for people with Special Needs. Our DM programs in [redacted], [redacted], and [redacted] specifically address populations in the states' Aged, Blind, and Disabled waivers. Additionally, APS conducts utilization management programs for Arkansas, Florida, Georgia, Maine, [redacted], [redacted], and [redacted] to improve access to and utilization of medically necessary behavioral health services, completing thousands of authorizations daily. With this background, we understand the diversity of experience, interests, and requirements of people with special needs. Our outreach and education programs for Enrollees with special needs will be grounded in this experience, and developed in coordination with the Department. It will include education on:

- Services available to Enrollees with special needs, including autism spectrum disorders (ASD). With programs for people with intellectual and developmental disabilities in five states, APS is very familiar with the complex developmental, physical, and behavioral health issues that people with ASD and their family members face. Our programs for all people with special needs will include preventive and primary healthcare, family planning for adults with special needs, obstetrical/gynecological issues, dental, and vision services, as well as how and when to access and obtain these services. (A special component of our dental outreach will address identification of dentists practicing sedation dentistry, a common request of people with special needs).

- Special purpose brochures, posters and pamphlets to address issues associated with Enrollees with Special Needs, with attention to alternative formats and media to help ensure access to these materials across a broad spectrum of Special Needs issues.

- Health initiatives that target their specific needs, such as smoking cessation for pregnant women, childhood obesity, HIV/AIDS, developmental disabilities, cervical cancer screening, and other services as directed by the Department. Because the Special Need can assume a prominent position in Enrollees' lives, too often not enough attention is paid to basic primary and preventive healthcare. Our programs will help address this issue directly through development of educational programming, and indirectly through our "people first" focus, which always emphasizes the *person* who has the special need, not just the special need itself.

- Our programs will also be sensitive to the language preference of Enrollees as well as other communication barriers, including vision and hearing, speech, and the need for assistive technology to access information. The APS ACCESS Plus website, for example, will speak the ACCESS Plus telephone number when opened in a browser so that Enrollees with visual limitation can easily find this number. We will also maintain information in APS CareConnection® for access by providers and the Department concerning Enrollees' Special Needs.

For Enrollees in the Disease Management (DM) program, APS' educational materials address primary and co-morbid chronic conditions and psychosocial issues, including depression, which is an underlying barrier to chronic care and health status improvement for many Enrollees with chronic diseases. For example, our analyses of 2006/2007 data found [redacted] Enrollees with pharmacy claims for medications associated with depression or anxiety. Costs for these Enrollees were $[redacted] million in medical costs and $[redacted] million for pharmacy costs, or [redacted]% of total costs for Enrollees in the DM program. Behavioral health issues also

compromise realization of DM goals. There were [redacted] Enrollees with chronic conditions in the DM program who filled prescriptions in 2006/2007 for medications used to treat Bi-polar disorder or psychoses. Medical costs for these Enrollees were $[redacted] million for the time period; pharmacy costs were $[redacted] million. APS has also introduced the concept of the "dental home" in our DM programs, helping Enrollees understand critical relationships between oral and physical health.

In addition, our materials and methods take into account functional and cognitive disabilities that Enrollees may experience. For this reason, we offer our educational literature in a variety of formats. A consistent theme of our communication pieces is the reinforcement of health and self-care messages to Enrollees. Improving self-management skills through motivational interviewing is a feature of our DM programming (which we would be glad to share with the Department), delivered through materials such as Self Care Handbooks, Condition-Specific Newsletters and Disease-Specific Tip Sheets. Examples of these materials are in **Exhibit 12**.

APS will take a similar approach to educating Enrollees with long-term Special Needs that are not eligible for Disease Management (e.g., Enrollees with Cerebral Palsy). These Enrollees need specialized information about services and benefits that are covered by ACCESS Plus, including access to special transportation services (see **Exhibit 10**) and special language services. Enrollees also need good access to information about community-based services and other programs (such as supported employment, day habilitation, etc). Finally, Enrollees need information that addresses their primary and preventive health care needs - e.g., information on tobacco cessation, stress management, etc. It is important to understand that Enrollees with special needs are people first – and need access to the same information and services as Enrollees without Special Needs. Information and services may have to be adapted to meet the Special Need but APS understands these accommodations and incorporates them into our approaches to Enrollee Outreach and Education on a routine basis.

Enrollees with Special Needs may need a Specialist to manage their primary care. APS will verify if the Specialist is enrolled in ACCESS Plus. If not, APS will assist the provider with enrollment, including having a Provider Representative visit the office to assist the provider in accurately completing and signing the Supplemental Agreement so that enrollment can be expedited to ensure the Enrollee's needs are met. APS will also provide their PCPs with support services, including training on treating and developing individualized care plans for Enrollees with Special Needs and help in developing individualized care plans for Enrollees with Special Needs. It is also the case that some Enrollees may prefer to keep their Pediatrician as their PCP even after turning 21. In this instance, APS also facilitates this process to ensure continuity of care.

Lastly, for Enrollees with Special Needs involving functional or cognitive limitations that prevent participating in treatment plans and self-management objectives, APS works intensively with families and caregivers. Our Care Coordinators/Health Coaches identify natural and community supports, including agencies able to work one-on-one with Enrollees. Care Coordinators/Health Coaches provide education, advice and support to assist in the understanding of self-management objectives for families and caregivers. Education helps to ensure an understanding of Enrollees' conditions, and ensures families can implement recommended treatment regimens. We know that including people important to Enrollees in all aspects of care planning and delivery is essential to achieving positive outcomes.

C. Describe outreach and education the Offeror will conduct to encourage Enrollees to attend scheduled appointments. Methods may include procedures for tracking missed appointments, conducting follow-up with Enrollees who miss their appointments, identifying and resolving barriers to access to care and offering Enrollee incentives for keeping appointments. Identify challenges associated with encouraging Enrollees to attend scheduled appointments, including barriers Enrollees may face and explain how the Offeror will mitigate these challenges.

Missed appointments are reasons providers frequently offer for their unwillingness to serve as Medicaid providers. Given limited reimbursement and administrative burdens of documentation and billing, treating patients who are routinely "no shows" is an additional disincentive to participation. With our experience supporting Medicaid programs in 20 states and Puerto Rico, APS is familiar with this issue and has developed procedures and systems to address it.

Enrollee Outreach & Education Regarding Missed Appointments

As part of ACCESS Plus, APS will make welcome calls to all newly eligible ACCESS Plus Enrollees identified through the Department's daily eligibility file. Our Care Coordinators will call new Enrollees within eight (8) to fourteen (14) days after the effective date of Enrollment in ACCESS Plus. During the welcome call, the Care Coordinator will discuss the program with Enrollees and emphasize making and keeping routine appointments with PCPs. We help Enrollees understand the important of a medical home, and assist with eliminating barriers (e.g., transportation, etc.) to ensure they receive recommended services. APS encourages PCPs to note their appointments within APS CareConnection® and contact us if their Enrollees miss or continually miss appointments. APS follows up directly with Enrollees to remind them about upcoming appointments. We also assess with Enrollees possible causes for missed appointments, and help Enrollees to overcome such barriers (e.g., scheduling transportation).

Mitigating Challenges of Missed Appointments

Missed appointments are often caused by transportation problems, lack of childcare, concern that the PCP may confirm a suspected health issue, or lack of basic reminder systems – such as not having a telephone. To mitigate these challenges, APS offers PCPs a number of solutions. PCPs using APS CareConnection® can document upcoming appointments. Using our automated reminders, Care Coordinators then contact Enrollees directly to remind them about appointments and identify other reasons for missed appointments. We also encourage Enrollees, PCPs, and other providers to notify us about Enrollees who miss appointments so that we can intervene with reminders, assistance, and problem-solving tools for both PCPs and Enrollees. With an extensive field presence in the 42 county ACCESS Plus region, APS Health Coaches and Care Coordinators will also visit Enrollees who may not have telephones to help Enrollees address barriers to keeping appointments.

This last approach is the most effective one for Enrollees with a pattern of avoiding appointments or who are reluctant to go to an appointment because they are apprehensive about the confirmation of a suspected health problem. Our compassionate nurses help Enrollees understand how important it is to see their PCPs for routine care – and the significant benefits of early detection and treatment of health problems for themselves and their family members. Health Coaches help Enrollees identify resources they will need should a health problem be confirmed and plan for those resources in advance. No one approach addresses appointment-skipping for all Enrollees. APS therefore uses a variety of methods: calls, reminder notes, visits, coordination with offices, and sometimes just a sympathetic ear, to help Enrollees make and keep their appointments.

D. Describe how the Offeror will identify and educate Enrollees who use the emergency department, instead of their PCPs, for non-emergent conditions.

APS will identify whether Enrollees are demonstrating excessive emergency department (ED) usage, including use of emergency departments for dental services, through analysis of utilization claims data. APS will also notify PCPs when Enrollees on their roster demonstrate inappropriate use of emergency department services. APS then engages with the PCP to identify possible causes for non-emergent utilization, such as a need for access to evening hours because of child care needs. We encourage the PCP to discuss emergency department utilization with the Enrollee at their next scheduled appointment and address the issue by providing education on appropriate emergency room visits (e.g., specific symptoms, etc.). This approach also enables PCPs to build trust and rapport with Enrollees so that they feel comfortable with office visits. APS supports the approach through direct contact with high utilizers to also identify Enrollees who need new PCPs, a process we facilitate through the EAP Contractor.

We encourage PCPs to contact APS when they identify issues that may lead to non-emergent reliance on emergency department services. We will then reach out to Enrollees and help them make changes in their care-seeking patterns, assisting with transportation, child care, PCP assignment (if, for example, Enrollees need PCPs who speak their language, have evening or weekend hours, are closer to transportation systems, etc.) and other barriers.

Care Coordinators and Health Coaches are also responsible for educating Enrollees on the proper use of covered services. This education includes appropriate use of emergency departments as well as what to do if Enrollees need immediate assistance scheduling appointments with their PCPs. If during conversations with Enrollees, Care Coordinators/Health Coaches discover that Enrollees have been using emergency room services because they are not comfortable with their PCP, APS will connect the Enrollee with the EAP Contractor to select another PCP. If the reason is due to lack of appointment ability with their PCP, APS will work with the PCP to ensure they are adhering to appointment scheduling standards or assist the Enrollee in locating another PCP by connecting them with the EAP Contractor. The Care Coordinators/Health Coaches will also remind the Enrollee about the 24-hour/7 day Hot Line that they can use to determine whether or not they need to go to the ER.

Additionally, APS will provide information in Enrollee newsletters about the cost and quality of health care. This information will address appropriate emergency department utilization to assist Enrollees in making better informed decisions about health care services. At least annually, APS will also publish costs for common procedure codes as directed by the Department in Enrollee newsletters, and post this information on the ACCESS Plus website.

APS' Field Care Coordinators/Health Coaches will establish relationships and conduct visits to high volume emergency departments. If Care Coordinators/Health Coaches are present while Enrollees attempt to access unnecessary emergency care, APS staff will provide face-to-face education on appropriate care and offer to help Enrollees make appointments with their PCPs. Care Coordinators and Health Coaches or the ED staff can then schedule appointments for Enrollees with their PCPs via a telephone call or My Health Direct®. My Health Direct® (MHD) is an innovative resource-scheduling system that links EDs with PCPs, setting an appointment and printing an appointment notice in the Enrollee's language with the PCP's name and office location. This appointment is then faxed to the PCP office. Through MHD we can also schedule MATP transportation for the Enrollee and fax the appointment schedule to the MATP provider.

E. Describe how the Offeror will communicate program benefits to Enrollees.

Understanding that individuals are unique in the way they process information, APS provides multiple options and media for outreach to ensure high levels of Enrollee engagement. For each of our public sector programs, APS develops State-specific Enrollee Outreach Plans, and will do the same for ACCESS Plus. APS will communicate program benefits to ACCESS Plus Enrollees by mail, phone and in-person, as well as through PCPs, pediatricians, hospitals, community organizations (e.g., FQHCs, WICs, community health centers, etc.), emergency/urgent care facilities, and other key stakeholders with influence on Enrollee health decisions. The Enrollee Handbook will include a summary of program benefits as well. We provide a sample Member Outreach Plan in **Exhibit 13**.

All our mailings are brief, attractive, understandable and informative, culturally sensitive, clearly state the program's toll-free number, and reinforce that the program is free and voluntary. Enrollee materials are also based on important foundations of social marketing, learning theory, health literacy, accessibility and cultural competency. Our materials utilize culturally diverse images and examples and are available in alternative languages and formats. We use the Flesch-Kincaid method to score reading level and reading ease, with our materials typically written for reading levels between fourth (4th) and sixth grade (6th) and a reading ease score between 80 and 90 (easily read by 10-11 year olds). ACCESS Plus materials will be provided in alternative languages and formats (e.g., Braille) as requested to ensure enrollees' access to important program information.

Given that over 64% of ACCESS Plus Enrollees are under 21 years of age with Temporary Assistance for Needy Families (TANF) eligibility, APS will develop educational materials specifically for this population and their families. For example, marketing materials will be designed for and distributed to the parents of potential Enrollees; we will also include coloring books, reading materials for children, and other age appropriate materials. For Enrollees who are between 15 and 18 years old, we will also include specifically-designed material.

Additionally, Care Coordinators will also make welcome calls to Enrollees or Enrollee parents/guardians. As described in Exhibit A, our calls will address at a minimum:

- An explanation of the ACCESS Plus Program and the role of APS' Enrollee Services.
- Collection and/or confirmation of identifying information for the Enrollee and other family members enrolled in the ACCESS Plus Program.
- The availability of oral interpretation and written translation services.
- The role of the PCP and the concept of the medical home, including the importance of establishing a relationship with the PCP before the Enrollee requires care due to an illness or condition.
- An explanation of the EPSDT program, and discussion of whether Enrollees or family members are up to date on EPSDT services.
- When to get a referral from PCPs, and responsibility for payment if they do not (except Emergency Services). We will also explain that Enrollees cannot see Specialists without referral from the PCP identified the Enrollee's ACCESS Plus card.
- How to change PCPs, how to schedule urgent appointments with PCPs, what to do in an emergency, how to access and obtain Behavioral Health and MATP Transportation services, how to make a complaint, and the Department's Fair Hearing process.

- Roles of ACCESS Plus Health Coaches, Care Coordinators, and the Enrollee 24/7 line; the Intense Medical Case Management Unit and the Disease Management Program.
- Language preference of Enrollees and information about special needs; services available to Enrollees with special needs, including autism spectrum disorders, and how to access and obtain these services.
- If Enrollees are pregnant and can provide information about their pregnancy (e.g., have they initiated treatment, and if so, are they maintaining their pre-natal visits frequency).

If the Enrollee has selected a PCP by the time the Enrollee receives the welcome call, APS will also provide information about the PCP selected by the Enrollee, including the address and phone number. If not, APS will connect the Enrollee to the EAP contractor's toll-free phone number so that he or she may select a PCP. Our educational programs also include the activities of our field-based Care Coordinators and Health Coaches, who provide in-person education and engagement to eligible Enrollees at the places where care is delivered (e.g., federally qualified and community health centers, etc.) as well as in Enrollees' homes or mutually selected locations (even McDonald's). We believe that our behavioral change techniques, coupled with our partnerships with local providers, help ensure outreach and engagement success. APS is committed to high levels of improvement in HEDIS and ACCESS Plus program measures. Our outreach and educational programs will focus on these services.

APS' experience from our [redacted] and other programs has demonstrated that this approach not only is effective in engaging Enrollees, but can be used to collect accurate, real-time data that can be integrated into the program's planned approach for assessment of Enrollees at risk for future medical cost. It also is effective in establishing meaningful relationships between Health Coaches and high-risk Medicaid Enrollees. These relationships, often initially formed through this localized outreach strategy, provide a solid basis for ongoing interventions to assist Enrollees in the DM program manage their chronic conditions and achieve overall improvements in health status. We have implemented this model successfully in other states such as [redacted], [redacted] and [redacted]. For Enrollees not enrolled in DM, this approach helps to strengthen the Medical Home, improving primary and preventive care for Enrollees.

Beyond providing program education through more traditional periodic mailings, APS leverages our collaborative partnership approach to provide Enrollee education through other social marketing techniques and vehicles. These methods include:

- **Direct-to-Consumer Strategies.** APS **utilizes principles of social marketing to educate Enrollees**, including direct-to-consumer (DTC) strategies via mail and telephonic contact. Each high-risk DM Enrollee is assigned a designated Health Coach who works with them intensively to monitor their health status, coordinate services, and implement appropriate interventions. Our staff, both field-based and call center-based, are able to tailor their interventions and outreach to the needs of the Enrollees on their caseload.

  Our program uses one-on-one interactions between our clinical staff and selected Enrollees to impact their health – especially for Enrollees in the ACCESS Plus general and DM populations who we have identified with uncoordinated care patterns. APS staff exhibit genuine respect for the individuals they serve, as demonstrated by direct, compassionate communication in all situations. APS is recognized for our strong focus on cultural competency and respect for diversity in our communications and educational programs. Within our care and disease management programs, we have found that providing Enrollees with open access to our Health Coaches is one of the most important components of the program in terms of getting program Enrollees involved in their health and affecting clinical outcomes and ultimately financial

outcomes. For ACCESS Plus, Enrollees can call the 24/7 Enrollee Hot Line to speak with a Health Coach or Care Coordinator. APS Care Coordinators are lay educators, behavioral health professionals, and peers of Enrollees who help Enrollees solve problems with all aspects of the program.

- **Community-Based Strategies.** APS recognizes that public program recipients may change addresses and telephone numbers frequently so they may not receive important material via DTC channels. Therefore, APS makes health education resources accessible within the local communities by placing materials in the provider offices including high-traffic emergency rooms, federally qualified health centers, WICs, community service organizations and even at local health fairs. We also offer to make educational materials available in Department offices, and at those of other Department agencies serving Medicaid Enrollees in the State. Examples of community-based education strategies are:

    - **Posting disease-specific posters** in areas Enrollees visit, such as ER waiting rooms, Community Health Centers, community pharmacies, and Medicaid provider offices.
    - **Posting general health-related posters** in areas Enrollees visit, such as ER waiting rooms, Community Health Centers, WICs, community pharmacies and Medicaid provider offices.
    - **Taking advantage of cable access community affairs programs** in communities throughout Pennsylvania to promote the education of Enrollees.
    - **Exhibiting at community health fairs and events** to distribute disease-specific and general information and screenings to eligible Enrollees, families and the public.
    - **Publicizing health messages via the media**. Advertising events in local newspapers, on the radio, and on television with public service announcements (PSAs). Press releases and contributed articles can also contain information on program highlights and enrollment information.
    - **Providing educational text to the Department that can be posted on statewide web sites**, as well as local stakeholders' web sites.
    - **Working with local extension offices** to develop county-specific and health-related educational programming, such as programs for parents of children with special needs, meal preparation for people with diabetes, or healthy diets for children.
    - **Working with local school systems** to improve delivery of school-based services and ensure school officials are aware of ACCESS Plus and coordinate educational programming for special needs and other children of school age (with parental consent and approval of the Department). Work with schools to heighten awareness of other services, such as immunization needs mandated by state and federal requirements for school enrollment, through school nurse communications.
    - These venues allow APS and the Department to deliver educational messages on health and self-care to Enrollees who we may not be able to reach by mail or telephone. Additionally, these social marketing techniques reinforce the value of the program within the community and to those stakeholders who influence Medicaid Enrollees.

- **Provider-Based Strategies.** Putting educational tools for Enrollees in the hands of providers is another important strategy we undertake. We use APS CareConnection®, which has a specific feature **enabling PCPs and other providers to access health education material**s. In addition, APS CareConnection® offers links to information from nationally-recognized clinical organizations to support providers own office-based chronic care improvement projects and general patient education initiatives.

Educational interventions rendered by local providers can be collected within APS CareConnection®, our web-based community health record solution, so that providers and APS' health coaching staff have access to information that provides a comprehensive picture of education, wellness and clinical management efforts directed toward a high-risk Enrollee. For example, in our [redacted] the [redacted] Health Management Program, we reach a number of eligible Enrollees through connections made by providers at the point-of-care. In APS' experience physicians, emergency room nurses, hospital discharge planners, staff at community health centers or community mental health centers, community organizations, and state agencies are invaluable sources of information to potential Enrollees who would be eligible for care management services.

F. Describe how the Offeror will provide outreach to Enrollees whose eligibility is scheduled to be re-determined.

We will locate and contact Enrollees whose eligibility is scheduled to be redetermined as identified on the Department's monthly file. If possible, we will initiate this process 45 days in advance of re-determination timeframes to ensure that Enrollees are not at risk of losing coverage during this process. For Enrollees under 21, we will contact parents or responsible entities (e.g., Treatment Foster Care). For Enrollees with special needs who may need assistance with communication, we will identify the person who knows them best to help coordinate re-determination. Specifically, our Care Coordinators will explain the re-determination process; detail the steps the Enrollee should take to complete the process, including the information the Enrollee must provide and who to contact; and specify the actions that will occur if the Enrollee does not complete the process or provide the required information, including the loss of benefits. If the Care Coordinator identifies a concern with the Enrollees' understanding of this process and/or ability to complete it, we will identify a Health Coach/Care Coordinator who can visit the Enrollee to make sure the process occurs within necessary timeframes.

II-3 Work Statement

17. ADULT WELLNESS PROGRAMS

A. Describe how the Offeror would develop and implement programs that rely on adult wellness promotion, the prevention of complications and treatment of chronic conditions for Enrollees, as required by the Agreement. Identify challenges associated with designing and implementing wellness programs for a MA population and strategies for mitigating these challenges. Provide examples and descriptions of any existing wellness programs offered by the Offeror.

State Medicaid programs are increasingly looking to wellness programs as a means to not only improve the health of their residents but also to reduce costs related to deteriorating and poor health conditions. It is estimated that the United States' health care costs are approaching $1.8 trillion each year, with States accruing upwards of $21 billion per year to treat chronic conditions such as diabetes, cancer, and cardiovascular diseases – diseases that are often preventable. As moderate exercise, weight loss, and tobacco cessation strategies can save billions of healthcare dollars annually, a focus on wellness programs has become an extremely attractive incentive for States to promote healthy behaviors among Medicaid members. [1]

Furthermore, new flexibility under the Deficit Reduction Act (DRA) has allowed States to customize programs for certain populations, develop more innovative strategies for member engagement, and determine which activities truly work best for them. A number of basic strategies have been identified for State governments to encourage healthy behaviors. These strategies include offering wellness incentives to Medicaid beneficiaries as well as financial incentives to providers to encourage wellness services (such as fee-for-service payments) for Medicaid members. Strategies also include partial capitation or increased payments for primary care case management and capitation payments for managed care organizations, and targeting and customizing Medicaid benefits to wellness by developing benefit packages that address specific benefit needs by region or diagnosis under DRA.[2]

Given the recent trends in Medicaid wellness programs and the Commonwealth's interest in offering wellness services to ACCESS Plus Enrollees, APS both commends the Commonwealth's vision and welcomes the opportunity to develop and implement such programs that will help your Enrollees achieve and maintain healthy lifestyle choices. In accordance with **Draft ACCESS Plus Agreement (Appendix A), Section C.8 – Adult Wellness Programs**, APS will deliver wellness services to Enrollees. Our approach will establish a health promotion and disease prevention campaign that we update annually with input from the Department, which will focus on helping Enrollees remain healthy, prevent complications and treatment for those who are at risk, and encourage appropriate treatment of chronic disease. Our proposed annual campaign includes:

- **Partnerships with Local Providers and Community Businesses** – APS will educate PCPs on wellness services available to their Enrollees and train them on how to order wellness materials, which can be mailed directly to Enrollees homes. APS will also partner with large retail stores such as Walmart to provide them with various wellness program materials. Materials will then be easily accessible to ACCESS Plus Enrollees as they go about their normal activities like shopping for groceries, filling prescriptions, etc.

[1] NGA Center for Best Practices. Issue Brief: Creating Healthy States: Promoting Healthy Living in the Medicaid Program. http://www.nga.org/Files/pdf/0608CREATINGHEALTHYSTATESMEDICAID.PDF
[2] NGA Center for Best Practices. Issue Brief: Creating Healthy States: Promoting Healthy Living in the Medicaid Program. http://www.nga.org/Files/pdf/0608CREATINGHEALTHYSTATESMEDICAID.PDF

- **Leveraging RAC members and Faith-based and Community Organizations** – As part of the RAC meetings, APS will educate RAC members on the importance of healthy behaviors and how wellness services can help prevent chronic conditions. We will also equip RAC members with materials that they can provide to local faith-based organizations, community-based organizations, school systems, senior centers, day care centers, WICs, etc. As a result, Enrollees can access information from various avenues within their community, particularly from organizations like churches that they trust and respect.
- **Partnering with National Associations** - This includes participating in community activities such as Walk-a-Thons sponsored by national associations (e.g., American Cancer Society, American Lung Association, etc.) and providing relevant literature. For example, in our [redacted], our staff have been trained to be exercise leaders through the Arthritis Foundation and offer the arthritis exercise program to various communities we serve. Additionally, we opened our facility for a training day to provide anyone in the community the chance to become an arthritis exercise leader and then offer this program anywhere in the community.
- **Posting Wellness Materials on the ACCESS Plus Enrollee Website** – APS will post health promotion and disease prevention materials (e.g., tip sheets on weight management, healthy heart activities, nutrition, safety, cholesterol management, stress management, tobacco cessation, etc.) on the ACCESS Plus Enrollee website for easy viewing and downloading. The content of these materials will address preventive services (mammography, OB/GYN exams, immunizations, well visits, etc.), and recommended treatment for chronic disease.

Additionally, APS Health Coaches will also be available to ACCESS Plus Enrollees who are in need of wellness services through their dedicated toll-free number. Through active listening and motivational interviewing techniques, our Health Coaches gain an understanding of the Enrollee's health issues, lifestyle behaviors, readiness to change, psychosocial factors, etc. They can then facilitate a referral to the Enrollee's PCP so that he/she can manage the Enrollee's needs in the most holistic manner possible. The Health Coach can also provide supportive wellness coaching and send out wellness tip sheets to the Enrollee until they meet with the PCP.

Challenges of Implementing Wellness Programs & Strategies for Overcoming Challenges

There are a number of challenges that Medicaid Enrollees face in establishing and maintaining healthy lifestyle behaviors related to preventative care. According to the Center for Health Care Strategies, a nonprofit health policy resource center that focuses on "improving the quality and cost effectiveness of health care for Americans with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations," some of the key challenges include limited transportation options (e.g., cost of gasoline, etc.) as well as the high cost of exercise-related programs (e.g., gym memberships, weight watchers, yoga classes, etc.). They are also unaware of the value of regular tests and assessments that can yield valuable information about their health maintenance and don't know how often these evaluations should take place. As part of ACCESS Plus, our Care Coordinators and Health Coaches can easily assist Enrollees in locating wellness-related programs in the community and coordinating transportation with the MATP. Additionally, other Medicaid agencies have developed innovative strategies to overcome the financial barriers of wellness programs. For example, Idaho's Healthy Behaviors Incentive Program created a list of exercise-related vendors in the local community and offers Medicaid Enrollees assistance in paying for physical activity classes. [3] APS would like the opportunity to

[3] Barth, J; Greene, J. (July 2007). Center for Healthcare Strategies, Inc., *Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho*.

discuss options like this with the Commonwealth to overcome barriers and assist Enrollees in engaging in healthy behaviors without the worry of financial burdens. Our goal would be to assist ACCESS Plus Enrollees in gaining access to such beneficial wellness programs. We look forward to strategizing with the Commonwealth on how to achieve this end. APS' program model equips Enrollees with the tools they need to establish and maintain healthy lifestyle behaviors. Please see **Exhibit 14** for supporting articles.

Wellness Program Examples

APS offers a number of wellness services as part of our State Medicaid Programs. For example, our programs in [redacted] and [redacted] are perfect examples of how wellness strategies can enable Medicaid Enrollees to make healthy lifestyle choices.

[redacted] **Administrative Services Program -** In [redacted], APS was awarded the administrative services contract for [redacted] for disease and case management as well as health and wellness services for the traditional fee for service Medicaid population. As part of the program's wellness efforts, APS sends out **general wellness mailings** quarterly to all program Enrollees. Mailings are short, succinct, written at a fifth (5th) grade reading level, and focus on one or two achievable goals. We have found that providing too much information at one time can be overwhelming and discouraging to most Enrollees. By identifying one or two attainable goals, Enrollees feel a sense of accomplishment and have the confidence to continue making healthier lifestyle choices. APS also developed a **network of faith- and community-based organizations** to engage Enrollees in our wellness and disease management programs. These organizations act as educators to Enrollees and help provide referrals to APS for those who need assistance with managing their diabetes, quitting smoking, etc. Furthermore, we offer **Enrollees incentives** including $[redacted] telephone cards for getting their blood tested for five consistent months (verifiable by their provider) as well as a $[redacted] Walmart gift card for completing a Health Risk Assessment (HRA) if name, address and phone number can be verified.

[redacted] **Total Population Health Management Program -** APS' total population management program, ***Healthy Together!,*** provides a comprehensive array of services to [redacted] (Medicaid) Enrollees to facilitate healthy behaviors and self-management of illnesses. Our program uses a variety of strategies, including an annual wellness campaign that promotes preventive health services through multi-media education, partnerships with community resources and personalized wellness coaching. The goals of our wellness and prevention activities include encouraging Enrollees to practice habits that support ongoing health and vitality; improving the Enrollee's ability to be more effective in self-management of his/her health problems (since educated Enrollees seek emergency services less often); and promoting wellness and prevention education to the media and general public. Specifically, the program encourages Enrollee attendance and promotion of wellness and educational events, such as health fairs, blood draws, annual wellness check-ups, and screenings throughout the state; utilizes various forms of public relations and marketing to present messages (e.g., proactive media outreach, issue-specific press releases, fact sheets, and media alerts); and distributes educational materials to Enrollees and their families that explain appropriate use of resources and when to seek medical attention.

To promote lifestyle modifications, we also equip Medicaid Enrollees with the decision making tools they need to improve their quality of life and health. We focus on the social context of behavioral decisions and assist members in developing the personal and social skills required to make positive health behavior choices. Appropriate levels of wellness coaching are implemented to reinforce information from the Enrollee's healthcare providers and assist them in incorporating the behavior into their daily healthcare and lifestyle

decisions. We generate results by supporting clinical interventions with continuous reinforcement through printed, web-based, and verbal education and support. APS will leverage our extensive experience in providing wellness services to developing the most effective and meaningful wellness program for ACCESS Plus.

B. Explain how the Offeror would coordinate the wellness programs with the Disease Management program and other initiatives the Department implements, as applicable.

Given that wellness services are integral to chronic care management, APS' approach embeds wellness services within our disease management programs. Our Health Coaches are seasoned clinicians who provide both chronic care and wellness coaching to help ACCESS Plus Enrollees achieve and maintain healthy lifestyles. We also promote and improve the use of screening services, including EPSDT services and recommended services such as those measured by HEDIS. APS is committed to exemplary customer service and will support current and new Department goals.

APS also welcomes the opportunity to partner with the Department on other initiatives it implements. For example, in our [redacted], APS has also participated in and collaborated with the counties and community in planning yearly Health and Wellness Fairs as well as health and safety fairs where tables/booths provided education regarding healthy nutrition, the importance of proper hand washing, how to increase physical activity, proper dental care and relaxation techniques.

II-3 Work Statement

18. CONSUMER INCENTIVES

A. The selected Offeror will be required to design and implement a Department-approved consumer incentives program to encourage Enrollees to use appropriate services. Describe the Offeror's proposed approach to researching and implementing an appropriate consumer incentives program for ACCESS Plus Enrollees. How will the Offeror provide information to the advisory groups (Regional Advisory Committees and Quality Management Committee) and seek input from these groups in regard to the development of the program?

Proposed Approach to Consumer Incentives

The use of rewards as incentives for desired consumer behavior has increased in popularity with Medicaid programs as the benefits to be gained in functional status and cost management have increased. When appropriately designed and administered, consumer incentives for people with chronic diseases can lead to more appropriate utilization of clinically recommended and preventative healthcare services, greater adherence to medication regimens, and increased adoption of healthy behaviors. In this section we describe our proposed approach to this component of the ACCESS Plus Program.

The Agency for Healthcare Research and Quality (AHRQ) published its Final Contract Report as a decision guide to purchasers.[1] This 2007 report summarizes the literature on consumer incentives and provides a comprehensive (as of that date) reference list of publications that address the topic of consumer incentives. The report is an example of the type of research that APS conducts when developing incentive programs. We also conduct searches on other healthcare policy and program development sites. These sources help identify possible approaches as well as identifying program features that may act as a *disincentive* and which should therefore be avoided. Our proposal draws on information included in the AHRQ report.

In developing an incentive program for the approval of the Department, APS will identify the incentive proposed, provide a rationale for the selection of the incentive and identify the target audience for the incentive program. Additionally, the AHRQ Decision Guide also recommends the identification of goals that are expressed in terms of specific behaviors as well as the selection of relevant performance measures that can be used to evaluate results. A baseline for these measures is also necessary so that results can be assessed against the baseline. We also recommend a basic environmental scan to identify any similar programs that may be available to Enrollees (not through ACCESS Plus) that may influence Enrollee behavior and impact performance measures. For example, local announcement boards in area pharmacies may publicize diabetes support groups when a state-sponsored program is being deployed. The fact that confounding activities may occur is not necessarily a reason to abandon the program. It is important, however, to understand what other activities occur at any given time so that the results of the program are not over- or under-stated.

[1] Dudley, R.A., Tseng, C.W., Bozic, K., Smith, W.A., Luft, H.S. (2007). *Consumer Financial Incentives: A Decision Guide for Purchasers*. Rockville, MD: Agency for Healthcare Research and Quality. AHRQ Publication No. 07(08)0059

Articulating goals for the incentive program helps to ensure that expectations and desired outcomes are explicitly stated and well-understood. Incentives can have unexpected and undesired results especially when the goals of the program are not well thought out and carefully examined. For example, literature indicates that the results of incentive programs for smoking cessation and weight loss do not differ significantly between incentive groups (who attend support group activities and receive incentives) and control groups (who only attend support group activities). Participation in the group seems to be the feature associated with the desired outcome (whether weight loss or smoking cessation). In this example, an appropriate goal for the incentive program might be increasing group attendance, not necessarily weight loss or smoking cessation. It may also be just as effective to make it easier for Enrollees to attend such activities, even without a specific incentive to do so, by offering different hours and locations. This example demonstrates that consumer incentives may not always be the only or the best choice of options to increase utilization of desired behaviors.

Similarly, specifying a target audience for the program is necessary to ensure that incentives are culturally appropriate and represent rewards that are attractive to that audience. Research suggests that consumers will change their behavior when the new behavior is perceived to:

1. Offer benefits superior to those of the existing behavior (*better*).
2. Involve fewer barriers than the existing behavior (*easier*).
3. Be supported by people they value (*popular* with their role models).[2]

Using a data-driven approach to identify opportunities to improve health status and increase utilization of recommended healthcare services, our approach will build on the following strategies recommended in the literature:

- Divide large populations into segments of people who share common perceptions of better, easier, and more popular.
- Prioritize and target segments most amenable to change and focus on consumers for whom change is most important.
- Provide products, services, and communications that effectively compete with existing behavior in terms of what is *better*, *easier*, and more *popular*.
- Monitor and adapt programs to meet changes in segments and perceptions.

This discussion highlights two important criteria in addition to drawing on literature and research. First, the use of eligibility and claims data is an important component of identifying population segments for potential incentive campaigns. As we describe in Section II-3.4, Care Coordination and Intense Case Management, we will populate APS CareConnection® with the PCCM population, not just the DM population. This process will enable us to conduct claims-based predictive modeling with Enrollee data as well as profile Enrollee utilization by demographic characteristics. Profiling these data will enable us to identify populations and subgroups where we can design positive interventions for behavior change. In identifying potential segments, we will also take into account age, gender, and race/ethnicity, demographic characteristics that can aid in identifying target audiences. There are many opportunities to design consumer incentives that represent effective interventions for ACCESS Plus Enrollees, including:

[2] Ibid., page 30.

- Supporting healthy diets for overweight children.
- Encouraging pre-conceptual women to adopt maternity-healthy behaviors.
- Helping women with postpartum depression seek help.
- Promoting appropriate use of asthma medications through complementary incentives in the provider pay for performance program and rewarding families who receive appropriate medications.

Role of the Regional Advisory Committees and Quality Management Committee

We suggest in the appropriate sections that the Regional Advisory Committees be restructured as Regional Ambassador Councils (RAC), and this different role provides insight into ways in which the RAC can play an active part in successful consumer incentives. First, we envision the RACs to include representatives from each county in the region. These individuals will be invaluable in helping us understand the geographic differences in perceptions and values that contribute to positive incentive programs. During the development of these programs, we will discuss potential populations and incentives with the respective RACs to gain understanding of consumer interests and preferences in the regions. This understanding will help us design interventions that meet the criteria of "*better*, *easier*, *popular*."

In addition to providing insight into consumer preferences and interests during the planning process, the RAC will also act as outreach representatives for the program, ensuring that information about the program is accessible to community and faith-based organizations, local Extension offices, public centers, schools, and other forums where Enrollees can learn about the program – *easier.* Their outreach efforts are as significant to the success of the consumer incentive program as their support of the program. In addition, their outreach efforts are fundamental for ACCESS Plus Enrollees because the limitations of mail and telephone communications are well-documented in the Medicaid population. By using alternative communication methods, we will reach the target population with information about the incentive program. Also of importance, many members of the RAC will also be Enrollees, and their support of the program helps to make it a *popular* choice because it is promoted by people who are familiar to Enrollees.

The Quality Management Committee (QMC) also serves an important role to ensure broad provider and stakeholder input. The role of the QMC in consumer incentives is to help prioritize health behaviors that are the focus of incentives by identifying actions that are evidence-based, draw on resources available in the geographic areas, and are also promoted by the Enrollees' PCPs. An additional role for the QMC will be to identify ways in which the P4P program and consumer incentives can be aligned to maximize the benefit of both programs – *better*. The QMC will help us select sound measures to be used in establishing baseline and follow-up performance, and help interpret the results of baseline and follow up performance measures.

B. Identify challenges associated with designing and implementing consumer incentives programs for an MA population and strategies for mitigating these challenges. Describe how the Offeror will determine potential barriers to care and develop effective, appropriate consumer incentives that account for these barriers.

There are many challenges to be addressed in designing and implementing consumer incentives. Communicating the availability and intent of a consumer incentive program is a challenge, as are all communications to Medicaid Enrollees. For programs seeking to promote use of evidence-based healthcare (e.g., cholesterol testing), limitations in health literacy impact the ability of people to recognize what behavior

is incentivized. There is a risk that incentives aligned with a specific behavior may overshadow other appropriate behaviors, for example, a focus on medications at the expense of diet. Mistrust of government-sponsored programs can also limit the effectiveness of incentives in some populations. It is also difficult to accurately predict the extent to which incentives are associated with specific behavior change. Thus, it is important to use available literature to inform the incentive program and then test it. Even with challenges, research indicates that incentives are effective to promote desired behaviors, especially among individuals with limited incomes.

Challenges discussed here highlight the need for context, transparency, and consensus, which are effective in limiting the negative potential of incentives. Navigant Consulting recommends that including providers in the planning process is key.[3] Incentives must be designed and implemented with an understanding of providers' attitudes toward consumer incentives and respect for their views. It is essential that Primary Care Providers (PCPs) be aware of and support consumer incentive programs, since PCPs can reinforce behaviors and may be asked to document delivery of services. PCPs can also help prevent an inappropriate focus on incentivized behaviors in favor of other needed services and so can frame desired behavior in the *context* of health improvement.

Transparency for the program is also important, and empowering the RAC and QMC to be active participants in the process helps to ensure that stakeholders are engaged. A transparent incentive program that draws on literature and evidence and has the support of Enrollees' PCPs, the RAC, and the statewide QMC is a program that is *consensus*-based. The guidance of evidence, coupled with the input and feedback of informed stakeholders, increases the identification of priority health behaviors and meaningful incentives. With this guidance and the approval of the Department, the incentive program will focus on optimal health choices – *better* choices for consumers. Engaged communities make it *easier* for Enrollees to participate. Broad support also demonstrates that role models might participate – increasing program *popularity*.

C. Describe how the Offeror will evaluate the effectiveness of its consumer incentives program. Include a description of any challenges associated with evaluating consumer incentives programs and methods the Offeror would employ to mitigate these challenges.

A priority in evaluating consumer incentive programs is to clearly articulate the goals of the program. If the goals and objectives are not stated in actionable terms, it will be difficult to establish baselines and ongoing measurement of results. Measures that are selected must therefore express the achievement of desired outcomes – utilization of recommended services, enrollment in support and/or activity groups, avoidance of undesired activities and the ultimate goal of the consumer incentive program – improvement in clinical outcomes. It is also important that data for performance measures can be collected efficiently and affordably from reasonably reliable sources. Challenges are thus associated with the difficulty of selecting clear measures, problems with data availability or cost of collection, use of measures that may not be appropriately constructed, or failure to calculate baselines for comparison purposes, and take into account confounding factors in the environment.

[3] Oldham, S. Navigant Consulting: Presentation to Medical Health Plans of America, November 11, 2007.

Mitigating these challenges requires planning, communication, and documentation. During planning phases, APS will consult the literature, conduct data analyses to identify population segments, and identify other programs that may be conducted among the target population or within the ACCESS Plus region. In addition, we will use expert recommendations on measuring performance (e.g., National Quality Forum performance measures and AHRQ recommendations on measuring and reporting quality) to help ensure selected performance measures are feasible, economic, and suitable for reporting to intended audiences. We will also communicate with the Department, the RACs, and the QMC to discuss alternatives. With the conceptual foundation for the program having been designed, it is also important that the program be adequately documented through a formal plan that describes the data used to target the audience; the result of stakeholder comment and feedback; the measures selected and their operational definitions; and factors taken into account in selecting specific incentives (such as gift cards, discounts for products, or "points" that can be redeemed for merchandise).

Testing the program helps to resolve issues with evaluation and impact that may impair the program if not addressed.[4] Since consumer perspectives and health-related choices can be complex and hard to understand, a pilot of the program helps identify program features that do not perform as intended. Once implemented, we will monitor the performance measures selected for the program on a quarterly basis, and make adjustments to the program as needed. These adjustments will be reviewed with the Department and clinical consultants prior to use. As we compile data on utilization, impact, and Enrollee and provider feedback it will be possible to evaluate the incentive program against evidence and goals, and at no less than an annual basis we will formally assess the program and either continue or terminate it.

[4] Ibid.

II-3 Work Statement

19. ESTABLISHING AND MAINTAINING A PCP NETWORK AND RECRUITING SPECIALISTS

A. Describe how the Offeror will develop and maintain an adequate PCP network. Include a description of the process for identifying and recruiting PCPs, including ensuring an adequate number of PCPs to provide EPSDT services. Include in the description any challenges associated with recruiting PCPs to serve the ACCESS Plus population and how the Offeror would mitigate these challenges.

APS' Network Development Experience

APS understands the network development will be a collaborative effort between APS and the Department as well as local professional associations, medical societies, community-based organizations, and other stakeholders. We have extensive experience developing provider networks for both our private and public sector customers including engaging both PCPs and Specialists to increase provider participation in our programs.

APS succeeds in building strong relationships with providers, local community-based organizations and other stakeholders – for provider "buy-in" that improves program participation.

In order to build robust provider networks, our network development strategy focuses on recruiting those providers who can best support the populations we serve and forming strong alliances with our customers' existing provider networks. We identify potential providers by reaching out to those who have historically served members, as well as locating potential providers through researching community health directories, hospital outpatient clinics, national provider associations, state provider listings and references from current providers. As we begin developing the network, we also conduct Geomapping analyses during implementation and on an ongoing basis to assess the geographic availability of the network.

This analysis compares membership data to provider locations, and yields information regarding the percentage and number of members who meet customer-defined access standards. This analyses also includes assessing the demographic and clinical needs of the population relative to the current network and identifying additional areas for development (e.g., identifying areas where the network does not sufficiently address the needs of the elderly, child/adolescent and disabled populations). The results of these analyses shape our network development activities, which are led and overseen by Provider Networks staff to ensure contract compliance.

The State of [redacted] and State of [redacted] are examples of our proven network strategy to re-contract with providers in short timeframes:

- APS implemented the [redacted] EAP contract and contracted with [redacted]% of the existing network in less than 60 days.
- APS contracted with [redacted]% of existing providers for [redacted] in 120 days.

Table 19-1 demonstrates the specific number of providers we successfully contracted with and credentialed for each contract.

Table 19-1 Summary of Selected Network Implementations		
	State of [redacted]	State of [redacted]
Number of Employees/Members	[redacted]	[redacted]
Number of Key Recruitment Sites	16 Cities	29 Cities
Number of Practitioners of Facilities Contracted & Credentialed	53 Facilities 800 Practitioners	136 Facilities 1204 Practitioners
Days to Complete Credentialing and Contracting	60	90

When we asked our clients in the State of [redacted] how they would rate APS' network expansion efforts during implementation, [redacted], Contracts Manager for the State of [redacted] stated:

> "Most impressive. Network development was a high priority, since our Plan will require all MH/SA benefits to be rendered within the APS network. APS secured agreements with all of the existing mental health/substance abuse inpatient and outpatient facilities in the State, and its provider recruitment has exceeded the number of providers that were in the existing network. APS has also achieved a high percentage of overlap with those providers identified as the Plan's "high volume" providers. Communications and updates during the recruitment process were timely and informative, so that our office was aware of the progress of network recruitment efforts at all times. "

The biggest challenge we have experienced with regard to network development is locating qualified providers in rural areas. To overcome these challenges, APS has implemented innovative strategies to increase provider access including recruiting of community service providers and treatment programs that meet our credentialing criteria (which is based upon NCQA standards). For example, for the [redacted], APS developed a unique system of care that included the recruitment of community service providers and development of staff model clinics that place behavioral health resources in areas where historically members had never been able to access care due to the rural landscape of some areas of [redacted]. We have also created credentialing criteria and recruited professionals in rural areas where specific providers do not exist. For example, we have recruited Certified Addictions Counselors (CACs) in areas where access to licensed substance abuse providers is limited. Furthermore, in areas where there simply are no resources, APS' solution is to have the member travel to the nearest provider. In these circumstances we typically use Centers of Excellence, and assist the member in making arrangements for transportation. These strategies have enabled us to break down geographic barriers and provide exceptional care and services to members who do not have access to treatment in their locations.

In addition to our experience building contracted networks, APS has been extremely successful in increasing provider participation in our Pay for Participation contracts in both [redacted] and [redacted]. From our experience, lack of provider awareness of the program, disconnect between providers and their Office Managers, as well as geographic issues (e.g., rural locations) have made provider recruitment challenging. However, we have been successful in building strong relationships with providers, local community-based organizations and other stakeholders, which have resulted in provider "buy-in" in our programs and ultimately provider program participation. For example, for the [redacted] Health and Wellness program where providers are provided financial reimbursements for treatment plan approvals within APS CareConnection®

and program participation, one of the biggest challenges we faced was reaching providers due to resistant Business Office Managers. As a result, APS:

- Presented to the [redacted] Medical Group Management Association to educate them about the [redacted] Health and Wellness program and explain the benefits of program participation such as improving Enrollee outcomes and helping Medicaid Enrollees keep their scheduled appointments through APS' coordination efforts.

- Developed outreach plans that specifically targeted Business Office Managers, and positioned them with the knowledge to present program information and benefits to providers within their offices.

- Designated a team of Provider Outreach staff who were strategically placed throughout the State given the rural landscape of [redacted], and were responsible for reaching out to Business Office Managers as well as providers to obtain program buy-in and participation. As our Provider Outreach staff was extremely knowledgeable on the provider communities in their region in terms of legislation, common provider challenges, etc., they were able to build positive relationships with providers and garner program participation and support.

- Provided a number of local medical and specialty associations, which we were members of, with educational materials as well as language for their quarterly newsletters on our program including the benefits of program participation.

APS has recruited and trained 1,125 providers in [redacted] from April through December 2008 as shown by the chart in Table 19-2:

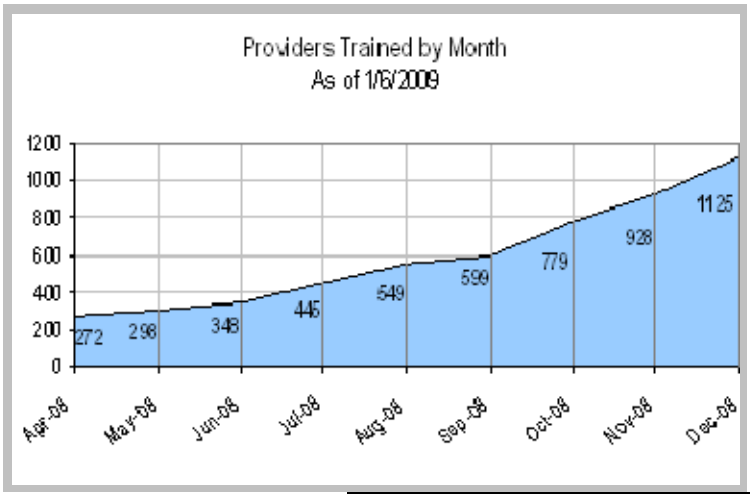

Table 19-2 Count of Providers Trained in [redacted] Program

In June 2007, APS was asked by the State of [redacted] to support their Pay for Participation Program, which included recruiting participating providers. Under this program, participating providers receive increased reimbursement for referring their eligible Enrollees to [redacted] [redacted]! Health Management program; completing specific disease, age and gender screenings; and providing health education for Medicaid patients with chronic illness. As part of the recruitment efforts, APS conducted a claims query to identify top

Medicaid providers, and targeted outreach to those provider offices. Outreach included meeting face-to-face with the provider and staff to provide education on the program and its benefits (e.g., improved billing, more informed patients, increased revenue, and support from APS via health coaching, answering Enrollee questions, reinforcing plans of care, etc.) as well as handing out P4P Information Packets. Similar to our [redacted] experience, provider recruitment was particularly challenging in the State due to resistant providers as well as resistant Business Office Managers who acted as gateways to providers. To overcome this challenge, APS implemented a number of other strategies including arranging for Health Coaches to visit clinics and initiating provider-to-provider outreach through APS' [redacted] Medical Director and the [redacted] State Medical Officer, [redacted]. For example, APS' [redacted] Medical Director and the [redacted] State Medical Officer reached out to [redacted] clinics, and as a result, APS was able to schedule face to face meetings with providers and their staff to gain program support and increase program participation. Through our provider-to-provider effort, we achieved a [redacted]% success rate. Other promotional efforts APS initiated to increase provider participation included:

Currently, 100 provider clinics participate in [redacted] Pay for Participation program due to APS' provider promotion and outreach efforts.

- Launching a statewide promotional campaign in 2008.
- Leveraging "Champion Providers" to promote statewide initiative.
- Presenting to the [redacted] Medical Society, the [redacted] Academy of Family Physicians and the [redacted] Healthcare Commission.
- Providing program education and updates to the Medicaid Physician Advisory Group, comprised of local providers within the community.
- Developing a P4P Manual.

In 2008, our outreach efforts also increased the number of referrals from providers into the [redacted]! Program by [redacted]% in one year. We show the results of our outreach efforts in the chart in Table 19-3.

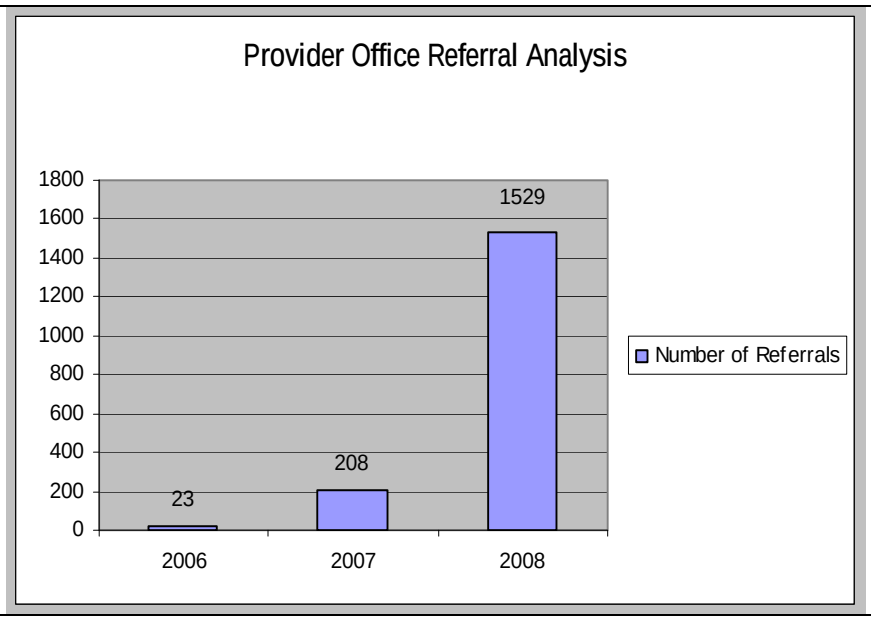

Table 19-3. Results of Provider Outreach

As these results demonstrate, the P4P program brought significant additional value to the [redacted] Program and was a key incentive for providers to join [redacted]! and engage in the P4P program. This program has consistently met guaranteed savings percentages (expressed as a Return on Investment ratio), generating savings of $[redacted] PMPM for aged, blind, and disabled waiver enrollees in 2007.

Network Identification & Recruitment Strategy for ACCESS Plus

APS will leverage our experience to ensure ACCESS Plus Enrollees have access to an accessible and adequate PCP network. Our network strategy will ensure that we establish and maintain an adequate PCP network, as approved by the Department, in accordance with **Draft ACCESS Plus Agreement, Section D.1 – Establishing and Maintaining a PCP Network** – all of which will improve Enrollee access to primary care services and offer Enrollees more provider choices. Our goals for provider recruitment for ACCESS Plus are to:

- Obtain sufficient PCP network capacity to meet the access needs of ACCESS Plus Enrollees.
- Include as many providers as possible who are familiar with ACCESS Plus Enrollees so that they will experience as little change as possible in their provider relationships.
- Identify and include providers experienced in working with special needs populations so that Enrollees who do not currently receive regular healthcare are well served.
- Develop a true partnership with PCPs, promoting best practices for all Enrollees.
- Partner with established state programs and other contractors in our work with the provider community, ACCESS Plus Enrollees and key stakeholders while limiting duplication of any services.

Our field-based Provider Representatives, Care Coordinators and Health Coaches will be responsible for overseeing the PCP network recruitment process for ACCESS Plus. As part of our provider recruitment activities, APS will ensure that the PCP network meets the Department's requirements including but not limited to the following (unless a waiver is issued by the Department after APS has demonstrated a good faith effort toward establishing and maintaining an acceptable PCP network):

- **Adequate Access**. GeoNetworks software will be employed (further described in greater detail in **Question G** below) to ensure ACCESS Plus Enrollees have adequate access to qualified ACCESS Plus providers according to the following standards:
    - Enrollees will have a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). Travel time will be measured via public transportation, where available.
    - Enrollees who want a pediatrician as their PCP will have a choice of two pediatricians with open panels for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).
    - This evaluation also includes assessing whether an adequate number of PCPs are recruited to deliver EPSDT services. Please note that our partner, Pennsylvania State University, Center for Health Care and Policy Research (PSU CHCPR), will assist with conducting Geomapping and related analyses to determine PCP provider network adequacy and to identify areas where additional Specialist, including dentist recruitment, efforts may be needed.

- **PCP Qualifications**. APS will emphasize recruitment of PCPs with appropriate credentials and qualifications:
    - Seventy-five percent to one hundred percent (75%-100%) of the network will consist of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics.
    - No more than twenty-five percent (25%) of the network will consists of PCPs without appropriate residencies but who have (within the past seven (7) years, five (5) years of post-training) clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics.

- **Appropriate PCP to Enrollee ratio to ensure Enrollees have freedom of choice in selecting a PCP**. For example, one (1) FTE PCP will serve no more than one thousand (1,000) ACCESS Plus Enrollees (however APS may decrease the number of Enrollees assigned to a PCP if necessary to maintain the appointment availability standards).

To identify potential ACCESS Plus PCPs, APS' staff will reach out to those providers who currently participate in the MA program as identified by the Department to verify their willingness to participate in the ACCESS Plus program. We will also reach out to other organizations, associations and services such as the State Board of Medicine, local medical schools, the Pennsylvania Medical Society, Pennsylvania Medical Group Management Association, references from MA-enrolled providers, commercial physician identification services, community health directories, hospital outpatient clinics, etc. to identify additional providers.

To overcome similar challenges as described above (e.g., lack of provider program awareness, geographic challenges, etc.), APS will develop an aggressive provider promotional campaign to create "buzz" within the Pennsylvania provider community and generate provider interest in the program. The promotional campaign explains the program and informs providers how to contact APS (via phone and/or email) in order to participate in the program. Specifically, promotional activities include:

- **Introduction letters** to PCPs in the Pennsylvania to educate them on the commencement of ACCESS Plus, introduce them to APS as the contractor and give instructions on how to enroll in the program.

- **Outreach to providers** and their staff through face-to-face meetings, medical society presentations and through outreach to business office managers to inform them about the program and assist with enrollment.

- **Conducting a series of meetings** across Pennsylvania to introduce key personnel and our operations to interested PCPs. We have found this approach to be most helpful. In fact, in one state a meeting a participant commented, "This is the first time I have ever seen our contractors in person. What a nice change!"

- **Identify Provider Champions** who represent the interests of the program to their colleagues and assist with recruitment. We have found that using well respected practitioners to promote participation can be among the most effective approaches to recruitment.

- **Promotion to local Pennsylvania media**. APS recognizes that for an organization to successfully reach its audience in rural environments, such as Pennsylvania, it must utilize principles of social marketing. APS recognizes the power of the media and uses strategies to harness this influence by engaging in proactive media relations campaigns (e.g., public service announcements on television and radio; press releases in newspapers). These venues allow us to reach providers, as well as members of providers' community—such as local public health organizations, legislators and hospitals—that can help influence provider adoption of the program, and ultimately enrollment in the program. We've seen much success in the area of introducing our public programs state-wide to providers.

- **Partnerships with Community-based Organizations and Pennsylvania Professional Associations**. APS recognizes the importance of building valuable partnerships with organizations that can be instrumental in motivating providers about the advantages of ACCESS Plus and the important of their participation. We have found that organizations such as community health providers and state professional associations have the resources and relationships to motivate providers to enroll in ACCESS Plus. In fact, our work with FQHCs and other community-based primary care systems serving Medicaid and low income recipients—which APS developed in [redacted] and the State of [redacted]—has been of great assistance to us in developing these constructive relationships and successful programs. For example, for our [redacted] Health and Wellness program, APS partnered with large hospitals such as the [redacted] and the [redacted] Medical Center to promote the program to their providers including program requirements for participation as well as the financial incentive payments available based on the provider's performance.

- **Informing and Educating those Stakeholders who Support Providers.** APS will educate stakeholders who influence providers to help gain support and ultimately recruitment for the ACCESS Plus Program. Stakeholders that we've engaged in other programs include state legislators, state health organizations, and agencies within the state health and human services departments.

- **APS website**. Information will include program benefits as well as details on enrollment.

- **Involvement of the Quality Management Committee.** APS will involve the Quality Management Committee to obtain their input related to provider enrollment to help ensure our enrollment efforts are targeted and effective.

Once a provider, or group of providers, has expressed interest in participating in the program, APS staff will contact them to set up training and enrollment into the program. Our field-based Provider Representatives, Care Coordinators and Health Coaches will be responsible for educating providers on the MA and ACCESS Plus Programs, and assisting PCPs with enrollment into these programs. If the department determines that electronic signatures are acceptable, APS can offer network registration through email or via the web. Provider training includes explaining the PCP's responsibilities and answering any questions they may have related to the Supplemental Provider Agreement to ensure the Agreement is signed. APS will then forward signed Supplemental Provider Agreements to the Department's Division of Provider Services for approval within three (3) months of the Agreement effective date.

Once we are notified by the Department of those providers who have been approved for participation in ACCESS Plus, APS will update and maintain our PCP Network Database. APS will also update our PCP Network

as providers' statuses changes for those potential providers who have been pended or rejected as ACCESS Plus Providers by the Department. Please note that APS will not exclude, discriminate or penalize any Provider who objects to the provision of or refuses to provide Covered Services when the refusal is based on moral or religious grounds, and will maintain this information to assist Enrollees with identifying appropriate PCPs.
For those providers who are already enrolled in the MA Program, APS will verify the Provider MA identification information in the Department's PROMISe™ system. For those Providers whose information does not match what is in the Department's PROMISe™ system, including PROMISe™ Provider ID numbers, APS will forward this information to the Department's Provider Services Division on a weekly basis. Once the Provider's PROMISe™ information is verified, APS will note the appropriate indicator type as indicated by the Department (e.g., solo practitioner, group, individual provider commonly working under the group) for each PCP on the file and electronically notify the Department of the PCP's ACCESS Plus participation.

APS will also accept and process the Department's monthly file containing the ACCESS Plus PCP Network as reflected on the Department's PROMISe™ system. APS will then compare this file with our ACCESS Plus PCP Network to identify discrepancies between the files, and submit the discrepancies to the Department for reconciliation.

To ensure an adequate number of providers are available to conduct EPSDT services, APS' strategy involves identifying and recruiting clinics that can deliver EPSDT services. We propose conducting a pilot in underserved areas where clinics offer EPSDT services after normal business hours and on weekends, and then educating Enrollees on the availability of these services. Based upon the success of the pilot, APS could design an incentive program for providers and Enrollees. For example, if the pilot proves to be an effective means for Enrollees to receive EPSDT services but is more difficult for the provider to administer, we could develop a provider incentive program to encourage the provision of EPSDT services. Furthermore, APS will educate providers on the link between the Pay for Performance Program and EPSDT services such as pediatric lead screenings and well child visits, so that they know and can take advantage of providing such services.

B. Describe how the Offeror will work with the Department to identify all current ACCESS Plus PCPs and request that the PCPs sign an updated Supplemental Provider Agreement.

APS will work with the Department to identify all current ACCESS Plus PCPs and request that the PCPs sign an updated Supplemental Provider Agreement. We request that the Department provide APS will a listing of all current ACCESS Plus PCPs. APS' field-based Provider Representatives, Care Coordinators and Health Coaches will then reach out to these PCPs to ensure they sign the updated Supplemental Provider Agreement, which reflects changes made to the ACCESS Plus Program. Our staff will be available to explain the responsibilities of the PCPs as well as answer any questions they may have regarding program changes in-person as well as through the ACCESS Plus Provider hotline. Once we receive the signed Supplemental Provider Agreement, APS will forward such documentation to the Department's Division of Provider Services for approval within three (3) months of the Agreement effective date.

C. Describe how the Offeror will meet Department requirements to assess the PCPs' Americans with Disabilities Act (ADA) accessibility standards. Describe how the Offeror will use the information collected (e.g., how it will share the information with the Department, with the EAP contractor and with Enrollees, etc.).

As part of our network development activities, APS' Provider Representatives will conduct in-person site visits to those offices of PCPs who are new to ACCESS Plus to ensure they comply with Americans with Disabilities Act (ADA) accessibility standards (e.g., wheel chair accessible, parking, etc.). This visit will be conducted during the enrollment process to ensure that provider offices are appropriately compliant with ADA standards as well as their ACCESS Plus contract.

We will also evaluate compliance during the PCP audit, to be conducted on a sample of PCPs annually. Technical auditors will be responsible for assessing whether the provider's office meets ADA requirements. APS currently conducts compliance audits as part of our External Quality Review Organization contracts with the State of [redacted] and the Commonwealth of [redacted]. These audits are conducted using protocols developed by the Centers for Medicare and Medicaid Services (CMS) for the purpose of standardizing compliance and quality reviews. As such, they provide a helpful model for the conduct of the PCP audits. We leverage this experience by proposing one of our External Review Consultants [redacted], to lead the site audit process. [redacted], Executive Director, [redacted] External Quality Review Organization (EQRO) will assist with the development of the site audit process and report. [redacted]. [redacted] has a background in Medicaid and managed care, and has worked with the Commonwealth of Massachusetts to adapt CMS protocols for use with both senior care organizations and behavioral healthcare organizations (including ValueOptions). This background will enable us to implement an efficient audit process that generates feedback useful to PCPs and the Department through a comprehensive annual report.

With approval from the Department, the information we obtain through this process will be used to assign PCP offices to different levels of compliance: fully compliant, substantially meets standards, meets some standards, and not compliant. We will identify all areas of non-compliance so that Enrollees are aware of differences between PCP offices in this regard and can make informed choices about the extent to which offices meet their requirements. PCPS may request an updated assignment if they have made improvements that impact ADA compliance and APS Provider Representatives will visit the offices to evaluate the changes. APS will then update the online directory to indicate the changes in the office status. In this way, offices that meet standards and also make improvements in areas where they do not meet standards will be readily identifiable to assist Enrollees with making a choice of PCPs and office locations. Offices meeting ADA standards will be noted in the PCP directory, along with these assignments. The PCP directory will also be available to Enrollees via the ACCESS Plus website so that they can verify whether a specific PCP's office meets ADA accessibility standards should they need a provider with this accommodation. APS will also communicate results to the Department and the EAP Contractor by sending the PCP directory electronically to the EAP Contractor on a daily basis via secure transfer method such as SFTP or secure email.

D. Describe how the Offeror will recruit Specialists, including physician Specialists and dentists. Include a description of the processes for:

1. Identifying and recruiting Specialists, including dentists, into the MA program. Include in the description any challenges associated with recruiting specialists to serve the MA population and how the Offeror would mitigate these challenges.

APS' network recruitment activities for Specialists, including dentists, will be implemented in accordance with the **Draft ACCESS Plus Agreement, Section D.4 – Recruiting Specialists for Participation in the Medical Assistance and ACCESS Plus Programs**. Specialists include providers among a range of specialties including not limited to obstetrics/gynecology, gerontology, hematology/oncology, pediatric oncology, physical therapy, pain management, dentistry, nephrology, urology, occupational therapy, etc.

To identify Specialists, APS will reach out to those providers who currently participate in the MA program as identified by the Department to verify their willingness to participate in the ACCESS Plus Program. For example, we will identify dentists who will serve MA recipients by referring to the BFFSP list of enrolled MA providers, and will solicit providers who participate in MCO programs but may not yet accept ACCESS Plus patients for counties that border the HealthChoices regions or participate in the voluntary MCO program in ACCESS Plus counties. In areas where there are no MCOs, APS will reach out directly to Specialists to encourage them to accept at least a few Medicaid members, many of whom they may have already treated before. For example, given increases in ACCESS Plus enrollment as a result of increases in the number of people unemployed, some individuals are now receiving benefits through Medicaid who previously were covered by private insurance. Specialists who decide to accept Medicaid patients can then continue to see individuals they have already treated, and maintain the relationship with these patients after they return to work.

APS will contact other organizations, associations, and services such as the State Board of Medicine, the Department of Health, local medical and dentist schools, the Pennsylvania Medical Society, the Osteopathic Society of Pennsylvania, the Pennsylvania Dental Association, Pennsylvania Medical Group Management Association, commercial physician identification services, references from MA-enrolled providers, community health directories, hospital outpatient clinics, etc. to identify additional Specialists who do not currently participate in the MA program. In fact, we have already reached out to local organizations such as the Pennsylvania Chapter of the American Academy of Pediatrics to understand the local issues including access (see **Exhibit 27** for their letter of interest).

For those identified Specialists who are not already participating MA providers, APS will explain how enrollment in the MA program is required for participation, and if the Specialists are willing, assist them in enrolling in the MA and ACCESS Plus Program. Our Care Coordinators are also responsible for explaining Specialist responsibilities to the provider as part of the recruitment process. As part of the recruitment process, APS will provide the Department with the names of Specialists who are interested in providing services to ACCESS Plus Enrollees and who are not currently enrolled MA Providers. At the same time, APS will notify the Department of Specialists who elect not to participate in the MA Program or elect to stop participating in the MA Program including a reason for not participating or discontinuing participation.
APS recognizes that challenges exist with recruiting Specialists, particularly dentists, into the MA program. For example, as reported by the Arc of Pennsylvania "less than 20 percent of the total available dentists in

Pennsylvania participate in the Medical Assistance (MA) program. Of this small percentage, even fewer MA-participating dentists agree to treat MA clients on a regular basis" due to many issues such as missed appointments, commensurate loss of revenue[1], the difficulty of providing services to individuals with intellectual or developmental disabilities, the limitations in reimbursement arrangements permitted by the Commonwealth, and a sense of isolation from the mainstream of Medicaid with limited communication opportunities. Most of these barriers apply to other Specialists as well, and can be difficult to address, especially for specialties that are in scarce supply for the general population. APS addresses these barriers through a consistent and continual recruiting effort as well as direct interventions with Enrollees, for example, to prevent missed appointments. We have also worked directly with Medicaid and other agencies to develop innovative alternatives to traditional office visits, such as email appointments, group appointments, telemedicine, Nurse Triage lines, and peer support in behavioral health. As part of our proposal for ACCESS Plus, we propose a specialized case management function for high risk neonates which includes 24/7 access to Registered Nurses with specialized neonatal experience and credentials. These diverse approaches together help bridge gaps between primary and specialty care – and proactive primary care can help to avoid the need for some specialty care altogether.

As we begin populating the Specialist Resource and Referral database with potential Specialists, Geomapping analyses will be conducted on an ongoing basis to evaluate whether the number of Specialists is sufficient to ensure adequate access to Enrollees. This analysis includes evaluating:

- The anticipated ACCESS Plus enrollment and expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in ACCESS Plus.
- The number and types, in terms of training, experience and specialization, of Specialists required for Medicaid services, and the number who are not accepting new patients.
- The geographic location of Specialists and Enrollees, considering travel time consistent with that of the general public, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.

APS' Specialist Resource and Referral Database will be updated on a monthly basis to ensure PCPs, the Department and APS' staff has the most current information when facilitating Enrollee Specialist referrals. We will also track whether the Specialist is accepting new patients and update this information within the Specialist Resource and Referral Database. Additionally, APS will note whether Specialists' offices meet ADA accessibility standards within our Specialist Resource and Referral Database. Please note that APS will also not exclude, discriminate or penalize any Provider who objects to the provision of or refuses to provide Covered Services when the refusal is based on moral or religious grounds; we will maintain this information within our Specialist Resource and Referral Database to assist Enrollees with Specialist identification.

2. Educating Specialists, including dentists, about the ACCESS Plus Program to encourage MA-enrolled Specialists to see ACCESS Plus Enrollees.

APS will provide MA-enrolled Specialists with education on the ACCESS Plus Program to encourage them to see ACCESS Plus Enrollees. As stated previously, APS' field-based Provider Representatives, Care Coordinators and Health Coaches will be responsible for explaining how the ACCESS Plus Program works, its benefits, their

[1] Position paper of The Arc of Pennsylvania With Regard to Access to Dental Care for People with Disabilities. April 2008. http://www.thearcpa.org/images/position%20papers/Dental.pdf. Accessed February 6, 2009.

specific responsibilities, and how to enroll in the ACCESS Plus Program. Part of this process will focus on how our coordination efforts will help Enrollees keep their scheduled appointments. Other unique features of APS' offerings is the availability of Health Coaches between Enrollee visits who can reinforce treatment recommendations with the Enrollee, provide Enrollee education and answer general Enrollee questions – all of which ultimately takes some of the burden off providers and allows them to address other pressing issues. Furthermore, Specialists will be supported by our team of Care Coordinators and Health Coaches. We will also educate Specialists on APS CareConnection® and its benefits such as access to their Enrollees' plans of care as well as activities of other providers to facilitate communicate and coordination of care.

Additionally, by implementing a Dental Home campaign, we will build positive relationships between the provider and the Enrollee based upon mutual trust and respect. When Enrollees feel they can trust and have a rapport with their dentists, they are more likely to keep their scheduled appointments, take education regarding the importance of oral healthcare to heart, and comply with the dentist's treatment regimen. Dentists are then also more comfortable with Enrollees and willing to expand their capacity for Medicaid recipients. Furthermore, APS will build partnerships with community health providers and state professional associations that are typically influential in motivating providers about program advantages and the importance of their participation. By leveraging established relationships with these types associations, we hope to encourage MA-enrolled Specialists to accept ACCESS Plus Enrollees into their practices.

3. Handling resource and referral issues when access to Specialists, including dentists, is limited (e.g., an Enrollee cannot schedule a Specialist visit within a reasonable timeframe or the Enrollee cannot locate a Specialist).

APS Care Coordinators will be responsible for assisting Enrollees who are having trouble scheduling an appointment with a Specialist (including Dentists) within a reasonable timeframe or who cannot locate a Specialist who meets their needs. Care Coordinators will first access APS Care Connection® to verify whether the PCP identified a particular Specialist for the Enrollee. If a Specialist is not identified, the Care Coordinator will then access our Specialist Resource and Referral Database to locate a number of Specialists who may fit the referral criteria and meet the Enrollee's needs. The Care Coordinator will either call or email the Specialist to set up an appointment, and coordinate transportation if necessary.

Our process also includes working directly with the PCP to expand the specialty type to include additional specialties if possible in the event that our initial approach is unsuccessful, as well as working with the specialty community to identify resources for the Enrollee. This process is conducted with the supervision and direction of our Medical Director, who will be responsible for outreach to PCPs, specialists, and specialty societies. We have found that peer engagement can be successful where outreach by lay personnel is not.

E. Describe how the Offeror will maintain its Specialist Resource and Referral database so it is current and up to date. Describe the information the Offeror would recommend to include in the Specialist Resource and Referral database.

APS will be responsible for establishing and maintaining the Specialist Resource and Referral Database for the ACCESS Plus Program. The database will be maintained directly with data collected from the Supplemental Agreements, and additional data entry conducted by APS Coordinators in our Harrisburg office. This will ensure that PCPs, the Department, and APS have access to the most current information on Specialists when Specialist

referrals are needed for Enrollees. APS recommends the following data elements to be included in the Specialist Resource and Referral Database:

- Specialist Demographic Information: Name, address(es), county, specialty.
- Practice Type: Individual, clinic, multi-practitioner site; multi-specialty location, number of years at each location.
- Office hours and days open (with encouragement for evening hours and Saturdays).
- Panel Information: Open, closed, restricted (including nature of restriction), current number of ACCESS Plus Enrollees.
- Languages available in the office other than English, point of contact for arranging assistive supports (e.g., sign language interpreter) if available. (If not, APS will coordinate this function.)
- Americans with Disabilities Act (ADA) accessibility standards: office status.
- If a dental specialty, availability of sedation dentistry.
- Referral limitations.

We will work with the Department to finalize these data elements prior to implementing the database, which will then become accessible on the ACCESS Plus website as well as through APS CareConnection®. The database will be uploaded to the Department on a monthly basis. The Department's staff will also be able to create a downloadable spreadsheet from the database on an ad hoc basis.

F. Propose approaches to work with the Department to develop and expand the ACCESS Plus PCP network and increase the number of Specialists, including dentists, included in the Specialist Resource and Referral database. Proposed approaches should include strategies for addressing provider shortages in health professional shortage areas (HPSAs) and dental health professional shortage areas (DHPSAs).

APS will work collaboratively with the Department as well as local professional associations, medical societies, community-based organizations, and other stakeholders to develop and expand the ACCESS Plus PCP network as well as increase the number of Specialists in the Specialist Resource and Referral database. The HPSAs and DHPSAs designations are established by the Health Resources and Services Administration (HRSA), and areas may be designated because of an under-served population group, a geographic area, or the presence of public facilities such as comprehensive health centers, rural health centers, federally qualified health centers, federally qualified health center look-alikes, or other public facilities, such as correctional institutions. It is of interest that, according to HRSA, only Monroe County is not designated as an HPSA for medical care, dental care, or mental health care. In Section II-3.23 Disease Management, we provide a brief discussion of our analysis of avoidable Emergency Room (ER) utilization, noting that Erie and Luzerne counties each had between [redacted] and [redacted] avoidable ER visits in 2006/2007. Luzerne County is an HPSA as defined by HRSA for medical (geographic area), dental, and mental health care; Erie County is an HPSA for medical (geographic area and public facilities), dental, and mental health care. This designation helps us understand the context for this volume of avoidable ER use as well as prioritizing our network development activities. One strategy APS has identified is to work with the Pennsylvania Association of Community Health Centers, which is an APS team member, on their workforce development project. In addition to this effort, we will work to establish collaborations between counties to potentially share resources. For example, Wyoming and Sullivan counties were among counties with the lowest number of avoidable ER visits. A potential strategy to address high numbers of visits in Luzerne County, then, might include developing ER diversion strategies that build on

resources in neighboring counties. With the following activities that are intended to build capacity, APS will conduct a consistent, area-wide, and focused campaign to increase the PCP, Specialty, and Dental network for ACCESS Plus:

- APS will market the program as an "extension" of the PCP's/Specialist's office. Our outreach strategy positions our program and staff – from Care Coordinators to Health Coaches – as vehicles to reduce the typical burdens PCPs/Specialists who treat Medicaid Enrollees face. We recognize that many provider offices are understaffed and overworked. We provide reassurance to providers that APS will assist them by:
    - Answering health related and program related questions from Enrollees through APS' toll-free hotline.
    - Providing Medicaid Enrollees with condition-specific educational information.
    - Reinforcing the provider's treatment plan by helping the Enrollee understand the treatments recommended and the importance of following such treatments.
    - Assisting Medicaid Enrollees in keeping their scheduled appointments through our coordination efforts.

- APS will work closely with our partner, Pennsylvania Association of Community Health Centers (PACHC), and their workforce development initiative that focuses on increasing the number of providers in HPSAs. APS will outreach to advanced practical nurse associations as well as dental assistant associations to assist providers recruit office physician and dentist extenders (e.g., Advanced Registered Nurse Practitioner, dental assistants, etc.) to increase capacity within the existing network within DHPSAs.

- APS will identify PCPs/Specialists who participate with the MCOs but do not participate with Access Plus. Once identified, APS will provide information about fee schedule increases that are available under ACCESS Plus as well as the incentive payments that will be offered within the P4P programs.

- APS will promote ACCESS Plus in medical associations (e.g., Pennsylvania Coalition of Nurse Practitioners, etc.), specialty society and hospital associations through providing education on ACCESS Plus benefits and details on how to enroll at their meetings, for inclusion in their newsletters and websites. We can also distribute Supplemental Provider Agreements that they can pass onto PCPs/Specialists. Leveraging established relationships of these types associations with APS' thoughtful, but aggressive, outreach activities, we anticipate a good response to program information and positive enrollment into ACCESS Plus.

- In regions where there is no MCO penetration, APS will perform outreach calls to PCPs/Specialists to encourage them to accept at least a few Medicaid members, many of whom they may have already treated before (e.g., patients who are now on Medicaid due to recent layoffs, etc.).

- APS will develop an ACCESS Plus Best Practice initiative to recognize PCPs/Specialists for their achievements in improving clinical outcomes for Enrollees. This award will be shared with the community via various media (e.g., published in local newspapers, radio announcements, etc.). We believe by acknowledging the efforts of our provider partners and showing the appreciation of the program, some PCPs/Specialists may be more encouraged and willing to participate in ACCESS Plus.

- APS will implement a Dental Home campaign to encourage Enrollees to identify a local dentist with whom they could establish a relationship. The Dental Home concept encourages a positive relationship between provider and Enrollee as both parties will have the opportunity to develop trust and rapport with one another. Confidence in the relationship helps improve Enrollee adherence as well as Provider willingness to treat.

- APS will identify and utilize PCP and Dental champions – who represent the interests of the program to their colleagues and assist with recruitment. We have found that using well respected practitioners to promote participation can be among the most effective approaches to recruitment.

If necessary, APS can also offer the Specialists teleconferences that focus on medication management and provide a forum for them to ask questions related to medication management. For example, psychiatric Medical Directors in our [redacted] Quality Improvement Organization Program conduct telephonic grand rounds to assist providers with medical management questions and concerns.

As part of the implementation process, we would like to sit down with the Department to discuss our experience in recruiting providers through successful programs such as [redacted] and [redacted], as well as lessons learned during the process. Our Field Care Coordinators, who will also have experience with the provider community and the challenges they face, will be another asset to the APS team as they can help shape our network recruitment and outreach plan.

G. Describe how the Offeror will use geomapping analysis to determine PCP provider network adequacy and identify areas where additional Specialist, including dentist, recruitment efforts may be needed. Describe how the Offeror will account for open and closed provider panels in its analysis. Include samples of provider network geomapping analyses the Offeror has conducted, if available.

APS' network strategy is focused on ensuring ACCESS Plus Enrollees have adequate access to qualified ACCESS Plus providers. A key tool in this process is the GeoNetworks application, an industry standard software package for analyzing and communicating the accessibility of networks, which will enable us to conduct targeted Geomapping analyses for the ACCESS Plus Program. GeoNetworks is used by virtually every major managed care network and healthcare consulting firm in the nation, and produces presentation-quality maps, graphs and tabular reports that are widely recognized as the industry's best for analyzing and communicating network accessibility. The software provides sophisticated analytical capabilities to quickly and easily communicate and report on the geographic density and dispersion of network providers compared with a customer's Enrollee locations via eligibility files.

As stated above, APS' partner, Pennsylvania State University, Center for Health Care and Policy Research (PSU CHCPR), will be responsible for conducting Geomapping and related analyses to determine PCP provider network adequacy and to identify areas where additional Specialist, including dentist recruitment efforts may be needed. As a result, we will be able to determine if our PCP network meets the contract's requirements (e.g., whether ACCESS Plus Enrollees in urban areas have access to at least two (2) PCPs within 30 minutes, etc.) and identify those areas where additional providers are needed to help shape and direct our network recruitment activities. APS will conduct Geomapping analyses (see **Exhibit 15** for a sample) on at least quarterly basis and upon request from the Department.

As part of this analysis, APS will use provider files that differentiate between open and closed provider panels to ensure that our Geomapping analyses reflect those providers who are accepting new patients and can provide services to ACCESS Plus Enrollees. Geomapping reports will detail the number, location and specialties of PCPs and Specialists with open panel slots, and the number of ACCESS Plus Enrollees who reside within the specified Provider access standards. Through our Geomapping analyses, APS will be able to determine and help ensure the network is adequate and accessible to ACCESS Plus Enrollees.

II-3 Work Statement

20. PROVIDER EDUCATION AND TRAINING

Training and technical assistance are a cornerstone of APS' approach to services that emphasize quality improvement, provider participation, and appropriate and efficient use of services. The positive outcomes in our [redacted], and [redacted] operations are based upon extensive collaboration with state officials, providers, and recipients in addressing system needs for improvement in clinical, administrative, and fiscal functions. In developing the training program, APS will provide a thoughtful provider training model for the Commonwealth of Pennsylvania.

This model assures that we complete an annual Training Needs Assessment, so that programs are responsive to perceived system strengths and weaknesses. This model also ensures that provider feedback from the annual satisfaction survey and ongoing provider meetings are also included in this analysis of training activities. From this comprehensive analysis, APS develops an Annual Provider Training Plan. This plan contains goals for formal training and informal technical assistance activities for providers and the system of care as a whole. APS distributes a comprehensive Training Evaluation Form after each training session and each form is tabulated when training is complete. In conducting training as part of a process of continuous quality improvement, APS incorporates the results of these training sessions and evaluations into the Annual Provider Training Plan, updating it as needed.

A. Submit a draft education and training program/outline for both PCCM and Disease Management Providers.

APS has a comprehensive library of clinical information, including numerous PowerPoint presentations, on a variety of clinical topics. All clinical information is based on nationally recognized evidenced-based guidelines, which we have developed for other state government programs. APS will compile these and other printed materials for disease-specific guidelines for the highest volume, highest impact conditions. These will include:

- Asthma: National Asthma Education Program
- Diabetes: National Diabetes Education Program
- Cholesterol: National Cholesterol Education Program Adult Treatment Panel III
- Hypertension: JNC-V11 for hypertension
- COPD: GOLD Standards

APS has a comprehensive library of clinical information on a variety of clinical topics, all based on nationally recognized evidenced-based guidelines.

Additionally, APS will provide linkage via the provider website to extensive listings of guidelines for a full range of conditions and patient variables. We will encourage Pennsylvania providers to share this rich clinical education information with their staff in an effort to improve the care of their patients. APS brings a history of successful provider training *in Pennsylvania* through our Southwest Health Care Quality Unit (HCQU, which we describe in the experience section). **Exhibit 16** includes selected materials from topics that APS HCQU staff has developed and presented in the last 12 months such as:

- Diabetes Management
- Foot Care
- Smoking Cessation
- Autism and the Hospital Experience
- Dysphasia
- Seizure Disorder

- Weight Management
- Prevention of Falls
- Heart Disease
- Autism
- Psychotropic Medications
- Traumatic Brain Injury
- Substitute Decision Making
- The Role of the Psychiatrist in Developmental Disabilities

In addition to being a clearing house for providers on nationally recognized evidenced-based treatment guidelines, APS believes in the value of looking closely at the local population—via our Gap Analysis informatics profiles and stakeholder feedback—to determine what education on guidelines may be needed to improve the care of a specific population. For example, in Wyoming asthma is the most prevalent medical condition within the Medicaid population. Access to allergy and respiratory specialists is very limited so many PCPs, who are treating a multitude of other chronic illness, are the sole providers of diagnosis and treatment for adults and children. Realizing this is a complex job, especially with rapidly changing protocols on treating asthma, APS developed a provider tool kit for practitioners, general practitioners, pediatricians, internists, physician assistants, and nurse practitioners. The kit, in **Exhibit 17,** includes a pocket card for quick reference on treatment protocols, medication management guidelines, and educational tools for patients that providers can use.

Outline of Provider Training Program

APS will provide Continuing Medical Education credit for PCCM and DM training programs through APS' partner, the Pennsylvania Association of Community Health Clinics. APS will include agenda items in training sessions as listed below. The combination of agenda items for any given set of sessions will be determined with input from providers, the QM Committee, and the Department. APS will comply with the **Draft ACCESS Plus Agreement, Section D.9** on training schedules, notification, and formats.

- **The ACCESS Plus Program.**
  - Expectations of the provider in the program.
  - Communication work-flow, including communicating with Care Coordinators and Nurse Care Managers/Health Coaches on Patient Care Plans.
  - EPSDT services, authorization process, and reporting requirements.
  - Prior authorization requirements and process.
  - Provider and Enrollee rights and responsibilities.
- **Medical Home and DM Program Improvement.**
  - Establishing a medical home in primary care settings.
  - Tools for physician offices to implement the chronic care model.
  - Methods for process improvement to enhance workflow and patient outcomes, including tips on working with Medicaid clients.
  - Pay for Performance (P4P) results
  - HEDIS performance measure results
- **Analytic results from APS Health Intelligence and APS partner, Penn State CHCPR.**
  - Geographic analysis of regional variation.
  - Comparative practice profiles by region, condition, and Enrollee demographics.
  - Translating research to practice.
- **Update on clinical guidelines for patients with chronic illness and prevalent ACCESS Plus enrollee conditions.**
  - Topics such as the GOLD standard for COPD; performing foot exams and treating neuropathy

in diabetes; the use of ACE Inhibitors in congestive heart failure; Wellness care, immunizations and health promotion; and EPSDT requirements.

- Provider performance measurement and pay-for-performance payments.

Training and Education for Professionals

APS recognizes that training programs for professionals must be designed around topics relevant to attendees and collaboratively conducted. For this reason, not all training topics will be presented by APS. For example, our analyses will identify best practices among ACCESS Plus providers in terms of service delivery, adoption of evidence, and work flow. APS will invite providers to showcase their best practices and share them with other PCPs. We also propose special resources to help ensure the quality of our training and education programs through APS' partner, Black Consulting Services. Education is a *core capability* for Black Consulting, a Pennsylvania Women-Owned Business Enterprise, Their instructional development specialists will support all providers and Enrollees to ensure the quality of all ACCESS Plus educational offerings.

B. Describe how the Offeror will educate Providers on the payments for Provider Pay for Performance.

This aspect of training will be a priority for the ACCESS Plus Medical Director, the Pay for Performance Coordinator, the Provider Services Manager, and the regional Provider Representatives. During implementation we will prepare regional-level and blinded P4P profiles of participating providers using historical claims data to illustrate the opportunity for providers to benefit through improving service delivery to Enrollees. The benefit of this material is to illustrate the extent to which providers can augment their reimbursement by providing recommended services to Enrollees – "doing well by doing right." We will provide formal training sessions at the regional level during implementation (organized with the same regions as the current Enrollee Regional Advisory Committees), where the ACCESS Plus Medical Director will present the P4P program in detail, including examples of payment amounts, timeframes, and data collection methods. In addition, the Provider Newsletter will include reminders about P4P measures, upcoming data submission deadlines, and clinical evidence from guidelines and literature to remind providers that P4P services are recommended and important services for Enrollees with specific conditions. The Provider Representatives and Health Coaches will also have a standard information packet on the P4P program to leave with provider offices as reminders of the P4P program and instructions on how to enroll.

II-3 Work Statement

21. PCP SERVICES

APS has earned its reputation as a provider-friendly company through exemplary customer service in each of our 41 Medicaid programs in 20 states and Puerto Rico (which we discuss in Section II-4, Prior Experience). We have a diverse service offering that is organized around program management and improvement – through these services we have worked with primary care clinics, physicians, advance practice nurses, dentists, psychologists, waiver providers, specialists, and facilities. We currently conduct over 300 on-site inspections of care on an annual basis and understand provider workflow, record management, and facility/office structures. With this background, our approach to PCP Services for ACCESS Plus PCPs will be customer-focused, responsive, and focused on quality improvement and patient-centered care.

APS has earned its reputation as a provider-friendly company through exemplary customer service in each of our 41 Medicaid programs in 20 states and Puerto Rico.

A. Describe the Offeror's process for responding to PCP inquiries.

APS uses various systems to ensure provider inquiries are responded to in a timely, accurate and professional manner. Our approach for ACCESS Plus PCPs will comply with the requirements detailed in the **Draft ACCESS Plus Agreement, Section D.10 – PCP Services**. Access for providers via the ACCESS Plus dedicated toll-free number will be from 7:00 a.m. to 8:00 p.m. Eastern Standard Time (EST) Monday through Friday, and from 10:00 a.m. to 2:00 p.m. EST on Saturdays, except on holidays and unless otherwise approved by the Department. The Call Center menu will include an option for PCPs to connect to a Provider Services Representative or the Provider Technical Helpdesk. With several important information tools available to ACCESS Plus providers, we ensure that they can access these resources with live, Harrisburg-based technical assistance available during Provider Service hours. Provider Services Representatives will also be available to address program-related questions and concerns. PCPs expect that the individuals with whom they interact about clinical issues will have significant expertise in specific chronic diseases, program features, and evidence-based care. APS' clinical staff members have expertise in these areas and our policy is therefore that only health professionals can discuss clinical aspects of the program with providers.

ACCESS Plus providers will be able to make a variety of inquiries via the dedicated toll-free number, including to ask questions about the program, ask questions about the website, request clarifications about coverage and Enrollee benefits and make a complaint. We've outlined APS' response to each of these inquiries in the pages to follow.

PCP Complaints about APS or ACCESS Plus

Each complaint is taken seriously and is viewed by APS as an opportunity for improvement. APS follows a consistent procedure in resolving and responding to provider complaints that include the following:

- Documentation of the substance of the complaint within APS CareConnection®.
- Full investigation of the complaint, including any aspects of clinical care involved.
- Actions taken to resolve the issue.
- Notice to the provider of the dispute disposition and the right to appeal, as appropriate.

- A standard resolution time that depends on the nature of the concern and its relation to Enrollee services, but is within 30 calendar days at the most.

An "emergency" concern or complaint will be handled immediately, taking into consideration the medical exigencies, with resolution achieved within 4 hours. All complaints classified as "urgent" will be forwarded to the responsible entity for resolution as soon as possible taking into account the medical exigencies of the complaint, but no longer than 72 hours after APS' receipt of the complaint. An urgent complaint is any complaint that, if unresponded to, has the potential to become a threat to the health or safety of the enrollee. All complaints of that are clinical in nature are reviewed by clinical staff. If the resolution is not satisfactory to the provider, APS may offer other options to resolve the complaint, including referral to the Department. **Table 21-1** illustrates our PCP complaint process.

PCP Complaint Process		
Receipt	Discovery	Resolution
1. Provider Services Representatives (PSR) respond to PCP calls. 2. PSRs document concerns 3. PCP concerns are resolved by PSRs immediately if possible. 4. If concern cannot be resolved, PSRs triage concern/complaint and assign to APS staff member. 5. PSR sets sets status for resolution – within 4 hours for Enrollee emergency; 36 hours for urgent; 5 working days for routine.* 6. APS CareConnection® queues concern/ complaint by staff assigned: Clinical, Medical Director, Executive.	1. DPW notified of concern if Enrollee emergency. 2. Staff research concern/complaint. 3. Staff discusses with PCP, Enrollee, field staff, others as needed. 4. Clinical and other documentation reviewed as needed. APS CareConnection® is updated. 5. APS staff determine cause of complaint or concern and document resolution. 6. Policies and procedures updated to prevent re-occurrence. 7. Staff retraining and/or discipline completed.	1. Complaint/concern logs updated to reflect status. 2. APS management approves resolution. 3. Health Coach, Supervisor or Clinical Director respond to PCP verbally. 4. If resolution is approved by PCP, resolution is confirmed in writing. 5. DPW is notified of concern resolution immediately if Enrollee emergency. *For emergency and urgent concerns updates to policies and procedures, staff retraining and discipline occur after resolution is approved.*

Table 21-1. APS Process for PCP Complaints/Concerns

*All concerns/complaints will be resolved within 30 calendar days. Some complaints may require review of multiple medical records and therefore require longer than 5 days.

If a provider complaint is received in writing, the complaint is processed as described above. All written complaints are given to the Provider Services Department for entry into APS CareConnection®, the tracking system, and then forwarded to an ACCESS Provider Services Representative to facilitate resolution. The PCP will receive a return call from APS to describe the solution. If the PCP is satisfied with the response, the APS Medical Director will send a written response to the PCP. The response will indicate time and date of receipt of the complaint/concern, documentation of the complaint, resolution to address the complaint, and closure of the concern. Providers will also be notified that they have the option of speaking with the APS Medical Director and/or Executive Director, or contacting the Department.

An emergency concern or complaint will be handled immediately with resolution achieved within 4 hours.

Complaints about the Medical Assistance Program

APS will document complaints from PCPs concerning the Program's policies and procedures, and explain to the PCPs that we will refer these concerns to the Department. The Department will be able to access these concerns via our web-based platform - APS CareConnection®, and with a queue that organizes complaints by date. The Department, at its discretion, will also be able to create a spreadsheet with queue items for additional tracking. The APS Provider Services Manager will also refer complaints of this type directly to the Department if this method of communication is preferred.

ACCESS Plus Program Questions and Communication of Changes

Exemplary customer service to PCPs and providers requires that we have office and field staff who have extensive understanding of ACCESS Plus and Medicaid program requirements, the Supplemental Provider Agreement, current status of ACCESS Plus, and the status of their assigned providers as ACCESS Plus enrollees. The Provider Services Representatives will include twelve (12) staff members deployed in the ACCESS Plus region, field-based Technical Specialists, additional office-based clinical and administrative Call Center staff, and technical Helpdesk staff. In addition to assisting PCPs with questions regarding ACCESS Plus, the Provider Services Representatives will also notify PCPs about any changes to the ACCESS Plus Program, as directed by the Department. Our online provider file will include all PCP demographics, enrollment date, current roster, and Office Manager point of contact. When PCPs or enrolled providers call with questions, we will be able to quickly locate the information they need and respond verbally, and/or send materials to the callers' offices the same day as they are requested. In addition, we will be able to provide comparison data regarding provider performance results including (1) Enrollee compliance with self-management care plans; (2) gaps between recommended and actual care provided to Enrollees; (3) Enrollee health status; and (4) utilization statistics.

Educating PCPs about the 18 Visit Limit

APS will provide a variety of educational interventions to PCPs about specific characteristics of the ACCESS Plus Program so that healthcare delivery to Enrollees can be provided within program requirements. For example, the Medicaid Eligibility Handbook, Section 338.12, which describes services for adults, states:

> Up to a combined maximum of 18 clinics, office and home visits (specific evaluation and management procedures) per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics, and FQHCs. NOTE: Only a specific list of billable procedures count toward this limit.

Because of this limit, it will be important for PCPs to understand which billable services contribute to this limit and which may be continued beyond 18 visits per fiscal year. We identify such issues that require specialized training through our frequent interactions with providers, provider organizations, the Regional Advisory Committees, the Quality Management Committee, as well as through PCP complaints and calls for information. We are able to track recurring PCP concerns because we document concerns and calls in APS CareConnection® and systematically share information from stakeholders throughout our organization. We respond to these diverse needs in a variety of ways so that all PCPs will be able to easily locate information through:

- Provider Services Representatives through the Call Center or visits to PCP offices.
- ACCESS Plus website.
- APS CareConnection® resources for physicians.
- Provider Manual.
- Tip sheets and "Frequently Asked Questions" materials.
- Hardcopy and electronic newsletters, posters, and other program materials. Please see **Exhibit 18** to view a sample of our Provider Newsletter.

ACCESS Plus Website

PCPs and other providers throughout Pennsylvania will have access to program information, contact numbers and resources via our dedicated ACCESS Plus Program website and APS CareConnection® APS CareConnection® supports secure communications between providers and APS Health Coaches so that questions about specific patients can be addressed confidentially and within HIPAA regulations. The ACCESS Plus website is designed to accommodate the specific needs of the ACCESS Plus Program, including a set of provider pages that contain materials about the program, disease management, chronic conditions, medical home characteristics, and other relevant information. PCPs and other providers will also be able to submit their inquiries through our dedicated ACCESS Plus Program website. This secure site will enable PCPs/Providers to submit questions to APS at any time. APS will respond to questions and comments related to ACCESS Plus and the Disease Management Program within one (1) business day of receipt.

Other features of the ACCESS Plus website for Providers includes but is not limited to:

- ACCESS Plus PCP handbooks and Provider Newsletters, flow sheets, tip sheets, and Frequently Asked Questions, and "What's New" items.
- Comprehensive information about the Disease Management and Case Management Programs, including a description of each Program and information about how to access services and how to refer patients to Disease and Case Management Programs.
- Information about the Pay for Performance Program, with information about results and achievements, including aggregate reimbursement for performance.
- Explanation of the role of the Regional Advisory Committees, including current members, schedule of meetings in each region, action work plans for the regions, and community-based organizations that are supporting the Regional Advisory Committee (or Regional Ambassador Council) initiatives, including meeting materials (e.g., agendas, meeting minutes, etc.).
- Information on ACCESS Plus Quality Improvement, including but not limited to:
    - Quality Management Committee schedules and membership, minutes (if approved by the Department), and quality improvement initiatives.
    - Summaries of chart audits and Clinical Quality Measures.
    - Provider and Enrollee Satisfaction Surveys and Results.

  - Quality Improvement Initiatives and Results
  - Selected reports regarding the provider network and provider participation in ACCESS Plus, including geomapping and other analyses conducted by APS team member, the Pennsylvania State University Center for Health Care Policy and Research.
  - Schedules for provider training sessions, with locations and agendas.
  - How to submit best practices for presentation at regional meetings.
- Medical Director point of contact information.
- A secure portal so that Providers can download real-time panel roster data, and adult preventive care screenings and EPSDT screening information. This information will also be available on APS CareConnection®, with sortable queues so that providers can group like services to facilitate scheduling.

Another helpful feature of our website is online provider training materials. In addition to a wealth of educational material, community resources, publications, links to national and state-specific sites and other information available through the dedicated program website, APS will post all training materials on the ACCESS Plus website. Web-based training can be accessed and used by anyone who registers on the website and is free of charge. We highlight our Pennsylvania Health Quality Unit (HCQU) website in **Exhibit 1**, particularly because of our proposed approach to web-based training applications. APS maintains program specific websites for the [redacted] Service Organization (ASO) program, the [redacted] Behavioral Health ASO program, the [redacted] Management Program (GAMMP), the [redacted] Review Program, [redacted] program, the [redacted] Quality Review Organization (EQRO), and the [redacted] Improvement Organization (QIO) program. Examples of these sites are also shown in **Exhibit 1**. These websites document the extent to which APS maintains a flexible communication interface that is tailored to specific state needs and demonstrate the breadth of APS' program offerings.

B. Describe how the Offeror will address Provider complaints about Enrollees who miss appointments.

The extent to which Medicaid Enrollees miss appointments is a frustrating challenge faced by PCPs. It is a frequent reason providers cite for not enrolling in Medicaid. When Enrollees fail to keep their appointments there are multiple impacts on the provider office and the Enrollee. Office resources may have to be allocated to contact and reschedule appointments, providers who are typically busy have a gap in their schedules that other patients could possibly have used, and the Enrollee who missed the appointment may then lack services that were needed and should have been delivered. As frustrating as these occurrences are for the providers, they can also be frustrating and embarrassing for Enrollees. Most often, missed appointments are caused by lack of knowledge, fear of the receiving diagnosis, transportation problems or lack of childcare.

With our extensive presence in Medicaid programs across the country, APS is very familiar with this problem. We begin addressing it proactively – before Enrollees miss appointments. We approach this effort in a number of ways, beginning with requesting PCPs to document upcoming appointments in APS CareConnection®. With this documentation, we can use automated reminders as well as directly calling Enrollees with reminders and problem-solving techniques, including scheduling their transportation and recommending community-based resources for childcare and transportation if Medicaid service providers are not available.

For Enrollees in the DM program, Health Coaches work collaboratively with the provider offices to facilitate relationships with Enrollees that lead to the *productive interactions* that the Chronic Care Model prescribes. We also call Enrollees directly to help them resolve barriers to keeping their appointments, sending reminders and scheduling reminder calls to ensure adherence.

Even so, we know that Enrollees will miss appointments with their providers – a waste of scarce resources in any area and of even more concern in rural areas such as the ACCESS Plus region where providers may not be plentiful in all counties. We encourage PCPs and other providers to notify us when Enrollees miss appointments so that we can intervene with reminders, assistance, and problem-solving tools for both PCPs and Enrollees.

One such tool that APS will use in the ACCESS Plus Program is My Health Direct®, an Internet-based appointment scheduling system designed to help divert unnecessary emergency department utilization. ACCESS Plus hospitals and community-based providers will be able to use My Health Direct® for that purpose. Additionally, PCP offices and APS will use My Health Direct® to work with Enrollees who have missed appointments. With this tool, APS can work with the Enrollee on the telephone or in person to schedule the appointment and print an appointment notice in the Enrollee's language that includes the PCP's name and office location, a brief summary of the reason for the visit, and the Enrollee's name and address. We will configure this system to allow us to also contact and schedule MATP transportation for the Enrollee. Once the appointment is scheduled, APS will send the appointment notice to the Enrollee (if the appointment is far enough in advance) and fax an appointment notice to the PCP office. Of interest, My Health Direct® hospital users have found that while the system can distribute email, many providers still prefer to receive faxes. Also of interest, users have found that the written notice of the appointment containing the provider and Enrollee information and a brief summary of the reason for the visit seems to elevate the significance of the appointment for Enrollees, making them more likely to keep appointments.

C. Describe how the Offeror would coordinate with the Department's Division of Provider Services.

APS works as a valued partner with our state customers to meet the goals of their Medicaid and other programs. APS will develop a similarly collaborative relationship with the Department's Division of Provider Services. This relationship will facilitate our ability to develop effective processes to ensure coordination of services and resolution of issues for both PCPs participating in the ACCESS Plus Program and Specialists who provide services for ACCESS Plus Enrollees. Our coordination efforts will include, for example:

- An established schedule of in person meetings to raise and resolve billing issues and provider concerns that our combined Provider Services departments can address.
- Planning and scheduling joint training and education sessions with the Department's Claims Processing Vendor on Claims submission and processing, including frequently occurring errors, best practices, and new procedures.
- Working directly with individual Provider Services staff members to resolve Provider Complaints (as we indicate in our Complaint process).
- Advance planning for system changes impacting claims payment and submission.

In the area of claims submission and processing, APS has extensive expertise in our Information Technology Department from interfaces we maintain with MMIS vendors for the [redacted] public sector prior authorization programs we manage. In these programs, APS CareConnection® is configured with functionality for prior authorization and concurrent review. Service authorizations are transmitted on a nightly basis to the state MMIS vendor, and authorization numbers issued to providers for approved services. We therefore work with the

APS works as a valued partner with our state customers and will develop the same type of collaborative relationship with the Department's Division of Provider Services.

Provider Services Departments and the claims processing vendors (EDS, ACS, Unisys, and First Health) to resolve any issues with pended claims, delays in claims processing, disagreements between authorized and billed services, etc. This experience will be valuable to ACCESS Plus providers, because we are highly familiar with claims processing conventions and requirements.

These types of issues will be discussed at length during the implementation phase of the contract to ensure all parties understand their roles and responsibilities and to develop seamless processes that are aligned with the Department's preferences (e.g., when, who and how to transfer calls to the Department concerning complaints about the MA program policies and procedures). As a result, our collaborative efforts will ensure that we can best assist ACCESS Plus Providers with accurate information in accordance with the Department's expectations.

D. For Enrollees who seek and/or receive specialty services without a required PCP referral, describe how the Offeror will contact the Enrollees' PCPs, with the Enrollees' consent, and notify them of the specialty services received or otherwise ensure that the Enrollee's PCP is notified. Describe how the Offeror will work with the PCPs of Enrollees who receive unreferred specialty services or who receive specialty services with referrals from a PCP not assigned to the Enrollee to reduce Enrollee use of inappropriate referrals and use of specialty services without a referral.

In our experience, these referral and specialty care issues are characteristic of the TANF population that represents the majority of ACCESS Plus Enrollees. Our analysis of claims received from the Department indicates that the average eligibility span for Enrollees is [redacted] months – we are also aware that the TANF population loses and regains eligibilities over time. These changes in eligibility introduce gaps in continuity that can result in the issues described in this item. Further, the same Primary Care Case Management program features can act as both a benefit to Enrollees – a medical home in the healthcare neighborhood – and at the same time create problems for both PCPs and Enrollees, as the following examples indicate:

- Individuals re-enlist in ACCESS Plus and believe they have the same PCP without verifying the PCP assignment. When they attempt to access specialty services – even with their physicians' authorization – services are denied because authorization came from the *wrong* provider.
- Specialty services are denied because the PCP office made an error in the number when documenting the referral, or the specialists' offices made an error in entering the authorization number when submitting the claim.
- Enrollees seek specialty services without an initial visit to the PCP and the PCP refuses to authorize the service because they haven't seen the Enrollee.
- Enrollees arrive for an appointment without their authorization in hand and specialty office has trouble retrieving it electronically and is denied care.

Each of these examples were cited to APS by Geisinger Health Systems as opportunities to improve coordination of information for ACCESS Plus providers and Enrollees during our conference call with hospital staff members. Some of these errors can be addressed by the providers so that they are corrected and services are delivered and reimbursed. Others are irreversible. Our information tools are specifically designed to provide assistance to PCPs and specialists in all of these circumstances. In addition, during implementation we will work with selected providers, such as Geisinger, to develop procedures that reduce the administrative burden they currently experience.

APS will use two basic approaches to addressing issues with referrals. We understand from Item 4 in RFP Flyer 3 that the Department will provide a report that identifies specialist services that were received without a referral. These services will have been denied during claims processing because of the absent authorization from the PCP. APS will contact the PCP and specialist offices to ensure that they are aware of the appropriate process for referring an Enrollee to specialty care. This approach is retrospective – the services may already have been provided without a referral or the Enrollee could not access care because no referral was made. In either case, the services will not be reimbursed. While effective problem-solving is useful to prevent reoccurrences, we will also address common problems with referrals proactively so that Enrollees can receive services and ACCESS Plus providers can be paid for services they deliver.

This latter type of approach is characteristic of both our customer service culture and our consistent efforts to eliminate costly waste from the healthcare programs we serve. It is wasteful to deliver services that are denied and require interventions from the Department and/or a vendor to address an educational need. It also distances both PCPs and specialists from the program, each other, and the Enrollee. A more effective approach is to identify common opportunities for referral problems and address them systematically. We will do this for the ACCESS Plus Program with efficient communications and information tools:

- Recognizing that losing and regaining eligibility is a situation that can lead to inappropriate service utilization, APS will prepare special-purpose materials that highlight changes in PCP assignment – for example, an oversize "PCP Change" notice in bright colors that draws Enrollees' attention to this important change.
- In this situation, APS will also conduct a follow up call to the Enrollee and offer to schedule an introductory appointment with the PCP, using My Health Direct® to schedule the care. To make this approach effective, we will present it to PCPs during implementation orientation and request approval in advance from the Department to ensure that PCPs are aware of the approach and that the Department supports it. Or, APS can refer the Enrollee back to the EAP contractor to reassign the Enrollee to a PCP.
- APS will send automated alerts in APS CareConnection® to the new PCP and the former PCP to notify both of the change. PCPs will also be able to tell from their roster listings in APS CareConnection® and on the ACCESS Plus website if the Enrollee has a previous PCP (again, with approval from the Department to list the former PCP).
- PCPs will also be able to document referrals in the APS CareConnection® Plan of Care, and specialty offices will be able to view this referral in APS CareConnection®. Any concerns can then be communicated to the PCP office through secure communications.
- Specialty offices will be able to validate referrals and the correct, current PCP in APS CareConnection® and address any referral issues directly with the PCP office *before* the Enrollee arrives for the service.

As our discussion illustrates, APS is well-prepared to support PCP Services with experienced clinicians, Provider Services Representatives with training in program features, tools, and materials, and a management team that is dedicated to a positive program environment for PCPs, specialists, and the ACCESS Plus Enrollees they serve. Our state-of-the-art information tools support appropriate referrals before care delivery; our prompt outreach and education efforts enable us to connect with PCPs and specialists in the event a service is delivered without a referral, and provide the information that will help reduce reoccurrences.

II-3 Work Statement

22. PCP MONITORING

A. Submit a monitoring plan detailing how the Offeror will ensure PCP compliance with ACCESS Plus requirements. Include in the monitoring plan annual medical record reviews for a representative sampling of PCPs.

APS will monitor ACCESS Plus Primary Care Providers (PCP) to ensure compliance with provisions included in the PCP handbook and **Appendix A Supplemental Provider Agreement**. PCP requirements will be documented in the Provider Manual, which will be updated during the implementation process and accessible on the ACCESS Plus website in PDF format. The Manual will also be available on CD to providers with limited Internet access. In addition to updating the Manual to reflect changes in contractor status, we will also update the Manual to include any other program changes. As part of our update, we will include a compliance matrix that summarizes PCP requirements with hyperlinks to relevant detail sections of the Provider Manual. Using this compliance matrix, PCP offices will be able to quickly identify program requirements and ensure that these requirements are part of their basic office policies to ensure they are in compliance. It is important to note that our integrated approach will bring new, actionable information tools for PCPs and offices to use in managing their ACCESS Plus patients.

APS Compliance Monitoring:

- **Ensures Supplemental Provider Agreement standards are met.**
- **Is focused on improving the quality of Enrollee services.**
- **Is data-driven with actionable results.**

Our PCP monitoring approach combines assessment with an educational, quality improvement oriented style that will increase the capacity of the PCP network to use APS information tools to improve the health status and healthcare of ACCESS Plus enrollees. As literature indicates, provider use of performance information depends in part on the extent to which criteria represents evidence-based practice and the credibility of reviewers applying the criteria toward a common purpose of quality improvement.[1,2] Our monitoring approach will therefore be transparent in development, collaborative in process, and provide actionable information that PCPs and staff members can use to quickly identify and address non-compliant areas. Our monitoring approach is comprehensive. We will evaluate structure and process compliance through onsite audits and record reviews. Enrollee outcomes will be monitored through CAHPS surveys, DM Enrollee surveys, and PCP profiles. If a non-compliant area is identified, we will report the identified area to the Department and at the same time further investigate the area of non-compliance. When our investigation is complete, APS will provide a proposed corrective action plan to the Department for approval. The final decision on any corrective measures that will be taken by a provider will be made by the Department. When corrective actions have been determined, APS will send a letter to the provider to inform them of the area identified and the steps that are being required to correct the non-compliant areas. Depending on the severity and number of non-compliant areas, a meeting may be arranged to address the corrective action. These meetings may consist of 1:1 meetings with the APS Medical Director and the PCP, group trainings, and/or webinars. If the non-compliant

[1] Reinertsen, J.L., Gosfield, A.G., Rupp, W., Whittington, J.W. (2007). *Engaging Physicians in a Shared Quality Agenda.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. (Available on www.IHI.org)
[2] Smith, W.R. (2000). *Evidence for the Effectiveness of Techniques To Change Physician Behavior.* Chest (118), page 8S – 17S.

area is found to be severe – i.e., a person's care is in question – APS will contact the Department immediately for immediate action. Included in the corrective action plan will be expected timeframes – generally 30 days – to correct the non-compliant area. APS will follow up to confirm that the corrective actions were completed. If we determine that areas of non-compliance were not corrected, APS will notify the Department to identify further action to be taken. The ACCESS Plus Medical Director will have overall responsibility for PCP monitoring and for managing the feedback and improvement process, supported by the Provider Services Manager and field-based Provider Representatives. Our monitoring activities will also follow the compliance matrix to help ensure that we have appropriate procedures in place to assure the Department that PCPs follow state and federal requirements.

PCP Monitoring

Table 22-1 presents our draft approach to PCP monitoring based on requirements listed in **Section D.11 of Appendix A, the Draft ACCESS Plus Agreement**. During implementation, we will adapt existing monitoring tools for approval by the Department. The revised monitoring tool will be tested with a small sample of PCP offices to ensure that it collects information accurately and efficiently, and will then be finalized subject to Department approval. We will review the tool annually, and update as needed.

Table 22-1. PCP Monitoring Plan

Requirement	Monitoring Method
PCP management of services to ensure that the provision of services is sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.	Analysis of performance measures, benchmarks, utilization statistics, and outcomes (e.g., hospitalizations, services, ER use). Site visits and record review.
Program standards regarding service accessibility as set forth in Section D.1, Establishing and Maintaining a PCP Network.	Geographic analysis of PCP coverage by county, specialty (e.g., pediatrician, obstetrician) and number of enrollees.
Appointment standards as set forth in Section D.7, Appointment Standards.	Use of CAHPS surveys to identify network level issues; review of appointment schedules and policies during site reviews; enrollee complaints and grievance files.
Affirmative outreach whenever an Enrollee misses an appointment and documenting this in the medical record.	Documentation in APS CareConnection® and individual medical records during site visits.
The twenty-four (24) hour, seven (7) days-a-week availability of coverage for emergency care.	Use of CAHPS surveys to identify network level issues; review of appointment schedules and policies during site reviews; enrollee complaints and grievance files.
Assisting Enrollees to schedule and receive referred services and maintaining medical record documentation for those referred services.	Analysis of utilization profiles of specialty service utilization by PCP and follow up review of medical records.
Outreach to Enrollees not up to date with EPSDT screens and immunizations.	Utilization of EPSDT tracking reports and documentation of outreach.
ADA accessibility as set forth in Section D.6, ADA Accessibility of PCP Network.	Site visit to PCP offices.
Participation and coordination of care for Enrollees participating in the Disease Management (DM) Program, as set forth in Section E, DM Program Requirements.	Interaction with PCPs and enrollees during DM interventions; analysis of PCP and enrollee profiles; site visit discussions; review of medical records.
Compliance with Supplemental Provider Agreements.	Site visit to PCP offices.
Whether Enrollees of certain PCPs are Specialist	Analysis of referral patterns for enrollees by PCP and

Table 22-1. PCP Monitoring Plan	
Requirement	**Monitoring Method**
Referrals from other PCPs and excessive Referrals to specific PCPs or Specialists.	Specialist.
Whether Enrollees of certain PCPs are demonstrating excessive emergency department usage, including use of emergency departments for dental services.	Analysis of ER utilization profiles by PCP.
Physical health and behavioral health coordination.	Medical record review during site visits.

All PCPs will be monitored through profiling reports, feedback from CAHPS and other surveys, complaint and grievance monitoring, APS CareConnection® plans of care, and Call Center documentation. At least 120 PCP sites will be visited on an annual basis to conduct medical record review, assess ADA compliance, and compliance with Supplemental Provider Agreements. A sample PCP Monitoring Report has been included in **Exhibit 19**. Site visits will be integrated with the medical record review process, and conducted by the Provider Representatives and a Quality Management nurse. We describe the sampling and scheduling process below.
Medical Record Reviews. According to the current Provider Manual, a 5% random sample of sites is selected, with 50 medical records selected at each site. We recommend a slightly higher percent to ensure that the sample is representative of the PCP network – that is, that the results of the site and record reviews can be generalized to the network as a whole. Materials distributed at the Medical Assistance Advisory Committee, Consumer Sub-Committee meeting in October identified 1,236 sites in the ACCESS Plus network. A 5% sample of these sites generates a sample of 62 sites. To achieve a 90% confidence level with a 10% sampling error, a sample of 65 sites is required. We therefore propose to select an annual sample of 130 PCP sites. These site reviews can be conducted at once or split into two segments. It is important to note, however, that the results will be representative of the PCP population on an annual basis, and record reviews will be generalizable to the Region on an annual basis as well (with the limitation imposed by sampling PCP sites first).

Prior to finalizing the sampling methodology, we will discuss it with the Department and Quality Management Committee to identify factors that impact compliance and quality, for example, PCP sites with a large number of enrollees. If these sites perform well, care will be improved for a greater proportion of the population. However, because smaller sites serve fewer enrollees they may not be as familiar with ACCESS Plus requirements and may not conform as consistently to those requirements. By discussing the sampling process with the Department and knowledgeable stakeholders, we will balance these factors to achieve the maximum benefit for PCPs and their patients. The sample will be selected to generate at least 384 enrollees in each region; enrollee records will be randomly selected for the site.

Scheduling Process. APS will notify PCP sites at least 30 days in advance of the site review and audit. We will identify the time and date of the visit, as well as provide the staff names and credentials for individuals conducting the review. A copy of the site and medical record review tool will be included with the notification to PCP sites. At least 10 calendar days before the site visit, APS will fax a list of enrollees whose records have been selected for review. APS will identify any changes to the roster that will impact the availability of records, and notify PCP offices if substitutions to charts must be made.

Review Process. We will make the selection from the PCP's roster of enrollees. Using the Department-approved site and medical record review tool, we will conduct the review, and provide an exit interview with preliminary findings before leaving the site (unless the PCP declines). Medical Record reviews will be completed by trained Registered Nurses under contract to APS' partner, BT Consulting. As an External Quality

Review Organization (EQRO), APS is experienced in compliance auditing, and our EQRO staff members in Massachusetts will be a resource in the design of the audit as well as assist with audit activities and report writing. Review results will be finalized after the site visit, and preliminary findings submitted to the PCP site and the Department. Medical record results will be aggregated at the PCP and regional levels for reporting to the Quality Management Committee and Regional Advisory Committees.

B. Describe what mechanisms and processes the Offeror will use to identify and control over- and under-utilization of PCP referrals to Specialists.

Since the appropriateness of referrals to specialists can depend significantly on the nature and extent of individual clinical conditions, it is difficult to accurately characterize referral patterns as appropriate or inappropriate without clinical information and discussion with individual PCPs. Our goal in PCP monitoring is to build capacity in the network to effectively coordinate the care for ACCESS Plus enrollees using their experienced clinical judgment and the most relevant evidence. To accomplish this goal in the area of referrals to specialist care, we will create profiles at the enrollee cohort level to understand referrals to specialty care by relevant clinical condition, demographics of the enrollee, and ACCESS Plus region, as these factors can influence specialty referrals. These profiles will help us create an "expected" level of referrals for individuals in the cohort; we will then identify the PCPs for enrollees whose observed level of specialty care is outside the limits of expected referrals, either higher or lower. PCPs with referral figures that are more than one standard deviation from the mean (taking into consideration the factors that influence referrals) will receive informational profiles that explain the methodology used to identify the referral pattern, with feedback that the specific PCP's referrals for enrollees are statistically different from average referrals for similar enrollees in the region. We will also provide regional/cohort information at the summary level so that PCPs can compare their own referrals to those of other PCPs with relevant enrollee characteristics. Since each enrollee in ACCESS Plus will have a model plan of care in APS CareConnection®, PCPs will be able to evaluate the utilization of individual enrollees who were not "expected" to be referred to a specialist against a model plan of care.

Literature indicates that physicians will use feedback to change practice patterns if it is succinct, relevant, and actionable. In particular, comparative peer information is useful in changing practice patterns. By providing comparison information at the summary level and a claims-driven plan of care for each enrollee that PCPs can use to evaluate their own practices, PCPs can make improvements in care for their roster of enrollees. This methodology will be used for *most* cases when PCP referral patterns are statistically different from the mean. PCPs profiled for multiple quarters or with referral patterns that are three standard deviations greater than or below the mean will receive individualized letters identifying exceptions with examples of relevant guidelines. The PCP will be asked to briefly document the rationale for the enrollees' care and respond to the APS Medical Director. This level of interaction will be infrequent and reserved for cases that indicate a need for intervention with the PCP. Immediate intervention with the PCP will be taken in the event we identify potential fraud and abuse or a threat to the health and safety of the enrollee, including contacting the PCP directly, visiting the site and reviewing enrollee records, requiring educational activities, or reporting to the Department.

II-3 Work Statement

23. DISEASE MANAGEMENT PROGRAM REQUIREMENTS

APS will meet all requirements as outlined in **Appendix A, Section E – Disease Management Program Requirements**. In our response to this section, we first present the conceptual framework for our Disease Management (DM) programs. This framework has been adapted from the Chronic Care Model and integrates the role of APS interventions in promoting the adoption of healthy behaviors among Enrollees. It also helps to illustrate how APS' efforts strengthen the critical component of *productive interactions* between Enrollees and their family members with care teams. The integration of our dedicated service center and field staff into the "medical neighborhood" (which we describe above in our response to Item II-3.4, Care Coordination and Intense Care Management) provides a cohesive and comprehensive approach to DM that is person-centered and provider-friendly – hallmarks of APS' DM programs. APS also innovates within our contracts to enhance the effectiveness of our DM programming. For example, traditional DM approaches stratify Enrollees into tiers according to risk, as defined by predictive modeling systems that identify potential future costs and burden of disease. In this model, the intensity and frequency of DM interventions are mapped to the risk strata, with higher risk Enrollees receiving more and more frequent interventions and lower risk Enrollees receiving fewer. Within this model, APS pioneered approaches that made interventions more effective through our community partnership model that aligns APS health coaching activities with high volume providers such as Federally Qualified Health Clinics, large provider practices, and hospital Emergency Departments. Most recently, the APS model has evolved to strengthen the healthcare neighborhood for Enrollees with patterns of *uncoordinated care* – an approach that yields better outcomes, is more efficient, and is particularly well suited to primary care case management. It is this model – holistic, person-centered, and provider-friendly – that we propose for ACCESS Plus.

> APS innovations advance the science of interventions in disease management:
> - Integration with provider practices to engage both providers and Enrollees.
> - Routine screening for depression that underlies chronic illness for many Enrollees and limits effectiveness of DM programming.
> - Behavior change techniques, such as motivational interviewing, that enhance effectiveness of interventions.
> - Focused interventions using data mining techniques to identify uncoordinated care.

In our efforts to continuously improve the precision and effectiveness of our DM program interventions, we have adopted advanced data mining techniques to profile Enrollees with and without chronic diseases to identify instances of *uncoordinated care*. With proprietary algorithms developed and performed by APS partner Southeast Consultants, we use claims and pharmacy data to identify Enrollees with patterns of care such as avoidable Emergency Room utilization, admissions for Ambulatory-sensitive conditions (as defined by the Agency for Healthcare Research & Quality Prevention Quality Indicators), polypharmacy, duplicate scripts from different prescribers, pharmacy-shopping, non-adherence patterns of medication utilization, and frequent PCP changes, for example. These Enrollees are also typically high cost utilizers of Emergency Room and Inpatient services with fewer outpatient and ambulatory services. We also see patterns of high pharmacy utilization and cost. For example, we observed the following characteristics in the ACCESS Plus population for Fiscal Year 2007 claims:

- Over [redacted]% of Emergency Room visit costs (over $[redacted] million) were avoidable.

- Hospitalizations for ambulatory-sensitive conditions cost the program over $[redacted] million in FY 2007, with a rate of almost [redacted]% for DM eligible enrollees.
- Enrollees with outlier total costs (between 1-3 Standard Deviations from the mean for total costs) included:
  - Approximately [redacted] Enrollees with Congestive Heart Failure and total claims costs of almost *$[redacted] million*.
  - Almost [redacted] Enrollees with Coronary Artery Disease and total claims costs over *$[redacted] million*.
  - Nearly [redacted] Enrollees with Diabetes and total claims costs close to *$[redacted] million*.
- More than [redacted] individuals during FY 2007 have *more than three* comorbid conditions, or [redacted] *% of the population* eligible for the Disease Management program.
- Over [redacted] Enrollees eligible for the DM program were in the top [redacted]% of all Enrollees for total costs in FY 2007, with pharmacy costs exceeding $[redacted] million and medical costs in excess of $[redacted] million. *Total costs for these Enrollees were over $[redacted] million*.
- The *top* [redacted]*%* of all Enrollees by pharmacy cost (approximately [redacted]) account for *nearly* [redacted]% of all pharmacy costs in FY 2007; the *top* [redacted]*%* of Enrollees by medical cost account for *over* [redacted]% of medical costs in the same time period.
- Almost [redacted] *DM-eligible Enrollees* with pharmacy and/or medical costs associated with Bi-Polar Disease, Psychosis, or Depression. Total costs for these Enrollees alone for FY 2007 were over *$[redacted] million*. These comorbidities can significantly increase the harm of uncoordinated care and place a significant burden on the system as a whole.

By identifying Enrollees whose care is not coordinated and who are high utilizers of service, we are able to identify Enrollees with the greatest need for interventions. This analytic approach helps to ensure that interventions are focused on Enrollees who need them. Predictive modeling identifies individuals with severe chronic disease as high risk; it does not indicate if their care is already well-coordinated. Therefore, interventions may focus on individuals with medically necessary and appropriate high utilization who *do not need the intervention* at the expense of lower risk Enrollees with uncoordinated care who are at significant risk because they are not getting the care they need – the right care, at the right time, in the right setting. Our Enrollee stratification uses both predictive modeling and advanced analytics to identify individuals with chronic disease, and further, with care that is not well coordinated. We then prioritize our telephonic and face-to-face interventions where they are most needed – to improve coordination, link Enrollees to behavioral healthcare, deliver risk-reduction strategies such as smoking cessation, and improve self-management techniques. This approach also strengthens the relationship between the Enrollee and the Medical Home by streamlining the delivery of services, re-focusing the Enrollee on appropriate primary and preventive care, and ensuring that the Primary Care Provider can coordinate referrals to specialty care and monitor medications. Our information system, APS CareConnection® supports this process through an Enrollee "Dashboard" that integrates medical and pharmacy claims – and behavioral health claims/encounter data if available. This system will be available to ACCESS Plus providers with no cost beyond Internet Explorer and their customary Internet Provider.

Important Note: APS did not conduct uncoordinated care analyses using data provided for proposal purposes. We will complete these analyses when we can link Enrollee eligibility data and claims to unique Provider identifiers. We present proxies for that analysis by summarizing Enrollees with one or more chronic diseases with care profiles that are cost and/or utilization outliers. **Table 23-1** presents total and average utilization and cost for the 17,685 Enrollees with utilization and/or costs that are three or more Standard Deviations from the mean, for the twelve month period ending June 30, 2007.

Table 23-1. Top 10% of Enrollees by Total Cost and Eligible for Disease Management Program – Fiscal Year 2007

Description	Total Number	Total Cost	Average Claims Per Person	Average Cost Per Person
Enrollees	[redacted]	[redacted]	[redacted]	[redacted]
Prescriptions	[redacted]	[redacted]	[redacted]	[redacted]
Professional Claims	[redacted]	[redacted]	[redacted]	[redacted]
Inpatient Claims	[redacted]	[redacted]	[redacted]	[redacted]
Outpatient Claims	[redacted]	[redacted]	[redacted]	[redacted]

The figures in **Table 23-1** indicate that this population accounted for over $[redacted] million in costs to the Medicaid program over the course of fiscal year. While this analysis includes individuals with serious chronic disease whose care *is* coordinated (for example, there are individuals in the DM population who have Alzheimer's Disease or Psychosis/Bipolar Disease and are thus incurring significant medical charges associated with a disorder outside of their DM program disease) we present this chart to illustrate the program impact of Utilization/Cost Outliers on program expenditures. As defined above, outlier characteristics are features of uncoordinated care that may be susceptible to DM interventions. Through careful analysis of claims data during implementation and throughout the course of the project, we will identify individuals with chronic disease and stratify the population not only by burden of disease and predicted cost, but also by the need for improved care coordination and self-management skills to stabilize cost and improve quality of care.

A. Propose a plan for implementing and operating each component of a Disease Management program for each of the following conditions. Include, at a minimum, the proposed approach, the Offeror's capacity to build an infrastructure to support all programs and whether the Offeror is proposing to have separate subcontractors for each Disease Management program. If the Offeror has separate subcontractors for each Disease Management program, describe how the Offeror will avoid duplication of effort in managing Enrollees enrolled in multiple Disease Management programs:

In response to this item, we first discuss the APS approach to Disease Management for the ACCESS Plus population as a whole. This discussion confirms the importance of a holistic DM program grounded in the CCM model – that is, a person-centered program that strengthens productive interactions between Enrollees and providers. We then discuss the results of data analysis for conditions identified to be managed: their distribution across the ACCESS Plus region, cost characteristics of the population in the 42 ACCESS Plus counties, variations that we observed between regions (and between counties within regions), specific co-morbidities that represent challenges to the DM program, and any special features of our approach to DM.

Approach to Disease Management

APS was founded on the belief that a full service specialty healthcare organization yields an improved kind of care management system: a comprehensive portfolio of healthcare products and services to manage the ***whole person*** across the continuum of health and healthcare. Whether the person has diabetes and depression or acute leukemia, APS' knowledgeable and experienced clinicians deliver management services that result in sustained and meaningful improvements in health status and health outcomes. This approach uniquely prepares APS to deliver consistently superior results – for example, the $[redacted] PMPM in savings that the [redacted] program delivered in 2007. Applying this integrated approach to disease management is a *core capability* of APS, and we bring 14 years of experience in commercial and public disease management to this important program. As we illustrate in **Table 23-2**, APS addresses the full continuum of

Population Health Management with a comprehensive service offering that is effective, efficient, person-centered, and provider-friendly.

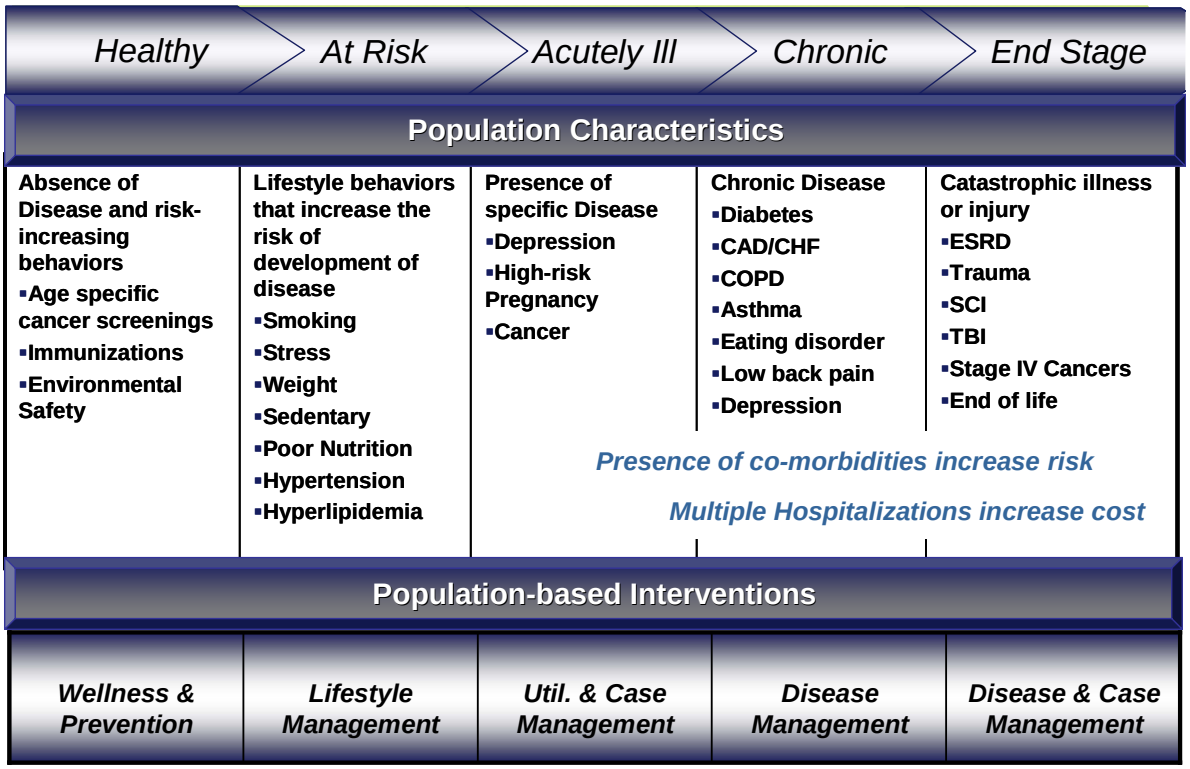

Table 23-2. Population Health Management Approach

APS does not propose to manage the DM Scope of Work conditions discretely and therefore will not utilize subcontractors to manage any disease within this program. Our holistic approach avoids the duplication of effort that occurs with treating chronic conditions as if they were independent – that approach is far from evidence-based and inconsistent with the reality that ACCESS Plus Enrollees experience daily. For example, we found that over [redacted] DM eligible Enrollees have between [redacted] and [redacted] co-morbidities (almost [redacted] of the population eligible for DM), and costs for these Enrollees exceeded $[redacted] million for FY 2007.

The APS approach focuses on Enrollees, their family situations, their community environments, their physicians and caregivers, and the unique circumstances and characteristics that Enrollees bring to the challenges of chronic disease. As a [redacted] enrollee told us, "I think it is all great. Now there is someone to talk to who understands." This understanding is grounded in our holistic approach. Our analysis of the data suggests that a comprehensive approach which recognizes that a large percentage of individuals with chronic conditions have multiple chronic conditions reinforces the need for a cohesive infrastructure that can manage multiple complex diseases by focusing on the whole person, not one disease at a time.

Proposed Approach to Disease Management for ACCESS Plus Enrollees

We deliver all DM interventions directly to the Enrollee and provider populations. This approach provides greater management control of program services and greater accountability to the Department for program outcomes than an approach based on management of subcontracted services. The APS integrated disease management approach delivers consistent program content and a unified interface to providers and Enrollees across chronic diseases and comorbid conditions. Our interventions are person-centered, not condition-centered. Through claims data and individual assessments, we identify chronic conditions and comorbidities for each person, with the identification of the risk status of each person for future hospitalizations, incurred

cost, and increase in illness burden, and most importantly, for characteristics of uncoordinated care. We are then able to provide a strong program that integrates interventions, avoids duplication of service, and provides a coherent "single point of contact" for Enrollees and their PCPs. Our approach to Disease Management ***is*** holistic and focused on providing Enrollees with proactive, ongoing support and education for their identified chronic condition/health risk(s) and all co-morbid conditions and issues that affect their overall health. Our intervention methodologies are tailored according to the Enrollee's motivation to address their risk factors and their confidence to make a change; we help Enrollees to develop the courage to make positive changes for themselves and family members through compassionate health coaching. The outline in **Table 23-3** summarizes our overall ACCESS Plus Disease Management approach.

Table 23-3. Summary of APS Disease Management Program

Activity/Stage	Responsible Party	Results
1. Claims data are analyzed to identify cohort with chronic diseases and co-morbidities (initial identification may be done by the Department; if done by APS, codes specified by the Department will be used).	Conducted by Health Intelligence Unit and uploaded to APS CareConnection®	DM target population identified by principal diagnosis; APS CareConnection® populated
2. APS distributes "Welcome" letters to Enrollees with program information, including program reminder materials such as magnets with toll-free number. (See **Exhibit 12** for an example.)	PRWT (Subcontractor)	Formal notice of DM program availability; incorrect addresses are noted and updated; notices reissued.
3. Predictive modeling conducted to identify members in standard risk pools AND Enrollees with uncoordinated care. (Predictive modeling may be conducted by the Department or APS at the Department's direction)	Same (typically part of Activity 1)	DM population stratified for interventions by risk, burden of illness, and opportunity for intervention criteria.
4. Enrollees with the greatest need for interventions are contacted by Health Coaches directly and/or through PCPs for a disease specific assessment, overall behavioral risk assessment, and screening for depression.	APS Field and Call Center-based Health Coaches	Claims profile updated with results from in person assessments and interventions identified for each Enrollee.
5. Formal care plan established for Enrollees in APS CareConnection® with education/intervention needs, Enrollee self-management goals, timeframes for follow up, and education approach.	Health Coaches APS CareConnection®	Automated model plans of care and refinements after Health Coach updates available for APS, Department, and Providers.
6. APS conducts outreach to PCPs and other providers.	Provider Relations	Providers are notified about DM program structure, content, Medical Director POC, APS CareConnection® and training schedules/locations.
7. APS Health Coaches routinely visit/call PCPs for high acuity Enrollees for introduction and information.	Health Coaches	APS keeps providers alert to Enrollee needs and issues, promotes use of APS CareConnection®.

Table 23-3. Summary of APS Disease Management Program		
Activity/Stage	**Responsible Party**	**Results**
8. APS initiates interventions structured for specific risk categories.	Health Coaches APS Fulfillment	Health Coaches initiate in person contact with High Risk Enrollees, either in person or by telephone; Moderate and Low Risk Enrollees receive scheduled educational material.
9. Routine reporting tracks progress with Enrollees, identifies need to update Enrollee stratification, need for alternative intervention strategies.	APS ACCESS Plus Reporting Analyst/ Health Intelligence Unit	Periodic re-assessment of Enrollee status, success of interventions, gaps in care (e.g., immunizations, well visits). Intervention program can be re-focused if not achieving goals.
10. Continued in person, Call Center, and mail interventions, e.g., appointment reminders, health tips, goal setting and monitoring of goals.	Health Coaches APS Fulfillment	Tied to routine reporting and updates to Enrollee's Plan of Care.
11. Period performance measurement identifies impact of interventions	APS ACCESS Plus Reporting Analyst/ Health Intelligence Unit	Review of measurement results by APS and Quality Improvement Committee identifies improvement opportunities.
12. APS/Department review results, recommendations, APS makes program level changes.	APS	Refinement of interventions, introduction of changed strategies for program improvement.

We consistently evaluate each stage of our DM programming and look for opportunities to improve the program and our performance. An example of our use of performance measures to improve operations is the [redacted] program ([redacted]). APS identified a low Enrollee contact rate as a barrier to engagement in GAMMP. In response to the measure of engagement, we implemented automated calling software. The chart in **Table 23-4** shows the impact of this improvement strategy on Enrollee engagement.

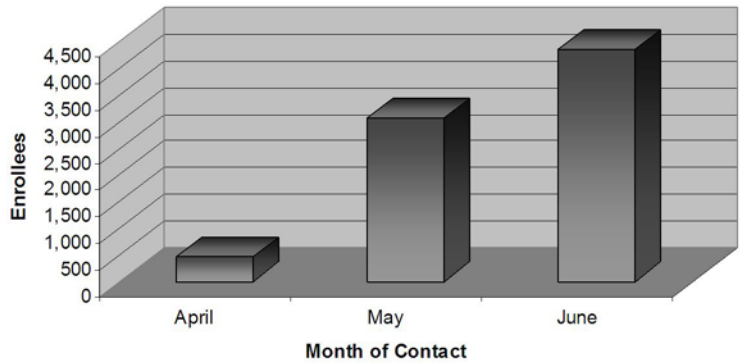

Table 23-4. Impact of Process Change

APS offers formalized Disease Management Programs for the following disease states that the Department requires for the ACCESS Plus Program: Asthma, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, Diabetes, Gastro Esophageal Reflux Disease, Hypertension, Hyperlipidemia, and Low Back Pain. We also offer the following disease/health management programs: Cancer, Depression, Health and Wellness Promotion, Maternity, Nutrition,

Schizophrenia, Stress, Tobacco and Smoking Cessation, and Weight Management.

APS will develop appropriate programming for Cystic Fibrosis, Hepatitis, Inflammatory Bowel Disease, Migraine Headaches, Multiple Sclerosis, Peptic Ulcer Disease, Rheumatoid Arthritis, Seizure Disorders, and Systemic Lupus Erythematosus. For Cardiac-related conditions, we will enhance our existing cardiac programming. We have already initiated the process of developing condition-specific assessments that guide interventions. We describe our specific approach for Enrollees with each of these conditions in response to Items 1-6 below. Through our experience with other clients we have found that this approach meets the needs of Enrollees by focusing on the coordination of care and education for Enrollee and PCP needs regarding the diseases being managed. Our modified case management methodology is especially appropriate for conditions with a small population, where consensus and evidence about optimal treatment methodologies are still emerging, or where a high degree of individuality in treatment choices is appropriate, or where Enrollees are experiencing coordinated care and direct interventions are not necessary. Our emphasis on close coordination with and support of PCPs is an important factor in successful management. For example, the 2007 Disease Management Consensus Statement issued by the National Multiple Sclerosis Society noted:

> "Significant obstacles to obtaining these agents [medications] exist for appropriate candidates with MS. One is the lack of adequate information reaching primary care providers and general neurologists, who each may have only a few patients with MS, but collectively care for a large percentage of the MS population." (**Exhibit 22**, Page 3)

These issues are particularly relevant to the ACCESS Plus area, with rural counties, scarce clinical resources, and Enrollees who may have low health literacy in general, may speak English as a second language, and who may lack the family and personal capacity to identify and access local and regional resources. Our blended approach works directly with Enrollees and their PCPs to identify optimal treatment strategies, health behaviors that contribute to desired outcomes, and community resources that are available to support Enrollees and their families. The synergies across service components we offer are key factors to our success as an organization and help ensure that we meet the following goals:

- Treatment regimens that better conform to evidence-based guidelines.
- Primary care providers who are more aware of and incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care that is less fragmented and more holistic (i.e. in addressing physical and behavioral health care needs and in considering both medical as well as social needs), and increased communication across settings and providers.
- Enrollees who have greater involvement in their care management.

We significantly improve Enrollees' health care experiences by:

- Helping Enrollees understand their health, their benefits, and relevant care options.
- Providing valuable, timely information and resources to inform their decision making.
- Helping them overcome the non-clinical obstacles to getting the right treatment in the right setting at the right time.
- Supporting Enrollees as they struggle with lifestyle improvements and compliance with their treatment as prescribed by their physician.

As a result, Enrollees are more confident in their ability to make good healthcare choices and:

- Learn to navigate the health care system more confidently.
- Expect services that are medically necessary and adhere to PCP directions.

- Lead healthier and more productive lives.

Health Coaches: The Key to Outcomes

APS' Health Coaches are Registered Nurses who work with each Enrollee to customize their care plan so that it aligns with their specific motivators for change and addresses all relevant factors negatively impacting their health. The Health Coach works collaboratively with available resources based upon the Enrollee's most pressing need at that time In each interaction with Enrollees, Health Coaches:

- Monitor the Enrollee compliance with recommendations and intervenes when non-compliance is identified.
- Assess, plans, implements, and evaluates Enrollees' health education needs.
- Act as a professional resource for health education.
- Conduct motivational interviewing, behavioral modification, and education and guidance on the Enrollee's condition.
- Provide medication adherence monitoring.
- Enter into collaborative brainstorming and action planning to achieve the Enrollee's health goals.
- Coordinate local resources to improve compliance with the provider's treatment plan.
- Encourage the Enrollee to practice habits that support ongoing health, such as helping Enrollees make better lifestyle choices concerning weight management, stress management, eating properly, and smoking cessation.
- Help Enrollees better manage medical, emotional, and personal issues, that may be associated with their condition(s).
- Facilitate relationships and communications between Enrollees and their healthcare neighborhoods.

Field-based Health Coaches may be based at home, and routinely visit locations where Enrollees can be contacted such as clinics, high volume provider practices, senior centers, and hospital emergency rooms. APS Health Coaches work directly with DM Enrollees as well as provide valuable support to PCPs and office staff. In addition to the Health Coach, APS also includes Master's prepared Social Workers and Behavioral Health Professionals to act as Care Coordinators. These professionals assist Health Coaches to identify and resolve non-clinical issues that pose barriers to successful outcomes, such as childcare needs that interfere with the Enrollee's ability to keep appointments. Other Care Coordinators will be lay educators, former ACCESS Plus Enrollees who understand the program and ACCESS Plus Enrollee experiences and perspectives.

Infrastructure Development for Disease Management

Combining a dedicated service center with field based Health Coaches is an APS best practice that characterizes our DM programs. Between 2005 and 2008 APS implemented dedicated service centers for DM programs in [redacted], and [redacted]. This dedicated service center model is so successful we also use it for other programs, and during the same time period implemented new programs in [redacted], and [redacted] (adding a program to an existing service center), for a total of nine service center implementations within three years. With this experience we have developed the core organization needed to successfully implement new programs, most often within 90 days. These core services include facility implementation and management, network installation and IT development, recruiting, screening, and hiring management and clinical staff, communications and outreach to local stakeholders and providers, and training for APS staff, clients, and providers.

With an office currently in Harrisburg, APS is well-positioned to implement the infrastructure needed for this program. APS will expand our Harrisburg presence to house the office-based staff, including program management, clinical oversight, and member/provider call center staff.

The key to our infrastructure development and deployment, APS CareConnection® will be configured for use with the ACCESS Plus Program (described in Section II-3.1., Information Technology). This system will be accessible to all APS personnel, as well as the Department and ACCESS Plus providers (in phase two). The system includes APS disease-specific and general assessments, the SF-8 Functional Assessment that we use to gauge initial and on-going functional status of DM Enrollees, our library of intervention materials, the person-level "dashboard" that displays the integrated database of claims, assessment, and plan of care data, links to specialty societies and organizations (such as the American Diabetes Association), and links to the Department sites. This system is accessible through Internet Explorer and does not require any special software, hardware, or setup in addition to the basic Windows environment (although a broadband connection is preferred to dial-up, the system can be used with only a dial-up Internet connection). The system therefore provides a comprehensive tool for care management that is transparent to providers and the Department. We populate this tool during implementation with claims, provider, and Enrollee information, as well as standard versions of our DM materials and interventions. These materials will then be adapted by corporate clinical staff for use in the ACCESS Plus Program, and new materials will be added for case management/disease management programs specific to ACCESS Plus.

Ongoing maintenance is conducted on an annual basis, as new conditions are added to the program, or changes to materials and programming are made necessary by updates in guidelines and clinical criteria.

Subcontracting for Disease Management Services

As we explain in Section II-2, Statement of the Problem, the APS team has been composed to bring organizational core capabilities to each aspect of the ACCESS Plus Program for a "best of class" approach to program services. Disease management is a core capability of APS Healthcare and we therefore do not subcontract for DM services. A major reason not to subcontract for DM services is explained by Item A itself – subcontracting among multiple DM vendors increases coordination needs, creates the risk of fragmented communication with Enrollees and providers, and disperses accountability for program results among multiple parties. An equal disadvantage to a non-integrated program approach is the potential for the Department to have to address functionality through multiple channels – increasing the administrative burden on the Department for oversight of the DM program. APS believes strongly in subcontracting, especially with disadvantaged program vendors, and we propose a team that strengthens our ability to deliver exemplary customer service in coordination, information, and educational programming throughout the ACCESS Plus Program, including Enrollees with chronic disease and the providers who deliver their care.

Characteristics of the ACCESS Plus DM Program Population

We analyzed data from FY 2007 to examine the burden and impact of disease on utilization and cost for conditions to be managed as part of the Disease Management Program. We found that [redacted]% of adults have only one chronic condition and [redacted]% have between [redacted] **and** [redacted] chronic conditions. This group with multiple comorbidities accounted for over $[redacted] million dollars in expenditures for the time period. Additionally, over [redacted] adults have between [redacted] *and* [redacted] *chronic conditions* with total cost exceeding $[redacted] million. In the DM population there are [redacted] unique patients taking medications for Psychosis or Bipolar Disorder and they account for [redacted]% of all costs for the DM identified group, with $[redacted] million in pharmacy costs and $[redacted] million in medical costs. Also of concern – we identified [redacted] unique individuals in FY 2007 data with a DM condition who were taking prescriptions for depression. Over [redacted] of these Enrollees are under the age of 15. This DM population would be poorly served by an approach that does not support the person holistically – ACCESS Plus Enrollees with chronic disease struggle with a number of factors in their lives, and the burden of chronic disease is only one. A successful DM approach addresses the whole person across the continuum of physical and behavioral health challenges at personal, behavioral, medical, and social levels. Aside from the imperative of delivering person-centered programming, there is also an important clinical reason to approach this DM population holistically: unrecognized and untreated depression and mental illness are serious barriers to

development of the self-management skills that give Enrollees the resources to deal with their chronic diseases. This APS approach has also been endorsed by the APS Clinical Advisory Panel (CAP). We include selected resumes for CAP members with other APS resumes in **Exhibit 2**. [redacted] and a member of the APS CAP expressed our position on holistic disease management:

> "Our work...with APS Healthcare has allowed us to analyze [redacted] data specifically for identifying ways to intervene and improve health outcomes for the disabled segment of Medicaid. Our co-morbidity analysis, for example, reinforced our belief that the program is really one of population health management, not one disease-at-a-time protocols."

Examining the data for FY 2007 by Enrollee county of residence and region (counties were assigned to regions according to the Regional Advisory Committee placement), APS found the distribution of Enrollees with any chronic disease displayed in the chart in **Table 23-5**. North East (with the Wilkes Barre/Scranton population center) is the largest region with over [redacted]% of Enrollees, followed by the North West region (Erie county and surrounding area) with [redacted]%.

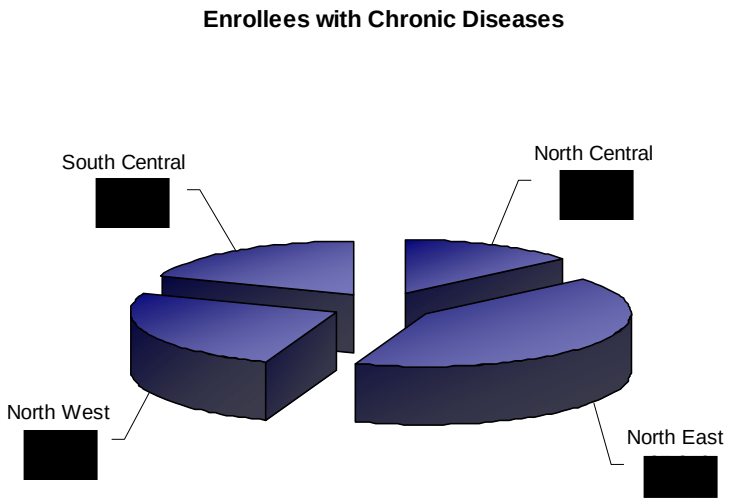

Table 23-5. Distribution of Chronic Disease by ACCESS Plus Region

This distribution will help to guide our allocation of field-based staff across ACCESS Plus counties. Our analysis of specific diseases within overall categories at the regional level will also assist us with evaluating priorities for provider recruitment. For example, within the North East region, Coronary Artery Disease accounts for [redacted]% of all Cardiovascular Diseases in that region – so it will be critical to focus recruitment on cardiology specialists in the region.

Infrastructure for Integrated Disease Management Program

The illustration in **Table 23-6** displays our proposed infrastructure for the ACCESS Plus Disease Management Program – an integrated program of education, outreach, and intervention for Enrollees and their PCPs to achieve the goals of the ACCESS Plus Program through use of proven intervention techniques and strategies that APS has developed as innovations for DM based on our expertise in Medicaid DM programming.

APS also balances our strategies for community presence, engagement, and educational programming for multiple, alternative audiences and methods for delivering these strategies to ensure that messages reach the audience of DM Enrollees and providers. This balanced approach is why both Enrollees and providers accord our programs high marks for customer service and clinical expertise; it is an approach that is also well suited to Enrollees across the spectrum of disease burden and cost because it integrates program dimensions at the person level – and approaches each person with respect and flexibility.

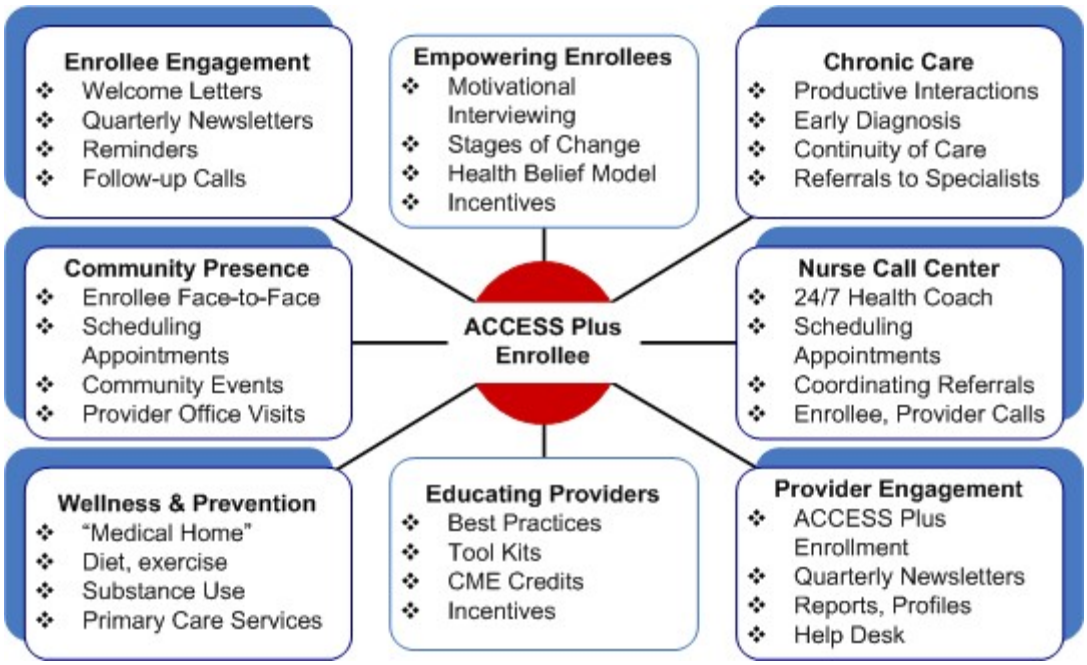

Table 23-6 Integrated Infrastructure of APS DM Programming

Enrollees with Cost Outlier Characteristics

As our discussion below in this section indicates, there is considerable variation between regions in average costs and Per Member Per Month (PMPM) costs. An ongoing analytic focus for the project will therefore be on identifying causes of variation that are not related to differences that can be accounted for by variations in Enrollee health status and healthcare needs. In **Table 23-7**, we present a summary of Enrollees with the highest outlier costs, showing the dramatic impact of these costs.

Table 23-7. Summary of Total DM and Outlier Costs

Description	Number
All Enrollees with Chronic Disease	[redacted]
Enrollees with Outlier Costs	[redacted]
Percent of DM Population	[redacted]
Total Costs for DM Population	[redacted]
Total Costs for Outliers	[redacted]
Percent of DM Costs	[redacted]

One source of variation is the presence of critical chronic conditions in the overall disease management population. In addition to Enrollees who are high cost and utilization outliers, we found [redacted] Enrollees with hemophilia and [redacted] with Alzheimer's disease. These Enrollees will require special consideration in the DM Program to ensure stability of their care and support for relationships with PCPs and specialists.

The high outlier DM population represents less than one-fifth of one percent of the total DM population, with an impact on healthcare costs more than [redacted] times its relative size. Our Total Population Health Management approach addresses the needs of these fragile Enrollees. APS Health Coaches are Call Center-based and Field Nurses who conduct interventions with the DM and PCCM populations. They will receive a special briefing on these conditions to ensure that they are oriented to best practices for these Enrollees; we will also consult with specialists at the Pennsylvania State University School of Medicine and the ACCESS Plus

and Department Medical Directors to ensure that our approaches are evidence-based and current. We provide additional discussion of our innovative approaches to these difficult conditions in our response to Item R.

In the following sections we present the results of our analyses of data for the specific clinical conditions to be addressed by the DM Program. We comment on special considerations that will indicate initial directions to validate our findings, as well as circumstances that will influence our health coaching and care coordination interventions. In response to this item we then present our integrated Disease Management Program that will address the care management needs of ACCESS Plus Enrollees.

Please note: In analyzing data for the ACCESS Plus population with chronic disease, APS used several different approaches to identify various aspects of population distribution, cost, utilization, and risk. The numbers we reference in our proposal, therefore, also represent different aspects that we have examined to gain an understanding of the population, its utilization profile, and potential opportunities for program organization, focus of interventions, and staffing allocation.

1. Cardiovascular Diseases

i. Congestive Heart Failure
ii. Coronary Artery Disease
iii. Stroke
iv. Transient Ischemic Attack (TIA)
v. Hypertension
vi. Hyperlipidemia
vii. Peripheral Vascular Disease

Using data provided for FY 2007 to identify candidates by diagnosis codes identified in the RFP 44-08 Re-issued Databook, APS found almost [redacted] Enrollees with a diagnosis of cardiovascular disease. **Table 23-8** shows the prevalence of these conditions with medical, pharmacy, and total costs. Of the total number of Enrollees, only [redacted] were identified with Transient Ischemic Attack ([redacted]% of Enrollees).

Table 23-8. Cardiovascular Diseases

Region	Enrollees	Average Cost	Average PMPM
North Central	[redacted]	[redacted]	[redacted]
North East	[redacted]	[redacted]	[redacted]
North West	[redacted]	[redacted]	[redacted]
South Central	[redacted]	[redacted]	[redacted]
Statewide	[redacted]	[redacted]	[redacted]

Shown in **Table 23-9**, the majority of Enrollees with Cardiovascular Disease live in the North East Region. Within this region, [redacted]% of Enrollees have Hypertension and [redacted]% have Coronary Artery Disease. Overall, Cardiovascular Disease represents [redacted]% of all chronic diseases to be included in the DM program.

The small number of Enrollees with Stroke and with TIA (389) can be expected, given that the majority of the population is less than 21 years of age. As we mention below, a special characteristic of our DM programming will be our approach to very small populations. Within Cardiovascular conditions, the greatest number of Enrollees had diagnoses of Hypertension (over [redacted]), followed by Coronary Artery Disease (just over [redacted]).

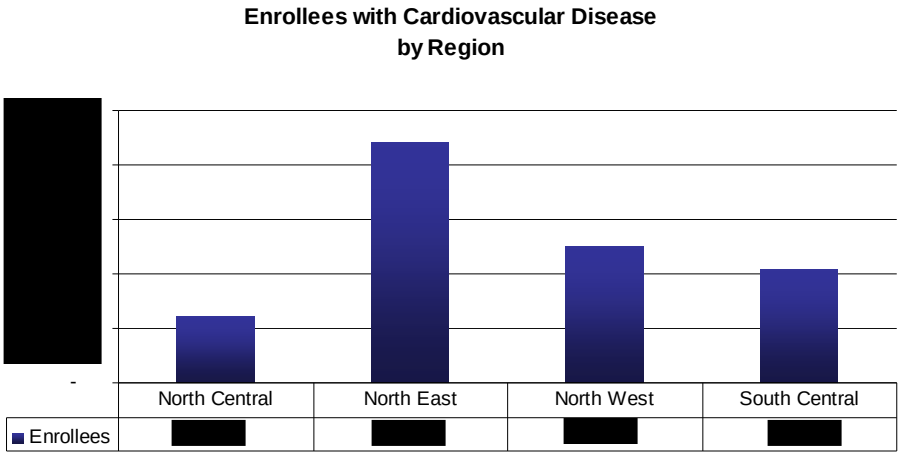

Table 23-9. Distribution of Cardiovascular Disease by Region

While the North East Region has by far the highest number of Enrollees, average costs are highest in the North West. Cardiovascular Disease is most expensive to treat in the North West region, as shown in **Table 23-10**. Average cost for this condition in the North West region was almost $[redacted]. Among all Cardiovascular Diseases, Congestive Heart Failure (CHF) was most expensive to treat, with the North East region having the highest average cost at almost $[redacted], influenced by average costs in Cameron County of $[redacted]. This region demonstrated considerable variation in average cost, with the lowest average in Pike County at just under $[redacted] and the highest in Cameron County.

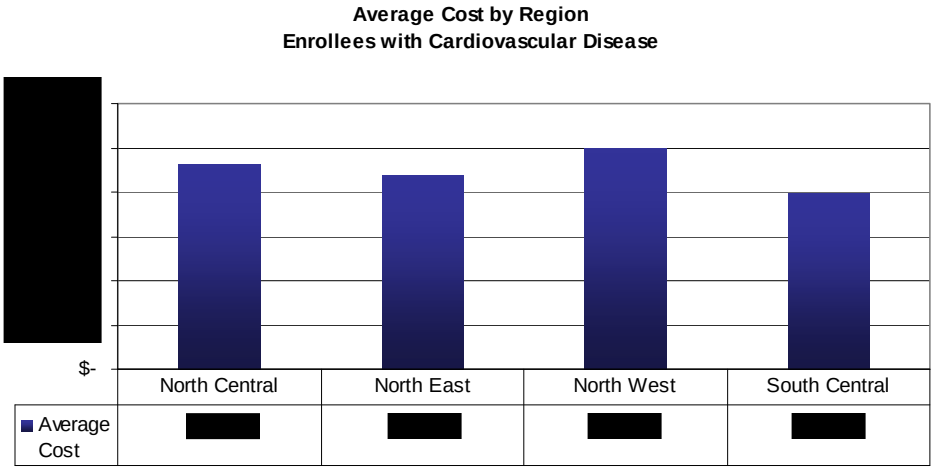

Table 23-10. Cardiovascular Costs by Region

While not reflected on this table, there is also considerable variation in average costs between counties in the North West region. For Congestive Heart Failure, Pike County had the smallest average expenditure, at $[redacted]; Cameron County had the highest average expenditure for CHF - $[redacted](a large difference but not statistically significant and attributable to outliers). The smallest region, North Central was second highest in average cost. Within this region, Potter County, with the smallest number of Enrollees, had the highest average cost for all Cardiovascular conditions combined ($[redacted]). Congestive Heart Failure ($[redacted]) and

Stroke ($ [redacted]) were largely responsible for the average cost in Potter County. In the North East Region, Wyoming County exceeds the average cost ($[redacted]) for the region by more than two Standard Deviations.

As shown by **Table 23-11**, Per Member Per Month rates seem relatively uniform across regions – with variation in total costs disguised by variation in number of members. However, within regions, PMPM rates show considerable variability. For example, in the North Central Region, the overall average PMPM rate for Cardiovascular Disease in Clearfield County is $[redacted] while the overall average in Snyder County is less than half that amount ($[redacted]). Similarly, in the North East Region the overall average across all Cardiovascular Diseases in Sullivan County is $[redacted] while in Schuylkill County the average is greater than two Standard Deviations from the mean at $[redacted].

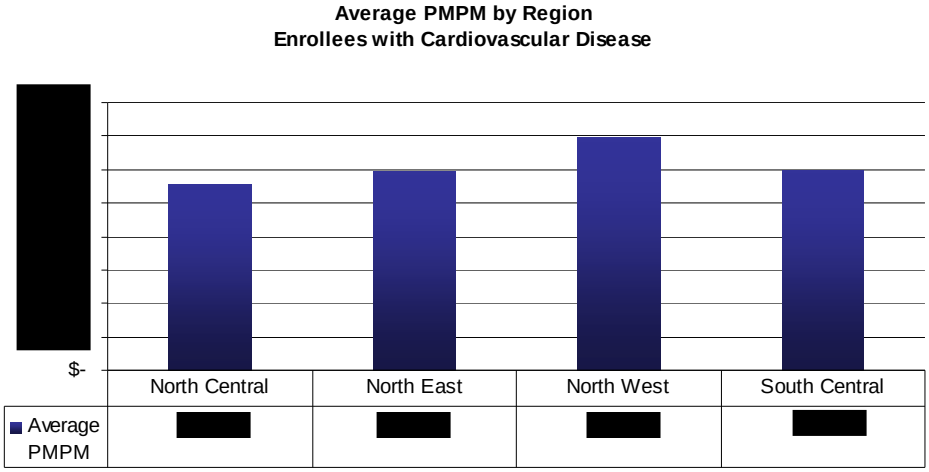

Table 23-11. Average PMPM Rates

In each county and with considerable variation, the presence of one or more Enrollees with outlier costs helps to drive cost; however, even without these Enrollees variation remains between counties within the same region; therefore, we believe there are opportunities to increase use of evidence-based treatment and control cost. Our examples of DM materials demonstrate our approach to managing cardiovascular diseases focuses on helping Enrollees adopt healthier lifestyles: making changes to their diets, increasing exercise under the supervision of their PCPs, adhering to medication regimens prescribed by PCPs and specialists, and achieving and maintaining a healthier weight.

Special Considerations for Disease Management

Cardiovascular Disease includes conditions that APS manages across our DM programs. This population will therefore be addressed by our Population Health Management approach that we describe in Table 23-3. The exception to this approach will be for Enrollees who have experienced Strokes or Transient Ischemic Attacks. We do not recommend risk stratification for populations with such small numbers. With these small populations, we will focus on Enrollees with uncoordinated care – a major feature of our DM approach in general. Our program will emphasize assurance of an effective medical home.

2. Respiratory Diseases

i. Asthma
ii. Chronic Obstructive Pulmonary Disease
iii. Cystic Fibrosis

Table 23-12 shows a summary of Respiratory diseases by region. As this table demonstrates, respiratory

diseases represent a large portion of the overall DM population, largely owning to the prevalence of asthma within the ACCESS Plus population.

Table 23-12. Summary of Respiratory Diseases

	RESPIRATORY DISEASES		
Region	**ENROLLEES**	**AVG COST**	**AVG PMPM**
North Central	[redacted]	[redacted]	[redacted]
North East	[redacted]	[redacted]	[redacted]
North West	[redacted]	[redacted]	[redacted]
South Central	[redacted]	[redacted]	[redacted]
Statewide	[redacted]	[redacted]	[redacted]

As displayed in **Table 23-12**, and **23-13** Enrollees with Asthma are also highest in the North East, and with [redacted] individuals in the ACCESS Plus region, Asthma has the highest number of Enrollees in DM. This prevalence is not unexpected given that over [redacted]% of Enrollees in ACCESS Plus are under the age of 21.

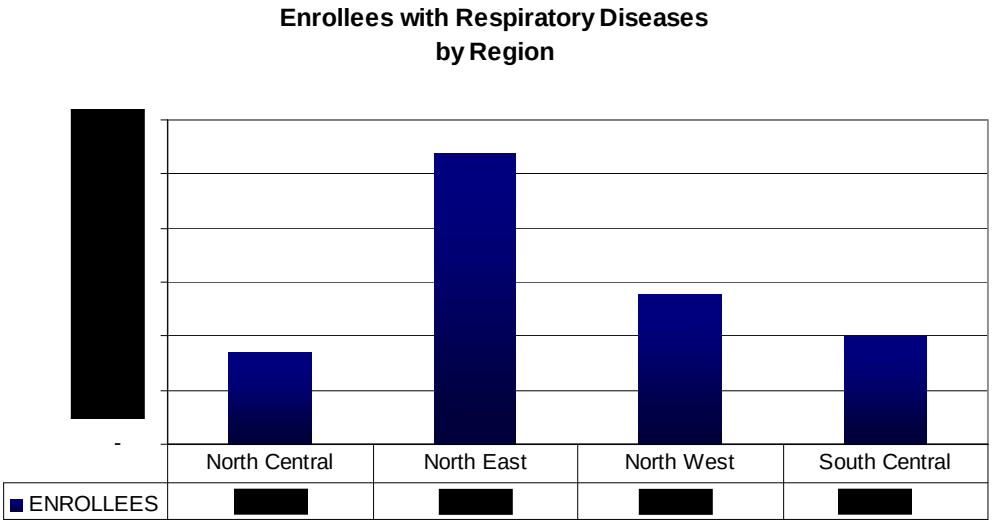

Table 23.13 Comparison of Enrollees by Region

Cystic Fibrosis (CF) is a new disease covered by this scope of work, and statewide we identified [redacted] Enrollees with this condition. Nine ACCESS Plus counties (Crawford, Elk, Forest, Fulton, Juniata, Montour, Potter, Sullivan, and Wyoming) had no Enrollees identified as having CF. Luzerne County had the greatest number ([redacted]). As we point out in briefing mentioning special considerations for DM, it is important that populations with small numbers receive what is essentially individual programming, since population-based programs may be inappropriate. For these Enrollees, we understand that the most important program outcome is an effective medical home in a well-coordinated healthcare neighborhood – access to both primary and specialty services as well as attention to other Enrollee social welfare and health needs (such as access to dentists). Our DM program will therefore place special emphasis on engaging PCPs for these Enrollees, as well as focusing on access to essential specialty care.

Table 23-14 displays a summary of costs for all respiratory conditions across the four regions.

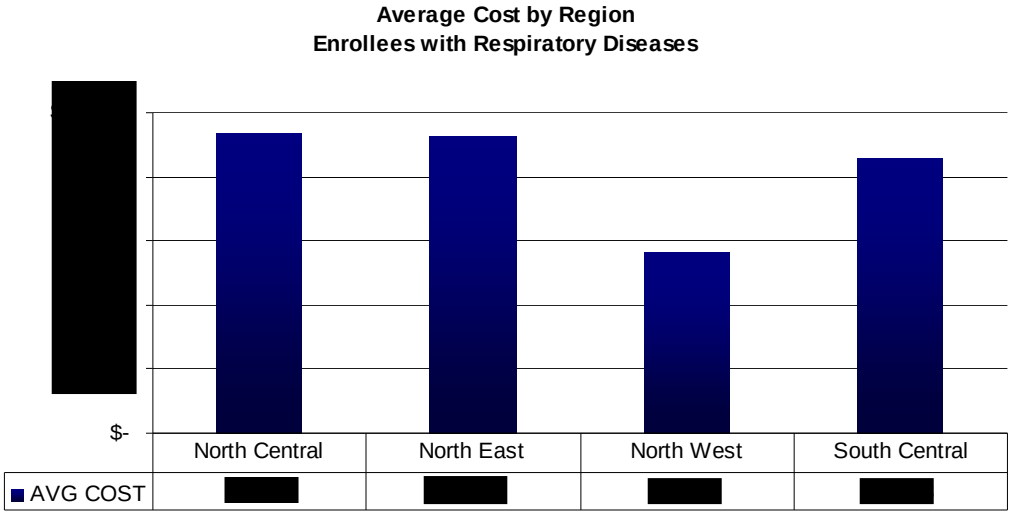

Table 23-14. Average Cost of Respiratory Diseases by Region

The relatively similar average costs across three of the four regions are not disproportionately influenced by Enrollees with cost outlier or utilization outlier status. In the North Central Region, the average outlier cost ($[redacted]) represents 5% of all outlier costs and in the other three regions average outlier costs are only [redacted]%-[redacted]% of total outlier costs. Based on our analyses, we believe variation between the North West Region and the other three regions is worthy of more detailed consideration and consultation with the Department.

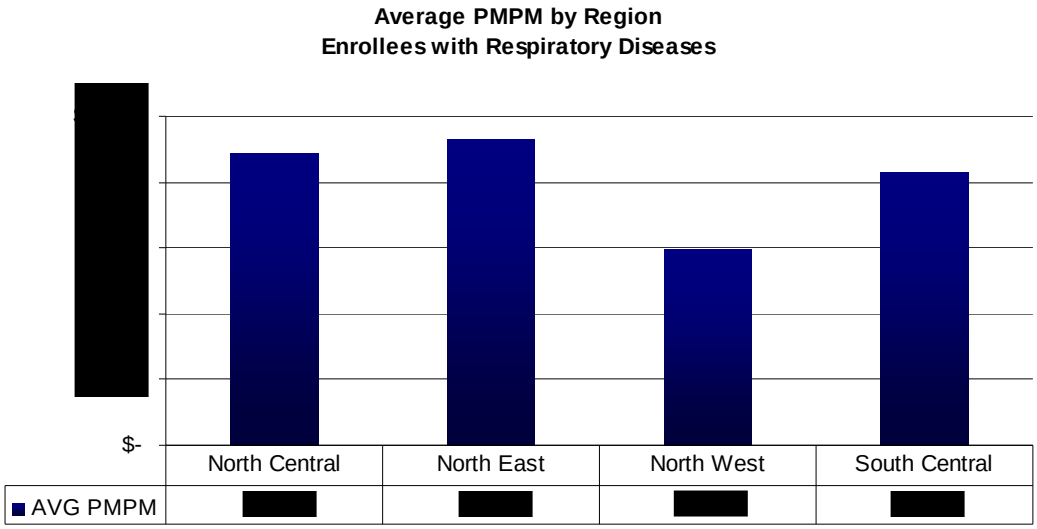

Table 23-15. Comparison of Average PMPM by Region

Average costs and average PMPM rates are lowest for the North West region, as shown in **Table 23-15**. With the second highest number of Enrollees with outlier costs in FY 2007 this region demonstrated a much lower impact on cost from outlier cases. This result suggests the possibility that providers in the region have developed best practices that manage a fairly large population of clinical outliers more effectively than other regions. This possibility in particular will be interesting to examine and exciting to confirm, given the large number of individuals in the population with Asthma.

Since parental understanding of Asthma self-management is key to preventing emergency department utilization, and Enrollee self-management is key to successfully avoiding adverse outcomes with Asthma, APS will meet with providers and Enrollee families in this region to identify best practices to share with other regions during Regional Ambassador Council meetings, Enrollee Outreach Activities, and Provider training.

Special Considerations for Disease Management

Our data analysis found [redacted] Enrollees in ACCESS Plus counties with Cystic Fibrosis (CF), compared to almost [redacted] Enrollees with Asthma. With a small number of Enrollees identified with CF, APS will identify Enrollees with uncoordinated care; intervene to establish effective medical homes, and continue to monitor all Enrollees with CF and intervene as needed for the life of the contract. We will use our Population Health Management approach described in Table 23-3 for all other Enrollees.

3. Gastrointestinal Diseases

i. Inflammatory Bowel Disease
ii. Gastro Esophageal Reflux Disease
iii. Peptic Ulcer Disease
iv. Hepatitis

Enrollees with Gastrointestinal Diseases seem to be distributed across the regions in proportion to the size of the regions as shown in **Table 23-16 and Table 23-17**; even though there is variation in the number of Enrollees, both the average cost and the average PMPM are much closer together.

Table 23-16. Summary of Gastrointestinal Diseases

	GASTROINTESTINAL DISEASES		
Region	**ENROLLEES**	**AVG COST**	**AVG PMPM**
North Central	[redacted]	[redacted]	[redacted]
North East	[redacted]	[redacted]	[redacted]
North West	[redacted]	[redacted]	[redacted]
South Central	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]

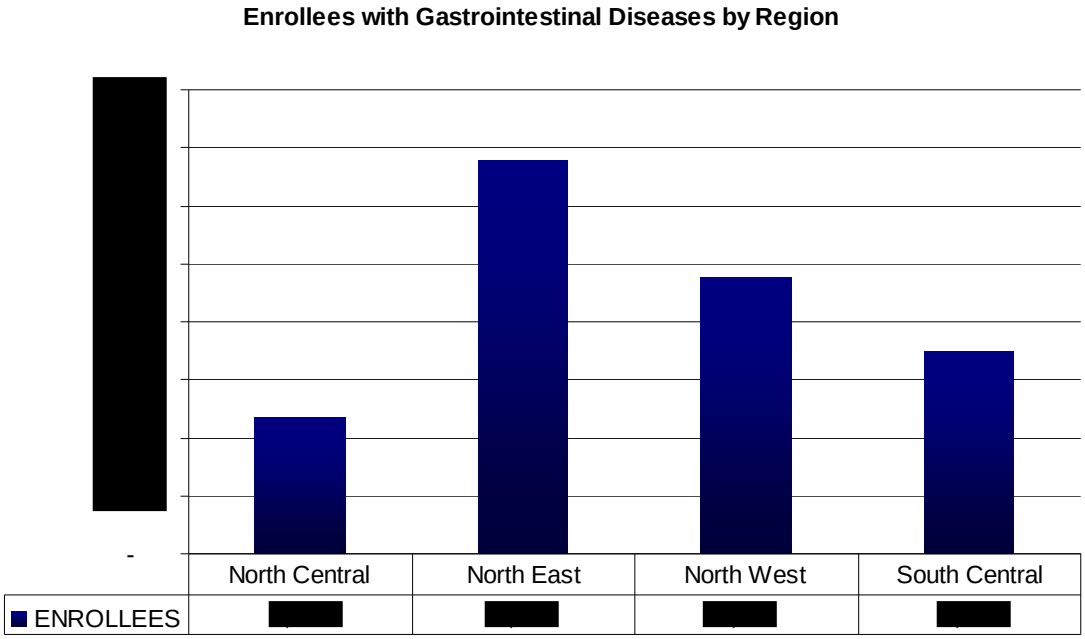

Table 23-17. Distribution of Enrollees with Gastrointestinal Diseases by Region

Table 23-18 compares average costs for gastrointestinal disorders. In the North Central Region, however, this average is driven by a maximum average cost in Snyder County ($[redacted]) for costs of ulcer treatment and a minimum average cost in Clearfield County for ulcer treatment ($[redacted]) that are both more than two standard deviations from mean costs. The extent of variation in costs between counties in this instance is likely driven by outlier costs, since Snyder has the smallest Enrollee population with this condition.

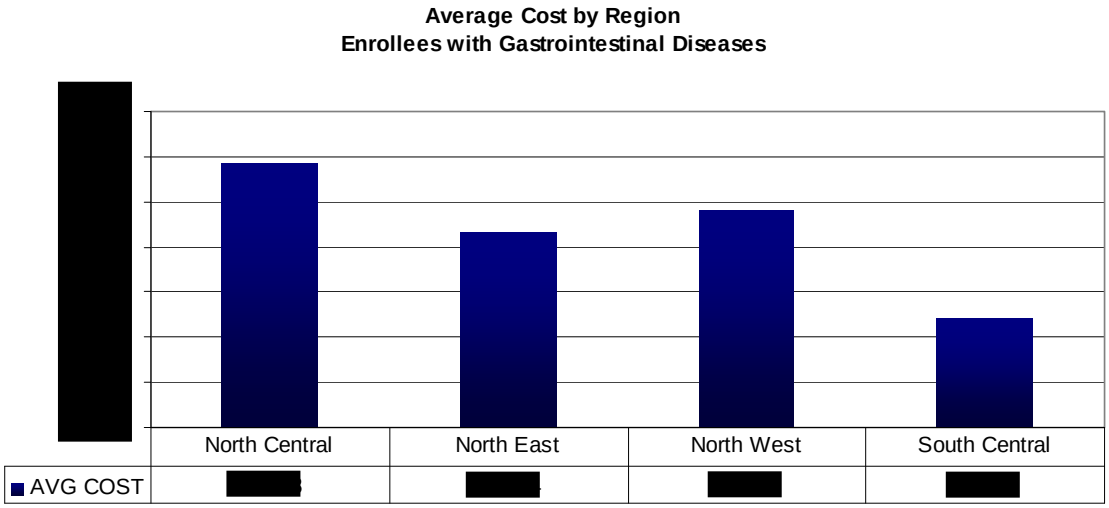

Table 23-18. Comparison of Average Costs for Gastrointestinal Diseases

As **Table 23.19** indicates, this consideration also influences the average PMPM for Gastrointestinal Diseases, bringing the average for the North Central Region (which has [redacted] Enrollees with a Gastrointestinal Disease) within $[redacted] of the North East Region, which has more than double the Enrollees with Gastrointestinal Disease.

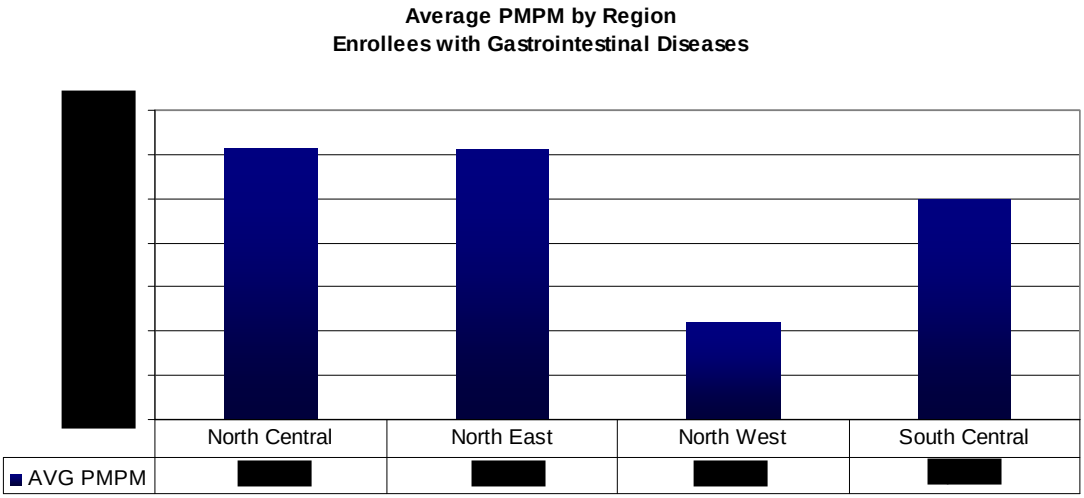

Table 23-19. Average PMPM for Gastrointestinal Diseases

This example illustrates the compelling need for careful analyses of variation in healthcare costs at the regional level, as well as the impact of outlier costs and utilization in rural areas with limited populations. The discussion also highlights the importance of *local* input into sources of variation and possible improvement opportunities to reduce variation through adoption of evidence-based practice. Appropriate practice for only one extremely fragile Enrollee can distort the cost profile of an entire county for a year. For this reason, APS removes outlier cases from operational analyses.

Special Considerations for Disease Management
With a small number of Enrollees identified with Peptic Ulcers, APS will identify Enrollees with uncoordinated care; intervene to establish an effective medical home, and continue to monitor all Enrollees and intervene as needed for the life of the contract. We will use our Population Health Management approach described in Table 23-3 for all other Enrollees.

4. Diabetes

The prevalence of Diabetes is relatively low in this population owing to its age. Enrollees in the general ACCESS Plus population averaged [redacted] years of age; Enrollees eligible for the DM population averaged between [redacted] and [redacted] years of age. This age group is not one where Diabetes is most prevalent and average costs and PMPM rates are also low relative to an older population.

Table 23-20. Summary of Enrollees with Diabetes

	DIABETES		
Region	**ENROLLEES**	**AVG COST**	**AVG PMPM**
North Central	[redacted]	[redacted]	[redacted]
North East	[redacted]	[redacted]	[redacted]
North West	[redacted]	[redacted]	[redacted]
South Central	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]

As **Table 23-20** and **Table 23-21** below indicate, the North East Region has over [redacted]% of all Enrollees with Diabetes. Our Outreach efforts will have dual targets: with the lowest average cost and second lowest average PMPM, providers in this region seem to be delivering services efficiently to the population. We will carefully examine the analyses of uncoordinated and coordinated care for both opportunities for improvement as well as best practices. By contrast, the North West Region, with the second highest number of Enrollees and an urban center (Erie) had both the highest average costs and average PMPM. In our experience, sharing regional variations such as these without drawing conclusions that providers in one region are delivering inappropriate care is an excellent way to prompt discussion and learning that can lead to a decrease in variation unrelated to differences in Enrollee acuity.

Enrollees with Diabetes by Region

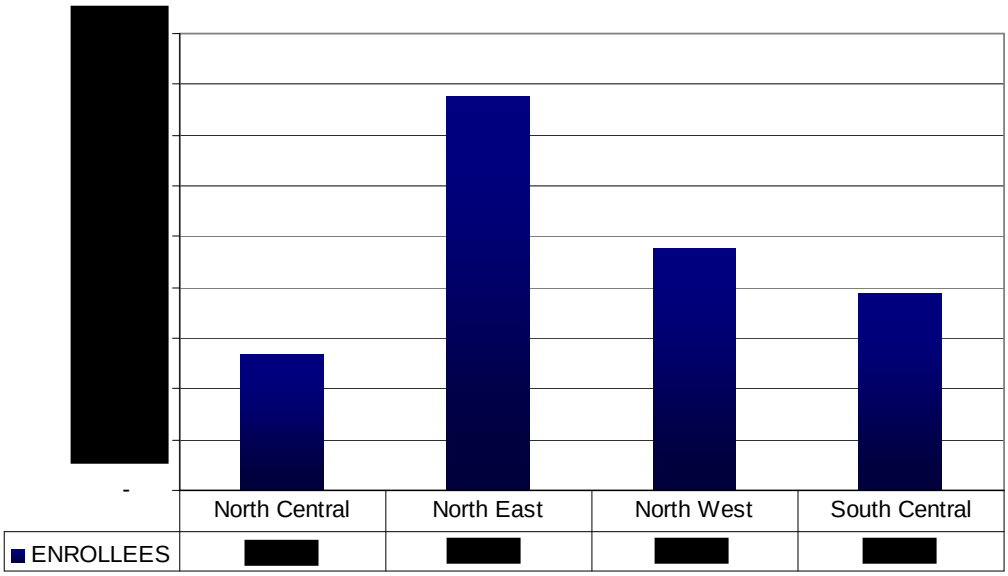

Table 23-21. Regional Distribution of Enrollees with Diabetes

Average Cost by Region
Enrollees with Diabetes

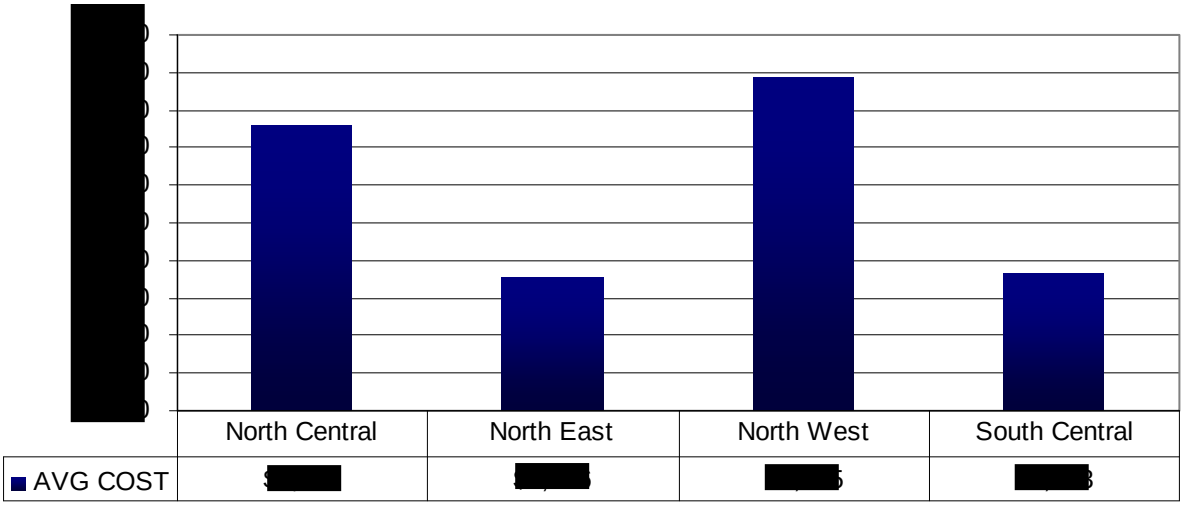

Table 23-22. Average Cost of Diabetes Care by Region

Table 23-22 shows variation in average costs by ACCESS Plus region. Since Diabetes is one of the most commonly managed conditions in the DM field, and has been in the ACCESS Plus DM program since its inception, the extent to which this regional variation is observed is of interest. Should APS be awarded this important contract, we will examine this and other patterns of utilization and cost to determine the source of the variation (outlier or practice) and share best practices that may have emerged in the North East and South Central Regions, as **Tables 23-22** and **23-23** show.

Average PMPM by Region
Enrollees with Diabetes

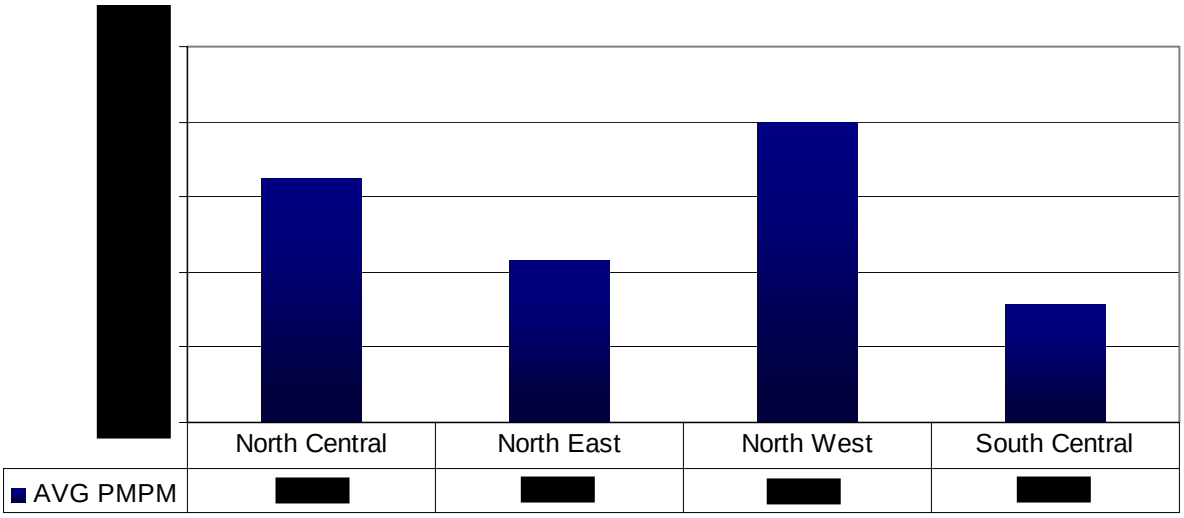

Table 23-22. Average PMPM for Enrollees with Diabetes by Region

For Enrollees with Diabetes, weight and diet improvements are essential. This emphasis is consistent with Governor Rendell's Rx for PA which will focus attention on the issue of obesity. This focus is another reason to examine the patterns of utilization and cost by region for diabetes.

Special Considerations for Disease Management
APS will use the Population Health Management approach presented in Table 23-3 for all ACCESS Plus Enrollees with Diabetes. APS is currently URAC-accredited for Diabetes and will maintain this accreditation.

5. Rheumatological Disorders

i. Rheumatoid Arthritis
ii. Systemic Lupus Erythematosus (SLE)
iii. Low Back Pain

Table 23-24. Summary of Enrollees with Rheumatological Disorders

	RHEUMATOLOGICAL DISORDERS		
Region	**ENROLLEES**	**AVG COST**	**AVG PMPM**
North Central	[redacted]	[redacted]	[redacted]
North East	[redacted]	[redacted]	[redacted]
North West	[redacted]	[redacted]	[redacted]
South Central	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]

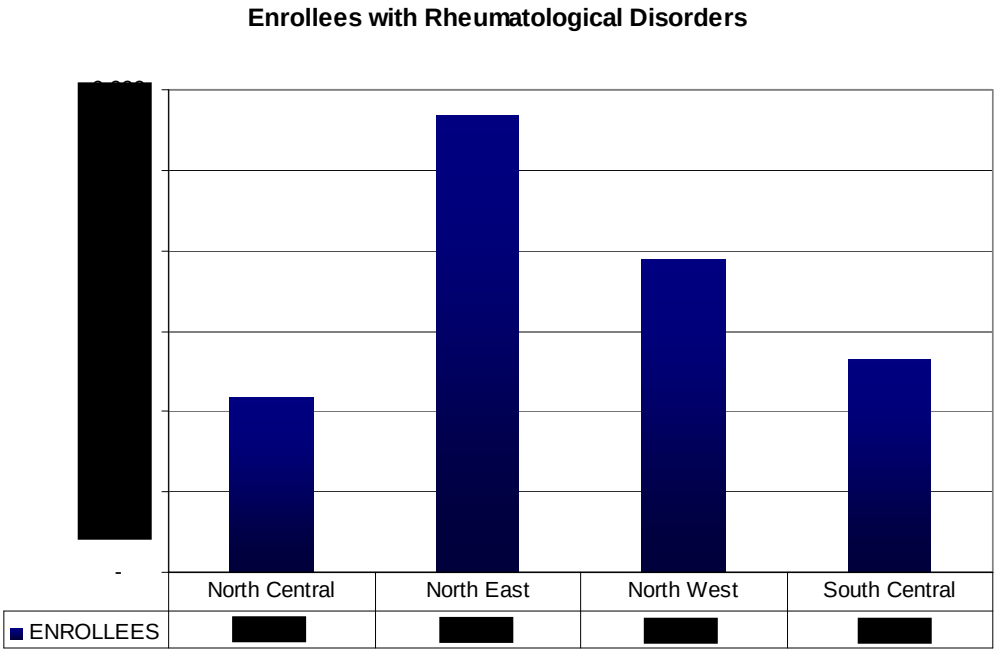

Table 23-25. Summary of Enrollees with Rheumatological Disorders

As might be expected, the number of Enrollees with Low Back Pain dominates this disease category, with [redacted]% of Enrollees. Only [redacted]% of Enrollees were identified with SLE; [redacted]% of Enrollees were identified with Arthritis. Both SLE and Arthritis demonstrated considerably greater variation in costs between counties and

regions, which tended to make regional variation seem higher for the entire disease category as shown in **Table 23-24**. The North East Region again had by far the greatest number of enrollees, as **Table 23-25** displays.

Average Cost by Region
Enrollees with Rheumatological Disorders

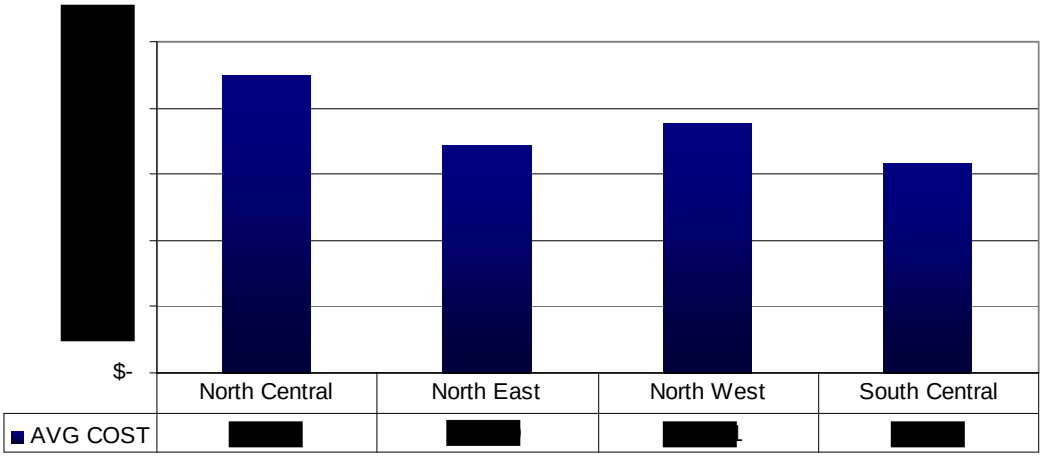

Table 23-26. Average Costs for Rheumatological Disorders

Over %of Enrollees in this category live in counties in this region, with Erie County having the greatest number ( ). Additionally, a slightly greater percentage of Enrollees with Low Back Pain diagnoses are in this county (%), and % of Enrollees in Erie County in this category overall had Low Back Pain diagnoses. **Table 23-26** displays the average cost by region associated with Rheumatological Disorders. The North Central Region had several counties with high costs associated with Arthritis (Clearfield, with average costs of $ and Potter with average costs of $) but both counties had a small number of Enrollees with this condition, potentially accounting for high average costs.

The impact of small numbers and outlier costs is also seen in the average PMPM rates for the North Central Region, and this variation is displayed in **Table 23-27.**

Average PMPM by Region
Enrollees with Rheumatological Disorders

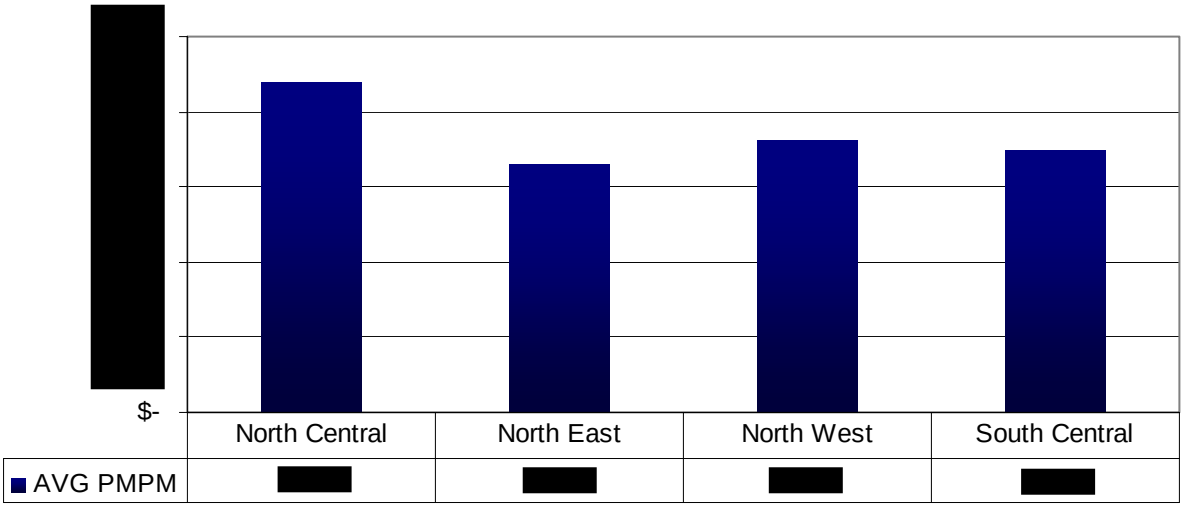

Table 23-27. Average PMPM by Region for Rheumatological Disorders

APS also observed small numbers reported for provider audits; we suggest extreme caution in reporting percentages based on small numbers (and in some cases an 'n' of 1) and also recommend that the Department address this issue where possible by stratifying sample sizes by a greater number of units than statewide. For the ACCESS Plus CAHPS survey, for example, we propose to draw the sample stratified by Region so that we can report meaningfully to the Regional Ambassador Council at the level of each Council's own Region.

Special Considerations for Disease Management

APS has conducted DM programs for Enrollees with Low Back Pain for over five years, and will continue to use our tested approach for ACCESS Plus. We identified slightly more than [redacted] members with Arthritis, and fewer than [redacted] members with Systemic Lupus Erythematosus (SLE). We propose to use our small population DM management approach with these Enrollees: identify Enrollees with uncoordinated care, intervene to ensure access to a usual source of care through their medical home; monitor Enrollee utilization, and follow up as necessary to ensure that Enrollees receive appropriate care throughout the life of the contract. Enrollees with Low Back Pain will be offered the Population Health Management approached described in Table 23-3.

6. Neurological Disorders

i. Seizure Disorders
ii. Multiple Sclerosis
iii. Migraine Headaches

This disease category is also distributed unequally across the ACCESS Plus region and disproportionately by disease with Migraines accounting for the largest percent of Enrollees ([redacted]%) followed by Seizure Disorders ([redacted]%) and Multiple Sclerosis with only [redacted]% of total Enrollees. **Table 23-28** illustrates the distribution of members by region.

Table 23-28. Summary of Enrollees with Neurological Disorders by Region

	NEUROLOGICAL DISORDERS		
Region	**ENROLLEES**	**AVG COST**	**AVG PMPM**
North Central	[redacted]	[redacted]	[redacted]
North East	[redacted]	[redacted]	[redacted]
North West	[redacted]	[redacted]	[redacted]
South Central	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]

The North East Region again accounts for the greatest percentage of Enrollees, with [redacted]%. Table 23-29 shows the distribution of Enrollees with neurological disorders by region.

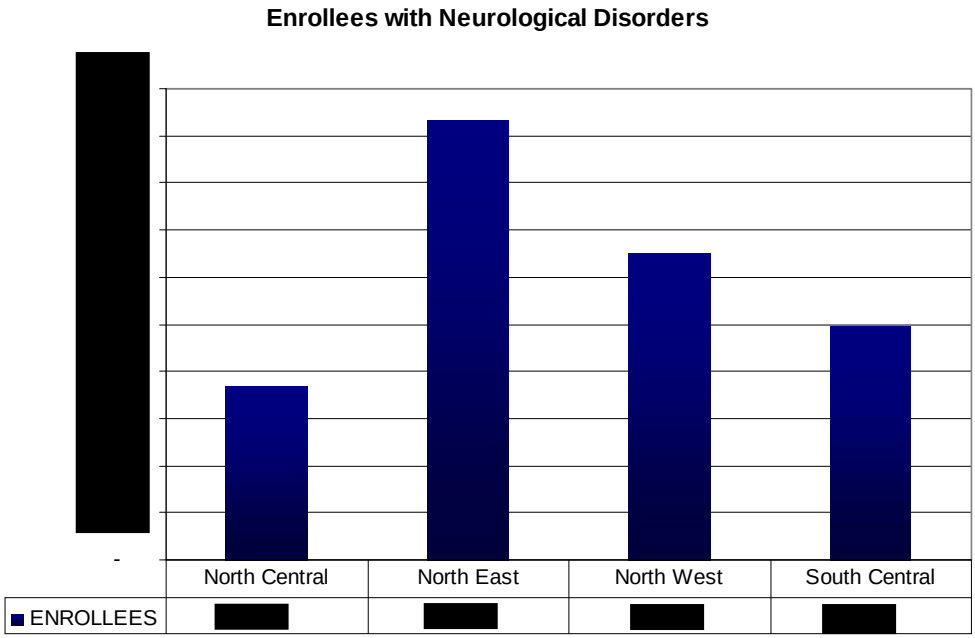

Table 23-29. Regional Representation of Enrollees with Neurological Disorders

The considerable difference in distribution between Regions again offers an opportunity to focus Health Coaching and Care Coordinator resources according to the prevalence of Enrollees in each Region. During implementation, APS will work with the Department to allocate field resources appropriately across the Regions and at the same time ensure that ALL ACCESS Plus Enrollees in the DM program receive appropriate, person-centered, and effective DM services.

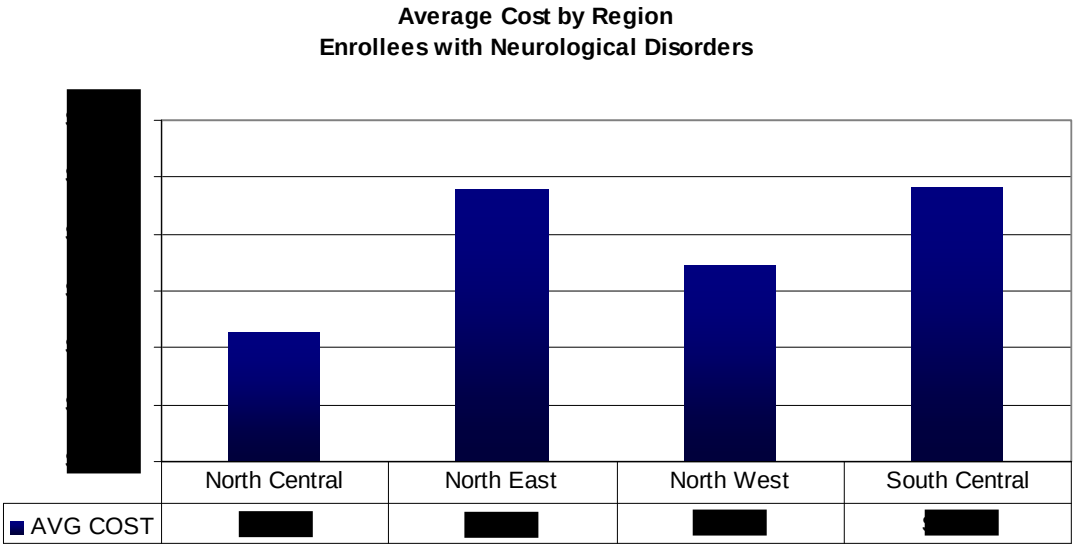

Table 23-30. Average Costs of Neurological Disorders by Region

The high average cost in the South Central Region (shown in **Table 23-30** and compared to the smaller number of members) is associated with a small number of Enrollees with diagnoses of Seizure Disorders and very high

costs, so it is not possible to determine if the high average cost for this region indicates possible over-utilization, or again, the impact of small numbers driving high averages. Similarly, **Table 23-31** below displays a similar effect on the average PMPM rates.

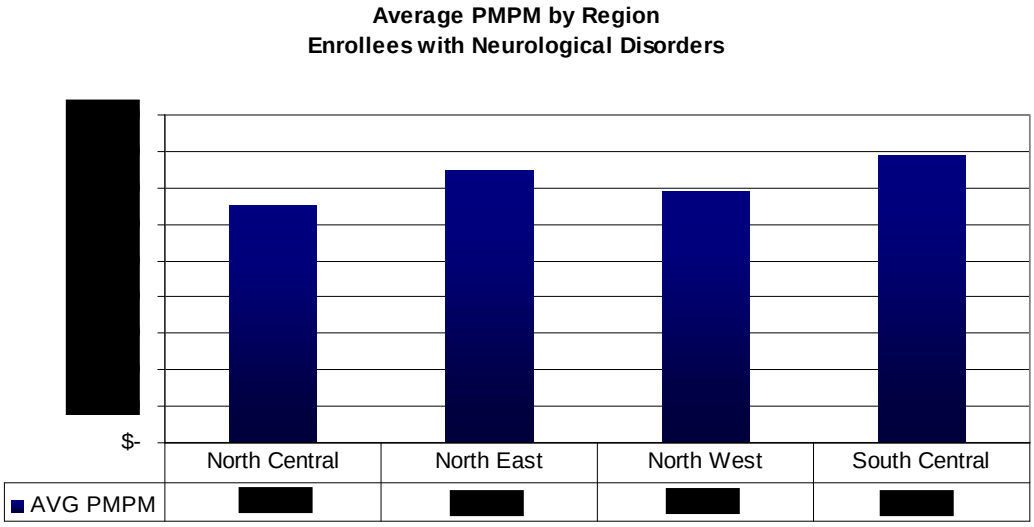

Table 23-31. PMPM Rates for Neurological Disorders by Region.

Special Considerations for Disease Management

APS will use the DM approach we outline for small populations to ensure that Enrollees with Multiple Sclerosis receive effective, well-coordinated care, with just over Enrollees identified in our analyses. The DM Population Health Management approach we describe in Table 23-3 will be used for all other Enrollees.

As our analyses of Enrollee utilization costs and outliers indicates, a successful Disease Management approach **must** proceed holistically to be able to take into account the impact on program costs that results from small numbers of individuals with high cost conditions and potentially uncoordinated care. Effective interventions for these Enrollees must strengthen Enrollee-PCP relationships with support for PCPs to exert greater management and coordination over utilization of specialty, inpatient, and pharmacy costs. During the development and initial outreach phases of our implementation, the APS Medical Director, Executive Director, and Health Services Director will establish relationships with providers in each region so that our statistical analyses can be reviewed with the provider community and the Quality Management Committee to distinguish severely chronically ill Enrollees whose care is well-coordinated and therefore would not benefit from interventions from Enrollees whose health status may be less impaired but who are not experiencing coordinated care for their chronic conditions and are thus at greater risk for future burden of disease and increased cost to the ACCESS Plus Program.

B. Describe the process for identifying an Enrollee eligible for a Disease Management program and the Offeror's responsibilities during that process. Include, at a minimum, a description of how the Offeror will 1) identify eligible Enrollees who will benefit from participation in a Disease Management program, 2) determine into which strata they will be assigned and 3) re-assess and re-stratify Enrollees. Include in the description how often the Offeror will re-assess and re-stratify Enrollees and how the Offeror will incorporate predictive modeling results to identify high-risk Enrollees and inform case management processes for these Enrollees.

Identifying Individuals with Chronic Disease

APS used the diagnosis codes cited by the RFP to identify Enrollees for our analysis. Because we know that pharmacy utilization is a significant driver of cost for Enrollees with chronic illness, we also applied algorithms that identify potential DM candidates through pharmacy utilization. **Table 23-32** presents the results of identifying potential DM Enrollees through analysis of pharmacy claims only.

Table 23-32. Identification of DM Enrollees by Pharmacy Claims

Description	Enrollees	Pharmacy Cost	Medical Cost	Total Cost	Average Cost Per Enrollee
Cardiovascular Disease					
Cardiac	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Hyperlipidemia	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Anti-Coagulants	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Respiratory Diseases					
Asthma/COPD	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cystic Fibrosis	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Gastrointestinal Disorders					
Gastric Disorders	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Hepatitis	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Diabetes					
Diabetes	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Rheumatological Disorders					
Inflammatory/ Autoimmune	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Muscle Relaxants	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Neurological Disorders					
Seizure Disorders	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Multiple Sclerosis	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Totals	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Individuals identified through this analysis did not have medical claims associated with a diagnosis of one of the chronic diseases. Within the limitations of the data it was not possible to identify the extent to which Enrollees were appropriately (and evidently) only receiving medication associated with a chronic illness without seeing a physician in an office, outpatient, or inpatient setting. Owing to the timing of pharmacy and medical claims, for example, the Enrollee may have seen a physician late in the year and the pharmacy claim was processed in 2006 and the medical claim was processed in 2007. It is also possible that individuals were receiving medications outside of prescribing protocols for the medications, and this possibility is another reason medical claims may be absent for certain individuals. These possibilities do not fully account for the number of individuals for which no medical claims were found. During our initial analyses of a full and more current claims set, we will identify individuals with prescriptions and no medical claims to determine if there

are a) more individuals in the DM population that expected; b) cause for concern with prescribing for these individuals; or c) data anomalies that can be explained with further examination.

Identification and Stratification

To identify individuals who may benefit from our Disease Management services, APS will perform risk stratification through claims-based predictive modeling and analysis of uncoordinated care on eligible ACCESS Plus Program Enrollees. This stratification is based on an analysis of eligibility and claims data, including pharmacy, behavioral health and laboratory data, and total costs. APS' initial stratification process will result in each Enrollee being classified along a continuum based on their probability of incurring future costly health care episodes. APS uses the University of California San Diego system, CDPS, which was developed specifically for the Medicaid population. Our expertise with predictive modeling will guide APS in identifying Enrollees who have a "high risk" potential for costly episodes of care. The combination of risk stratification based on CDPS and analyses as described above of uncoordinated care allows us to prioritize Health Risk Assessments and Member Baseline Knowledge (MBK) surveys. The MBK was developed to further stratify program Enrollees by gaining additional detail on the Enrollee's functional status, risk for non-adherence to recommended care, risk for poor self-management, as well as several other factors not present in claims data. A copy of the MBK survey is provided in **Exhibit 33**. In the process of filling out the MBK survey, APS collects crucial information on a member's health status, including:

- General health and medical history.
- Recent signs and symptoms associated with the chronic illness.
- Current treating health professionals and medications.
- Individual understanding of his/her disease(s).
- Willingness to learn self-management skills.
- Barriers to care posing risks for non-adherence, e.g., functional limitations, transportation, financial, educational, psychosocial, language/cultural or social isolation issues.
- Functional and psychosocial status and lifestyle risk factors, co-morbidities, etc.

Although our PM provides the initial screen of eligible Enrollees, the heart of our screening and assessment occurs in one-on-one interactions between Enrollees and Health Coaches. Our Health Coaches conduct a more detailed clinical interview to obtain more recent utilization history and assessment of the Enrollee's ability to manage their disease. Those Enrollees at highest risk will receive holistic health assessments by APS Health Coaches first. Highest-risk Enrollees will be pursued as a first priority, while secondary efforts will be focused on Enrollees with moderate or lower risk factors.

APS offers a flexible, yet aggressive, approach to distributing and collecting HRAs, as traditional channels will not capture all eligible high-risk Enrollees. Therefore, we propose a variety of creative outlets, and potential partners, who will assist in our effort to engage Enrollees in the program. APS will distribute and collect HRAs through a variety of mechanisms, including telephone, in person meetings at community provider and partner settings. In addition, APS' flexible approach to the administration of the HRA will allow Enrollees to complete HRAs at all stages along the Enrollee identification, enrollment and engagement continuum. The HRA may be completed by Health Coaches or Case Managers.

Procedures for Holistic Assessment within APS CareConnection®. For those Enrollees who are determined to be high-risk through our predictive modeling process, APS Health Coaches will contact the Enrollee, or in the case of children, contact their parents/guardians to:

1. **Confirm basic information within APS CareConnection®** such as:
   - Enrollee demographics, primary language, and contact information.
   - Enrollee's diagnosis and medical history.
   - Risk status, including risk for depression and substance abuse.

- Presence or absence of routine source of care.
- Significant health service use, including ER and medications.

2. **Administer the HRA and Baseline Knowledge Survey** if not already completed.
3. **Collect crucial information on an Enrollee's health status**, including:
   - General health and medical history.
   - Recent signs and symptoms associated with the chronic illness.
   - Current treating health professionals and medications.
   - Individual's understanding of their disease(s).
   - Willingness to learn self-management skills.
   - Barriers to care that may pose a risk for non-adherence such as functional limitations, transportation, financial, educational, psychosocial, language/cultural or social isolation issues.
   - Functional and psychosocial status, lifestyle risk factors (e.g. smoking), co-morbidities, etc.
4. **Conduct** depression, other mental health, substance abuse, dementia and most common co-morbid condition screenings. When a co-morbid condition is identified, APS clinical staff uses co-morbidity assessment tools to further evaluate the other medical conditions that are impacting the member's health. The results of the assessment generate the assignment of a subsequent level of stratification, as well as frequency of follow-up contacts.
5. **Evaluate existing treatment regimen and adherence**, and initiate development of an individualized, Enrollee-centered Plan of Care.
6. **Establish a medical home** for each Enrollee by determining the Enrollee's primary care provider or facilitating linkage to one in the absence of a routine source of care.

HRAs and holistic assessment information are entered into our proprietary APS CareConnection® community health record information system, which is predicated on national guidelines and the Health Outcomes Institute, a recognized leader in the process of outcomes management. All Enrollee assessments will be made available to the Enrollee's treating providers, including the Enrollee's primary care physician (PCP), via the Internet-enabled APS CareConnection®. In addition to sharing these assessments, APS will communicate with the providers about how to make updates and changes in the results of the assessment via the web-based APS CareConnection® solution. APS CareConnection® will give providers a powerful tool for facilitating a quick, ongoing review and discussion cycle. Rather than pushing faxes with scribbled margins back and forth, providers will be able to sign online, view the existing assessment results, and indicate their acceptance or changes based on additional information the provider may have. This gives the provider instant access so if additional information becomes available, the provider can update the assessment. In addition, this assessment information is now available to other treating providers without delay. This broad-based, technology-enabled, exchange of assessment information allows APS' clinical staff to support planned, structured interactions for the Enrollee's long-term care needs as well as identifying potential acute episodes which help us work proactively with the Enrollee's providers to respond to patient's treatment needs. In this respect, APS' assessment tools contained within APS CareConnection® help to continually identify Enrollees at risk for higher utilization of health care services and greater medical costs.

A sample of an HRA we use in another program, to be used with the target population, can be found in **Exhibit 34.** APS anticipates using a similar HRA for the ACCESS Plus Program and will look to the Department and our Clinical Advisory Committee for feedback on specific needs. The Department will have final approval of the HRA before it is distributed to Enrollees.

Based upon this information and subsequent program engagement, Health Coaches will evaluate the existing treatment regimen and adherence to confirm or adjust the Enrollee's acuity level. Enrollees are then given an acuity rating, ranging from Low to Severe – the first level (low) constitutes Medical Care Management while level II thru IV represent acuity levels within the DM program:

- **Medical Care Management – Severe** – Enrollees at this acuity level tend to have high-cost/high-risks with complex co-morbidities that require case management interventions. They often have had a recent inpatient or high cost episode and express difficulty understanding the management condition(s) in the assessment interview. These enrollees may also have received care from multiple providers - primary care and specialists, as well as utilizing high volumes of pharmacy services. DM level Enrollees who are being discharged from an inpatient stay or have had a major surgery will be elevated to this level for appropriate discharge planning. These are typically Enrollees with the most frequent contact during the first month, which persists until immediate linkages for appropriate services (e.g. substance abuse, mental health, pain clinics) are established. Nurse triage and health advice provided through the Nurse Call Center are forwarded to an assigned Health Coach for follow-up interventions. This level includes all lower-level "touches" as described below.
- **Disease Management – Level High** – These Enrollees have utilization and expenses in the high-risk range due to one or more recent hospitalization, ER visits, etc. They will also most likely be treated by multiple providers, with high costs of inpatient care, pharmacy, and Emergency Department care. These patters indicate *uncoordinated care*. Interventions include up to weekly contact by RN Health Coaches for an initial time-limited educational period. If progress is made, calls are scaled back to every quarter and continued if not appropriate for graduation. These Enrollees receive education on self-care practices needed for improvement and may need assistance with barriers to disease amelioration. Nurse triage and health advice provided through the Nurse Call Center are forwarded to an assigned Health Coach for follow-up interventions. This level includes all lower-level "touches" as described below.
- **Disease Management – Level Moderate** –These Enrollees at moderate-risk require ongoing coordination with treatment providers and facilitated communication on an as needed basis to address issues and alerts related to identified gaps in treatment. Outbound telephone contact by RN Health Coaches is generally made bi-weekly. Education on general health and self care is provided to better manage the clinical aspects of their disease, to assist their learning self-care skills, to secure supportive resources and/or to assure barrier to care elimination. Nurse triage and health advice provided through the Nurse Call Center are forwarded to an assigned Health Coach for follow-up interventions. This level includes all lower-level "touches" as described below.
- **Disease Management – Level Low** – These are typically Enrollees who are identified as lower risk through predictive modeling related to their chronic disease(s) and receive initial assessments (HRA, baseline knowledge surveys and holistic assessment) followed by individualized education and quarterly contacts by Health Coaches to Enrollees and their primary care physicians. APS provides linkage to a medical home if the Enrollee has no routine source of care. Nurse triage and health advice provided through the Nurse Call Center are forwarded to an assigned Health Coach for follow-up interventions.

Re-assessment and Re-Stratification

Each new DM Enrollee is initially stratified according to CDPS and factors of uncoordinated care. Severe and High risk Enrollees then are requested to complete an assessment with a Health Coach that confirms the stratification and identifies interventions associated with a Plan of Care. Re-assessment and re-stratification of Enrollees will vary based on Enrollees' acuity levels. Health Coaches complete a re-assessment monthly if Enrollees have very high acuity levels or every six months if Enrollees have low acuity levels. After each re-assessment, re-stratification is also completed by the Health Coach. An exception to this schedule is if an Enrollee experiences an onset of a new illness or experiences a new event that triggers a change in acuity level; Enrollees may improve their health status and shift into less acute stratification levels as well. If these events occur, Enrollees will be re-assessed and re-stratified by their Health Coach prior to their scheduled time.

Below, we provide an example of APS CareConnection® screen that shows the Enrollee "Dashboard" which summarizes diagnoses, utilization, and medications. [Please note: This screen displays information from the APS test database and does not present actual Enrollee or provider data.] The data on this screen image

reflects the way in which APS integrates assessment activities and information for individuals so that we are able to obtain a comprehensive understanding of the medical conditions that must be addressed by integrated DM interventions.

As this screen indicates, APS CareConnection® combines Enrollee data in an integrated, Enrollee-centered database that can then be used flexibly to conduct initial and on-going assessments of clinical and behavioral risks, and stratify Enrollees to appropriate acuity levels for interventions.

C. Describe how the Offeror will design the program to be readily accessible to Enrollees of all ages, as appropriate.

A program that is readily accessible to Enrollees regardless of age is one that features strategies that are age-appropriate and effective for the individual Enrollee in the context of each personal, family, and healthcare environment. APS tailors materials and intervention strategies to eligible Enrollees of all ages. Our DM program is designed to address the needs of Enrollees of all ages; generally, however, we do not begin providing services until age five. We have found that prior to this age, if a child has a disease that requires management; they are often already being closely monitored by their PCP and specialists. When services are indicated, they are carefully coordinated with parents and PCPs. The most common disease states that we manage for children are Diabetes and Asthma. If a child over the age of five has a disease that APS is monitoring, we work with the parent to improve management skills and parent educational capabilities. When children enter their teen years, the dynamics between child and parent often change. During this time APS is often asked by parents to work directly with their adolescents. APS does so in a manner that best facilitates the transfer of information. For example, we have found that it often works well to work with young adults and adolescents on the phone with parents also on the line. We also work directly with adolescents by email

and other social networking methods that are effective at engaging pre-adults. We mention a variety of these sites in Section II-3.16, Enrollee Outreach. All APS communications adhere to HIPAA regulations and therefore personal health information would not be shared, and the email system would be secure.

D. Propose a Disease Management outreach plan, including a timeline for specific Enrollee outreach tasks. Include outreach strategies the Offeror will conduct for each stratum.

The APS Outreach Plan is shown in **Table 23-33.** APS will review this plan with the Department on no less than an annual basis, and more frequently to reflect opportunities to improve outreach activities. Traditional programs organize levels of communication according to Enrollee stratification. We understand that all Enrollees require health education and therefore include these outreach methods for all Enrollees. Outreach for higher risk Enrollees includes a greater degree of direct contact; outreach for lower risk Enrollees may feature a greater use of mail interventions.

Table 23-33. Enrollee DM Outreach Plan

Outreach Strategy	1 Time	Ad Hoc	MO	QTR
Educational Mailings				
Welcome packet with self-care handbook, tip sheets	◆			
Enrollee Handbook providing information about ACCESS Plus and: ▪ Clarify appropriate use of resources ▪ Identify when to seek attention ▪ Emphasize the importance of finding a "medical home"	◆	On Request		
Reminder Notices, PCP Scheduling Assistance		◆	◆	
DM Enrollee Newsletter				◆
Health improvement/special topic publications		◆		◆
Health Coach "Hello" – Postcards and tips		◆		
EPSDT Screening Reminders (preventive/primary care for <21)		◆	◆	
Regional Ambassador Council Outreach				
School presentations (as approved by local school systems and Department)		On Request		
Outreach through patient groups (e.g., local diabetes support group)			◆	
Individual Enrollee presentations				◆
Provider-based Outreach				
Monthly EPSDT Mailings			◆	
Roster Listings with Identified Service Gaps			◆	
Distribute brochures which highlight the features of the ACCESS Plus DM Program and encourage members to self-identify. Welcome Medicaid Members with brochures distributed through providers		◆		
Community- and Faith-based Outreach				
Distribute issue-specific radio public service announcements (PSAs) to support monthly disease specifics, for example February is heart month, provide a PSA on CAD prevention			◆	
Participate in community health fairs to provide an opportunity to reach Medicaid members, promote program, enrollment and answer questions about the ACCESS Plus Program.				◆
Newsletter to community churches with program information (Copies of Enrollee Newsletter with Cover Letter)				◆
Retail Strategies				
Posters for high volume retail stores (e.g., WalMart)	◆	◆	◆	◆
Brochures and posters for specialized retailers (e.g., salons, sporting goods stores, convenience stores)				◆

Overview of APS Outreach

Understanding that each individual is unique in the way he/she processes information, APS provides multiple options and media for outreach and educational information. We will provide a broad variety of educational materials for ACCESS Plus Program Enrollees, based on needs, risk status and individual Plan of Care. APS information and interventions are customized and tailored according to each member's disease severity, co-morbidities, current level of self-management skills, and readiness to change. Education will be provided in person for most high-risk Enrollees with uncoordinated care, as well as telephonically, by mail, or through the web.

Educating at Introduction, and Throughout Program Participation

All eligible ACCESS Plus Program DM Enrollees will receive a "Welcome Letter" introducing the program. The program "Welcome Letter" will state that the member has been enrolled in the program, and that it is free and voluntary. This communication will briefly introduce the program, including the toll-free, 24-hour call center phone number to contact a Health Coach and information explaining program benefits, objectives and limitations. Shortly after the Welcome Letters are distributed, APS staff will contact high-risk Enrollees to verbally educate them on the program, as well as obtain consent for participation, conduct a baseline assessments (if not already completed) and set an appointment for additional education sessions with the Enrollee's Health Coach. Educational materials we will distribute will include information on program services, also demonstrating the value of the ACCESS Plus Program, and educational materials specific to chronic disease processes and current treatment protocols. APS' education materials are based on clinical evidenced-based guideline and developed appropriately for high-risk members:

- **Self Care Handbooks.** As Enrollees are engaged in the DM Program, they will receive a Self Care Handbook for their specific disease state(s) that provides a wealth of information related to leading a healthy lifestyle.
- **Enrollee Newsletters.** Enrollee newsletters will focus on healthy lifestyle choices, problem-solving, and medication adherence. An example of a newsletter is included in **Exhibit 12**.

A sample of the handbook and the health tip sheets are included in **Exhibit 12.** These educational materials are provided by APS clinical staff on a monthly or more frequent basis, as appropriate. Educational materials will also be provided in alternative languages and formats, if necessary, to ensure that Enrollee's have a full understanding of the information. Beyond providing program education through more traditional periodic mailings, APS will leverage our collaborative partnership approach in providing member education through several other vehicles, including:

Direct-to-Consumer Strategies. APS will utilize principles of social marketing to educate Enrollees about the ACCESS Plus Program, including direct-to-consumer (DTC) strategies via mail, email including FaceBook and to a limited extent, telephone contact. Our program for high risk Enrollees relies on the use of one-on-one interactions between our clinical staff and Enrollees to achieve successful interventions. DTC education commonly appears as individualized communication between Enrollees and Health Coaches. APS hires staff with a genuine respect for the individuals they serve, as demonstrated by compassionate communication in all situations. APS is recognized for our strong focus on cultural competency and respect for diversity in our communications and educational programs. ACCESS Plus Program Enrollees may also contact APS' 24/7 Enrollee Call Center to receive expert guidance on system resources. During business hours, Health Coaches will be available to provide referrals for individuals with complex needs and to evaluate whether the individual may be identified as a high-risk member, needs assistance with coordination of services, and needs to speak with their respective Health Coach.

Community-Based Strategies. APS recognizes that public program recipients may change housing and telephone numbers frequently so they may not receive the important material via direct channels. Therefore, APS **makes health education resources accessible within the Pennsylvania communities** by placing materials

in the provider offices including high-traffic emergency rooms, Federally Qualified Health Centers, community service organizations and even at local health fairs. We also offer to make educational materials available in Department offices, and at those of other Department agencies serving Medicaid members in Pennsylvania. Examples of community-based education strategies are:

- Posting disease-specific posters in high volume areas, such as ER waiting rooms, Community Health Centers, community pharmacies, and other Medicaid provider offices.
- Posting general health-related posters in high volume areas, such as ER waiting rooms, Community Health Centers, community pharmacies and other Medicaid provider offices.
- Taking advantage of cable access community affairs programs in communities throughout Pennsylvania to promote the education of members.
- Exhibiting at community health fairs and events allowing staff us to distribute disease-specific information and screenings to eligible members, families and the public.
- Publicizing health messages via the media. Advertising events in local newspapers, on the radio, and on television with public service announcements (PSAs). Press releases and contributed articles can also contain information on program highlights and enrollment information.
- Providing educational text to the Department that can be posted on statewide web sites, as well as local providers' web sites, such as Community Health Centers.

These venues allow APS and the Department to get educational messages on health and self-care to high-risk members and program Enrollees who we may not be able to reach by mail or telephone. Additionally, these social marketing techniques reinforce the value of the ACCESS Plus within the community and to those stakeholders who influence Medicaid members.

Provider-Based Strategies. Putting member education tools in the hands of providers is another important strategy we undertake. We will first populate the ACCESS Plus website with these tools, and after implementation is complete migrate the tools to APS CareConnection®. APS CareConnection® will also offer links to information from nationally-recognized clinical organizations to support providers own office-based chronic care improvement projects and general patient education initiatives.

APS' approach to Enrollee education in the ACCESS Plus Program will incorporate learning theory, social marketing, health literacy, and cultural competency into the program. In order to accomplish the educational strategies that support self-management, context is equally important to content. In that respect, the material must be appropriate for the many audiences to which it is delivered. Therefore, APS makes a significant investment in assuring that the content is appropriate for our audiences and that the education is delivered in a manner in which the program members can trust and will adopt.

E. Describe how the Offeror will "manage the person" and provide Disease Management and case management services for Enrollees enrolled in Disease Management who have co-morbidities. The selected Offeror is required to manage all physical health comorbidities, including co-morbid conditions that are not included in the Disease Management program, and coordinate care with BH-MCOs for behavioral health comorbidities. Include how the Offeror will identify Enrollees as having behavioral health co-morbidities. Include how the Offeror will provide services to Enrollees with comorbidities if 1) the Offeror contracts with multiple Disease Management subcontractors, 2) if an Enrollee has more than one Disease Management condition, and 3) if an Enrollee has one Disease Management condition and other conditions that do not have a specific Disease Management program. Explain any hierarchies and enhancements used for participating co-morbid Enrollees. Identify any challenges associated with managing comorbidities and explain how the Offeror would mitigate these challenges.

APS brings particular expertise to the Department in the area of co-morbidities. APS was one of the first DM companies to explicitly manage behavioral health co-morbidities and focus on a holistic approach to DM. Our programs build on our 15+ years of behavioral healthcare experience to assist individuals with chronic diseases to make healthy choices and better manage their conditions. By infusing our traditional person-centered approach to education with proven behavioral strategies, APS is able to achieve better results with our programs.

APS' innovation in the area of co-morbidities provides a care collaboration model that produces improved outcomes whether the individual has a single disease or multiple co-morbid conditions. The successful management of co-morbidities is essential in reducing preventable utilization events and improving outcomes for individuals with chronic illnesses. In other sections of our response, we describe the informatics tools, clinical guidelines and expertise which allow us to accurately stratify recipients within our care and disease management programs based upon both their primary and co-occurring conditions, including behavioral health co-morbidities. From this in-depth stratification process, Health Coaches are given a roadmap on which they base their interventions and subsequent care plans. The road map consists of a series of questions with branching logic that Health Coaches use to build up an individual plan of care (POC) that addresses the Enrollee's primary chronic condition as well as any co-morbidities and barriers to care or need for assistance.

As Health Coaches develop and implement the POC, they are provided information on and are required to respond to the entire spectrum of health care issues facing Enrollees. As part of the assessment process, our clinicians conduct thorough evaluations of each member's situation and then use specialized screening tools (i.e., substance abuse, depression, dementia, suicidal tendencies, homicidal tendencies, domestic violence, etc.) to identify risk. In addition, with our screening and assessment tools our clinicians to balance the perceived hierarchy of needs against clinical needs and develop appropriate clinical short and long term goals based upon Enrollees' full clinical picture. This approach promotes the success of the POC. Furthermore, the Health Coach will identify appropriate and qualified community based organizations and appropriate agency programs which can also assist the member.

APS supports the person rather than managing the disease. Our principle for this program is straightforward:

One Person – One APS

The logic built into the POC is based upon the assumption that the capacity of Enrollees to stabilize and improve their health is a direct manifestation of their ability to:

- Understand the relationship between their primary and co-occurring conditions.
- Be actively involved in making healthcare decisions.
- Feel confident about their relationship with their primary care physician and specialists.
- Monitor key health indicators.
- Manage their medications.
- Make more effective use of their medical home.

For example, Enrollees diagnosed with congestive heart failure (CHF) undergo thorough personal assessments and evaluations including review of their cardiac histories, co-morbid conditions, documentation of diagnostic studies completed, and identification of modifiable risk factors that promote disease progression. Health Coaches enter this information into APS CareConnection® a customized case management plan with suggested interventions, ongoing monitoring and evaluation timelines, and recommendations for new interventions as needed. The resulting POC for the client with CHF and no co-morbidity will be different than the strategy for a client with CHF and a co-morbidity of diabetes or depression. To ensure interventions are tailored according to the specific needs of each Enrollee, Health Coaches actively seek Enrollee input around their perceptions of their disease and how interventions will help improve their health. During discussions with Enrollees, the nurses look for both obvious and subtle indications of the recipient's readiness to change their behavior. By

working with their perceived hierarchy of needs, we enhance the potential for the Enrollee's acceptance of the treatment plan and ensure we are addressing co-morbidities, barriers to care, and the need for basic primary and preventive care, including EPSDT screening for Enrollees under 21.

Identification of Behavioral Health Co-Morbidities

As a part of our assessments, our Health Coaches evaluate all of the factors – behavioral, medical, or life stressors - that impact an Enrollee's health and ability to break the cycle of unhealthy behaviors. Our Health Coaches pay specific attention to the mental-physical connection, and thus, actively manage the interplay between the mind and body. This type of approach helps improve the overall health of individuals, reduce total expenditure of health care, and ultimately drives improved clinical outcomes. APS' Health Coaches intimately understand this, and look at the Enrollee's entire situation and health status, particularly those with co-morbid conditions, to develop interventions that work.

Pennsylvania's mental health system is administered at the county level, with MH/MR Offices for each county (some counties with smaller populations may combine the MH/MR Office). Between 1997 and 2007 counties have implemented managed behavioral healthcare (MBH), with Community Care Behavioral Health (CCBH), Value Behavioral Health (VBH), Magellan Behavioral Health (MBH), Community Behavioral Healthcare Network of PA (CBHNP), and Community Behavioral Health (CBH) contracted at the county level for managed behavioral healthcare. The behavioral healthcare system also has a regional structure – although not with the same regional organization as the ACCESS Plus RAC regions. Coordination between ACCESS Plus and the Behavioral Health system must therefore occur at many levels – provider, county, regional, and with the managed behavioral healthcare organizations. The APS Community Partnership model – a model in which we develop strong working relationships with community stakeholders and foster proactive communications to benefit the Enrollee – is ideally suited to multi-level system. To ensure that an understanding of this system is integral to our work for ACCESS Plus, APS has designated more than a third of our field- and Call Center-based Care Coordinator positions to be filled by Behavioral Healthcare professionals licensed in Pennsylvania. Since these Care Coordinators will have direct experience with the Behavioral Healthcare system, they will have existing county, regional, and organizational relationships that facilitate the development of linkages between ACCESS Plus and the behavioral healthcare system that are needed to ensure coordination is effective and person-centered. As a leading behavioral healthcare company, APS also has the relationships with the MBH organizations needed to facilitate a positive and professional working relationship. Finally, as we explain in our discussion in Section II-3.5, Behavioral Health Services Integration/Coordination, we will establish both formal and informal points of contact and coordination activities with the Community Support Program of Pennsylvania, the Mental Health Association of Pennsylvania, county MH/MR Offices, and the MBH organizations to promote the goals of the behavioral health system. These goals are also APS' in our national work in behavioral health – transformation of children's behavioral health to systems that are family-driven and youth-guided; a profound commitment to resiliency and recovery for adults that promotes community integration and independence, and sensitive and compassionate recognition of the unique needs of older adults – as we indicate by our recognition of the implications for ACCESS Plus DM services for Enrollees who also have diagnoses of psychosis or Bi-polar Disorder.

Disease Management Services for Enrollees with Co-Morbidities

APS does not subcontract for Disease Management services. In the event an Enrollee presents with multiple Disease Management conditions or conditions that are not a specified Disease Management program, our Health Coaches will ensure that the presented diseases are included in the POC and/or have been referred to the appropriate vendor, based on the services available. Clinical direction for development of a Plan of Care will be coordinated with the PCP and the ACCESS Plus Medical Director. If necessary, we will consult with specialists at the [redacted] and the Department Medical Director to ensure our coordination is evidence-based and transparent.

Challenges and Mitigation for Managing Co-Morbidities

APS understands the central challenge to successful management of Enrollees with comorbid conditions: fragmentation of diagnoses, services, and medications (*uncoordinated care*) caused by organization of data around individual providers and discrete services. Even an electronic health record – with its provider-centric orientation – does not address this issue. Chronic disease "registries" make it worse by creating discrete datasets of individuals by chronic disease. Only a data set integrated at the person level – **a person-centered data system** truly mitigates the challenge of providing DM services to individuals with chronic and co-morbid conditions. APS CareConnection® provides a person-centered data system, with an integrated Plan of Care so that Health Coaches (and post-implementation for ACCESS Plus providers) can understand the variety of diagnoses, services, and medications that make up the health status environment for each Enrollee. With integrated assessments for the variety of diagnoses Enrollees bring to their health pictures, Health Coaches can evaluate the interactions of the conditions, identify the extent to which one condition may be more prominent or provide greater concern than another, and effectively modify the Plan of Care to address the reality of Enrollees' health situations. With [redacted]% of Enrollees having between two and five comorbidities, this approach is crucial.

F. Provide samples of the Evidence-Based Clinical Practice Guidelines the Offeror anticipates using for its Disease Management program.

APS has adhered to nationally recognized evidence-based guidelines since our founding in 1993. We work carefully with our state partners and stakeholder advisory groups in developing pro-active goals to ensure care is in alignment with recognized standards of care. Our staff, tools, and processes assure that technical assistance, clear milestones of success, and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance and improve the health status of our program members. APS and its related entities review recommended evidence-based clinical practice guidelines and protocols on an ongoing basis, updating information as needed, and providing updates to providers within the networks. This function is provided by APS' Clinical Advisory Panel (CAP), which is composed of a nationwide collaborative of highly talented and energetic providers who are stakeholders in building successful DM initiatives within their own communities and across the nation.

Table 23-34 displays samples of evidence-based clinical practice guidelines our programs reference.

Table 23-34. Evidence-Based Guidelines for ACCESS Plus Disease Management
Cardiovascular Diseases
1) Congestive Heart Failure
• American College of Cardiology (ACC)
• American Heart Association (AHA), Management of Chronic Heart Failure in the Adult, 2001
2) Coronary Artery Disease
• National Institutes of Health. Update on Cholesterol Guidelines: More-Intensive Treatment Options for Higher Risk Patients, 2004
• AHA/ACC Guidelines for Preventing Heart Attacks and Death in Patients with Atherosclerotic Cardiovascular Disease: 2001.
3) Stroke
• Update to the AHA/ASA Recommendations for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack, 2008
• National Stroke Association's stroke prevention guidelines
4) Transient Ischemic Attack
• Update to the AHA/ASA Recommendations for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack, 2008
• National Stroke Association Guidelines for the Management of TIA

Table 23-34. Evidence-Based Guidelines for ACCESS Plus Disease Management
5) Hypertension • National High Blood Pressure Program, Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7) NHLBI National Cholesterol Education Program • AHA Guidelines Issued For Treating Resistant Hypertension, 2008 6) Hyperlipidemia • National Heart Lung and Blood Institute's Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), 2004 • Cholesterol Treatment Guidelines Update, National Cholesterol Education Program of the National Institutes of Health National, 2001 7) Peripheral Vascular Disease • ACC/AHA 2005 Practice Guidelines for the Management of Patients with Peripheral Arterial Disease • American Diabetes Association (ADA) Consensus Statement for Peripheral Arterial Disease Care in Diabetics, 2003 **Respiratory Diseases** 1) Asthma • National Heart Lung and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma (EPR-3) • National Asthma Education and Prevention Program (NAEPP) Expert Panel Report II guidelines 2) COPD • Global Initiative for Chronic Obstructive Lung Disease (GOLD) Standards, 2003. Panel reviewers included representatives from the National Heart, Lung and Blood (NHLBI) Institute and the World Health Organization (WHO). • American College of Physicians (ACP) clinical recommendations for chronic obstructive pulmonary disease, 2007 3) Cystic Fibrosis • Cystic Fibrosis Pulmonary Guidelines, The Cystic Fibrosis Foundation committee, 2007 • Guidelines for diagnosis of cystic fibrosis in newborns through older adults, Cystic Fibrosis Foundation consensus report, 2008 **Gastrointestinal Disease** 1) Inflammatory Bowel Disease • American Gastroenterological Association Guidelines • Thoracic Manifestations of Inflammatory Bowel Disease, American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition), 2007 2) GERD • Updated Guidelines for the Diagnosis and Treatment of Gastroesophageal Reflux Disease, Institute for Clinical Systems Improvement (ICSI), American Gastroenterological Association, 2005 • Initial management of dyspepsia and GERD, ICSI, revised 2006 3) Peptic Ulcer Disease • Medical treatment of peptic ulcer disease: Practice guidelines. Practice Parameters Committee of the American College of Gastroenterology, 1996 • Initial management of dyspepsia and GERD, ICSI, revised 2006 4) Hepatitis • Sexually Transmitted Diseases Treatment Guidelines: Chapter on Hepatitis A, Centers for Disease Control and Prevention, 2005 • Guidelines on Hepatitis B Management, National Institutes of Health, 2008 • Diagnosis, Management, and Treatment of Hepatitis C, American Association for the Study of Liver Diseases, 2004

Table 23-34. Evidence-Based Guidelines for ACCESS Plus Disease Management
Diabetes
• Standards for Medical Care for Patients with Diabetes Mellitus, American Diabetes Association, updated 2008
• National Standards for Diabetes Self-Management Education, American Association of Diabetes Educators and the American Diabetes Association, 2007
Rheumatologic Disorders
1) Rheumatoid Arthritis
• Rheumatoid Arthritis Treatments: Guidelines for Non-biologic and Biologic DMARD Use in Rheumatoid Arthritis, American College of Rheumatology, 2008
• Self-Management Education for Arthritis, Arthritis Foundation Self-Help Program (AFSHP), no date
2) Systemic Lupus Erythematosus
• Guidelines for Referral and Management of Systemic Lupus Erythematosus in Adults, American College of Rheumatology
• Therapy insight: guidelines for selection of contraception in women with rheumatic diseases, Weill Medical College of Cornell University, Hospital for Special Surgery, Department of Medicine
3) Low Back Pain
• Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline, American College of Physicians and American Pain Society, 2007
• Self-Care Guidelines for the Management of Nonspecific Low Back Pain, Department of Environmental Health, Harvard School of Public Health, 2005
Neurological Disorders
1) Seizure Disorders
• Efficacy and tolerability of the new antiepileptic drugs I: Treatment of new onset epilepsy, Report of the Therapeutics and Technology Assessment Subcommittee and Quality Standards Subcommittee of the American Academy of Neurology and the American Epilepsy Society, 2004
• Newer drugs for epilepsy in children. National Institute for Clinical Excellence, 2004
2) Multiple Sclerosis
• Disease modifying therapies in multiple sclerosis: Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines, 2002
• Immunization and multiple sclerosis: a summary of published evidence and recommendations, American Academy of Neurology and Multiple Sclerosis Council, 2002
3) Migraine Headaches
• Treatment of primary headache: patient education. Standards of care for headache diagnosis and treatment, National Headache Foundation, 2004
• Special treatment situations: alternative headache treatments. Standards of care for headache diagnosis and treatment, National Headache Foundation, 2004

APS currently offers DM programs for Asthma, Cardiac conditions, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, GERD, Depression, and Diabetes, and Low Back Pain. APS is fully accredited by URAC for Cardiac (Cardiovascular Disease, Hypertension, and Hyperlipidemia), Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Depression, and Low Back Pain. Building on this strong base of person-centered DM clinical development, we will draw on APS's partner The [redacted] to support us in evaluating clinical approaches for conditions not presently managed by APS, for example, Cystic Fibrosis. Additionally, our partner [redacted] will augment the analytic capabilities of our own Health Intelligence Unit with sophisticated analyses of uncoordinated care for DM and PCCM programs. In partnership with [redacted] we will also analyze pharmacy utilization to create Provider Profile Letters that will address outlier pharmacy utilization.

Combining these clinical and analytic resources with our proven outreach and intervention strategies will yield meaningful and sustainable improvements in the delivery of healthcare services, resulting in improved health status for Enrollees and savings across the continuum of healthcare service delivery.

G. Describe how the Offeror will incorporate the principles of the Chronic Care Model into the Disease Management program, as appropriate.

The past 15 years has seen increasing recognition that improvements can be best achieved through the development of care models that are explicitly oriented to chronic disease rather than acute illnesses. In 1994, Dr. Gregory Pawlson was one of the original critics of healthcare models for individuals with chronic diseases based on traditional models designed for acute care.[1] Dr. Pawlson described what has now become a widely-adopted perspective: treatment of chronic disease requires a fundamentally different approach to successful management than acute illness. That different approach emphasizes patient self-management, integration of community resources into a model of coordinated services, increased emphasis on primary care, and application of evidence to the selection of practice guidelines and behavioral interventions. One of the first researchers to describe this approach in terms of a model for chronic care was Edward Wagner, MD, MPH, and colleagues at his center, Improving Chronic Illness Care (ICIC).[2] The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care.

The APS care management program operationalizes and builds upon the theoretical elements of the CCM, augmenting the ability of the system as a whole to better serve individuals with chronic disease. Key elements to improving chronic care – making it more efficient and effective – are enhancing communication and productive interactions between patients and providers. APS supports the development of these interactions as a facilitator to Enrollees and their providers, with information that is timely, accurate, and complete. APS incorporates the emphasis on productive interactions into our care management approach that explicitly facilitates the process of informing and empowering Enrollees and their families and support communities. APS incorporates the approaches and methods outlined in the CCM because of its comprehensive approach to improving the care for individuals with chronic conditions. **Table 23-34** shows an enhanced Chronic Care Model with disease management interventions that reflect APS' programming. We adapted this model by integrating elements of the CCM for behavioral health to show the importance of resiliency and recovery in the context of DM.

As the graphic in **Table 23-35** illustrates, DM interventions activate empowering behaviors among Enrollees and family members, through delivery of evidence-based educational materials, motivational interviewing techniques used by APS Health Coaches to encourage Enrollees to adopt appropriate self-management skills, positive feedback to Enrollees to acknowledge gains, and significant information and coordination support to providers that enables PCPs to better manage health services and medications for their patients. Our recognition that both mental and physical health must be addressed by DM interventions has been an important strategy that APS pioneered in disease management – combining our strong backgrounds in both DM and behavioral health to develop integrated programs. We currently offer this integrated approach in DM programs for the [redacted] (two programs), [redacted] (two programs), [redacted], and [redacted], representing over [redacted]% of the [redacted] million Medicaid Enrollees we support through our state-based programs. This approach has also been recently selected by the [redacted] for its new program focused on Seniors and People with Disabilities and in [redacted] to replace its incumbent approach. The Department requires a comprehensive and holistic program to address not only the individual chronic conditions specified in the RFP,

[1] Pawlson, L.G. (1994). Chronic illness: Implications of a new paradigm for healthcare. *Joint Commission Journal of Quality Improvement, Jan 20(1), 33-39.*
[2] Wagner, E. (2006). The Chronic Care Model.

but the needs of the real people who live with these conditions. As this section documents, APS grounds our DM programming in current, relevant, and evidence-based literature, bringing the best of clinical and behavioral thinking to the important work of improving the health status and healthcare of ACCESS Plus DM Enrollees.

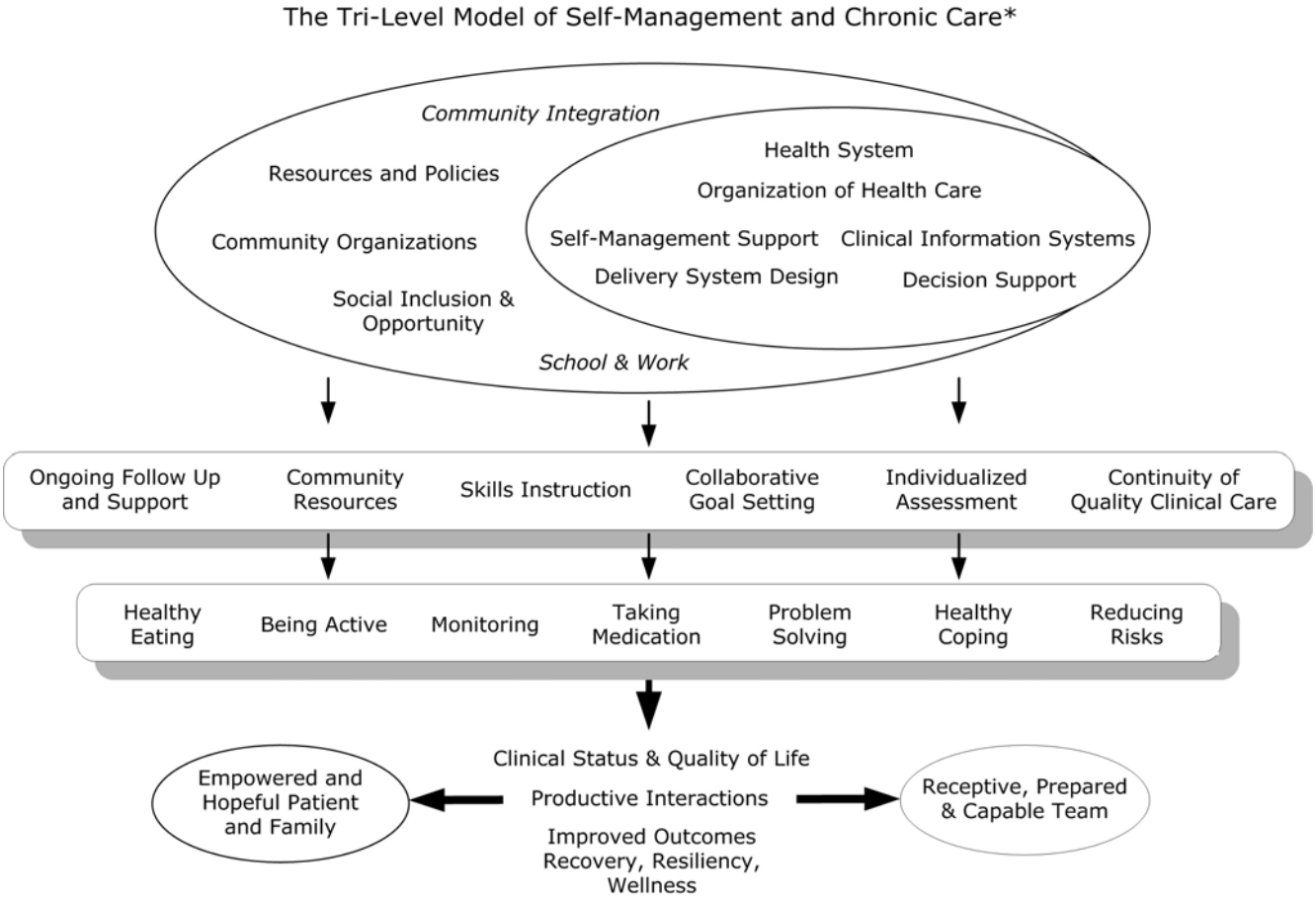

Table 23-35. Conceptual Framework for APS Disease Management Programming

Within the context of the Chronic Care Model, APS also works to promote the six aims that the Institute for Medicine defined for 21st Century Healthcare Systems: care that is safe, effective, efficient, person-centered, timely, and equitable. These aims aligned with the goals of the Department and serve as an ideal basis for an effective care management program. We believe what is unique, creative, and innovative about our approach is the organizational processes and informational systems that we have put in place to carry out this model in the ACCESS Plus population. The most dramatic impact of our programs is enhancement of the ability of Enrollees to confidently manage their diseases and the creation of an APS-provider team to engage Enrollees in meaningful interactions. The creative use of onsite Health Coaches and the unique capabilities of APS CareConnection®, our proprietary internet-based care system, are two elements that are most effective at promoting the productive interactions that the CCM places at the center of improved outcomes.

H. Provide examples of interventions that the Offeror intends to implement for Disease Management Enrollees with high risks versus low risks.

For the purpose of responding to this question we characterize "high risk" Enrollees as Enrollees identified by the Department's and/or APS' predictive modeling system in the top 10% of Enrollees at risk for exacerbation of the burden of disease and at risk for increased cost, and identified as having uncoordinated care. Therefore,

unlike many programs in which differences in interventions for different risk strata are identified only by frequency, APS interventions for high risk Enrollees are fundamentally different. These interventions focus on facilitated linkage to the medical and dental home, provision of preventive and primary care services that are missing (e.g., mammograms for eligible female Enrollees); reduction of behavioral health risks (smoking, weight, etc.); identification and remediation of behavioral health and physical health co-morbidities; and education in self-management techniques to maintain Enrollee motivation for change.

APS has structured our program in this way to provide low/moderate risk Enrollees with a myriad of resources and tools that will help them achieve their goals, while simultaneously allowing us to focus most of our coaching efforts on individuals with greater complexity, which requires a higher degree of attention. For example, a 37 year old with Hyperlipidemia with regular PCP visits and a Plan of Care is considered low-risk, and does not require a high frequency of contact from an APS Health Coach. These individuals are typically self-motivated and already making healthy lifestyle choices that will ultimately impact their health and do not necessarily require the help of Health Coaches to identify barriers and set attainable goals. **Table 23-36** displays examples of interventions that are targeted to high risk Enrollees.

Table 23-36. Examples of Interventions for High Risk Enrollees

Population	Clinical Metrics	Activities until goals met
Any DM disease as primary; co-morbidities and/or health risks	Dependent on primary DM disease	1) Home visits 2) Coordination of providers/services 3) D/C planning for inpatient episodes 4) Educating on medication management
Alzheimer's as a secondary	Dependent on primary DM disease	1) Home visit to assess function, resources, provide education 2) Coordination with providers (including participating in case meetings, if possible) 3) D/C planning for inpatient episodes 4) Educating on medication management, i.e. arranging pill boxes
Hemophilia as a secondary	Dependent on primary DM disease	1) Home visits/ assessments dangers, i.e. swing sets, etc. 2) Coordination of providers/services 3) D/C planning for inpatient episodes 4) Educating on medication management

Bio-behavioral risks that increase Enrollee overall risk assessment include:

- High Blood Pressure (BP), Blood Sugar (BS), Lipids, and/or BMI.
- Positive response to using tobacco products (Cigarettes, Cigars, Pipe, Chewing Tobacco or Snuff).
- Positive response indicating significant alcohol use.
- Limited physical activity.
- Screened positive for depression.

All Enrollees, regardless of their risk stratification have access to the same resources. The available resources have been listed below:

- Access to a Health Coach. The Health Coach is Enrollees' personal health advocate and works closely with them to provide an in-depth understanding of the impact of the chronic illness on overall health and well-being; discuss their action plan for lifestyle changes; assist the Enrollee in the identification of barriers and/or issues impacting effective self management and strategies to overcome the barriers; and facilitate navigation of the Enrollee's healthcare benefits and provider relationships.
- Access to clinicians 24/7 via a toll-free number for questions and concerns.

- Access to lifestyle improvement information on the ACCESS Plus website (e.g., smoking cessation tips, etc.)
- Access to online chronic condition information to increase the Enrollee's knowledge and assist in self management (e.g., diets for diabetics, exercise advice for parents of children with asthma, newsletters, etc.).
- Distribution of health and preventative self management reminders and education.
- Distribution of educational materials to help them understand their condition and ways to improve their health. We send Enrollees information on how to quit smoking, manage weight, exercise effectively, and eat nutritiously.
- Access to health fairs and other wellness related events during which Enrollees can complete "Interest Postcards" requesting that they be contacted by a Health Coach and/or receive specific educational materials.

Whether stratified as *low/moderate* or *high* risk, the disease management coaching an individual receives is *"holistic"* and focused on providing the individual with proactive, ongoing support and education for their identified health risk(s) and all co-morbid conditions and issues that are impacting their overall health.

I. The Department requires National Committee for Quality Assurance (NCQA) or URAC accreditation or NCQA certification for five (5) of the twenty-one (21) ACCESS Plus Disease Management programs. Submit the Offeror's current NCQA or URAC accreditation or NCQA certification for the five required conditions (Congestive Heart Failure, Coronary Artery Disease, Asthma, Coronary Obstructive Pulmonary Disease and Diabetes) including the forms and comprehensive, detailed reports. If the Offeror is in the process of obtaining accreditation or certification, submit the Offeror's application for certification. Explain the Offeror's plan for obtaining NCQA or URAC accreditation or NCQA certification for five of the twenty-one (21) ACCESS Plus Disease Management programs and the current status of its application process. Submit NCQA certification for any additional ACCESS Plus Diseases Management programs the Offeror may have. (limit: one page and/or copies of accreditations, certifications or applications for each disease/program)

APS currently holds URAC accreditation for four (4) of the twenty-one (21) required disease management programs, which have been designated at the program office level. We hold accreditation for Cardiac Conditions which includes Coronary Artery Disease, Hypertension and Hyperlypedemia; Congestive Heart Failure; Coronary Obstructive Pulmonary Disease; Diabetes, Depression and Low Back Pain for the Brookfield, Wisconsin, Missoula, Montana, and Atlanta, Georgia program offices. The remaining required accreditation for Asthma will be obtained after implementation and consistently with URAC accreditation procedures (which requires that the program be established for a period of time). Should APS be awarded the ACCESS Plus contract, we will work with URAC to immediately initiate the accreditation for all five conditions for the Pennsylvania program.

The Wisconsin, Montana, and Georgia programs were accredited as part of a single process. Therefore, we have attached the URAC Accreditation Certificates for each office, and included the consolidated URAC Accreditation Review Report. The URAC certificates are included in **Exhibit 21**, with also includes the Report. APS has confirmed with URAC that the attached Accreditation Report is the detailed Accreditation Report – the only report that URAC returns to the accredited entity.

APS is accredited by URAC for Cardiac, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes, Low Back Pain, and Depression for dedicated service centers in Montana, Georgia, and Wisconsin. In compliance with RFP requirements, APS will obtain URAC accreditation in CAD, COPD, CHF, Diabetes, and Asthma for the dedicated service center in Harrisburg, Pennsylvania. Since APS currently has full accreditation for four of five conditions in other service centers we will submit our application as soon as URAC permits after implementation is completed.

Additional Program Recommendation – Depression Disease Management

In addition to the twenty-one (21) disease states that the Department has included in the ACCESS Plus Program, APS is proposing that the Department consider including Depression as an additional Disease Management Program. Depression is one of the most prevalent and costly disease states today. Overall, 5-9% of individuals suffer with depression. In the United States alone, it is estimated that 17% of the total population will have at least one episode of depression during their lifetime. From our history serving customers and consistent with industry research, individuals with medical conditions are at increased risk for behavioral disorders – most commonly depression and other mood disorders. For example, the prevalence of depression in patients with chronic medical conditions is significant.

Behavioral health disorders are frequently accompanied by physical symptoms, such as fatigue, chest pain, dyspnea, and low back pain. It is estimated that half of medical patients identified as "high utilizers" are suffering from a behavioral disorder. The top 10% of these patients account for:

- 52% of all specialty visits.
- 40% of all inpatient days.
- 29% of PCP visits.
- 26% of all prescriptions.

We developed our Depression Disease Management program to address these challenges. Our Depression Disease Management Program was designed by a team of behavioral and disease management experts and based on nationally recognized best practices in the treatment of depression. Our *A Healthy Perspective!* program provides a solution to the challenges that represent barriers to positive outcomes for people with depression. As the only established disease management vendor in the industry to have a background and current programs in behavioral health, we offer a unique program that uses cutting edge technology and proven methodologies to improve outcomes and decrease costs associated with depression.

Our approach to depression is person-centric, emphasizing the importance of self-management and education. This approach focuses on educating Enrollees on depression and how to fully engage in the therapy process. We avoid intrusive interventions, but instead, promote collaboration between the patient, the therapist and APS to ensure compliance with the patient's treatment regimen. To achieve our treatment goals, we connect the patient with a wide variety of supportive services and utilize a continuum of interventions. APS structures our program this way because an Enrollee-centered approach to disease management is most effective in achieving positive outcomes through empowered self-management. Both self-management of a chronic disease state and adherence to prescribed treatment are essential to a successful disease management program. APS believes that Enrollee-centered methodologies are more consistent with disease management strategies and reflect the understanding that Enrollees' health status is a manifestation of Enrollees' ability to:

- Manage their diseases by moderating behaviors that aggravate their conditions;
- Be actively involved in making healthcare decisions and confident about relationships with primary care physician and specialists.
- Monitor key health indicators and manage their own medications.

Our Enrollee-centered approach focuses on providing the appropriate level of counseling on self-care skills; health management education; reinforcing information provided by the member's physician; and helping Enrollees understand and incorporate the information into their daily healthcare decisions. Additionally, our Health Coaches use a motivational interviewing approach with patients to supplement written materials on achieving healthier lifestyles and assuming more participative roles in their healthcare decisions. We look forward to discussing how this addition to the ACCESS Plus Program will benefit the Department and the Enrollees.

J. Describe how the Offeror will incorporate Enrollee self-management strategies for each Disease Management program.

APS' disease and care management programs on a national basis incorporate self-management strategies into our DM programming. We have found that while Enrollees conditions may differ significantly, the fundamental strategies of promoting self-management have a common theme, which we explain in this discussion – and emphasize the importance of standardizing diverse programming options on a common, evidence-based foundation.

When ACCESS Plus Program members are enrolled in APS' program, Enrollees will receive a "Welcome Letter" introducing the program. This communication briefly introduces the program and includes the toll-free phone number to contact an APS Health Coach and information explaining program benefits, objectives, and limitations. The initial mailing is intended to create an understanding of APS' program and pave the way for our outreach and education efforts. Enrollees are also sent a Member Handbook. Sample welcome letters and handbooks are provided in **Exhibit 12.** Our mailings are brief, attractive, understandable and informative, and reinforce health and self-care messages to enrolled members. This sound starting point then becomes the platform for continued development of self-management skills through individual health-coaching by telephone and in-person, during visits to PCPs and other providers, and in our newsletters and individual mailings.

Shortly after the Welcome Letters are distributed, APS staff will contact high-cost/high-risk Enrollees to verbally educate them on the program, conduct a Health Risk Assessment (if not already completed) and set an appointment for additional education sessions with the enrollees' Health Coaches. In addition, Health Coaches work with the Enrollees and support the physicians' treatment plan as well as find resources for the Enrollee as needed (transportation to office visits, food, clothing, etc.) Each head of household has access to a 24/7 call center and receives an Enrollee Handbook (**Exhibit 12**), which explains program benefits guide. The APS program is designed to support physicians and other healthcare providers and assist in supporting the treatment plan and encouraging patient compliance, a critical component in effective self-management.

K. Describe how the Offeror would incorporate initiatives or practices focused on physician education to encourage adherence to medications and appropriate prescribing patterns as part of its Disease Management program. Provide examples of any existing initiatives or practices the Offeror employs.

APS and our partner, [redacted], will perform physician provider profiling to identify cost and quality patterns. These profiling evaluations will be conducted quarterly with outputs that include:

- Identifying the top prescribers overall and within specialty groups by standard deviation groups for number of prescriptions, total number of patients and number of uncoordinated care patients, total cost, and cost per prescription compared within other specialist and general practice prescriber groups
- Conducting geographical mapping of all prescribers and outlier prescribers by specialty and identified problem issue at the regional, county, facility or zip code level as requested by the Department

- Evaluating the outlier prescribers for specialized drug product prescribing, specific classes of drugs including narcotics to asses appropriate dosing, frequency and quantity of drug prescribed related to patient diagnoses and use of other concurrent drugs
- Identifying physicians not consistent with HEDIS measures or national treatment guideline prescribing behaviors for various conditions such as antibiotic over usage, lack of inhaled steroid for asthma patients, etc.

APS will monitor, evaluate and encourage patient adherence to medications using several methods. First, patients will be assessed for day to day adherence to their drug regimens based on their adherence to the prescribed dosing, frequency of dosing and day to day patterns of medication usage. This assessment will be completed during periodic patient interviews and communications with Enrollees by the Health Coaches. In addition, Health Coaches will use every patient contact opportunity to educate patients about the importance of medication compliance and encourage them to be vigilant in using their medications consistently and correctly. Patients will also be educated regarding proper medication storage, potential side effects and how to deal with any side effects experienced. They will be encouraged to communicate regularly with all pharmacists and physicians involved in their care about their medication regimen, including any side effects or other medication related problems.

Second, retrospective and concurrent pharmacy claims analysis will be used to evaluate and monitor patient adherence and persistence to prescribed medications and identify clinically relevant treatment gaps that represent continuity of care issues as indicated by claims history. Providers who are observed via claims analysis to have patients that are consistently non-adherent to their medications will notified as to the nature and extent of the problem and encouraged to conduct counseling and interventions with those patients.

Measuring adherence using claims data is usually calculated by summing the number of days of medication supplied divided by the number of days between the first and the last refill. Therefore, at least two fill dates are required to calculate this ratio. The Medication Possession Ratio (MPR) is a formula used to determine compliance that is measured from the first to the last prescription, with the denominator being the duration from index (initial prescription) to the exhaustion of the last prescription and the numerator being the days supplied over that period from first to last prescription.

Medication possession ratios will be calculated using the following, widely accepted, formula:

Medication Possession Ratio (MPR) = Number of Days of Medication Supplied within the Refill Interval/Number of Days in Refill Interval

For Example:

MPR= 30 day supply of medication/45 days refill interval: MPR = 67%

Maximizing the usefulness of this approach necessitates that parameters be defined for what is to be considered tolerable within the bounds of therapeutic adherence as well as taking into account prospective drug utilization review (ProDUR) system edit limits that may be in place such as early refill edits. A somewhat restrictive threshold of tolerability for the MPR would be defined as two weeks beyond the exhaustion of a 30-day supply [1.5x number of days supplied]. This tolerability threshold, in effect, defines a less-than-67% compliance rate (30 days/45 days) as "termination of therapy" or non adherence. As we demonstrate in **Exhibit 6**, APS has used an MPR of [redacted] as a threshold for notifying providers concerning medication non-adherence with provider letter profiles and reports.

The most rigid threshold could be derived using the half-life of the examined agent as its basis. A more liberal approach to the threshold of tolerability of 3* 30-day supply has been used as the basis for establishing an extended threshold to include those patients with lower levels of compliance who make an effort to persist

with therapy, e.g., patients who consistently take their medication every other day, although it is prescribed for daily ingestion.

One would also need to extend the threshold to account for the impact of hospitalizations since outpatient prescription-refill data are not captured or reported when a patient has an inpatient hospital stay. In this case, attempting to reasonably assess whether a patient is adhering to a prescribed therapy could involve allowing an extended time period, e.g. days equal to the hospital stay, before the next refill is processed. If this level of adherence is not met, such patients could be considered "not persistent with therapy" and could be targeted for more intensive counseling and education. In this manner we are able to use the same instrument, MPR, to evaluate daily compliance as well as persistence of drug use over time. A practical approach to evaluating adherence and persistence for drug therapy used to treat chronic conditions involves a quarterly claims assessment.

Medication possession ratios or adherence rates can be misleading if there is not also a measure of persistence for chronically used medications. Therefore, APS will also track drug product-specific usage for patients to assess the “persistence” or continuity of care which includes evaluation of drug product switching rates and treatment gaps within therapeutic classes and subclasses. Frequent switching of drug products within the same therapeutic class or subclass are often indicative of uncoordinated care provided by multiple prescribers and multiple pharmacies and can occur concurrently in the same time period or longitudinally over time. This often results in therapeutic duplication of same or similar drugs leading to increased danger of serious side effects, poor clinical outcomes, and unnecessary medical and pharmacy costs to the program.

Coordination of care will be evaluated and monitored routinely for patients that are identified via claims data who exhibit patterns of care and medication utilization that are not consistent with positive outcomes and control of their chronic disease or acute conditions. Patients will be evaluated for adherence to their designated “medical home” and any patients identified with uncoordinated care will be counseled as to the importance of the use of their “medical home” and/or helped to change their “medical home” if they are not satisfied with the existing PCP relationship. Interventions and communications with providers and patients will be conducted to reduce this type of uncoordinated care and inform the “medical home” provider of these observed occurrences.

If the Department is able to provide real time pharmacy claims data, then more concurrent assessment, intervention and monitoring can be provided to increase actual adherence and persistence rates for medications. Depending on the rate of electronic prescribing use by providers, there may be opportunities to monitor electronic transmissions by prescribers and determine whether patients actually pick up medications that have been electronically transmitted to the pharmacy. This factor could be especially important for adherence and persistence to prescribed drugs for acute conditions which could later result in avoidable emergency department visits or inpatient admissions.

The importance of patient adherence to medications and the appropriate use of medications will be part of the educational process provided directly to patients by Health Coaches, Care Coordinators and others involved in monitoring care. Patients can be rewarded with various incentives to improve adherence and persistence – and the Department has already implemented a Consumer Incentive program to support this strategy. APS will therefore work closely with the Department to identify viable incentive programs, develop them for suitability to ACCESS Plus Enrollees, and implement them as we describe in Section II-3.18, Consumer Incentives.

L. Describe how the Offeror will develop a Disease Management program that generates overall cost savings for the Department. Identify any challenges associated with designing an efficient Disease Management program and estimating costs savings associated with Disease Management services. Identify proposed strategies for mitigating these challenges. (Please note that this response should

not specify a cost savings amount.)

The APS Disease Management program has been designed to achieve proposed guaranteed savings for the Department as well as improvements in HEDIS and provider P4P measures. APS has a designated Vice President of Clinical Product Development who works closely with the APS Clinical Quality Improvement Council (composed of APS Medical Directors from all [redacted] programs) to prioritize clinical guidelines; translate guidelines into practice-oriented protocols; identify the clinical path linking interventions and interim measures to patient outcomes; identify feedback mechanisms to assess and improve interventions; and design educational materials for Enrollees and providers. **Table 23-37** presents the APS intervention model based on evidence from the Diabetes Control and Complications Trial that established the importance of Glycemic control in the effort to reduce and delay the development of extremely high cost and high impact complications. Using this model to guide our intervention priorities, APS focuses on key predictor variables that impact cost and outcomes.

Table 23-37. Diabetes Intervention Model

Phase	Description
Outcomes	High Cost – High Burden Complications: • Diabetes-related Kidney Disease • Diabetes-related Eye Disease • Diabetes-related Nerve Disease • Diabetes-related Cardiovascular Disease • Amputations related to Diabetes
Outcome Measures	Prevalence of outcomes in population Incidence in selected continuously enrolled cohort (if available)
Predictor Measure	Glycemic control (blood glucose)
Interim Measures	Hospitalizations for diabetes related conditions Rehospitalizations for diabetes within 30 days of a diabetes related admission to an acute hospital Burden of Illness (Charlson Index)
Process Measures	Quarterly Physician office visits HbA1c tests (and results if available)
Interventions	Distribution of diabetes flow sheets to providers Feedback on process measures in population compared to peers Reminders to patients and providers to schedule visits Exercise and diet plan for members
Rationale	Increase in process measures will impact interim measures; management of diabetes in the ambulatory setting will prevent progression of disease and outcomes; defer incidence of outcomes.
Cite	Diabetes Control and Complication Trial National Institute of Diabetes, Digestive, and Kidney Diseases

The most important feature of our program is iterative data analysis to identify Enrollees with uncoordinated care that places them at risk of greater burden of disease and cost. As we explain in our introduction to disease management, APS could not conduct this analysis without both Enrollee and provider identifiers in a longitudinal claims file with medical and pharmaceutical claims. We describe a proxy for this analysis that identifies significant outliers for special outreach as part of the DM population. After conducting predictive modeling and *uncoordinated care* analyses, APS will identify a cohort with uncoordinated care – Enrollees who are at risk of greater burden of disease and greater cost because their healthcare services are uncoordinated, including some of the following symptoms:

- Multiple healthcare providers providing duplicated and/or inconsistent services.
- Excessive utilization of Emergency Department services.
- Excessive utilization of pharmacy services and "pharmacy shopping."
- "Provider shopping" – accessing multiple providers and frequently changing PCPs.
- Absence of routine visits to PCPs or other physicians, even with the diagnosis of a chronic disease.

As our staffing plan indicates, APS has proposed a number of Health Coaches (RN Disease Management specialists) and Care Coordinators that is greater than the minimum value. Additionally, approximately one-third of Care Coordinators will be Behavioral Health Specialists (e.g., a licensed Behavioral Healthcare provider such as licensed Psychologist or Social Worker). Other Care Coordinators will be lay educators, individuals who have been ACCESS Plus Enrollees. These Care Coordinators will receive special training from APS on disease management interventions. Further, our disease management intervention strategies have been engineered to focus on high cost attributes of the population that interferes with the achievement in improvements to Enrollee functional status.

A final strategy has to do with our configuration of APS CareConnection®. Our initial implementation of our care management system will focus on Health Coach and Care Coordinator functionality. Subsequent to implementation and during contract year two, we will implement the provider care plan for APS CareConnection® and provide a sign-on to this information system for *all* PCPs and other ACCESS Plus providers. We provide more information about this system in Section II-3.1 Information Systems. The Institute for Healthcare Improvement identifies a Plan of Care for *each patient* as a key strategy for patient quality and safety. Implementing a model Plan of Care for ACCESS Plus Enrollees provides the evidence-based template for disease management best practices – proven management techniques associated with lower cost, higher quality, and better outcomes. **Table 23-38** shows current APS clients where our effective strategies are being implemented to achieve program goals.

Table 23-38. Healthy Together[sm] Customers

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Through the [redacted] program, APS managed an average of more than [redacted] clients per month through its Healthy Together health management programs, which includes programs for clients with asthma, coronary artery disease, chronic obstructive pulmonary disease, chronic heart failure, depression, diabetes and other disease states. The average cost avoidance for clients in Year 1, while still maintaining quality care, was $[redacted] each month, which was $[redacted] above the target savings PMPM.

M. Describe the methods the Offeror will use to perform Provider outreach specific to Disease Management. Propose a Disease Management outreach plan for Providers, including a timeline for specific Provider outreach tasks.

We propose to integrate our DM-specific outreach into overall provider outreach during implementation to ensure that all providers are aware of this program and understand its benefits, parameters, focus, and methods of Enrollee identification. Our proposed DM Outreach Plan for Providers is presented in **Table 23-39**. During implementation, and with input from individual providers, provider associations, the Department, and the Quality Management Committee, we will create an annual outreach plan for ACCESS Plus DM providers,

including discussion of materials, methods, statewide and county-based stakeholder associations, and a timeline. This plan will then be revised on an annual basis for approval by the Department. Additionally, if we recognize an opportunity for improvement, we will also make interim modifications to our outreach plan for Department approval prior to initiation. This plan is predicated on the communication strategy that multiple, alternative media and messages are needed to ensure provider awareness and buy-in of the DM program, and that *any* provider communication should promote the achievement of outreach goals. All communications will be approved by the Department.

Table 23-39. Year One Provider Disease Management Outreach Plan

Description	Methods & Materials	Responsible	Timeline
1. Association Announcements	Letter notices to provider associations concerning ACCESS Plus award to APS	APS Corporate Marketing with direction from APS implementation team	After contracting signing
2. Announcements to Providers	Individual letter notices to providers outlining DM program, with new conditions, information about inclusion of new conditions	APS Corporate Marketing with direction from APS implementation team	After contracting signing
3. Transition Project Plan Notice	Transition timeline, contract information, changes to the program, impact on providers and Enrollees; contacts for information about transition	APS Chief Medical Officer (with Harrisburg Medical Director and Executive Director point of contact information)	Within 10 days of contract implementation project plan approval
4. Supplemental Contract Mailings to all Medicaid Providers	Cover letter for Supplemental Contract with directions for accessing alternative formats for Supplemental Contract (e.g., download from website, mailed electronic copy)	APS partner [redacted]	At least 60 days prior to "go live" estimated at October 1, 2009
5. Notices to Provider Patients	General letter to providers notifying the community that new packets are being mailed to Enrollees on their rosters	ACCESS Plus Medical Director	At least 30 days prior to "go live"
6. Association Status Reports	Updates to provider stakeholder associations so that information can be distributed to providers via websites and meetings; offer for clinical management to attend in person	ACCESS Plus Medical Director; QI Manager; Health Services Director as appropriate to association	Prior to monthly association Board meetings

Table 23-39. Year One Provider Disease Management Outreach Plan			
Description	**Methods & Materials**	**Responsible**	**Timeline**
		membership	
7. Provider Status Reports	Periodic updates to individual PCPs on Supplemental Contract returns, status of implementation, other information for providers	Provider Services Manager	Ongoing from award to go live
8. Medical Director Clinical Orientation	Regional conference calls and webinars; regional meetings to orient PCPs and specialists concerning DM program	Medical Director; [redacted]; and [redacted]	Within 30 days of go live
9. Implementation Milestones	Update on ACCESS Plus website notifying providers about achievement of key dates (e.g., closeout of Supplemental Provider Contracts; approval of DM and CM protocols for new conditions; announcements of new staff members)	Executive Director	Monthly "ED Letter to Providers"
10. Regional Orientation Meetings	Overall orientation to ACCESS Plus changes and specific orientations to DM changes, program features	Medical Director, ED, Provider Services Manager; Health Services Director, QI Manager	1st quarter after go live
11. Monthly Rosters	Mailings to PCPs	Provider Services Manager	Monthly starting 30 days after go live
12. Monthly Clinical Alerts (Medication, Other)	Targeted to PCPs with Enrollees with alerts for services and/or medications	Medical Director, Health Services Director	Monthly starting 30 days after go live
13. Monthly EPSDT Reports	Updates on EPSDT services for panel overall	Medical Director, Health Services Director	Medical Director, Health Services Director
14. "The Neighborhood News" - Quarterly Newsletters	Updates on programs, results of feedback from providers, educational material	Medical Director, Provider Services Manager, Health Services Director, QI Manager as appropriate	Within 30 days after close of quarter
15. Quarterly Regional Training Notices	Notice of regional training locations and dates, on	Provider Services Manager	30 days prior to training

Table 23-39. Year One Provider Disease Management Outreach Plan			
Description	**Methods & Materials**	**Responsible**	**Timeline**
	ACCESS Plus website		
16. Quarterly Regional Training	Quarterly training sessions for each region via conference call and/or webinar	Executive Director, Medical Director, Provider Services Manager, Health Services Director, QI Manager as appropriate	First month of each quarter
17. Quarterly Medical Director Call Notices	Notice for quarterly call	Provider Services Manager	1st month of each quarter
18. Quarterly Medical Director Calls	Special call with ACCESS Plus and Department Medical Directors	Provider only call to build community connectivity	Second month of each quarter
19. Initial Quality Management Committee Notice (Invitation to Participate)	Notice of QMC formation	Medical Director	On approval from Department
20. Quarterly Quality Management Committee Update	Minutes from QMC after meeting	Medical Director	Within 15 days of meeting
21. Ad Hoc Provider Best Practice Reports	Recognition for provider results and impacts	QI Manager	As appropriate and approved by Department
22. Provider Tool Kits for specific conditions in DM Program	Tip sheets, patient flow sheets, evidence reports, Enrollee materials	Medical Director, Health Services Director	As developed by APS and approved by Department
23. Annual Provider Audit Plan Notification	Overall plan, instrument, and point of contact for questions	QI Manager	At least 60 days prior to release of schedule
24. Annual Provider Audit Plan – Individual Provider Scheduling Notice	Specific schedule for sampled providers	QI Manager	At least 30 days prior to visit
25. Annual Provider Survey Call for Questions	Optional call for providers to offer input and perspectives on the survey process and questions	Provider Relations Manager and Medical Director	At least 90 days prior to survey approval from Department
26. Annual Provider Survey – Open	Notice to providers that annual survey site is open	ACCESS Plus and Department Medical Directors	Selected date
27. Annual Provider Survey – Reminder	Notice to providers that annual survey site is open and date of closure	Medical Director	Every 15 days until cut off date

Table 23-39. Year One Provider Disease Management Outreach Plan			
Description	**Methods & Materials**	**Responsible**	**Timeline**
28. Annual Provider Survey – Report	Results of annual provider survey	Medical Director	After approval from Department

Descriptions of these materials indicate their utility for provider practices:

- **Provider Tool-Kits.** APS will provide participating ACCESS Plus providers with toolkits of printed materials incorporating nationally recognized evidence-based treatment guidelines into the day-to-day care of patients with chronic disease states. The toolkit will be available electronically and the materials included therein updated in accordance with changes made in clinical standards of practice. Additionally, APS will develop *provider tool kits* for practitioners, general practitioners, pediatricians, internists, physician assistants, and nurse practitioners throughout the Program. **Our kits include a pocket card for quick reference on treatment protocols, medication management guidelines**, as well as educational tools for patients that providers can use in their clinics or facilities.
- **Provider Newsletters.** On a quarterly basis, APS will develop and distribute an ACCESS Plus Program Provider Newsletter which includes articles on topics such as chronic care management protocols, clinical guidelines, and best practices. In addition, we will periodically feature an *ACCESS Plus Program Champion Provider's* article which contains information on clinical guidelines relevant to the champion provider's area of practice or area of interest. APS is exploring the opportunity to provide e-newsletters to ACCESS Plus Program providers from the National Center for Primary Care, as well as concise, weekly clinical guideline "bits" via email or PDA.
- **Orientation materials in PowerPoint**. The majority of hands-on training materials will be presented in Microsoft PowerPoint slide format and will also include resource guides, informational sheets, reference lists and brochures. All Enrollees receive this packet of information, which will also be available to be downloaded from the APS ACCESS Plus Program website. The specific content and agenda (including the disease-specific clinical guidelines) that will be covered will be developed based on feedback from the provider community, the Clinical Advisory Committee, and the Department.
- **Program Provider Manuals.** APS will revise the existing ACCESS Plus Program Provider Handbook and distribute it to providers in electronic format and in hardcopy on request.

N. Describe how the Offeror will solicit input from Providers and Enrollees for development and ongoing operations of the Disease Management programs.

APS implements a practiced, systematic approach to monitor and evaluate our programs in all our contracts that is based upon continuous quality improvement principles. We work carefully with our state partners and stakeholder advisory groups in developing proactive goals for improvement. Our staff, tools and processes assure that technical assistance, clear milestones of success, and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance. APS' experience with other quality assurance and quality improvement processes has demonstrated that quality of the interactions between practice facilitators and providers will be an essential factor in the success of the ACCESS Plus Program. For this reason it is a critical performance area for ongoing assessment and improvement. Through this approach, APS will be able to do what it does best – collaborate with members, primary care providers and community advocates, family members and other member supports to enhance the delivery of high quality integrated care.

Member and Provider Satisfaction Surveys

Member satisfaction with disease management activities, including interactions with their Health Coaches, will be measured through a survey we will conduct. We understand that the Department is interested in using the newly published DM Enrollee survey published by *dmaa the care continuum alliance* (formerly the Disease Management Association of America). APS is a member of DMAA, and our [redacted], is a member of the Board of Directors. In addition, APS staff members served on the internal DMAA committee that participated in development of this survey. APS partner, [redacted], an NCQA-accredited CAHPS vendor, will administer this survey to DM enrollees.

APS and [redacted] received the DMAA member and provider surveys in preparation for this proposal. APS spoke with DMAA concerning administration protocols for the Enrollee survey to ensure that it is administered appropriately. At the time of this writing, DMAA has not finalized administration protocols for the survey and therefore does not have required activities that have been linked through validation of the survey to optimal response rates. [redacted] will therefore modify NCQA protocols for administration for suitability to the DMAA survey instrument, with input from DMAA and direction from the Department. [redacted] will closely monitor the process and results of administration, and share these results with DMAA to begin the process of developing standardized protocols. As one of the original NCQA accredited CAHPS vendors, and having continuously participated in the program since the inception of accreditation, [redacted] has the experienced and expertise to pilot this process for ACCESS Plus and help DMAA set national standards for administration of its survey instruments. [[redacted] will also administer the CAHPS survey for non-DM ACCESS Plus Enrollees.]

APS has reviewed the survey results published on the Regional Advisory Committee (RAC) website. We have a concern with the extent to which Enrollees could not be contacted for the previous survey, but to our knowledge no non-respondent analysis was presented to the RAC or Department. A non- respondent analysis reports on the characteristics of the non-respondent group compared to the respondent group, and evaluates the extent to which non-respondents and respondents are sufficiently equivalent such that the survey results can be generalized to the overall DM population. Given the large number of Enrollees who were contacted but did not respond, standard survey methodology dictates that a non-respondent analysis should be presented to the Department. [redacted] will conduct this analysis; our experience with their administration of CAHPS surveys supports their ability to generate acceptable response rates for DM and non-DM populations. As with the CAHPS survey, [redacted] will share its results with APS for discussion purposes, but will submit its survey report directly to the Department. In this way, we can assure the Department of the independence of our process and results. The DM population will be surveyed as a statewide population owing to its size and the disparate distribution of Enrollees across regions. [The CAHPS survey will be conducted on a regional basis; that is, adult and child samples will be selected for each of the four regions, and results will be presented at the regional level. We believe this approach will be useful to the Regional Ambassador Councils, the state-wide Consumer Sub-Committee, and the Department.]

In addition to monitoring activities we will conduct, providers will be able to participate in a survey available on our website. The survey instrument will include:

- Feedback on interpersonal interactions with APS staff;
- Knowledge of disease management and clinical conditions;
- Completeness and accuracy of information; and
- Opportunities to improve interaction.

Using the DM provider survey that the Department used in prior years (so that responses can be compared over time) as a basis for our survey, APS will finalize the survey questions with approval from the Department. This survey will also conform to standard survey methodology:

- A cover letter from the Department Medical Director will explain the survey, confirm that information will be used to improve the ACCESS Plus Program, and that provider responses will not be released without

prior approval in writing from the provider.

- Timeframes for response to the survey will be clearly identified.
- We will provide a non-APS point of contact for concerns, and an APS contact for survey questions.
- Providers will receive an assurance that results will not be released to Enrollees without provider approval.
- We will notify the provider community about survey administration and alternative methods for survey response.
- We will track survey response by method (e.g., website, mail, fax, telephone).
- We will employ multiple alternative methods until the acceptable response rate is received.

We will then load the questions on a website (using an efficient web-enabled system such as Survey Monkey) and notify providers that the survey site is open. In our notification we will inform providers how they can respond to the survey if they are unable to access the website (e.g., through mail and fax). We will then monitor the site and send reminder notices to providers to insure that the response is acceptable (at least 30%). Two of our Pennsylvania partners, the [redacted] and the [redacted], will then assist with the interpretation of provider survey results and recommendations for improvement based on these results. Through these partnership arrangements, APS has ensured that our provider results will be *independently* evaluated, and opportunities for improvement will be reported to the Department and Quality Management Committee.

Feedback on Materials and Reports

We will also solicit feedback from the Quality Management Committee, the Department, the Regional Ambassador Council, individual providers, and Enrollees on the format, content, and utility of our disease management materials and reports. We will also conduct a formal review of DMPP materials and reports on an annual basis to identify opportunities to improve these tools.

O. Describe how the Offeror will follow up with Enrollees and Providers should an Enrollee opt out of the Disease Management program. Include the frequency with which the Offeror will conduct follow-up and, if applicable, how the frequency of follow-up will differ depending on the risk of the Enrollee.

Enrollees may request to opt out of the Disease Management Program at any time. Each Enrollee will be informed that the program is voluntary, and the decision not to participate does not affect other benefits – or their ability to re-enter the program in the future. In our experience, one reason Enrollees opt out has to do with the intervention strategy of the vendor. Too few calls, mailings, and community outreach activities, and the Enrollee loses touch with the vendor; too many activities and Enrollees experience "communication fatigue" and opt out of the program to escape from unwelcome interactions. Our proposed approach balances these levels of activity, and focuses on Enrollees that will benefit from our outreach. When Enrollees continue to experience benefits, they are less likely to opt out. However, we still understand that some Enrollees will decide to leave the DM program.

For those individuals who contact APS to opt out from the program, APS' clinical staff will first work with each Enrollee to ascertain motivations for opting out. APS staff then **identifies key milestones, which mark individual health goals that the Enrollee has successfully achieved**. Staff will invite Enrollees to remain engaged in the program at a reduced level, and explain to them that they could continue to receive our disease-specific newsletters, without having further telephone contact with a Health Coach if that is a preference. If the Enrollee agrees to remain involved, staff will ascertain at what level they want to remain involved and, if appropriate, APS will continue our program interventions as documented in the Enrollee's Plan of Care.

If, after talking with their Health Coaches, Enrollees still wish to opt out, the clinical staff will perform an exit survey to formally record the member's decision process to opt out. APS will evaluate areas of concern in

order to correct potential opportunities for improve, and will evaluate areas of satisfaction for their impact on quality of care. This information will be entered into APS CareConnection® and will be shared with the Department on a timeline mutually agreed upon by both parties. APS will provide a monthly opt out report to the Department detailing the previous months opt out activity.

These Enrollees are moved to the group that continues to receive annual invitations to rejoin the program (or more frequently at the direction of the Department) and remains eligible to talk to our clinical staff if the need arises through the toll-free ACCESS Plus telephone number. Additionally, we perform ***watchful monitoring***. During watchful monitoring individuals can be re-identified for participation in the Disease Management Program. For example, each time APS refreshes claims data received from the Department, Enrollees' claims are reviewed. If their risk levels change or new conditions or co-morbidities are identified Enrollees are returned to "identified" status and the appropriate Enrollee engage initiatives are employed. The frequency of this "follow up" or re-identification will be dependent upon the frequency of claims data received by APS.

P. Describe how the Offeror will provide standardized continuing education to its Disease Management staff on medication-related issues and interventions.

Training and technical assistance are a cornerstone of APS' approach to services that emphasize quality improvement, provider stability and appropriate and efficient use of services. To that end, APS provides a standardized training program that is refined for local relevance, including training for clinical and non-clinical staff. **Table 23-40** illustrates how APS integrates multiple sources of communication content and strategies into a coordinated development process that ensures corporate learning and best practices are shared at the local level, and just as importantly, that local innovations are shared with other dedicated service centers and the APS corporate infrastructure. Through this process we are able to deliver training programs that are both *relevant* to local programs, with model methods and materials standardized at the corporate level.

For internal staff training and external provider training, Continuing Medical Education and Continuing Educational Units will be available through APS partner the [redacted]. Additionally, our partner the [redacted] will also contribute to clinical continuing education content and research to practice strategies.

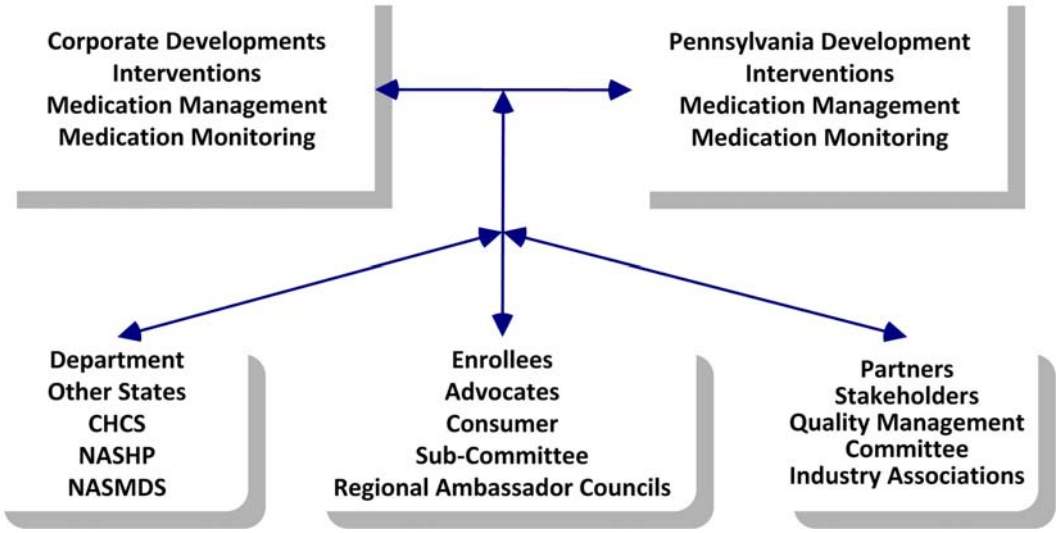

Table 23-40. Learning and Best Practices Shared Across the APS System

An overview of our clinical and other training includes:

- **Training to comply with the Department's clinical requirements.** These training programs are the

combined responsibility of the Medical Director, the Quality Improvement Manager, and the Health Services Director. The Medical Director is responsible to ensure that program materials accurately reflect the clinical interventions that have been designed; the Quality Improvement Manager is responsible for the development of training materials (and/or adaptation of standard corporate training materials); the Health Services Director is then responsible to ensure that staff members are scheduled for training; receive and understand the training; are monitored by the Health Services Supervisors to ensure its application to practice; and receive refresher training if practice demonstrates gaps in understanding and application. The Executive Director has overall responsibility to ensure that this process is routinely and rigorously applied to our operations. APS partner [redacted] will assist APS with the development of training materials and recommend appropriate training methods for clinicians. In addition to local ACCESS Plus staff and subcontractors, the APS Vice President of Clinical Product Development will work with the Medical Director and Health Services Director to ensure that corporate innovations in program interventions and materials are integrated into our local Pennsylvania program.

- **Training on program functions and changes**. Since many calls received by the Call Center are requests for program information, staff must be well versed in all program functions to offer prompt assistance and to make the right internal referrals. We conduct frequent training on program functions, and ensure that staff members have resource materials to consult on program questions and clarifications.
- **Customer Service training.** The goal of customer service and outreach is to provide friendly assistance to all callers. Therefore, our staff will be trained in telephone etiquette and technique, problem solving, and empathetic listening. This training will reinforce our customer friendly approach and ensure that every consumer is treated with respect and dignity. (This customer service training is not the same as our Health Coach training for motivational interviewing. Non-clinical staff receives an orientation to this technique but with few exceptions do not practice it; *all* APS staff members receive training on customer service expectations.)
- **Customized cultural competency training for staff.** The goal is to ensure outreach initiatives and intervention efforts are successful. APS will have a specific cultural competency training plan for the ACCESS Plus Program. This training will be incorporated in training for all Health Coaches and other clinical staff. APS understands the importance of aligning our chronic care management services with the cultural and linguistic nuances of each region and population. With experience delivering services to over 16 million Medicaid recipients, we know that culture significantly influences an individual's perception of their health and the healthcare system, as well as how they understand and use the healthcare information and materials they receive. We have been successful in understanding and tailoring our healthcare services to be respectful of the cultural and linguistic needs of beneficiaries in each of the states our public programs manage. Because of this due diligence, our services are (1) well received, (2) make a positive impact on beneficiaries' health, and are (3) provided in a manner consistent with each beneficiary's belief system. Staff will be required to attend a cultural competency-training program. As a part of this training program, we will provide training that reflects the beliefs, customs, and preferences of people with Hispanic ethnicity, people who are African-American, people who are deaf/hard of hearing, blind, or otherwise disabled, and people with intellectual/developmental disabilities, including Autism Spectrum Disorder. Another aspect of culture to be addressed within our education and training is the unique perspective of individuals who live in rural areas – a significant attribute of the ACCESS Plus region.

Q. Provide samples of Disease Management Enrollee outreach materials (e.g., brochures, handbooks, newsletters, video tapes, etc.) and describe ways materials will be updated/changed to meet the Department's needs.

We have included examples of our Welcome letters, educational materials, newsletters, and individual member communications in **Exhibit 12** to illustrate our friendly, colorful content that has been developed for

our 10 existing public sector DM programs. We will modify these materials to reflect the ACCESS Plus logo and color scheme, and submit them to the Department for review and approval in advance of using them for Enrollee outreach. This process will create the baseline outreach library for ACCESS Plus. These materials will be formally reviewed and updated on no less than an annual basis to ensure that they reflect current program information, clinical content, and interventions that are part of ACCESS Plus. In addition, we will update materials as needed to reflect changes in program information, clinical updates, or improvements in intervention process that require changes in our materials. We will be glad to make changes to the materials to meet the Department's needs – APS is a flexible and responsive partner for our customers and proactive in identifying ways that we can improve processes and materials.

To meet these needs APS will draw on the capabilities of our in-house marketing team. Our marketing team is led by [redacted]. [redacted] will be responsible for coordinating material development activities in consultation with the Executive Director and the Department. All graphical design is done in-house; managing fulfillment for this project is [redacted] a Pennsylvania-based company. Ad hoc material development and production can be conducted by APS to maximize the flexibility of our communications approach. Our marketing professionals are experts well-versed in creating communications that promote our DM program and speak directly to Enrollees' individual health care concerns in a person-centered way. In addition, content is created with the help of clinical personnel to ensure that it has been validated and is current, culturally competent, and reading level appropriate.

Our dedicated marketing team will work closely with the Department during every step of the process to deliver a communications program that adds quality, value and boosts participation. APS will follow the steps below to identify successful strategies for the communications program:

- Communications development meeting between APS and the Department during implementation.
- Development of a communications plan.
- Drafting of program materials.
- Presentation to the Department for approval.
- Once approved, program material integration with existing campaigns.
- Project management for accurate, timely delivery and fulfillment.

R. Recommend additional innovative Disease Management strategies the Department may want to consider for the ACCESS Plus Program.

In this section we present innovative ideas to provide supportive and effective DM services for subpopulations we identified through preliminary data analysis. We recognize that DM Enrollees with Hemophilia and Alzheimer's have special challenges in addressing the difficulty of managing chronic disease and these co-morbidities. Our approach, therefore, is to ensure that our person-centered program is adapted to these special needs.

Considerations for Management of Enrollees with Hemophilia

Hemophilia is an inherited bleeding disorder caused by a deficiency or defect of one of the proteins necessary for blood to clot properly. These proteins are known as *clotting factors*. Bleeding—which can be life threatening—occurs in joints, muscles, and vital organs, such as the brain. Over a period of time, this bleeding can lead to chronic pain, arthritis, deformity and disability. Hemophilia is rare in women; however, it occurs in 1 in every 7,500 male births.

Treatment of hemophilia is aimed at replacing the deficient *clotting factor*. This is done with infusions of concentrates containing the needed factor. Many patients are able to self-infuse the clotting factor concentrate when they bleed. This ensures prompt treatment, and gives them greater independence and more control over managing their disorder. However, factor is extremely expensive. The costs of treating hemophilia

range between $100,000 and $200,000 annually, depending on the patient's disease severity. In the ACCESS Plus populations, costs are significantly higher for some Enrollees.

While it is a life-long disorder and there is no cure for hemophilia, there are many resources available to ensure that even those with severe disease are still able to function normally, including attending school, obtaining employment, and enjoying a greatly increased life expectancy. To that end, APS' approach for care management of patients with hemophilia focuses on prevention of injury and bleeding, and promotion of normal functionality and integration in social life, including attending school and enjoying active hobbies and sports.

Strategies to encourage early recognition and prompt treatment of bleeds, as well as empowering patients to carry on normal lives, can help reduce inappropriate costs, as well as reduce disability associated with hemophilia. Specific strategies within our care management program include:

- **Patient and caregiver education and support**. APS provides education to encourage patients to comply with their medical treatment—including preventing bleeds, taking medications, getting routine lab tests and vaccinations—making safe decisions about daily activities, and dealing with emotions such as guilt, loss of control, and feelings of isolation. For minors, APS believes it is important to reinforce the responsibilities of the parents, in particular, with school officials in order to maintain a positive learning environment. This includes communicating the child's condition and factor treatment plan to caregivers and school officials, assisting the child in maintaining a positive healthy attitude toward school, and obtaining make-up work when the child is absent.
- **Care management and coordination.** Since vigilant monitoring of patient's clotting ability is necessary through routine laboratory studies (PT, PTT, factor levels), having a healthcare/medical home is paramount. For enrollees within the ACCESS Plus corridor, access to a Hemophilia specialist—a hematologist or one of the six hemophilia treatment centers (HTCs)—may be necessary. Additionally, APS staff will arrange for annual, comprehensive checkups, immunizations and regular testing for blood-borne infections, in partnership with the patient.

  APS nurses will also have the ability to perform environmental assessments in an effort to prevent injury, as well as help patients and families implement safety measures. We can help parents outline emergency plans for bleeding episodes at school or work, as well as obtain needed equipment/supplies. Finally, toward the goal of helping patients lead normal lives, APS will promote community support resources such Camp Hot-To-Clot hosted at Camp Judson in Springfield and the National Hemophilia Foundation's *The First Step* for parents of children with Hemophilia.
- **Medication monitoring.** Understanding that a patient's adherence to the factor treatment plan is pivotal in their ability to prevent bleeds, APS has the ability to monitor Medication Adherence. Data analytics will alert our clinical staff to patients who are noncompliant with their regime and we will then work with them to remove barriers and implement motivators to increase adherence.

Considerations for Management of Enrollees Alzheimer's Disease (AD)

Alzheimer's Disease (AD) is the seventh leading cause of death in the United States, and the fifth leading cause for individuals 65 and older. It is an expensive condition to treat—according to the Alzheimer's Association, Medicaid spending for beneficiaries with AD is estimated to be upwards of $33 billion in 2010—and difficult to manage. Adding to its complexity, national averages estimate that one-fourth of people with AD have other chronic illnesses, such as heart failure, chronic obstructive pulmonary disease, osteoarthritis, or diabetes. Considered by itself, the inevitable progression of AD creates problems with memory, thinking, and behavior and is severe enough to affect work, family and social relationships. Eventually, the most basic activities of daily living—the ability to bathe, eat and communicate independently—are compromised. Therefore there is a growing dependency on family members, friends, and long-term care facilities to provide basic care. AD is

incurable, it is fatal and the burden of the disease is felt by not only the patient, but the caregiver, provider, community and system.

When AD is coupled with another chronic disease, the ability to manage different medications, nutrition and hydration requirements, symptoms and even multiples providers often becomes overwhelming. For example, if an Alzheimer's patient who also suffers from heart failure (a disease which requires vigilant monitoring of daily weight, reducing sodium in their diet and taking diuretic medications) forgets any part of their regime, they could suffer a debilitating or deadly heart attack. Understanding the needs of AD and realizing that care at the end of life is expensive, fragmented, often substandard and disheartening to patients and families, APS has an approach that we believe improve outcomes for these patients. Some strategies include:

- **Care coordination.** APS will coordinate ACCESS Plus benefits for specialized services to help patients and families manage the many medical and psychosocial aspects of AD. These services include early-stage groups or adult day services for structured activities, respite care, and skilled nursing care. In addition, APS anticipates making referrals to social service agencies and support organizations, such as the Alzheimer's Association's MedicAlert® + Safe Return® program for patients who may wander.
- **Medication monitoring.** Four medications are approved by the U.S. Food and Drug Administration to treat AD. These drugs work by regulating neurotransmitters and may help maintain thinking, memory, and speaking skills, with certain behavioral problems. However, these drugs do not change the underlying disease process and may only be effective for a few months to a few years. Additionally, they cause unwanted side effects. APS will work with the patient, caregiver and provider to determine if AD medications are achieving the intended effect; if they are causing an adverse effect severe enough to warrant discontinuation; if there is an adverse effect when taken with other medications; if the medication is still necessary; or if the dosage can be safely decreased.
- **Patient and caregiver education**. While AD cannot be cured, helping patients understand that making healthy lifestyle choices—which include a nutritious diet, exercise, social engagement, and mentally stimulating pursuits—may help reduce risks of cognitive decline. In addition, we will work with patients and caregivers to help them understand and manage the most common behavioral symptoms of AD—sleeplessness, agitation, wandering, anxiety, anger, and depression.
- **Caregiver support.** Caring for a loved one with AD exacts a great emotional and physical toll on families and friends. Providing education about the disease process itself is one way to empower caregivers to make informed decisions, but can also help reduce stress surrounding what will come next for loved ones. In addition, APS will link caregivers with community programs that teach families about practical strategies for dealing with difficult care-giving situations, as well as those that offer legal and financial resources.
- **Provider support and education**. Many older patients—and especially those with AD—receive their care from a primary care physician who may be challenged with managing the medical, behavioral and social complexities of the disease, including identifying the inevitable terminal decline of a patient. For example, in the early stages of AD, treatment goals are similar to those of otherwise healthy patients. As an AD patient's dementia worsens and the ability to understand treatments and participate in medical decision-making declines, the goals of treatment should change to the relief of pain and discomfort. As part of the care team, APS staff can help providers guide patients and caregivers toward long-term care and hospice services when it becomes appropriate. In addition, APS can offer training sessions to help staff identify symptoms of terminal decline and the breadth and benefits of hospice care.

Understanding that this population requires complex management and multiple providers, APS believes our approach to Total Health Management will not only create cost savings for this group of patients, but increase caregivers' capacity to provide support for their loved ones.

II-3 Work Statement

24. CULTURAL SENSITIVITY

A. Describe the geographic and cultural variations across the covered regions and the associated health care disparities, and how the Offeror will address these health care disparities.

APS has conducted extensive outreach to regional stakeholders to better understand the cultural and geographic variations across ACCESS Plus' covered regions. In fact, as Lisa Davis, Director of the Pennsylvania Office of Rural Health explained, "Pennsylvania is considered to be one of the most *rural* states in the nation, with almost 2.8 million residents living in areas that are designated as rural. The economic, cultural, social, geographic, and demographic characteristics of rural communities are sufficiently different from those of urban and suburban communities to require special consideration." We realize the following issues impact the ACCESS Plus population and how we deliver services:

APS understands how geography and culture impact health care disparities. Some of the ways these disparities will be addressed include culturally competent staff that is strategically located in rural areas and providing culturally sensitive Enrollee materials

Rural landscape. The ACCESS Plus region includes small, rural counties as well as a few population centers. ACCESS Plus populations vary by county from 855 in Forest to over 43,000 in Luzerne (according to our analysis of 2006 and 2007 data).

Access to care. Given the rural nature of Pennsylvania, access to care can be challenging. With approximately 80 hospitals in the region, county-based hospital listings indicated that eight of 42 counties (Monroe, Pike, Snyder, Potter, Juniata, Montour, Forest, Cameron, and Sullivan) do not have inpatient hospitals. According to a report distributed to the Consumer Sub-Committee in October, 2008, as of September 30, 2008 almost 66% of ACCESS Plus provider sites were restricted or closed, possibly accounting for anecdotal concerns about access submitted to that Committee and the Regional Advisory Committees.

Chronic Care Issues. Analysis of the data for 2006 and 2007 by Enrollee county of residence and region (counties were assigned to regions according to the Regional Advisory Committee placement) identified the distribution of Enrollees with any chronic disease: North East (with the Wilkes Barre/Scranton population center) is the largest region with over [redacted]% of Enrollees having a chronic disease, followed by the North West region (Erie county and surrounding area) with [redacted]%.

In order to overcome the geographic challenges of the State, APS will embed Field Care Coordinators and Health Coaches within the community who understand the local climate, provider community resources, common provider challenges, etc. These individuals will be the "face" of the ACCESS Plus Program and will be tasked with building successful relationships with the local provider community to educate them on ACCESS Plus and the benefits of program participation. APS ACCESS Plus staff will also explain their roles (e.g., assist with coordination of care efforts, help Enrollees keep scheduled appointments, provide Enrollees education and support to help reinforce PCP treatment recommendations, etc.) and how they can help decrease burdens providers commonly face with treating Medicaid members. Additionally, the results of the chronic care analysis by region will also guide our allocation of field-based staff across ACCESS Plus counties, and assist us with evaluating priorities for provider recruitment. For example, within the North East region, Coronary Artery

Disease accounts for [redacted]% of all Cardiovascular Diseases in that region – so it will be critical to ensure cardiology specialists are a focus of recruitment in that region.

In order to increase access, APS will also develop an aggressive provider promotional campaign to create "buzz" within the Pennsylvania provider community and generate provider interest in the program. Specific activities include distributing program introduction letters; posting information on the ACCESS Plus website; outreach to providers and their office managers (e.g., face-to-face meetings, medical society presentations, etc.); promotion via local media such as public service announcements and press releases; partnerships with community-based organizations and Pennsylvania professional associations that can be instrumental in motivating providers about the advantages of ACCESS Plus and the importance of participating; and educating stakeholders who influence providers to help gain additional support for ACCESS Plus. The benefit to providers in participating in the ACCESS Plus Program is that they will be provided a financial incentive through the Pay for Performance program. In addition, the more participating providers that are available to ACCESS Plus Enrollees, the fewer barriers to care the Enrollees will have to overcome as their medical homes will be more geographically convenient.

Additionally, according to the Henry J. Kaiser Family Foundation, while the majority of the state is white (66%), approximately 15% of the population are Hispanic, 12% are African American, and 7% represent other nationalities (2006-2007).[1] APS' public programs are deeply committed to ensuring the services we provide – from case management interventions to health coaching to the ways we outreach and engage Enrollees – are culturally and linguistically sensitive to the populations we serve. Cultural competency activities for ACCESS Plus will include the following:

- APS will attempt to identify Enrollees who speak a language other than English as their first language, and document such information in APS CareConnection®. This will enable us to ensure translator services are available to meet language requirements of the ACCESS Plus membership. It will also enable APS to automatically send program materials in the primary language of the Enrollees if it is a prevalent language.

- APS will make all written materials available in Spanish as an alternative language, and other languages on request and with the Department's approval. Materials will be prepared at the fifth (5th) grade reading level and will be translated into Spanish for example. Directions on requesting materials in other languages will be included with all materials in each of the prevalent languages.

- APS' staff receive ongoing training in both cultural and disability competency, which enables staff to better assist Enrollees with limited English skills and Enrollees with disabilities in managing their own care. For example, APS includes Culturally and Linguistically Appropriate Services (CLAS) standards in our staff orientation program. We also require Health Coaches to attend cultural competency trainings offered through the Office of Minority Health (OMH) and obtain nursing credits. Furthermore, we encourage PCPs to also earn CMEs and nursing credits through OMH.

- APS uses the Telephonic Omni Network Language Line for individuals who do not speak English, and also use interpreters as necessary.

[1] Henry J. Kaiser Family Foundation (2006-2007). www.statehealthfacts.org. Accessed February 11 2009.

- APS will make it a priority to hire bilingual and/or bicultural staff members for the ACCESS Plus Program.

Furthermore, in the current economic environment, medical homes will be stressed and more individuals with chronic disease will need social and medical support. APS will leverage the resource historically playing a key role in rural communities – the county Extension Office – who can play an even greater role in health education for ACCESS Plus for poor, rural communities. School systems and churches will also provide a focus for community activation and a resource for communication to the broader community. The provider distribution, Enrollee age, and the rural character of the ACCESS Plus region also suggests that community-based organizations and even retailers will be valuable partners – churches, volunteer organizations, Wal-Marts, grocery stores, and drug stores will serve as "point of sale" locations for APS to reach Enrollees. With the average age of all Enrollees at 22, customary communications methods will also have to be extended to YouTube, Facebook, and Twitter. Thus, APS lay educators will have accounts, and be reachable by young Enrollees through Instant Messaging and social network sites. Our experience is that although ACCESS Plus Enrollees may be young and poor, they will be more like their counterparts in the private sector in terms of their communication preferences and messaging.

Please note that as part of ACCESS Plus and in accordance with **Draft ACCESS Plus Agreement, Section E.1 – Cultural Sensitivity**, APS will develop and submit all policies and procedures and materials on Cultural Sensitivity to the Department for review and approval in accordance with Section B.1, Policies and Procedures, and Section B.2, Materials Development and Distribution. Our programs are designed to help bridge gaps posed by language, culture, and/or disability.

B. Provide examples of how the Offeror has applied its understanding of geographic and cultural variations within a region to other programs, including how the Offeror identified these variations.

As part of our normal operations, APS assesses the geographic and cultural variations of our other programs. Examples are described below:

[redacted]. APS conducted an analysis for the [redacted] and [redacted] by region targeting the population's socio-economic characteristics, access to services and transportation issues, as well as Enrollee demographics (race/ ethnicity). As a result, we developed the [redacted] Cultural Competency Plan (see **Exhibit 23**) in collaboration with the National Primary Care (NCPC) at Morehouse School of Medicine. GAMMP covers all counties in [redacted], while [redacted] covers the [redacted] part of the state including the [redacted] area. APS knew that cultural competence was essential given the cultural and linguistic diversity within the state. Differences within the culture play an essential role in the rate at which members access healthcare and manage their health issues as well as which methods are more effective in supporting these members in achieving better outcomes.

The Cultural Competency Plan was developed to specifically address the diverse populations enrolled in [redacted] Medicaid, and incorporates the concept of self-determination to make members full partners in decision making. It also includes a discussion of ways to engage and provide support for people with different racial and ethnic backgrounds as well as people who have differences in language, community norms, and socio-economic characteristics. The Cultural Competency Plan shown in Table II-3.24.1 focuses on:

Table II-3.24-1. Cultural Competency Plan Focus
■ Staffing - Recruitment of culturally and linguistically diverse staff with a genuine respect for the individuals they serve. For example, we placed community Health coaches and Outreach workers in the communities where our members are such as [redacted] and several locations throughout the metro [redacted] area.
■ Training - Initial and ongoing training related to characteristics of different cultures that affects how they seek and accept help. Education focuses on the belief systems that surround utilization of healthcare resources by Hispanics/Latinos, Asian/Pacific Islanders, African Americans, and Native Americans. Staff training issues address various cultural perspectives, ensuring that education provided are not only clinically sound, but also sensitive to cultural norms.
■ Interventions - Strategies used by APS staff to support members and their families as they are assisted in gaining control of their healthcare.
■ Community Resources - Identification and development of a variety of community services and supports that are sensitive to the diversity within the community.

[redacted]. APS began working with the [redacted] even before the inception of APS' Disease Management (DM) program for the Office of Medicaid. Our Medical Director, Executive Director, and the [redacted] Executive Director met frequently during the program's ramp-up to get an understanding of the physician perspective in the state, barriers to adoption of the DM program (e.g., rural geography, etc.), and needs of providers that APS could satisfy. The partnership that has developed since the relationship was built has laid the groundwork for success of the DM program, as well as a shared sense of ownership for the well-being of the state's Medicaid clients. For example, we worked with the [redacted] to deliver education and information using a variety of approaches appropriate to the rural nature of many of the state's practices including videoconferencing to more than [redacted] sites around the state, web-based education and distribution through the [redacted] newsletters. We also learned that providers experienced challenges in obtaining CME due to access as it is rare that a sole practitioner who serves multiple rural communities can be away from the clinic for even a day. As a result, we leveraged available technology to deliver CME via videoconferencing to the state's rural provider communities.

Additionally, APS established a locally-based [redacted] Outreach Team of Health Coaches strategically placed throughout the state. Health Coaches are responsible for locating and engaging hard to reach Enrollees; conducting assessments; providing education and guidance; assisting non-compliant Enrollees to identify and address their reasons for non-compliance (e.g., psychosocial and/or financial issues, or functional status limitations that may be impairing their abilities); interacting with the Enrollee's health care team and other appropriate parties (e.g., family members and significant others); identifying care alternatives; setting short- and long-term goals with the Enrollee; monitoring goal achievement; promoting self-management skills; and providing disease-specific education. To strengthen the Medicaid Certified provider network to ensure a close interface with our health management services, APS also identified and established referral sources of every community resource within the [redacted] to facilitate continuity of services.

II-3 Work Statement

26. COMPLAINT PROCESS

A. Explain how the Offeror plans to triage Enrollee and Provider Complaints to the appropriate designated Offeror or Department staff.

APS has an established Complaints Process to ensure both verbal and written complaints from Enrollees and providers are responded to and resolved in the most consistent and effective manner possible. Please see **Exhibit 24** to review our Complaints Policy and Procedure. Under the ACCESS Plus Program, APS will register and respond to all verbal or written complaints received from Enrollees, an Enrollee's representative, providers, or other Pennsylvania state agencies. Each complaint is taken seriously and is viewed by APS as an opportunity for improvement. APS follows a consistent procedure in resolving and responding to complaints that include the following:

Complaints are rich sources of information that report on concerns Enrollees and providers' experience. Any complaint received is taken seriously and viewed by APS as an opportunity for improvement.

- Documentation of the substance of the complaint.
- Full investigation of the complaint, including any aspects of clinical care involved.
- Actions taken to resolve the issue.
- Notification to the complainant of the disposition of the complaint and the right to appeal, as appropriate.
- A standard resolution time of 30 calendar days, or sooner, dependent on the clinical urgency of the situation.

An "emergency" complaint will be handled immediately with resolution achieved within 4 hours. All complaints classified as "urgent" will be forwarded to the responsible entity for resolution as soon as possible, taking into account the medical exigencies of the complaint, but no longer than 72 hours after APS' receipt of the complaint. All complaints that are clinical in nature are reviewed by clinical staff. If the resolution is not satisfactory to the complainant, APS may offer other options to resolve the complaint, including referral back to the Department for resolution.

APS strives to maintain all interactions with providers and Enrollees at the highest level of professional courtesy and interpersonal respect, consistent with our values and those of our public sector clients and our clients' Enrollees. Infrequently, when our interactions do not live up to the expectations of our Enrollees or providers, we have received complaints that we responded to immediately. For example, if an Enrollee has a concern that a Call Center representative did not respond to a question courteously and promptly, with the expected information, the Enrollee will contact APS via the dedicated toll-free ACCESS Plus Program line with their complaint. On occasions when this type of complaint has occurred, APS responded directly to the Enrollee with a prompt and responsive handling of the grievance, documenting staff education or other disciplinary actions taken to address the concern and prevent its future occurrence. These steps are documented in the grievance files as any others would be, and routinely reported to our clients and to Consumer Advisory Committees where they are functioning.

Responding to Verbal Complaints

When an Enrollee or provider calls the single, dedicated toll-free ACCESS Plus Program line, they will hear a phone tree that will provide options to either speak with a staff member (i.e., Member Services Representative, Care Coordinator or Health Coach) for Enrollee issues or a Provider Relations Representative for provider related issues. Our Automatic Call Distribution system will then immediately route the caller to the most appropriate staff member to address their need. It's important to note that our call center staff – from Member Service Representative to Provider Relations Representatives - are trained in collecting and documenting complaints in our system (e.g., caller name, MA Recipient identification number, date and time of call, action taken by APS, whether the call was referred to a supervisor or another source, resolution of the call, etc.) to ensure issues are addressed in the most satisfactory manner and reported in a format approved by the Department. Furthermore, complaints about clinical care that are received by non-clinicians will be forwarded to the QI Director for assessment of urgency. Below, we have described how verbal Enrollee and provider complaints are triaged to the appropriate designated staff below.

a. The APS staff member who speaks directly with an Enrollee or provider enters the complaint in the Complaint tracking system. Complaints regarding clinical care that are received by non-clinicians will be forwarded to the QI Director immediately for assessment of urgency.
b. If the complaint is considered an "emergency," it will be handled immediately with resolution achieved within 4 hours. The QI Director will consult with the Health Services Director, Medical Director and/or Executive Director. If the complaint is considered "urgent," the QI Director will consult with the Health Services Director, Medical Director and/or Executive Director to resolve the complaint as soon as possible, but no longer than 72 hours.
c. The APS staff member identifies the source, content and substance of the complaint, the date and time the complaint was received and the disposition of the call. Additionally, the APS staff member entering the complaint identifies the person who is to be notified of the resolution of the complaint and the means of notification (verbal or written).
d. If the complainant does not request notification of the resolution, the APS staff member documents this in the tracking system.
e. The staff member receiving the initial call makes every effort to personally resolve the complaint to the satisfaction of the caller at the time of the call. If this is accomplished, the staff member indicates in the tracking system that the complaint was resolved and includes the actions taken to resolve the complaint. If the complainant is not satisfied with the staff member's response, the option of speaking with the staff member's supervisor is offered to them.
f. If the staff member cannot resolve the complaint at the time of the initial call, the complainant is informed that resolution will be reached within thirty (30) days of the call for non-urgent complaints and within 72 hours for urgent complaints. The complainant is asked if they would like notification of the complaint resolution, and if yes, how they would prefer to be notified (verbally or in writing). This preference is documented in the tracking system.
g. Complaints unresolved by the initial staff member are transferred to the staff member's supervisor/manager. Additional actions taken to resolve the complaint and the date of resolution are documented. A response is provided to the complainant if such was requested. The complainant is advised that if they are not satisfied with the response, they have the option to speak with a supervisor (if appropriate) or they may contact the state agency, as appropriate.
h. The QI Director will note his/her review within the tracking system and the complaint form is maintained electronically with limited access for confidentiality.

i. The QI Department is responsible for the logging, tracking, and trending of complaints. This information is reported to the Executive Director and Medical Director on a monthly basis at a minimum, and reported to the Department.
j. If the complaint is not resolved to the satisfaction of the Enrollee, they will be instructed to contact the state agency, such as the Department, for other options.
k. Breaches of confidentiality that are not resolved to the Enrollee's satisfaction are referred to APS' Chief Privacy Officer.

Below, we have described how written Enrollee and Provider Complaints are triaged to the appropriate designated staff.

Responding to Written Complaints

If a complaint is received in writing, the complaint is processed as described above. All written complaints are given to the QI Department for entry into the tracking system and then forwarded to appropriate personnel for resolution.

The affected department manager will send a written response to the complainant or complainant's representative. At a minimum, the response should indicate that the complaint was received and investigated and that if the complainant is not satisfied with the response, they have the option of speaking with a supervisor or contacting the state agency, such as Department of Public Welfare.

B. Describe how the Offeror will identify the need for corrective action based on complaint tracking results, implement corrective action and determine the effectiveness of the corrective action.

Complaints are rich sources of information that report on concerns Enrollees and providers experience with APS' system – as are compliments, which APS has received on many occasions. As part of our standard operations, APS tracks and trends the complaints and resolution time to identify areas for improvement at the program level as well as on an individual basis. Complaints are monitored and analyzed on a monthly basis by the Executive Director in conjunction with our QI Director. APS' Pennsylvania Medical Director will also participate in this process as needed. Based on the results of the complaint tracking, APS can then identify whether there is a need for corrective action. Corrective action plans or interventions are developed as necessary and re-measurement is done to ascertain the effectiveness of the intervention. The results will then be shared with the Department of Public Welfare and the Regional Advisory Committee, which will assist APS in identifying priorities for changes to our policies and procedures; training programs for staff members, and internal management.

C. Provide recommendations of the types of complaints to be tracked including the method for tracking the complaints.

APS can capture various types of complaints in our system. Complaint types are typically categorized as vendor-specific, service-specific, or provider-specific. Examples of complaints that we recommend tracking include but are not limited to: concerns with the professionalism and courtesy of staff or providers; concerns with transportation services (untimely, poor scheduling, etc.); dissatisfaction with the level of services received; Enrollees missing appointments; inability to attend provider training, etc. However, APS will work with the Department to ensure we capture all types of complaints and use the information to continually improve upon the ACCESS Plus Program. With regard to methodology, all verbal and written complaints are

documented in our Complaint tracking system for tracking, trending and reporting purposes by either our call center staff or QI department. As a result, we can provide complaint reports in accordance with Exhibit D, Required Vendor Reports including:

Enrollee (or an Enrollee's representative) Complaints Report
■ Monthly Summary Report (includes number of complaints outstanding from previous month, number received per month, number resolved, and number outstanding at the end of the month. Top 5 reasons that describe the nature of the complaints and % of complaints received. Average # of days to resolve provider complaints. Resolution Codes for Complaints) ■ Detail Report Log (Enrollee complaints listed by codes for ACCESS Plus and disease management; Name of Enrollee; MA recipient number; Enrollee Phone Number; Date of complaint; Name of call center staff; Summary of complaint; Resolution of complaint; Resolution Date; and Referral to another source (if applicable))
Provider Complaints Report
■ Quarterly Summary Report (Includes number of complaints outstanding from previous quarter; Number received per quarter; Number resolved; Number outstanding at the end of the quarter). Top five reasons that describe the nature of the complaints and percent of complaints received. Average number of days to resolve provider complaints. Resolution Codes for complaints. ■ Ad Hoc Detail Report Log (Provider complaints listed by codes for ACCESS Plus and disease management; Date of complaint; Name of provider; Provider phone number; Provider ACCESS Plus number; Summary of complaint; Resolution of complaint and date; Referral to another source (if applicable); and Name of call center staff).

II-3 Work Statement

27. CONTRACTS AND SUBCONTRACTS

A. Provide a description of each subcontractor with responsibilities to be performed and each subcontractor's qualifications and certifications relevant to this scope of work. Identify any past working relationships with these contractors. (separate response for each subcontractor. limit: two pages for each subcontractor)

The APS team of local, national, large, and small businesses has been recruited to delivery exemplary customer service in every aspect of the ACCESS Plus Program.

APS has chosen partners that combine with our background and experience in all aspects of the RFP to represent a comprehensive "best in class" team for the ACCESS Plus Program. Complementing our expertise in care management, disease management, provider services, and information technology, we identified partners with: direct experience with ACCESS Plus, core capabilities in information technology, specialized expertise with pharmacy data analyses; proficiency in risk neonatal care management, credentials in training and documentation, and certification as a CAHPS vendor. In addition to our exceptional disadvantaged business partners and other subcontractors, APS is pleased to propose organizations with deep clinical and cultural insight into the ACCESS Plus healthcare environment join our team: Pennsylvania State University Center for Health and Policy Research and the Pennsylvania Association of Community Health Centers.

The APS team enables us to meet today's ACCESS Plus requirements and respond to the challenges of tomorrow with exemplary customer service. We have provided a description of each subcontractor with responsibilities to be performed and each subcontractor's qualifications relevant to this scope of work on the following pages.

Adept Consulting Services, Inc.

Adept Consulting Services, Inc. (Adept) currently provides experienced Information Technology professionals under contract to assist with data management for the Department, with responsibility for several data systems that support the ACCESS Plus Program. Adept will leverage this experience to facilitate development of the data interfaces and processes for Department systems and field-based technical assistance representatives for adoption of APS Health Information Technology as part of the Access Plus Program. Adept will be responsible for supporting APS with the following components of the ACCESS Plus program:

- Adept will support the development and configuration of APS CareConnection® for deployment in the ACCESS Plus Program by providing consulting expertise in the Department of Public Welfare data systems, including PROMISe™, CaseNET, CaseManager™, Client Information System (CIS), and Medical Management Review System (MMRS).
- Adept will provide ad hoc services for the following types of services: onsite technical assistance to APS users; Problem identification and resolution; and Installation of new equipment.
- Adept will provide [redacted] in-field Provider Service Representatives who will visit and support providers in the four (4) regions designated in the ACCESS Plus geography.
- Adept will design a reporting plan for the EPSDT requirements. Adept will work with APS program management, IT management and the Department management to understand and define the requirements for a comprehensive reporting structure for the EPSDT data.

Adept is a Certified Minority Business Enterprise (MBE) with the Commonwealth of Pennsylvania-Department of General Services. Adept is also located within a PA designated Enterprise Zone. Adept has an extensive track record with eGovernment applications for the Commonwealth. Their technology experience includes Microsoft applications, Oracle, Web (Internet/Intranet), Java/J2EE, SAP and Remedy. Their senior team of application developers and consultant support staff have delivered and supported hundreds of eGovernment applications at these agencies. In addition, Adept has successfully delivered programming services to the following Commonwealth agencies: Department of Public Welfare (DPW), State Employees Retirement System, Corrections, State Police, Revenue, Veterans & Military Affairs, Office of the Budget, State Civil Service Commission and Department of Community and Economic Development. As a subcontractor, Adept has also provided senior level architectural consulting and development services for DPW, Office of Mental Retardation and Child Support Enforcement.

Operations and Help Desk Support

Adept is viewed as a leading on-site, Level II Operations and Help Desk provider on Pennsylvania projects (supporting almost 30,000 users). Large agency clients in this area have included: Department of Environment Protection, the Justice Network (JNET), DPW and Department of Conservation and National Resources. They have provided support to the distributed state-wide user community within each agency by resolving technology issues as well as application problems. Adept has developed an extensive knowledge base of the Human Services, Public Safety and Environmental business practices within Pennsylvania state government.

Black Consulting Services, Inc.

Black Consulting Services, Inc. (Black Consulting) will provide policy and procedure documentation support; development of training methods, materials, and evaluations for provider and Enrollee training and education, and assistance with Regional Ambassador Council. Black Consulting will provide the following resources in support of ACCESS Plus requirements:

- Full-time Regional Ambassador Council Coordinator.
- Senior Communications Consultant to assist APS with the development and execution of a Regional Ambassador Council Program. This program will be designed to facilitate communication between the APS, the Department, Enrollees and providers as well as provide a conduit for continuous improvement of the ACCESS Plus program.
- Curriculum Development Specialist and a Training Specialist to support APS' efforts to provide training and education programs offered to both providers and Enrollees.
- Communications Specialist, Curriculum Development Specialist and/or a Training Specialist to assist APS in promoting the benefits of the ACCESS Plus program and increasing the awareness and enrollment in the program.

Black Consulting is a Pennsylvania certified Women's Business Enterprise (WBE) located within a Pennsylvania designated Enterprise Zone. Black Consulting excels in assisting customers with training, professional development and project management initiatives by working as a team that is focused on their clients, company, and community. Black Consulting is an organization of professionals who bring demonstrated competencies in diverse industries and disciplines that can address a wide range of client situations and needs.

Black Consulting professionals have provided:

Project Management services on project-based systems integration for mid-to-large size organizations in most industries and in government and non-profit realms.

- ACS – Medical Management Review System (MMRS)
  - Coordinate development of the end user training program and training materials (user guide, job aides, simulations, and exercises)
  - Coordinate the User Acceptance Test (UAT) activities
  - Assist in system testing
- IBM – Unemployment Compensation Modernization Systems (UCMS)
  - Coordinate training and knowledge transfer of technology to the information systems staff
  - Coordinate development of the end user training curricula and training materials (trainer and user guides, job aides, simulations, and exercises)
  - Develop and management a Train-the-Trainer (T3) program to prepare the DLI trainers to deliver end user training

Professional Development services focusing on the development of an organization's human capital.

- Senate of Pennsylvania – Leadership Development
- Shippensburg University Small Business Center – Supervisor Communications Skills
- Luxor Events and Marketing – Executive Strategic Planning

Training services ranging from instructor lead training sessions to web-based training programs to blended training solutions.

- ACS – Medical Management Review System (MMRS)
  - Created training program to be delivered by instructor or via computer
  - Delivered instructor led end user training to Pennsylvania Department of Public Welfare employees
- IBM – Unemployment Compensation Modernization Systems (UCMS)
  - Created and delivered Train-the-Trainer (T3) sessions for DLI trainers
  - Developed end user training materials

BT Consulting, LLC

BT Consulting, LLC (BTC) will be providing IT Support for the Provider Help Desk and Call Center, Project Management staffing and nurse contracting for PCP audits and HEDIS data collection as part of the ACCESS Plus program. BTC will be responsible for assisting APS with the following components:

- Support network and system installation at APS' Harrisburg offices, including assistance with setting up workstations, printers, and other systems equipment. Provide onsite support to APS staff for systems use during implementation.
- Provide office-based and field-based Helpdesk support for PCPs and provider offices during implementation of APS CareConnection® and other systems deployed for ACCESS Plus.
- Provide project management expertise and oversight for provider audit activities by:
- Provide experienced project manager.
- Develop Audit Project Plan in Microsoft Project for submission to and review by the Department of Public Welfare. The audit plan will detail activities needed to conduct the medical records audit for primary care providers with 120 offices visited on an annual basis.
- Contract with experienced nurse auditors to conduct the onsite audit, including assuring timely data transfer from the automated system and completion of audit activities as indicated by the project plan.

BTC located in Lititz, PA, is a Certified Minority Business Enterprise (MBE) with the Commonwealth of Pennsylvania-Department of General Services.

Project Management Services

BTC provided project and operations management in support of core networks, maintaining existing infrastructure and upgrades as required. The company served as the primary manager and interface with outside vendors in support of core network upgrade to include all routers, switches, UPS, and servers at PENNDOT county offices, DL and Welcome Centers. This project was completed on time and on budget, with an approximate budget of $5 million. Other projects included the upgrade of the Engineering Construction Management System, the migration of the CADD group from NT 4.0 domain to Windows 2003 environment. BTC project management contracts also included acting as Chair of the shared development group deploying IBM Rational toolset to include ClearCase, ClearQuest and RSA. BTC also had responsibilities managing and supporting a staff of eight direct reports and based on project details, indirect reports as required.

Help Desk Services

BTC was contracted to provide help desk services to Liberty Property Trust in Malvern, PA. The BTC Desktop Engineer was responsible for troubleshooting hardware, software and network problems. BTC provided user support and conducted training on standard software applications, and was also responsible to inform, advise, train and support employees relative to the requirements of network security, accounts, and passwords. This project also involved supporting facility computer users on data and telecommunications hardware, in person and by telephone as necessary, in order to assess problems. BTC staff made recommendations and applied solutions. Other responsibilities included Installing Ghost images and other software and configuring and installing Lotus Notes.

ProgenyHealth

We offer a specialized approach to high risk neonatal case management through partner ProgenyHealth. Our approach is explained in detail in Section II-3.4, Care Coordination and Intense Case Management:

- ProgenyHealth will provide case management services for families of high risk babies in the ACCESS Plus Program for up to one calendar year from birth, according to standard ProgenyHealth case management protocols that include 24/7 telephonic support from experienced neonatal Registered Nurses and Board-certified Pediatricians.
- APS will notify ProgenyHealth of neonatal discharges eligible to receive case management services, and will provide data to support case management as approved by the Department.
- Prior to initiating the project, ProgenyHealth and APS will review enrollee communications materials with the Department, and make adjustments as requested by the Department.
- ProgenyHealth will submit data to APS in a mutually agreed on format to integrate with APS data for the purpose of reporting and performance measurement.

ProgenyHealth is certified as a Woman Business Enterprise in Pennsylvania through the Department of General Services. ProgenyHealth has a full accreditation by URAC in Health Utilization Management and is certified by the Pennsylvania Department of Health to operate as a Certified Review Entity (CRE) in the state of Pennsylvania. Relevant project experience includes the following:

Blue Cross Blue Shield of Delaware

ProgenyHealth provides full program services to the premature and medically complex newborn members of Blue Cross Blue Shield of Delaware, working with both their fully insured and self insured markets for a total of 420,000 members.

Requirements include utilization review activities for newborn infants admitted to a NICU/special care nursery after birth. ProgenyHealth NICU nurses interface regularly nationwide with the hospital staff at facilities where BCBSD members are admitted and collect and review clinical information and submit recommended NICU levels of care to the health plan based on ProgenyHealth approved policies, procedures and guidelines.

AmeriHealth Mercy Health Plan

ProgenyHealth provides full program services to the premature and medically complex newborn members of AmeriHealth Mercy Health Plan (AMHP), a Medicaid Plan in Pennsylvania with a membership of approximately 100,000 members.

Requirements include utilization review activities for newborn infants admitted to a NICU/and or special care nursery after birth. ProgenyHealth NICU nurses interface regularly with hospital staff at AMHP facilities and collect and review clinical information and submit recommended authorizations to the health plan based on ProgenyHealth approved policies, procedures and guidelines.

For both programs:

The clinical and authorization information is entered and stored in their proprietary software application, BabyTrax. Health Plan staff log on to BabyTrax and view daily authorization and discharge reports so they can update their internal authorization systems. When infants are more clinically stable and approaching discharge, ProgenyHealth staff assist hospitals as needed with their discharge planning activities including any home nursing visit authorizations, necessary DME in the home, etc. If an infant is readmitted during the first

year, ProgenyHealth provides utilization review services to BCBSD for the readmission case and the case managers follow up with the family after discharge.

Once the infants are discharged from the hospital, a ProgenyHealth case manager calls to introduce the case management program to them and performs a needs assessment to see how they can best meet the needs of the family. Customized introductory packets are mailed to families which include articles related to the medical needs of their babies. Also included are infant safety packets which include articles about how to keep homes safe, car seat safety, and first aid in the home, for example. For those infants requiring regular case management services, their primary care physicians (PCP) are contacted and a customized plan of care developed in conjunction with the family is shared with their PCP. These care plans along with a full library of articles pertaining to newborns are available on the web for the family and the PCP and are updated regularly.

My Health Direct® (MHD)

My Health Direct® is a resource identification and scheduling system used by hospitals and PCPs for emergency room diversion as part of the ACCESS Plus Program.

My Health Direct® will be responsible for supporting APS with the following components of the ACCESS Plus program.

- Configure My Health Direct® with Access Plus enrollment, eligibility, and provider data available from the Pennsylvania Department of Welfare (DPW) through the APS IT Department.
- Maintain the Pennsylvania configuration with data updates from APS on a scheduled basis.
- Provide access to My Health Direct® on a 24/7 basis with the exception of scheduled and/or announced updates and maintenance.
- Allow access to My Health Direct® as a link from APS CareConnection®
- Provide initial and annual training sessions for APS PCP Manager and PCP Representatives in the use of My Health Direct® (train the trainer).
- Provide direct training to Access Plus Hospitals during implementation and on an annual basis.
- Provide a 24/7 Help Desk for APS PCP Manager and PCP Representatives.
- Designate a Technical Liaison(s) to work with APS on the configuration and implementation of My Health Direct.
- Assist APS to recruit PCPs to contribute appointments to My Health Direct®.

APS and My Health Direct® have partnered with one another in other proposals and are eager to continue our partnership with the ACCESS Plus Program.

My Health Direct is a proprietary web-enabled system that promotes emergency room diversion through real-time scheduling of primary care visits for non-emergent patients. Providers enrolled in the Commonwealth of Pennsylvania Medicaid program will be able to access and use My Health Direct® under subcontract to APS as part of the Pennsylvania Access Plus program.

The Pennsylvania Association of Community Health Clinics (PACHC)

The Pennsylvania Association of Community Health Centers (PACHC) will be providing Continuing Medical Education (CME) credits, outreach support to Community Health Centers, provider satisfaction survey support including the interpretation of results and recommendations for improvement as part of the ACCESS Plus Program.

The Pennsylvania Association of Community Health Clinics (PACHC) will be responsible for supporting APS with the following components of the ACCESS Plus Program.

- The PACHC will also assist APS with the development, administration, and interpretation of results for the provider experience survey, including: providing comment and feedback on items to be included with the survey and evaluating the results and contributing to reporting the results, with recommendations for improvement based on PACHC knowledge and expertise in the delivery of primary care in Pennsylvania.
- Participate on the Statewide Quality Improvement Committee, including attending quarterly meeting and providing input and recommendations on the overall quality strategy for ACCESS Plus, as well as providing insight into the identification of disparities in care and strategies to address these disparities.

The Pennsylvania Association of Community Health Centers (PACHC), located in Wormleysburg, PA, is the state primary care association representing Federally Qualified Health Centers and other like-mission providers located in underserved areas throughout the Commonwealth. Established in 1981 as a private non-profit organization, PACHC was formed by and for community health center programs. PACHC programs and services are designed to strengthen, promote and grow health centers in today's complex and constantly changing health care environment.

PRWT Services, Inc.

PRWT Services, Inc**.** (PRWT) will be providing fulfillment and "Back Office" operations; Contracting Partnership Program (CPP) support which will include screening, training, and retention of CPP employees as part of the ACCESS Plus Program. PRWT will be responsible for supporting APS with fulfillment components of the ACCESS Plus Program, including:

- During Implementation:
  - Welcome letter packages with letter, gift, Enrollee Handbook; Provider supplemental contract notices/letters; fulfillment Labor.
- Throughout the contract period to both providers and Enrollees:
  - Provider items:
    - Quarterly newsletter; notifications for training schedule and agenda; DM PCPs newsletter.
  - General Enrollee items:
    - New Enrollee packets with letter, gift, Enrollee Handbook; monthly mailings; Quarterly Newsletters.
  - Adult Wellness Items:
    - Quarterly Newsletters.
  - EPSDT Items (APS will handle special EPSDT communications to Enrollees and providers):
    - Twice yearly newsletter.
  - Special Fulfillment Needs:
    - Quarterly mailings
  - PRWT will provide the following Ad hoc items:
    - New provider packets
    - On Going Fulfillment Labor
- PRWT will also provide Program Management Duties that will include Contractor Performance Reporting and assistance with the Contractor Partnership (which we describe in detail in the Contractor Partnership submission).

PRWT is based in Philadelphia, PA. Since 1988, PRWT Services has been offering high-quality business process outsourcing (BPO) to a full range of clients throughout the United States. PRWT is a certified minority business enterprise (MBE) offering services such as document processing, payment processing, mailroom services, lockbox, scanning and imaging, walk-in and call-center based customer service, and toll collection operations services. They focus on operational quality, efficiency, and productivity. Their core competencies include the delivery of specialized customer-care solutions and business processing centers, primarily for government entities. Projects that are relevant to the current scope of work include:

- ACS Government Solutions
  - Client Since 1988
  - 19 contracts including Philadelphia Parking Tickets, Los Angeles
  - Parking Tickets, New Jersey Surcharge, New York E-ZPass, and
- Ohio Child Support Payment Center
- San Francisco Municipal Transportation Agency
  - Client Since 1998
- Delaware River Port Authority
  - Client Since 1998
  - Manual toll operations on four bridges

The Pennsylvania State University, Center for Health Care and Policy Research

The Pennsylvania State University, Center for Health Care and Policy Research (PSU CHCPR) will be providing clinical support for program development and quality improvement through the Pennsylvania State University School of Medicine. The Center for Health Care and Policy Research will provide advanced analytics and "research to practice" training for providers as part of the ACCESS Plus Program.

The Pennsylvania State University will be responsible for supporting APS with the following components of the ACCESS Plus Program.

- Assist APS in clinical support for program development and quality improvement based on its academic research findings. APS will identify from this listing those diseases for which it will seek PSU's support for additional data and information. These services may include assistance in developing clinical panels composed of disease specific experts who would advise on appropriate outcomes for the particular interventions related to the disease conditions.
- Identify a staff member to participate in the Quality Management Committee on a quarterly basis, with approval from the Department.
- Develop special purpose profiles for the Quality Management Committee and the Department of Public Welfare that report on utilization and quality performance.
- Conduct geomapping of and related analysis to determine PCP provider network adequacy and to identify areas where additional recruitment efforts may be needed.
- Assist APS with identification of disease management best practices and Evidence-based Clinical Practice Guidelines for specified diseases, and assist with development of physician profiles, best practice reports, and other communication materials to distribute information to ACCESS Plus Providers.

CHCPR is part of the College of Health and Human Development at The Pennsylvania State University, in State College, Pennsylvania. The mission of CHCPR is to create and disseminate new scientific knowledge that will help private and public decision-makers to develop cost effective services and programs that improve people's health. In carrying out its mission, the Center: promotes innovative research on significant health care topics; supports faculty in submitting research proposals and executing funded projects; assists in the communication of research findings to policymakers and practitioners; furthers Penn State's educational mission by facilitating research experiences for students.

Southeastern Consultants, Inc. (SEC)

Southeastern Consultants, Inc. (SEC) will be providing advanced analytics to identify Enrollees with uncoordinated care that can be improved through clinical and programmatic interventions as part of the ACCESS Plus Program.

SEC will be responsible for supporting APS with the following components of the ACCESS Plus Program.

- SEC will provide advanced analytics to identify care management outliers and uncoordinated care among Enrollees.

SEC is a national pharmaceutical and health care consulting and data services firm that provides innovative data analysis methods. It provides services to Medicaid plans other government agencies, private health plans, academic institutions, industry, and professional health care associations in areas such as coordination of care analysis and predictive modeling for disease/case management and medication therapy management and review programs, pharmacoeconomic/outcome studies, pharmacy benefit management policy and operational strategies, claims data analysis, utilization review, reimbursement policy compliance and auditing. SEC is a Florida for-profit corporation that is women owned and managed and has been incorporated since January 1993.

SEC brings a team of consultant and clinical pharmacists as well as health economists who are experts in their fields with diverse and extensive experience in public and private health plans including Medicaid fee-for-service and managed care sectors. The pharmaceutical consulting and data services provided by SEC combine the experience of clinical and specialized consultant pharmacists, health economists and statistical researchers, and expert data management and programming support personnel.

WB&A

WB&A will provide CAHPS and DMAA survey administration as part of the ACCESS Plus Program and will be responsible for supporting APS with the following components of the ACCESS Plus Program. WB&A will:

- Administer the CAHPS and DMAA surveys using NCQA methodology.
- Collect Enrollee responses, analyze response data, and report on the results to APS, the Department, the Quality Management Committee, and the Regional Ambassador Councils.

WB&A currently holds the following certifications:

- National Committee for Quality Assurance (NCQA) certified to conduct HEDIS®/CAHPS® surveys. WB&A continues to be one of a limited number of research firms to be certified by NCQA.
- Marketing Research Association's Professional Researcher Certification (MRA PRC) - WB&A's project management staff are all among the first to be certified by the Marketing Research Association's Professional Researcher Certification program. This program was developed to encourage high standards within the profession in order to raise competency, establish an objective measure of a researcher's knowledge and proficiency, and encourage continued professional development.

WB&A is a leading market research firm located in Crofton, MD, approximately 2 hours from Harrisburg.

B. Provide a plan to ensure an effective working relationship with each subcontractor, including coordination from an information technology (IT) perspective.

APS has recruited an extensive team to best serve the ACCESS Plus Program, and during this selection process has developed the relationships with subcontractor key personnel that are needed to establish effective working relationships during contract performance. To ensure that our valuable team members are able to achieve optimal performance on their scope of work responsibilities, we have assigned a formal point of contact within the APS management team who is responsible to work directly with subcontractors on their responsibilities. Subcontractor personnel then take part directly in APS team, Department, and provider/Enrollee meetings as needed so that they function effectively as integrated members of the APS team. With the ACCESS Plus team, APS has already held formal meetings and conference calls to begin developing the team relationship so that subcontractors are familiar with APS, our proposed solution for the ACCESS Plus Program, the roles of each subcontractor and subcontractor personnel, and our expectations for performance, if awarded this important contract.

We show these relationships on the organizational chart included in Section II-5, Personnel. In addition, the lead development staff member for the procurement oversees the transition from teaming agreement to subcontract to ensure that the scope of work and pricing are represented accurately in the subcontract. The development team then works with the ACCESS Plus management team to transition the relationship to an operational status, ensuring that the strong bonds formed during procurement continue into operations. This effort is conducted until all parties are satisfied that an effective working relationship has been established. It is important to note that the Executive Director is responsible for contract and subcontract deliverables, and we explain our monitoring plan below.

Data Exchange and Information Technology

Each subcontractor who will exchange and/or share data with APS will have a signed business agreement in place prior to beginning work. The definition of data coordination and interface requirements will be finalized during implementation. Most subcontractors will not require coordination of information technology as the program functions they will perform either result in a work product that will be submitted to APS or are conducted by staff members who will be integrated into the APS team. The subcontractors that will require coordination of information technology are discussed below.

PSU CHCPR will require access to detail level data for Enrollees and providers, and will therefore require data coordination to define layouts, data use and reporting, storage and maintenance of data, and confidentiality and security provisions to protect ACCESS Plus data. Their profiles and reports will be submitted to APS and the Department in both hardcopy and electronic format, in commonly accepted formats such as Microsoft® Word documents or Adobe PDF files.

SEC will also require access to detail level data for medical and pharmacy claims, and behavioral health claims and encounter data if available. We will finalize data layouts, timing, and content after contract award. SEC will use these data to conduct uncoordinated care analyses to APS, identifying Enrollees who are experiencing care that is fragmented and uncoordinated. APS will integrate the results of these analyses into our own Enrollee assessment and profiling process that will enable us to intervene with Enrollees who have the greatest need.

ProgenyHealth, which specializes in high risk neonatal case management, will receive detail level data from APS with which to populate their case management system. Updates to this system will be accomplished

through a data sharing arrangement with ProgenyHealth. Information from this system will be formatted for integration into APS CareConnection® so that it is accessible to the Department, providers, and others. In addition, with approval from the Department, providers and Department staff will also be able to access the ProgenyHealth system directly through a link from APS CareConnection®.

C. Describe how the Offeror will be accountable for and monitor each subcontractor's performance to ensure Agreement requirements are met. Submit a subcontractor monitoring plan as part of this response. Describe what steps the Offeror will take if the subcontractor fails to perform up to the Offeror's expectations.

Subcontractor responsibilities and subcontractor monitoring are integrated into APS' work flow and monitored by senior members of the APS management team. We describe the APS subcontractor monitoring plan in Table II-3.27-1. This plan begins at contract award, and is a comprehensive approach to ensure that individual subcontractors are appropriately oriented to the project and their roles.

Table II-3.27-1 Subcontractor Monitoring Plan

Activity	Description
1. Kick Off Meeting	After contract award, team members meet with APS to discuss any changes in the scope of work in general and changes that affect any subcontractor. Subcontractor personnel will meet the Regional Senior Vice President for the Program ([redacted]), the Medical Director ([redacted]), and other APS senior personnel. The lead development staff member for this procurement, [redacted], organizes and facilitates this meeting. [redacted] will continue to act as the point of contact for subcontractors until permanent management staff members are hired in Harrisburg.
2. Finalize and sign subcontract	APS teaming agreements are designed to efficiently transition to subcontracts. During this process, the APS Legal Team will prepare subcontract documents, incorporating contract clauses as appropriate, and finalizing the scope of work with subcontractors. During this process any changes in the overall requirements are identified and mapped to subcontractor scope of work documents so that subcontractor responsibilities are congruent with the final APS contract.
3. Orientation	A formal orientation to the contract requirements, the APS proposed approach and staffing, including permanent staff members, is held to introduce subcontractors to each other and to the management team members who are responsible for monitoring and reporting on performance. Department staff members are also invited to this meeting to become acquainted with the APS team.

Table II-3.27-1 Subcontractor Monitoring Plan	
Activity	**Description**
4. Staffing Approval and Hiring	For subcontractors who will provide integrated staffing for APS (such as BT Consulting and Adept) we will go through the recruiting, approval, and hiring process with the subcontractor. The Department is invited to participate in this process for management team members, and other key staffing requirements at the Department's discretion.
5. Work Plan Meeting	Prior to implementation of subcontractor functions (if not long term staffing), APS and the subcontractor meet to develop a work plan for the function that adds timeframes and specific responsibilities to the subcontract agreement. This Workplan is shared with the Department for approval and information.
6. Routine Meetings	Once the Workplan is initiated, the APS staff member responsible meets with the subcontractor on a weekly or bi-weekly basis with the subcontractors. Management staff members conduct calls with all active subcontractors every month to compare actual performance to the work plan. For example, the Quality Improvement Manager will be responsible for monitoring subcontractor WB&A. If variation from the work plan is identified at that point, APS determines if the variation presents a negative impact on the project timeframes or deliverables. If so, we move to step 8.
7. Performance Reporting	Status and performance reports are defined from project initiation through completion of subcontracted activities or contract conclusion for long-term contractors. These reports will be shared with the Department. Again, if variation is identified from work plan timeframes, reporting deliverables, or quality of deliverables submitted, APS will move to step 8.
Approach to Non-Performing Subcontractors	
8. Issue Identification and Resolution	If an issue is identified with subcontractor performance, the responsible manager/director will identify the issue and work with the subcontractor to identify a resolution that maintains the project timelines and budget. MOST issues will be resolved at this level of intervention.
9. Escalation of Unresolved Issues	If this resolution is unavailable, the APS Staff Member will escalate the issue to the Executive Director, and then to the Regional Senior Vice President. For BMWBO-certified subcontractors, APS will consult with the Department and BMWBO to identify ways to resolve the issue and maintain the subcontracting relationship.
10. Notification to the Department	Issues that are escalated to Step 9 will be reported to the Department, with alternatives identified to meet contract requirements and deliverables.

Table II-3.27-1 Subcontractor Monitoring Plan	
Activity	**Description**
11. Subcontract Termination	If APS is unable to resolve issues and must terminate the subcontract, we will first notify the Department, identify alternatives if available, and ensure that overall project timeframes and deliverables are not impacted, either by assuming responsibility for subcontracted duties or recruiting a replacement subcontractor.

It is important to note that APS meets all contracting requirements for our 700+ clients, including disadvantaged business subcontracting, subcontracting with certified business for CAHPS and HEDIS requirements, for example. It is extremely rare for a subcontract to be terminated; our thorough process of recruiting subcontractors for core capabilities, defining a clear scope of work, developing timely subcontracts with detailed requirements, and proactive monitoring helps to ensure that our teams remain intact through the life of our contracting vehicles.

D. Describe what interaction, if any, the subcontractor will have with the Department, Enrollees, Providers and other stakeholder groups.

The interactions that subcontractors will have with the Department, Enrollees, and providers will vary based on the responsibility that each subcontractor holds. Black Consulting will have extensive interaction with Enrollees through the Regional Ambassador Council Coordinator, with the Department to plan and evaluate training and the RACs, and with providers to help conduct and evaluate training. MyHealthDirect and Southeastern Consultants will little interaction with Enrollees and providers as they will work primarily through APS. They may have considerable interaction with the Department through planning and evaluation for their individual functions.

WB&A will have direct interaction the Enrollees via the telephone as they conduct surveys. The Pennsylvania Association of Community Health Clinics (PACHC) will have direct interactions with the providers as they assist with training and Quality Improvement activities, and provide CME credits. The Pennsylvania State University, Center for Health Care and Policy Research (PSU CHCPR) will work directly with the Quality Management Committee and the Department. BT Consulting and Adept Consulting Services will both have direct interaction with the provider community. PRWT Services will interact directly with TANF recipients to provide screening, training, and retention of Contracting Partnership Program employees. In addition, PRWT will have indirect interaction with enrollees through fulfillment and “back office” operations. Finally, ProgenyHealth will have direct interaction with Enrollees, providers, and the Department in management of high risk neonates if the Department accepts this component of our proposal. It is important to note that APS will facilitate and monitor these interactions. We believe, however, in transparent operations, and will gladly make our subcontractors a visible part of the team so the ACCESS Plus community can interact with them.

II-3 Work Statement

28. FRAUD AND ABUSE

A. Describe the specific policies and procedures that the Offeror will adopt to prevent and detect Fraud and Abuse that may be committed by PCPs, Enrollees, employees or by subcontractors. Explain the Offeror's process for ensuring that suspected Fraud and Abuse is reported to the Department and identify the individual responsible for Fraud and Abuse reporting. Describe methods and technology the Offeror will use to detect Fraud and Abuse. Describe how the Offeror will ensure that PCPs are made aware of their responsibilities regarding Fraud and Abuse. Include a copy of the Offeror's compliance plan.

APS promotes and protects the integrity of Medicaid programs through proactive and vigilant detection and prevention of waste, fraud, and abuse. We include waste here because, similarly to fraud and abuse, it involves the use of Medicaid resources that don't benefit Medicaid Enrollees.

In this section we describe our Program Integrity Plan that details the responsibilities and methods that APS uses to ensure that Medicaid funds are used only for medically necessary services that are covered by the Medicaid program for eligible recipients and delivered by licensed Medicaid providers. We certify that neither APS, APS' parent(s), nor any Affiliate or related party of either, is currently under suspension or debarment, and has not received a notice of intention to suspend or debar by the Commonwealth, any other State or the Federal government.

APS promotes and protects the integrity of Medicaid programs through proactive and vigilant detection and prevention of waste, fraud, and abuse.

APS also has a Corporate Compliance Program designed to aid all employees in complying with the increasingly complex rules, regulations and accreditation standards governing the healthcare industry by providing uniform policies, procedures and guidance on ethical behavior. Our Corporate Compliance Program meets current federal regulations. Key to our Corporate Compliance Program are our Code of Conduct policies and procedures to ensure uniformity in standards of conduct by our employees. All employees of APS receive an orientation about this plan on hiring and are responsible to identify and report potential fraud and abuse. APS' **Corporate Compliance Officer,** [redacted], has the responsibility and authority at the corporate level for APS' Compliance Program. She serves as a contact for employees to report any potential violations of laws, regulations or the Corporate Compliance Program, and to take appropriate action against violations. Responsibility and authority for the state level Fraud and Abuse Plan is delegated to the Executive Director or Project Manager for the contract.

APS will employ these programs, policies and procedures as part of the ACCESS Plus Program to prevent and detect waste, fraud and abuse by PCPs, Enrollees, employees and subcontractors. It's important to note that APS, our employees and subcontractors will also cooperate fully with the State's oversight agencies responsible for waste, fraud, and abuse detection and prosecution activities (e.g., Bureau of Program Integrity (BPI), Governor's Office of the Budget, Office of Attorney General's, Medicaid Fraud Control Section, Pennsylvania State Inspector General, CMS Office of Inspector General and the United States Justice Department). This cooperation includes providing access to all necessary case information, computer files and appropriate staff, and may include participating in periodic waste, fraud, and abuse training sessions, meetings

and joint reviews of subcontracted providers or Enrollees. Additionally, APS will require all subcontractors to take all actions necessary to ensure APS complies with the fraud and abuse requirements in **Appendix A**.

Copies of our Corporate Compliance Program, Code of Conduct Policies and Procedures, and an example of a state-specific Program Integrity Plan are contained in **Exhibit 25**. APS will also submit our waste, fraud, and abuse policies and procedures to the Department for prior written approval during the Readiness Review.

APS Waste, Fraud, and Abuse Detection Program

APS believes that a data-driven approach is the most successful way to detect waste, fraud, and abuse, with investigation and validation based on analytic results. In the Medicare Integrity Program this approach has achieved success in confirming fraud through medical review after an efficient data-mining cycle using eligibility, encounter, and claims data. The following analyses are conducted on a regular basis to identify potentially fraudulent or abusive billing at the member and provider level.

- **Statistical profiling** – This process involves conducting a variety of analyses using claims and encounter data (if relevant) to identify billing and utilization norms. Statistical outliers are identified for further follow up through medical review of claims and records. Areas of interest include high cost procedures, durable medical equipment, prescription drugs, and personal and home health care.
- **Data mining** – Data mining also uses statistical techniques, and APS employs the following methods to identify potentially fraudulent or abusive behavior:
    - Geographic profiling of claims by submission date – The purpose of this analysis is to identify unlikely patterns of billing – claims submitted in a cluster of dates for Enrollees who are treated at geographically disperse locations.
    - Velocity billing – Providers engaged in fraudulent billing will start by submitting a small number of claims and increase the frequency before discontinuing submission.
    - Billing for statistically unlikely procedures and/or diagnoses based on population analysis.
    - Billing for a statistically unlikely number of Enrollees.
    - Cross-referring of Enrollees to a contained group of providers and specialists.

Profiles are analyzed by program staff members and analysts to make an initial determination if further investigation is required. Analysts will review a sample of individual claims, and may also request medical or other patient level records for review. In some cases APS staff will contact Enrollees or visit providers. These activities are then used to confirm a pattern of fraud and/or abuse.

Reporting Waste, Fraud, and Abuse

APS refers confirmed fraud and abuse cases to the Medicaid Agency. Prior to this referral, APS prepares a report that outlines the methods used to detect and confirm the potential fraud/abuse, estimates of the possible impact in terms of claims amounts, and suggestions, if appropriate, for educational interventions to address the concern. The APS Medical Director reviews all reports prior to submission to the Medicaid Agency to ensure that clinical concerns are accurately and completely represented. We certify:

- In accordance with Appendix A, APS will submit a policy on referral of suspected fraud and abuse to the Department for prior approval. For example, if APS suspects that either fraud or abuse may have occurred, we will report the issue to the Department's BPI and also report quality issues to the Department for further investigation. All fraud, abuse, or quality referrals will be made within 5 business days of the identification of the issue and before any contact is made with the provider to begin a targeted review.

Any egregious situation or act will also be referred immediately to the Department's BPI for further investigation.

- APS will also immediately notify the Department, in writing, if one of our subcontractors is subsequently suspended, terminated or voluntarily withdraws from participation in MA or any federal health care program as a result of suspected or confirmed fraud or abuse. Furthermore, APS will immediately notify the Department, in writing, if we terminate or suspend an employee as a result of suspected or confirmed activities of fraud or abuse. This includes informing the Department, in writing, of the specific underlying conduct that led to the suspension, termination, or voluntary withdrawal.
- APS will communicate with the Department's Recipient Restriction (Lock-In) Program, provide for appropriate resources to identify Enrollee misutilization of medical services, and report the information to BPI. APS will cooperate with the Department in all procedures necessary to coordinate, implement, enforce and monitor the restrictions.

Waste, Fraud, and Abuse Education Prevention Program

Education of providers and Enrollees is the best way to prevent waste, fraud, and abuse. To ensure providers are made aware of their responsibilities regarding waste, fraud and abuse, Program Integrity information is included with the Provider Manual. APS also provides provider education on appropriate coding and billing practices, and uses Program Integrity materials to prepare training on appropriate ICD-9-CM and CPT-4 coding.

APS also provides information about fraud in the member manual. In addition, APS publishes a quarterly newsletter with updates from the CMS concerning the Integrity Program and information from the state's own program integrity activities. Enrollees also receive periodic reminders about how to read their "explanation of benefit" information and identify potentially fraudulent billing among providers.

II-3 Work Statement

29. FINANCIAL AND REPORTING REQUIREMENTS

A. Describe how the Offeror will meet the reporting requirements established in the Agreement, including how the Offeror will report its compliance to the Department. Describe the current capability of the Offeror's system to provide required reports and any system modifications or updates that will be necessary.

Technology for Accurate Reporting

One of APS' most important strengths, cited by stakeholders in the policy, consumer and provider communities, is our data analysis and reporting. We work to serve our customers by using breakthrough technology and developing reports that drive informed decision-making and quality monitoring. APS employs highly qualified staff and uses state of the art information processing for reporting. We utilize SQL server databases as our backbone for collecting and storing data, which offer flexible and adaptable mechanisms for data management.

APS uses [redacted] Reports for query and development of reports. Crystal Reports is the industry standard software product most widely used for reporting, accessing, and analyzing data. This software allows for customized reporting so that information can be shared with others in a meaningful way. [redacted] enables APS to create numerous individualized and specialized reports covering all aspects of program operations and utilization, and quality and financial indicators. We use [redacted] to deploy reports to the web in a secure environment for instant client access. APS uses [redacted] as its primary statistical analysis tool.

ACCESS Plus-Specific Requirements

We will adapt APS CareConnection® and other MIS components to meet all Financial and Reporting requirements as stated in the **Draft ACCESS Plus Agreement (Appendix A), Section G. Financial and Reporting Requirements**. The ability of APS CareConnection® to address all of the reporting and data integration requirements is an important feature of our system. Specifically, APS will submit reports in the formats specified by the Department for areas identified in Exhibit D, Required Vendor Reports according to the required schedule below:

Report Name	Timeframe
PCP Selection	
■ PCP Selection	Quarterly
■ Enrollee Discrepancy Reconciliation Report	Weekly
■ PCP Discrepancy Reconciliation Report	Monthly
■ Medical Home Exception Report	Quarterly
■ Summary of PCPs requesting Enrollee reassignment	Quarterly
Provider Network	
■ Unduplicated Provider Type Count by County	Quarterly
■ Geomapping	Quarterly
■ Specialist	Quarterly
■ Additions, Deletions, Restrictions to Provider Network	Monthly

Report Name	Timeframe
per month	
■ Provider Outreach Activities	Monthly
■ Provider recruitment	Monthly
■ Provider Training (topics and attendance numbers)	Semi-Annually
Call Center	
■ Enrollee, Provider and Disease Management Call Center Statistics	Monthly
■ Call Center Report on Call Monitoring Scores	Quarterly
Care Coordination (including break-out of members with Special Needs)	
■ Care Coordination Activities	Monthly
■ Care Coordination – Appointment Scheduling Detail (including EPSDT, adult preventative care)	Monthly
■ Enrollee No-shows and Outreach	Monthly
■ Real time referrals to Disease Management	Monthly
■ Referrals to External Agencies / Departments	Monthly
■ Care Coordination for Enrollees in External Facilities	Monthly
■ Number of Enrollees Receiving Active Care Coordination Services	Monthly
Complaints	
■ Provider Complaint Summary Report	Quarterly
■ Enrollee Complaint Summary Report	Monthly
Disease Management	
■ Disease Management Enrollees by Age and Gender	Quarterly
■ Disease Management Enrollees Summary by Benefit Package	Quarterly
■ Disease Management Participation	Quarterly
■ Disease Management Program Summary Report	Annually
■ Disease Management Cohort-Group Improvement Report	Semi-Annually
■ Asthma Measures Report	Quarterly
■ CAD Measures Report	Quarterly
■ CHF Measures Report	Quarterly
■ COPD Measures Report	Quarterly
■ Diabetes Measures Report	Quarterly
■ Migraine Measures Report	Quarterly
Provider Pay for Performance	
■ P4P Program Tracking Report	Monthly
■ P4P Status Update	Monthly
■ P4P Return on Investment	Quarterly
Maternity Care	
■ Pregnancy Identification and Outreach	Quarterly
■ Prenatal Care	Monthly

Report Name	Timeframe
■ Maternity Care Coordination / Member Assistance	Quarterly
■ Maternity Providers	Quarterly
Financial	
■ Monthly - Cost Report	Monthly
■ Corporate Financial Statements/Filings	Quarterly and Annually
■ Guaranteed Cost Savings Credit Line Report	Ad-hoc
■ Audit Reports	Ad-hoc
■ Notice of Legal Action Report	Ad-hoc
■ Financial Contribution/Payment Report	Ad-hoc
Pharmacy Services	
■ Pharmacy Outlier Report	Quarterly
Surveys	
■ CAHPS-Adult and Child surveys	Annually
■ Provider Satisfaction Survey	Annually
■ Disease Management Survey	Annually
Quality Management	
■ Accreditation Report	Upon renewal
■ Quality Improvement Program Description and Workplan	Annually due June1st each year
■ Quality Improvement Workplan Updates and Issues Log	Quarterly
■ Quality Improvement Meeting Minutes	Quarterly
■ Quality Management Program Evaluation	Annually beginning June 1 2008
■ Medical Record Review Report	Annually at close of each MRR Cycle
Other	
■ Welfare to Work	Quarterly
■ Disadvantage Businesses	Quarterly
■ Staffing Report	Monthly on the 10th
■ Policies and Procedures Report	Semi-Annually
■ Fraud and Abuse	Semi-Annually

APS will work with the Department to establish and maintain a Department-approved system of records and reports for ACCESS Plus. During implementation, we will meet with the Department to review report contents and formats, and finalize our reporting approach. Once approved by the Department, our Reporting Analyst will develop the reports, conduct testing to ensure accuracy, and implement the reports on a production schedule. The ACCESS Plus Project Manager, in collaboration with our Reporting Analyst, will report our compliance with the reporting requirements to the Department.

Our reports will include data and narrative explanations of identified trends as well as charts and graphs to illustrate points. Annual reports will be submitted by the last Business Day of the month following the end of the year being reported. Quarterly reports will be submitted by the fifteenth (15th) Business Day of the month following the end of the quarter being reported. Monthly reports will be submitted by the tenth (10th)

Business Day of the month following the end of the month being reported. We can also furnish electronic reports upon request.

ACCESS Plus Ad Hoc Reporting Requirements

APS' [redacted] will also enable us to easily create meaningful ad hoc reports to meet the Department's requests in a timely manner. Ad hoc reports will be supplied within ten (10) Business Days of the request. Once an ad hoc report need is identified, APS will work collaboratively with the Department on the next business day after the request to begin outlining the report template.

Additionally, APS will work collaboratively with the Department to collect data for records identified by the Clinical Quality Measures based on HEDIS® Technical Specifications and Pennsylvania Performance Measures. These performance measures identified by the Department will be reported using the requested hybrid methodology (administrative data supplemented with medical record review).

B. Describe any potential circumstances or events that might impact the Offeror's willingness or ability to submit timely and accurate required reports to the Department.

APS does not anticipate any potential circumstances or events that may impact either our willingness or ability to submit timely and accurate required report to the Department.

C. Describe how the Offeror will collect provider non-claims data needed to calculate Provider Pay for Performance incentive payments. Identify any challenges associated with collecting provider data and strategies for mitigating these challenges.

APS has examined the Provider Pay for Performance measures described in the ACCESS Plus Summary of Payment Opportunities. For non-claims data to support the calculation of these measures, APS proposes to collect data from the Chronic Care Assessment Tool (CCAT) that is submitted electronically by providers. During implementation, we will work with the Department to develop a detailed understanding of the submission methods and media, format of the electronic data set (e.g., text or spreadsheet), and timeframes for submission. We will then establish the information processes to collect the CCAT, extract the data, and calculate the measures. This process will be conducted by the APS Health Intelligence group, which brings extensive experience in HEDIS performance measurement as we demonstrate in **Exhibit 19** (Sample PCP Monitoring Report).

II-3 Work Statement

30. EMERGENCY PREPAREDNESS

A. Describe how the Offeror anticipates an emergency, including a pandemic, will impact the Offeror's operations.

As Hurricane Katrina demonstrated so dramatically in New Orleans, emergencies can disrupt virtually every aspect of operations. Pandemics, while possibly unfolding more slowly than a catastrophic emergency, also have significant potential to disrupt operations through unavailability of staff for key functions both within our operations as well as in the community. For example, unavailability of staff may impede other program functions such as call center operations, member and provider services, case management activities, etc. This typically results in minimal communication and coordination of care with providers, confusion and frustration amongst members and providers with less staff to respond to calls, and the inability to properly document case management activities. Other areas of concern include travel, telecommunications, and information systems.

Such issues that may disrupt other companies' operations would have a significantly lower impact on APS due to our operational model, which is designed to deliver exemplary customer service to our clients and their program stakeholders. Specifically, APS' operational model has built-in features – such as our decentralized operations with offices throughout the United States and our adaptive technology which allows employees to work virtually – that make our operations less susceptible to disruption, and thus we have the ability to continue with normal operations through the majority of emergency situations, including pandemics. Our Business Continuity Plan leverages the strength of our operational model to further protect local operations from disruption. For example, APS can shift staff to work from home and shift Enrollee and Provider services to other locations quickly and transparently. With our clinical and behavioral health expertise, APS staff members are also valuable Public Health resources during emergencies. APS CareConnection®, our web-based care management system with its centralized infrastructure, will be a valuable technical resource to ensure that vulnerable ACCESS Plus Enrollees can be quickly located; their risk evaluated; and appropriate emergency care plans deployed.

APS employees are provided training and updates on routine basis to ensure that that all employees are knowledgeable and prepared in the event of an emergency.

B. Describe the Offeror's emergency response continuity of operations plan. Please attach a copy of the Offeror's plan, or at a minimum, summarize how the Offeror's plan addresses the following aspects of pandemic preparedness:

APS has a Disaster Recovery/Business Continuity Plan (provided in **Exhibit 26**) that details our effective response to natural or man-made emergencies to minimize disruption to our program operations and member services.

Our Disaster Recovery/Business Continuity Plan ensures a rapid identification of the scope and maximum possible duration of any service interruption, followed by a series of options available to each team. We can also deploy our Disaster Recovery/Business Continuity Plan in the case of a pandemic as such a situation requires similar activities. Some of our key activities in response to a pandemic include:

- Providing Employee training for "new staff" as well as annually there after.
- Rerouting of calls to other APS Service Centers.
- Rerouting calls to those APS employees who can receive calls and access APS' systems from home.
- Ensuring ACCESS Plus staff are available to act as consultants to those employees who will handle rerouted calls regarding the ACCESS Plus Program (e.g., provide education on how the program works, program interfaces, key contacts, where resources are, etc.).
- Recruiting nurses from within the ACCESS Plus Program (e.g., Case Managers) and outside of APS to support the infectious control efforts of the Department (e.g., provide onsite immunization, distribution of medications, etc.) as needed.

1. Employee training (describe the Offeror's training plan, and how frequently the plan will be shared with employees).

APS has a dedicated service center model for public programs and each service center conducts training on core APS topics (e.g., member services, data sharing, confidentiality, system security, etc.) with materials adapted to the specific needs of the contract. As part of the ACCESS Plus Program, all staff serving the ACCESS Plus Program will undergo contract-specific training on an annual basis in addition to the initial "new staff" orientation. The contract-specific training will include an overview of our disaster recovery procedures, including how we will respond to a pandemic. These annual trainings will serve as "refreshers" for staff to ensure they understand protocols and are provided with updates regarding chain of command, phone trees, contact numbers, etc. Two specific examples of the type of pandemic trainings we have provided to employees in the past include "What is an Influenza Pandemic?" and "Why Plan for a Pandemic?"

2. Identified essential business functions and key employees (within the Offeror's organization) necessary to carry them out.

APS' Disaster Recovery/Business Continuity Plan details all essential business functions and key APS employees responsible for carrying them out. For example, our plan requires that one or more of the following APS Senior Management team to be contacted if a disaster occurs or a potential disaster is identified:

- President and COO or CEO
- Chief Financial Officer or Executive VP Finance
- Chief Medical Officer
- Senior VP of IT/CIO (Chief Information Officer)
- Vice President Commercial Division
- Director of Claims
- Chief Security Officer
- Chief Privacy Officer
- Vice President of Corporate Purchasing and Facilities Management

When a significant disaster has, or is about to, interfere significantly with our operations, applicable key executive and senior staff members form the APS **Corporate Emergency Management Team**. Before declaring an emergency, the members will consult with as many other members as can be contacted to determine if an emergency response is appropriate.

The Corporate Emergency Management Team has the authority (once mobilized) to approve the actions and contingencies provided by the Disaster Recovery Response Team. This team is specifically responsible for initial investigation and verification of the extent of problem or damage; decision making for the contingency plan activation, evaluation of contingencies and available alternatives; monitoring and supervising activities; notification of appropriate people (executive management, board members, clients); control over insurance and legal matters; provisions for immediate funding for expenses and asset replacement; interfacing with the necessary authorities (police, fire department); creation of focal points (contacts) for vendors and internal staff; and public and patient relations.

The Corporate Emergency Management Team has the authority to form one or more **Disaster Recovery Response Teams**, as they deem appropriate. The Disaster Recovery Response Teams are responsible for the identification and resolution of the issues threatening or interrupting APS' business operations. They secure appropriate resources and interface with selected providers to ensure systems recoverability and restore delivery of service and normal operations. These Teams are responsible for designating specific recovery teams and coordination among the various teams and departments. Their responsibilities include interfacing with appropriate vendors; developing basic solutions to meet the companies' minimal operational needs; reviewing and communicating solutions to the Management Team; and organizing the retrieval of necessary equipment and data tapes to initiate the recovery process. These Teams consist of select business associates, local office, as well as corporate and technical workforce.

3. **Contingency plans for:**
   a. **How the Offeror will handle staffing issues when a portion of key employees are incapacitated due to illness.**

In case of a pandemic, APS's Call Centers and employee availability are monitored and adjustments are made either automatically or manually. If a portion of key employees are incapacitated due to illness, APS will utilize our staffing resources from our other Service Centers throughout the country. APS has [redacted] Service Centers with trained Disease Management Health Coaches and Case Managers and Call Center capacity, located in [redacted], and [redacted]. This geographic diversity helps protect our operational capacity from disruption at the local level. We also have 30 other Service Centers with clinical capabilities across the United States that could participate in operations in the event the primary service center was impacted by a pandemic. Many Call Center personnel have the ability to conduct reviews and interact with Enrollees from their homes or alternative locations to prevent disruption to Enrollee and Provider services. With these capabilities, APS could also support essential Department functions if employees are incapacitated.

   b. **How the Offeror's employees will carry out the essential functions if contagion control measures prevent them from coming to the primary workplace.**

All management and clinical staff members have the capability to work from home as part of our routine operational model, including complete access to our telephone system (both inbound and outbound) and data systems. APS can route calls to APS cell phones (also an existing capability that is routinely used by staff) as well as route calls to our corporate Call Center and warm transfer calls to local employees. Since our employees do not have to be in the primary workplace to carry out essential functions on a daily basis contagion control measures will not impact our ability to carry out these functions in the event of a pandemic or other emergency. Locally based personnel would be utilized to support any activities deemed necessary by the Department so that we are fully supporting any Departmental need during this time.

c. How the Offeror will communicate with staff and suppliers when primary communications systems are overloaded or otherwise fail, including key contacts, chain of communications (including suppliers), etc.

In an emergency situation, accurate, consistent and timely messages are key in notifying and educating APS employees, and in roll-out of the emergency plan as intended. Our role is to maintain a system to effectively communicate with APS employees; establish lines of communication and define APS staff roles and responsibilities clearly to avoid confusion and facilitate the best possible communication; regularly distribute informational updates to all APS employees and partners; develop a list of APS media spokespersons; and regularly update and maintain the APS website with information.

Mechanisms for communication with APS employees will vary depending on the phase of the pandemic and its impact on APS operations. A designated senior level executive or their designee will be responsible for coordinating with several groups within APS to ensure that we maintain an emergency communications capability sufficient to meet the requirements of a response to a major emergency. They include telecommunications, electronic systems and communications and computer infrastructure support.
As part of a master communication plan for the ACCESS Plus Program, key APS operations management staff will be identified and an emergency call list will be developed with various contact information including cell numbers and associated carrier company. Telephone trees will also be developed and posted in APS locations to provide communications to all APS employees.

APS understands that our employees will also likely encounter some unreliable and possibly false information through public information channels. We will also communicate accurate, reliable information regarding the pandemic and identify approved websites. Additionally, we will maintain communication efforts with all essential partners, and attempt to keep them completely informed throughout the pandemic.

d. How and when the Offeror's emergency plan will be tested, and if the plan will be tested by a third-party.

APS' Disaster Recovery/Business Continuity Plan is periodically tested by APS staff following our defined internal processes. APS uses third party auditors to validate our Disaster Recovery/Business Continuity Plan's tests. Audits of our internal processes are performed at least annually. APS does not outsource the testing, management, or control of internal systems as doing so does not align with our standards for securing client data.

e. How the Offeror will handle IT (including telephone systems) backup and disaster recovery.

APS has a Disaster Recovery/Business Continuity Plan in place to effectively address IT backup activities and disaster recovery issues. We review and update our Plan a minimum of once a year, and as a part of any significant hardware, software, or operational changes. We maintain the Plan's appendices continuously, updating contacts and responsible party lists. Our core plan involves rapid identification of the scope and maximum possible duration of any service interruption, followed by a series of options available to each team. We have established disaster-recovery protocols for four levels of disasters:

- **Level 1 and 2 Disaster** - Level 1 and 2 disasters are interruptions greater than the backup time but less than 24 hours. During Level 1 or 2 disasters, all calls are forwarded to another APS call center, which is advised of the expected increase in call volume.
- **Level 3 Disaster** - Level 3 disasters are defined as an interruption greater than 24 hours. All calls during a Level 3 disaster are forwarded to another APS call center, which is advised of the expected call volume increase. Hardware maintained for redundancy is put into production. Disaster duration estimates are used to decide if existing hardware will be repurposed for only primary applications or if additional hardware is needed to meet existing service level agreements. System recovery processes begin, which include recalling tapes, rebuilding servers, and restaging systems. Systems are rebuilt using last known good data from backup tapes and off-site replicated data.
- **Level 4 Disaster** - Level 4 disasters are defined as complete destruction of the site. In the event of a Level 4 disaster, we, in cooperation with outside telecommunications vendors have prepared a disaster recovery procedure that provides for business to be resumed within 48 hours (including all telecommunications services).

Based on each team's best judgment and the options open, service will either be restored in the affected location, or moved to another location. To ensure recovery is not delayed by lack of authority, permission to make decisions is granted to the highest-level officer or manager available.

A central part of this plan is our state of the art telephone-switching infrastructure. Utilizing extensive routing plans, both within our switches and in the telephone network, any call that cannot be delivered to its designated call center is automatically rerouted to a backup center. We also have the ability to reroute calls on demand, should we need to shut down a call center before the normal end of the business day. APS believes these processes and preparation will minimize or eliminate disruption of service to ACCESS Plus Enrollees, and ensure the integrity of the data collected, despite brief periods of IT system failure.

To minimize the potential for data loss from computer failure, we also employ a number of preventative measures including performing complete backups at the close of business each night; storing the previous night's backup tape off-site, which is immediately available should a catastrophe occur; using a 5-week tape rotation so tapes up to one month old are immediately available; and storing tapes in secure off-site locations at the end of the month and never returning those tapes to the rotation.

Our corporate data center and call center are protected by a Leibert uninterruptible power supply (UPS) and a whole-building Cummins generator capable of providing 24x7 coverage of power for our telephone and computer systems, as well as a dedicated call center, during a complete power blackout. All other locations utilize an uninterruptible power supply, which allows enough time for transferring telephone lines and graceful shutdown of equipment.

II-4. Prior Experience

In this section of the Offeror's proposal, describe the Offeror's prior experience, including prior experience with state Medicaid agencies, preferably as it relates to PCCM and Disease Management services. Experience shown should be work done by individuals who will be assigned to this project as well as that of the Offeror's company. Studies or projects referred to must be identified and the name of the customer shown, including the name, address, and telephone number of the responsible official of the customer, company, or agency who may be contacted.

Corporate Overview

APS has provided comprehensive health management services for various state Medicaid programs since [redacted]. Currently, APS and its related entities serve public sector recipients in over [redacted] programs through contracts in [redacted] states and Puerto Rico. Of these programs, [redacted] serve Medicaid recipients.

APS and its related entities serve more than [redacted] beneficiaries across the United States and Puerto Rico. Originally founded as a managed behavioral healthcare company, APS has evolved into a leading healthcare management company that provides customized, integrated healthcare solutions across the major product lines of care management and utilization review. The application of an integrated total health management approach to healthcare delivery enables us to achieve significant improvements in the quality and effectiveness of care on behalf of our public sector customers. APS and its related entities support Medicaid and other public sector programs with a variety of healthcare management services including utilization management; care and case management; disease management; quality improvement and external quality review; behavioral health administrative services; as well as training and education programs. APS has provided comprehensive health management services for various state Medicaid programs since 1994. Currently, APS and its related entities serve public sector recipients in over [redacted] programs through contracts in [redacted] states and Puerto Rico. Of these programs, [redacted] serve Medicaid recipients.

APS utilizes a dedicated service center model for administrative and clinical operations of many of our public sector programs, and will do the same for ACCESS Plus. This model establishes a local office and places program administrators within close proximity to state agencies. It creates a proven, highly-specialized operational infrastructure specifically designed and managed to support the service requirements of public sector customers. APS satellite offices receive implementation, IT, analytic, legal, facility, and financial support services from APS' corporate office to ensure all public sector clients are served effectively and efficiently. The combination of local leadership supported by central corporate resources has proven to ensure ample resources to develop local customized programs.

APS' experience and expertise qualify us to administer the Commonwealth's ACCESS Plus Program in accordance with your stated requirements and expectations. As requested, we have provided descriptions of our prior experience in the following paragraphs.

The Offeror must also describe experiences with the following:

- **Medicaid PCCM programs**

Medicaid PCCM Programs

APS brings a wealth of experience developing and administering Primary Care Case Management (PCCM) Programs and similar services to other Medicaid customers across the nation including [redacted], [redacted], and [redacted]. Our PCCM and related programs include various functions such as case management, utilization review, network management, provider profiling, provider relations, enrollee services, etc. APS has elaborated on our specific experience below.

[redacted]

APS serves as the quality improvement organization (QIO) for the [redacted] covering [redacted] lives. Our program is designed to enhance the overall quality and effectiveness of the state's healthcare delivery system, while ensuring Medicaid Enrollees in the state receive high quality clinical services that are medically necessary. As a part of our program, APS provides retrospective reviews of inpatient medical services and outpatient observation services; quality assurance studies and utilization management of all behavioral healthcare services. To improve provider satisfaction and administrative efficiencies, APS implemented our proprietary, electronic authorization system, APS CareConnection®.

APS' program is administered through a local office in [redacted] and is focused on providing leadership within the [redacted] medical and social service communities to facilitate delivery of care using best practices. One of our initiatives includes the establishment of a medical, education and intervention committee, which uses collaborative strategies to improve the quality of care delivered to Enrollees. As a part of this committee, APS tracks and reviews provider practice patterns and outcomes, and identifies opportunities for clinical improvements. We work collaboratively with community treatment providers to provide education and consultation to assist providers in delivering care that is aligned with evidence-based medicine. APS also measures the impact of these initiatives as a part of our continuous quality improvement process.

<u>Program accomplishments:</u>

- Development of [redacted] website to enhance collaboration with APS and the [redacted] provider community.
- Processing of [redacted] prior authorization requests for inpatient and outpatient behavioral health services.
- Processing of [redacted] retrospective review record requests for medical necessity and quality review.
- Completion of [redacted] on-site inspections of care at community mental health centers, acute behavioral health facilities, residential treatment facilities and therapeutic foster care facilities.

[redacted]

In 2008, APS was awarded the administrative services contract for [redacted] (Medicaid) for disease and case management as well as health and wellness services for the traditional fee for service Medicaid population (e.g., TANF) covering [redacted] lives. The focus on this program is to also improve the quality of care for participants with chronic illness, decrease complications associated with chronic illness and reduce costs associated with delivering care to this population. This program is an expansion of our existing contract with the State where we have provided a Chronic Care Improvement Program (CCIP) since 2007 to [redacted] aged, blind and disabled Enrollees for asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, gastroesophageal reflux disease (GERD), and sickle cell

disease. Our program uses a community-based care management model, which places nurse care managers in community health centers and provider locations throughout the state. The result is improved enrollee and provider engagement in care management, increased compliance with recommended care plans and improved coordination.

Program Accomplishments developed in conjunction with the [redacted]:

- Close collaboration with Federally Qualified Health Centers, primary care providers and faith based organizations.
- Developed a unique pay for performance system for providers.
- Developed real time interface with pharmacy and electronic prescribing functions.
- First state Medicaid disease management program in the nation to use a collaborative statewide repository for providers to access information regarding Medicaid enrollees to improve care coordination.
- Over [redacted]% of APS' [redacted] participants have a medical home.
- Increased provider participation over [redacted]% since May of 2008.
- Developing a collaborative delivery system with home healthcare agencies and in-home service providers to assist with Enrollee assessment, outreach, and ensure all Enrollees have a medical home.

[redacted]
APS provides a comprehensive array of services in [redacted] through contracts with various bureaus under the [redacted] umbrella. Our programs blend state of the art technology and outstanding customer service to achieve optimal outcomes. APS assists the [redacted] in their development and management of a high quality, accountable, public sector system for behavioral health, socially necessary services, and MR/DD waiver services.

APS was awarded our first contract in the state in 2000 with the [redacted] covering [redacted] lives. Through this contract APS conducts administrative service functions for Medicaid Enrollees who receive services at licensed behavioral health centers, eligibility determination for indigent care consumers and federal block grant reporting for the Bureau for Behavioral Health and Health Facilities. In 2003, APS' contract with [redacted] was expanded to include administrative service for private practice psychiatrists and psychologists who provide services to Medicaid Enrollees. Another part of the renewed five year contract included the development of a system for managing the person-centered budget process and other ASO activities for the Title XIX Mental Retardation and Developmental Disability Waiver Program. The concept of socially necessary services was also added in 2004 to the service package in response to the needs of the Bureau for Children and Families, which speaks to our understanding of the support systems Medicaid agencies need to ensure compliance with federal regulations.

Program accomplishments:

- Development of a customized version of APS CareConnection® to improve care coordination and provider satisfaction.
- Successful completion of 100% of all contract deliverables.
- Initiation of Socially Necessary Services.
- Development of Title XIX MR/DD Consumer Budgeting Model.
- Consistent, high levels of provider satisfaction.

In [redacted], we also have authorized over [redacted] requests for behavioral health service each year (within a two-day turnaround), audited over [redacted] medical records, provided [redacted] provider training sessions, [redacted] technical assistance sessions and over [redacted] hours of individual and group contact with consumers and families each year. Since initiating the program on August 1, 2000 we have reviewed a total of nearly [redacted] million requests.

[redacted]

In 2006, APS was awarded a contract with the [redacted] to provide utilization review for level of need, and to audit providers. Each individual newly entering the fee payment system is assessed by APS to determine the appropriate level of need. This level of need determines the funding for the individual and allows the individual to find a provider of choice for residential, day or supported employment programs. As part of the assessment, APS staff review documentation related to the individual's needs and conducts a personal interview with the individual, and the caregiver as appropriate. APS then completes an Individual Indicator Rating Scale and submits it to [redacted]. APS assesses over [redacted] people annually under this contract.

Additionally, as the utilization review contractor for [redacted], APS audits providers' delivery of services under the [redacted] program. APS performs on-site audits at the provider's administrative offices to verify that the paid hours of [redacted] service are being provided. The [redacted] audit procedure includes review of individual plans and provider records, plus on-site interviews. APS performs around [redacted] audits annually.

The final component of the contract is a consumer satisfaction monitoring plan that provides detailed information to [redacted] concerning the satisfaction of individuals and family members interacting with APS. Individual satisfaction about experiences with the APS utilization review staff are conducted on a sample of audits. The satisfaction tool is administered in person by an APS staff member who is sensitive to the needs of individuals with developmental disabilities (i.e., parent of a child with disabilities, staff member is disabled). This staff member is not involved in the audit process and captures consumer satisfaction separately. Results are reported to [redacted] on a monthly basis. Using a Likert scale, over [redacted]% of responses have been above the median.

[redacted]

Since 2007, APS has provided behavioral health administrative services for the [redacted]. The [redacted] program's first full year of operations was 2008. This program covers both mental health and substance abuse services for 273,000 adults and children who are [redacted]. The goal of this program is to improve the accessibility and quality of care while ensuring that only appropriate and needed services are provided.

The APS program in [redacted] includes prior authorization, continued stay review, retrospective review, provider relations and training, Enrollee services, quality management, analysis and reporting. In addition, APS provides a 24/7 customer call center and extensive web-based and IT resources for [redacted] Enrollees and providers. In addition, APS entered into an innovative agreement with the [redacted] to streamline data collection and reduce provider administrative burden. This agreement allows parallel State and APS data processes to merge into a single, streamlined process. This merger of data collection systems will reduce provider administrative burden, reduce costs for the State and result in improved data and information for both the state and providers. The process integration was implemented in September 2008.

Program Accomplishments:

- An average of [redacted] requests per month for service authorizations are submitted by providers to APS.
- Adoption of APS CareConnection® by virtually all providers statewide - [redacted] individual users and [redacted] provider organizations.
- Provider Advisory Council was established and quickly became a valuable partner in shaping the work of the ASO
- Member Advisory Council was established and has joined with APS in keeping the ASO accountable to [redacted]
- Extensive Reporting established on a daily, monthly, quarterly and annual basis. There are [redacted] different reports to date, broken out by up to [redacted] different categories of information.
- APS provided training, outreach and support with UM process trainings, clinical trainings, IT, billing and Data Forum conference calls, site visits and more throughout the year. Individuals trained have been [redacted] Providers, [redacted] Members and [redacted] staff.
- [redacted] website as a resource [redacted]

- **Disease Management, including any Disease Management experience specific to Medicaid populations**

Medicaid Disease Management Program Experience

APS and its affiliates have been providing disease, case, and care management services for more than [redacted] years and currently serve Medicaid disease management programs that cover over [redacted] million members. Our Medicaid DM program client list includes States such as of [redacted] and [redacted]. We are distinct among disease management companies due to the depth and breadth of our government contracts serving Medicaid clients.

APS has received industry recognition for its promotion of best practices. Disease Management Association of America (DMAA) named APS "Best Government Program" in [redacted] for our [redacted] program and in [redacted] for our [redacted] Program. The [redacted] program was also recognized by DMAA for "Outstanding Provider Engagement Initiative" in [redacted].

APS and its affiliates are particularly well known for:

- Innovative program operations.
- Collaborative and consultative work with government partners.
- Efficient and effective management of government resources.
- Seamless and expeditious implementations and transitions.

APS prescribes to an enrollee-and-provider centered model for coordinated care management. Our entire model—from identification to stratification to the development of interventions for patients—considers multiple facets of patient care. It considers the patient's disease, in the context of the entire person, considering aspects of individuals' lives that contribute to their physical and mental health. The model includes addressing the following elements:

- Health behaviors: behaviors that affect health, either constructively or destructively.

- Health attitudes: a person's perception of health, disease, and healing that influences them on whether or not to practice a healthy lifestyle or seek care.
- Health literacy: the capacity of an individual to obtain, interpret, and understand basic health information.
- Health hurdles: the socio-economic, psychosocial, and economic factors that can impede a person's ability to seek care.
- Health support: the support system, or lack thereof, which can have an impact on a person's predisposition to seek care.

Our innovative provider training and public health/public service integration model is designed to significantly benefit community health in a positive application of the precepts of "broken windows theory" credited with other social process improvements in public systems throughout the world.[1]

APS delivers these components within our enrollee-centered, provider-supported model of disease management and chronic care improvement. Our model views Medicaid Enrollees and their families in the context of their community, their treatment needs, and their ability to access and utilize services. Our approach emphasizes enhancing provider support, education and involvement, eliciting a high level of Enrollee engagement, education and health coaching, and promoting wellness and prevention for Enrollees.

In a challenging population where poverty, stress, and depression are often a way of life, and where health care is often a low priority, even the smallest intervention can make a difference. Prevention efforts are effective in educating the Enrollees and providing them with tools to assist them in making healthy lifestyle choices. We know that a healthy diet, smoking cessation, and increased physical activity can prevent or delay many chronic diseases and disabling conditions.

Below we provide descriptions of our care and disease management experience and successes.

Since July 2004, APS' total population management program, has provided a comprehensive array of services to nearly participants to facilitate healthy behaviors and self-management of illness. Our program provides health and wellness services for all program enrollees, and coordinates care management services for those with severe illness or disease, to decrease preventable, costly complications of chronic diseases. Our program is designed to improve quality of care, promote behavior that leads to better health outcomes, and optimize expenditures by reducing unnecessary healthcare costs. The program is administered locally with community resources positioned across the state to ensure that services are delivered in collaboration with key stakeholders. Our program was named the "Best Government Disease Management Program" by the Disease Management Association of America

Some of the activities of the program include providing Enrollees with toll-free, 24-hour access to a team of nurses, social workers and counselors who provide one-on-one education on making healthy decisions; and coordination of services when Enrollees are hospitalized, may be using services inappropriately, or need help meeting their socioeconomic need. In addition, APS' program supports healthcare providers in the community in their role in health improvement by actively promoting key

[1] James Wison and George Kelling, "Broken Windows," *Atlantic Monthly*, March 1982.

prevention guidelines and by providing education on evidence-based clinical guidelines, as well as guidance on implementation of the State's *Pay for Participation* (P4P) program. Under P4P program, participating providers receive increased reimbursement for referring their eligible Enrollees to the [redacted] program; completing specific disease, age and gender screenings; and providing health education for Medicaid patients with chronic illness.

Program Accomplishments:

- Produced cost avoidance of more than $[redacted] million for the [redacted] during the [redacted] years of the program ([redacted]).
- Generated dramatic utilization and clinical improvements in each measurement year; including reducing emergency room visits by [redacted]%, inpatient admissions by [redacted]%, the number of inpatient days by [redacted]% and readmissions within [redacted] days by [redacted]%.

In its third full year of providing total population health management services to the state's [redacted] members, the [redacted] program achieved the following key results in 2007:

- [redacted]% reduction in Medicaid inpatient hospital utilization.
- [redacted]% reduction in emergency room visits for members with asthma — with [redacted]% of asthmatics in the program receiving at least one dispensed prescription to control their condition.
- [redacted]% increase (since [redacted]) in percentage of members who have received an HbA1c diabetes test.
- [redacted]% increase (since [redacted]) in percentage of members with at least one prescription for a lipid-lowering agent (statin, niacin, fibric acid or ezetimibe).
- [redacted]% increase (since [redacted]) in percentage of members with asthma, COPD, heart disease or diabetes who have received an influenza vaccination.
- Currently, [redacted] provider clinics participate in [redacted] Pay for Participation program due to APS' provider promotion and outreach efforts.

[redacted]

APS contracts with the [redacted] to provide population and care management services to aged, blind and disabled (ABD) Medicaid beneficiaries covering [redacted] lives. More than [redacted]%of our Enrollees have multiple chronic co-morbid conditions, coupled with complex psychosocial and socioeconomic issues. [redacted] percent have co-occurring mental illnesses. APS' program provides beneficiaries who are diagnosed with chronic conditions with targeted support using a multi-disciplinary team of clinical professionals to improve health outcomes.

APS' [redacted] Program was recognized in [redacted] was recognized as one of the top Medicaid disease management programs in the U.S. by Health Industries Research Companies.

A key component of the *Community Health Partnership Model* in [redacted] is our collaboration with the [redacted]. [redacted] has helped APS reach out into the community to establish better coordination between the beneficiary, his/her health care providers and community stakeholders. More than [redacted] health coaches are placed statewide in federally qualified health centers and hospital locations, including [redacted] and [redacted], the two largest hospitals in the state. Health coaches meet with Medicaid beneficiaries to ensure they leave the facility with a discharge plan. Health coaches also provide on-site education and follow-up to prevent hospital readmissions. We work with Enrollees to develop a provider

relationship and establish a Medical Home where they may receive ongoing primary care in addition to their specialty care.

Program Accomplishments:

- Reduction in ER visits across 12 months for diabetic Enrollees from [redacted] to [redacted] ([redacted]% reduction).
- Reduction in inpatient costs across 12 months for diabetic Enrollees from $[redacted] to $[redacted] ([redacted]% reduction).
- [redacted] Disease Management Association of America award recipient for "Best Government Disease Management Program in the U.S."
- [redacted] Disease Management Association of America award recipient for "Best Provider Engagement Initiative."
- One of the first disease management programs in the nation to receive designation from the Disease Management Purchasing Consortium (DMPC) for return on investment.

[redacted]
In 2007, APS began providing the [redacted] for [redacted] (Medicaid) Enrollees covering [redacted] aged, blind and disabled lives. Incorporating the principles of disease management, care coordination and case management, the program serves vulnerable Enrollees identified with asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, gastroesophageal reflux disease (GERD), and sickle cell disease. The focus on this program is to improve the quality of care for participants with chronic illness, decrease complications associated with chronic illness and reduce costs associated with delivering care to this population. The [redacted] also uses our community-based care management model, which places nurse care managers in community health centers and provider locations throughout the state. Our model improves Enrollee and provider engagement in care management, increases compliance with recommended care plans and improves coordination. In addition, APS CareConnection® is also used to better coordinate care for participants.

Program Accomplishments developed in conjunction with the [redacted]:

- Close collaboration with Federally Qualified Health Centers, primary care providers and faith based organizations.
- Developed a unique pay for performance system for providers.
- Developed real time interface with pharmacy and electronic prescribing functions.
- First state Medicaid disease management program in the nation to use a collaborative statewide repository for providers to access information regarding Medicaid enrollees to improve care coordination.
- Over [redacted]% of APS' [redacted] participants have a medical home.
- Increased provider participation over [redacted]% since May of 2008.
- Developing a collaborative delivery system with home healthcare agencies and in-home service providers to assist with Enrollee assessment, outreach, and ensure all Enrollees have a medical home.

- **Development of Quality Improvement programs**

Development of Quality Improvement Programs

APS is committed to incorporating the principles of quality assurance and improvement into each activity and program that we undertake. Our public sector clients consistently comment that we are dedicated, responsive, and go the extra mile.

APS defines quality as the degree to which a product or service conforms to accepted standards and/or the requirements of our customers. To materially impact system performance, both internally and externally, a quality improvement perspective must be incorporated into every aspect of operations. Our quality improvement strategy has both an internal (e.g. developing new efficiencies) and external (e.g. identifying new opportunities to "add value" to our work) focus. As such, the development of our Quality Improvement Program integrates the activities and processes of all functions related to the delivery of services and care to Enrollees, including case management, provider operations, enrollee services and reporting.

The scope of the Quality Assurance Program also encompasses evaluating the interface between all of our departments, Primary Care Physicians, and other community stakeholders. We work carefully with our State clients as partners to develop pro-active goals for improvement. Our staff, tools, and processes ensure that technical assistance, clear milestones of success, and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance. Our Quality Improvement Program, includes both a Quality Improvement Work Plan and Evaluation, which occurs on an annual basis.
The quality of APS and its affiliate programs is reflected in the accreditations we enjoy from URAC. APS is fully accredited for Health Utilization Management, Case Management, and Disease Management. In addition, the APS designation by CMS as a Quality Improvement Organization (QIO) like entity entitles state payers to a 75% federal match under certain circumstances defined by CMS.

APS Healthcare Bethesda, Inc. and Innovative Resource Group, LLC dba APS Healthcare, APS Healthcare Northwest, Inc.		
Case Management	Full Accreditation	07/01/2010
APS Healthcare of Puerto Rico		
Health Utilization Management	Full Accreditation	03/01/2011
Innovative Resource Group, LLC. dba APS Healthcare		
Case Management	Full Accreditation	11/01/2010
Disease Management	Full Accreditation	11/01/2010
Health Utilization Management	Full Accreditation	11/01/2010

Stakeholder Partnership Philosophy

Another major part of APS' Quality Improvement process is active engagement of Enrollees, physicians, and community/government stakeholders. We have repeatedly demonstrated our ability to establish positive collaborations with providers and stakeholders. We quote below a recent comment about APS' relationships with the provider community, as APS was inducted as a Fellow into the [redacted] (the first time in its history that a non-member organization like APS was inducted):

"APS has gone the extra mile to involve providers in procedural and policy decisions, troubleshooting, training, and other aspects of operations. Additionally, APS has made innovative changes to streamline and improve the service approval system from the provider's perspective and its staff has been accessible, open and responsive to our organizational needs."

- [redacted]

We know that stakeholder collaboration is essential to confront problems, develop a community-wide understanding of desired system outcomes and deploy the interventions to achieve them together. Particularly during early implementation, close communication with major stakeholder groups is critical, so that input and feedback can be incorporated as the programmatic foundation is established.

Since the inception of our first Medicaid program in 1998, we have succeed in engaging consumers, families, advocates, providers, and government officials in ongoing, self-managing Quality Improvement Advisory Councils. We establish these Advisory Councils in each state program we operate to ensure that each stakeholder group within the community has a voice in program operations. Membership on the Advisory Councils is usually composed of 8-12 individuals who are representative of the diversity of opinions within the community or state that is being served. In each setting, we configure the advisory process in consultation with state officials, assuring that the process reflects the state's needs and preferences.

Our [redacted] program, which we have held since 2000, is a perfect example of the success of APS' Advisory Councils. A brief description of this Council follows:

- A Consumer Quality Improvement Advisory Council comprised of consumers receiving publicly funded health services, their family members, and advocates.
- An Intersystem Quality Improvement Advisory Council which includes broad, multi-system perspectives, including potential participants from state Medicaid and Human Services agencies, local or county stakeholders, the Department of Education, the state hospitals, the adult and juvenile justice systems, and other agencies as appropriate.
- A Provider Quality Improvement Advisory Council which includes representatives from the providers of the services being managed by the APS program. A range of disciplines and specialties, representing both major agencies and individual providers, is invited to participate with the objective of obtaining a wide diversity of perspectives.

"APS Healthcare has been very effective in establishing rapport with the provider community and with customers of service. They have instituted quality improvement councils for each group. Those councils have been helpful in shaping the new system and in minimizing resistance, misinformation and anxiety about this major change."

- [redacted]

Quality Improvement Council responsibilities in [redacted] include:

- Reviewing and refining program policies and communications materials.
- Reviewing and refining admission, continuing stay, and discharge criteria for service.
- Reviewing provider profiles, authorization data, and claims reports to recommend best practices, training, and quality improvement initiatives that have state-wide implications.
- Reviewing the performance of the program regarding consumer access, consumer satisfaction, complaints and grievances, timeliness of response and other quality of service issues.

Each Quality Improvement Advisory Council typically meets monthly during the first six months of operations, and sets their own schedule after implementation is complete. In addition, APS and/or the Quality Improvement Advisory Councils may, at times, form user workgroups for specific, defined tasks and periods of

time. Proposed policies and recommendations from these groups will be forwarded to the state client for review, revision as necessary, and approval before being put into place.

- **Other Medicaid Programs**

APS delivers a number of other program services to Medicaid customers across the nation including Puerto Rico. Examples include:

Program	[redacted]
Description	APS' [redacted] is dedicated to enhancing the quality of life of individuals with intellectual and developmental disabilities (I/DD) by leading initiatives that facilitate improvements in the delivery of healthcare and services to this population. The [redacted] provides collaborative, responsive educational support to an [redacted]-county region in [redacted]. Some of the activities of the [redacted] include: ■ Providing healthcare educational training, expertise and technical assistance to healthcare staff and caregivers in group homes, family living homes and provider agencies who house individuals with intellectual disabilities. ■ Identifying healthcare risks and conducting Health Risk Profiles. ■ Promoting capacity building activities to increase system access for individuals with I/DD. ■ Working with the [redacted] to continuously improve the quality of healthcare delivery systems and outcomes. ■ Offering a video and pamphlet resource library for caregivers and community professionals. <u>Program Accomplishments:</u> ■ Provided over [redacted] training sessions in the I/DD system per year. ■ Provided training to [redacted] participants covering [redacted] different healthcare and behavioral topics per year. ■ Developed and disseminate resources and information to the I/DD service delivery system; such as, a Medication Administration Policy and Procedure Resource Manual and Dental Resource Guide.

Program	[redacted]
Description	APS' [redacted] is responsible for completing individually customized reviews of the state's [redacted] County Mental Health Plans. The goal of the program is to assist the state and counties in measuring and improving services, processes and outcomes. The output of each customized review is the production of a report for each county as well as an overall statewide annual report, which serves as a guide for system and process improvements that will enhance overall quality of care. Other activities

Program	[redacted]
	include analysis and dissemination of relevant statewide, regional, and county-specific data. APS' program also facilitates diverse and active consumer/family involvement in improving mental health outcomes by soliciting input on access to culturally competent services. In addition, our program offers a range of technical assistance and training, including multi-county workshops, as well as MHP-specific consultation. This has included working with the County Mental Health Directors Association and the [redacted] to provide workshops designed to increase county collaboration in using data to improve services. Our program also supports the implementation of federal policies and applicable regulations governing mental health plan external quality review. <u>Program accomplishments:</u> ■ Contributed to a significant "culture" shift by widely sharing local mental health summary data for the first time across counties, the Department of Mental Health and other stakeholders. ■ Launched a website to provide EQRO-specific resources and other useful information to mental health plans and other stakeholders. ■ Provided and publicized data on state and county-specific disparities in healthcare services to stimulate performance improvement activities.

Program	[redacted]
Description	APS provides prior and concurrent review services of inpatient psychiatric and outpatient mental health and quality improvement services for Medicaid Enrollees under age 21 in [redacted]. The goal of our program is to ensure that eligible children, youth and their families in the state receive medically necessary, high quality mental health services. We use a collaborative approach to work with Enrollees and their families, the Department of Human Services, as well as key stakeholders to support a community-based care delivery system for mental healthcare. In addition to utilization review services, APS leads a variety of initiatives aimed at improving the quality and delivery of care in the state. These include providing informal clinical consultations to local professionals treating patients with complex needs; training/education programs to facility and treatment staff on medical necessity, utilization management, documentation and care coordination; and on-site reviews of both inpatient and outpatient treatment providers. In addition, we provide expert consultation to the Medicaid system on recommended revisions to policies and procedures to increase accountability and measurement of treatment outcomes. Our services have demonstrated their effectiveness in decreasing utilization of out-of-state

Program	
	facilities. <u>Programs Accomplishments:</u> ■ Decreased average length of inpatient stays for hospitalization. ■ Reduced daily census in out-of-state residential treatment facilities by more than %. ■ Consistently exceed contract requirements by performing more than % of outpatient and % of inpatient utilization reviews within one business day.

Program	
Description	APS is contracted by the Office of Vermont Health Access (OVHA) to co-manage the for Medicaid beneficiaries. The is an advanced health improvement program that incorporates the principles of disease management, care coordination and information technology to serve beneficiaries identified through a general assessment and disease stratification model. The program works in collaboration with other state initiatives aimed at improving the health status of . The joins forces with the , a program advancing innovative solutions for improving total population health, and the State's care coordinators to serve some of the state's most complex individuals, to help slow the growth of healthcare costs. Through industry leading technologies and population management services the is helping the effectively manage its overall healthcare resources. The provides comprehensive support services to assist both individuals themselves and healthcare providers to more effectively manage chronic disease. The focuses on reinforcing the partnership between Medicaid beneficiaries, providers and other community resources. APS' program includes interventions with individuals and physicians to improve chronic condition management of various disease states, which include arthritis, asthma, chronic obstructive pulmonary disease, chronic renal failure, congestive heart failure, coronary artery disease, depression, diabetes, hyperlipidemia, hypertension and low back pain. To enhance engagement and establishment of medical homes for participants, APS has deployed our community-based integration model, which places health coaches in provider locations throughout the State. Community providers and beneficiaries are also supported with access to APS' secure, state of the art Internet based electronic health information system, APS CareConnection®. <u>Program Accomplishments:</u> ■ In 15 months APS staff completed over health risk assessments.

Program	[redacted]
	■ Educational materials were received by over [redacted] individuals. ■ Program outreach occurred at all of the state's hospitals, rural health centers, and federally qualified health centers, in addition to dozens of physician practices and other health and human service organizations.

- **Call center operations**

Call Center Operations

APS and its related entities have been operating high volume call centers and crisis lines since 1990. We have call centers across the continental United States, Puerto Rico, and Hawaii. We provide experienced call center operations combined with best practices in health advice to ensure positive health outcomes. Our quality standards for telephone response meet and exceed standards set by our clients, as reflected below.

APS Public Programs - 2007 Call Center Stats	
Industry Standard	**2007 APS Results**
Average Speed of Answer (ASA) is 30 seconds or less	[redacted]
Abandonment rate is less than 5%	[redacted]

Utilizing state of the art Avaya and Nortel switching equipment and call management software, APS and its related entities handle millions of calls a year. Compliance with standards is measured by using the Meridian Max phone report software package. This software enables supervisors to view real-time call center information and allows greater flexibility to respond to changes in calling patterns that require a higher level of customer service. APS has established key quality indicators for phone responsiveness to ensure timely response to Enrollee and provider calls. Comprehensive reports on call activity are prepared daily, and statistics are reported in 60-minute intervals providing detailed information on our ability to respond to incoming calls. Continuous monitoring tracks average speed of answer, call abandonment rates, and numerous other metrics to assure the highest level of service from all our call centers. Phone statistics are monitored daily. Corrective actions are taken with the appropriate staff when needed. This may include training for specific staff, or augmented staffing to assure we meet or exceed standards.

The results of APS' call center operations are reported on a daily and monthly basis to senior management through an Automatic Call Distribution (ACD) report. The ACD report reflects the productivity of the call center and compares it against standards relative to a month-to-date total. APS service centers feature a sophisticated telephone system that enables us to meet all NCQA and URAC telephone access standards. We will utilize the best and latest technology, hire the most experienced staff and provide the tools to monitor, report, and market the Access/Crisis line.

The phone system also allows management staff to audit calls to ensure that our service is prompt, accurate, and professional and that we exceed expectations for overall customer service. As required by law, all callers are informed in advance that their call may be monitored or recorded, and callers may refuse to participate in a monitored call.

APS presents pertinent information to program Enrollees in a comprehensive and understandable manner, treating all participants with dignity and respect. Our interaction does not provide care but facilitates

appropriate care by empowering the Enrollee to be more engaged in their own care management. For individuals who do not speak English, APS first relies on the Omni Network language line, with capability in over 150 languages, including Pennsylvania threshold languages, for immediate access to telephonic language translation as needed. Recruiting for clinical staff emphasizes multi-lingual capabilities for Health Coaches and Care Coordinators.

- **Enrollee outreach and enrollment**

Enrollee Outreach & Enrollment

APS employs a multifaceted outreach model to promote enrollment and engagement of Medicaid Enrollees, and develops State-specific Enrollee Outreach Plans. **We attempt to reach Enrollees by mail, phone and in-person, as well as through those providers, community organizations and stakeholders who influence the health decisions Enrollees make**. APS is skilled at incorporating claims data and predictive modeling to identify high-risk Enrollees with chronic illness into our approach of actively reaching into the community to connect with those Enrollees whose conditions change (i.e., new or worsening symptoms, emergency room usage, inpatient admissions, medication non-compliance, and poor clinical indicators, such as higher reported blood pressure).

In development of an Enrollee Outreach Plan, APS typically collaborates with the **Clinical Advisory Committee**, which is comprised of representatives of various clinical stakeholders, providers, community physicians, and non-physician providers to develop these plans. We also seek the support of our **Clinical Advisory Panel (CAP)**, which includes APS' senior medical leadership for sharing best practices from across the entire organization and review of educational materials.

Enrollee outreach typically includes sending welcome letters to every eligible beneficiary. The Welcome Letter includes the following:

- States that the Enrollee has been enrolled in the program, that it is free and voluntary.
- Briefly introduces the program.
- Explains program benefits, objectives and limitations.
- Includes Enrollee rights and responsibilities.
- Includes the toll-free, call center phone number to contact a Health Coach/Care Coordinator.
- Includes information about the ability to opt-out of the program.

APS then reaches out to high-risk Enrollees to verbally educate them on the program, as well as obtain consent for participation, conduct a baseline assessment (if not already completed) and set an appointment for additional education sessions with the Enrollee's Health Coach.

Understanding that each individual is unique in the way he/she processes information, APS provides multiple options and media for outreach and providing educational information for our programs. All our mailings are brief, attractive, understandable and informative, and clearly state the program's toll-free number, as well as reinforce that the program is free and voluntary. We use the Flesch-Kincaid method to score reading level and reading ease, with our materials typically written for reading levels between fourth (4th) and sixth grade (6th) and a reading ease score between 80 and 90 (easily read by 10-11 year olds). APS also provides Enrollee education material to address primary and co-morbid chronic conditions, psychosocial issues, functional and cognitive disabilities. Furthermore, our communication pieces reinforce health and self-care messages to

enrolled Enrollees. Examples of educational materials include Self Care Handbooks, Condition-Specific Newsletters and Disease-Specific Tip Sheets (see samples in **Exhibit 12**).

Within APS' programs, **our outreach model emphasizes more than enrolling Enrollees - engagement is the most critical component.** As a result, our program model typically includes providing locally-deployed Health Coaches to Federally Qualified and community health centers to conduct outreach and engagement to eligible Enrollees at the places where care is delivered. APS' experience from our [redacted] and other programs has demonstrated that this approach not only is effective in engaging Enrollees, but can be used to collect accurate, real-time data that can be integrated into the program's planned approach for identification of Enrollees at risk for future medical cost. It also is effective in establishing meaningful relationships between Health Coaches and high-risk Medicaid Enrollees. These relationships, often initially formed through this localized outreach strategy, provide a solid basis for ongoing interventions to assist high-risk Enrollees in managing their chronic conditions and achieving overall improvements in health status. We have implemented this model successfully in other states such as [redacted] and [redacted].

APS also employs a collaborative approach with the State's PCPs, pediatricians, hospitals, community organizations, including FQHCs and community health centers and emergency/urgent care facilities, community pharmacies and other key stakeholders; and using predictive modeling tools to incorporate real-time information in improving care for Enrollees at risk for greater medical costs. Once an appropriate candidate is identified for our program, we employ principles of social marketing and stress the appropriateness of culturally sensitive communication in our efforts to engage the Enrollee. Our behavioral change techniques to enhance Enrollee outreach coupled with utilizing partnerships with local providers as a creative avenue to forward our outreach efforts ensures achieving a high level of engagement among high-risk Enrollees.

Beyond providing program education through more traditional periodic mailings, APS leverages our collaborative partnership approach in providing Enrollee education through several other vehicles, including:

- **Direct-to-Consumer Strategies.** APS **utilizes principles of social marketing to educate Enrollees**, including direct-to-consumer (DTC) strategies via mail and telephonic contact. Each program participant is assigned a designated Health Services Team member—a Health Coach based on the Enrollees' assigned tier—who works with them intensively to monitor their health status, coordinate services, and implement appropriate interventions. Our staff, both field-based and call center-based, are able to tailor their interventions and outreach to the needs of the Enrollees on their caseload.

- **Community-Based Strategies.** APS recognizes that public program recipients may change housing and telephone numbers frequently so they may not receive the important material via DTC channels. As a result, APS makes health education resources accessible within the local communities by placing materials in the provider offices including high-traffic emergency rooms, Federally Qualified Health Centers, community service organizations and even at local health fairs. We also offer to make educational materials available in Department offices, and at those of other Department agencies serving Medicaid Enrollees in the State. We also **publicize health messages via the media** such as advertising events in local newspapers, on the radio, and on television with public service announcements (PSAs), press releases. Additionally, these social marketing techniques reinforce the value of the program within the community and to those stakeholders who influence Medicaid Enrollees.

- **Provider-Based Strategies.** Putting Enrollee education tools in the hands of providers is another important strategy we undertake. This is accomplished through APS CareConnection®, which has a specific feature **enabling PCPs and other providers to access health education material**s which can be shared with the enrollee. In addition, APS CareConnection® offers links to information from nationally-recognized clinical organizations to support providers own office-based chronic care improvement projects and general patient education initiatives.

  - **Provider outreach and network development**

Provider Outreach & Education

APS recognizes physicians as key stakeholders in the health management process. As a result, our programs do not seek to disrupt the relationship the physician has with their patient, but instead support and complement it, by consistently referring participants back to their primary care physician or specialist for direction. We enhance communication and coordination between the physician and their patients by following up with the patient between office visits to ensure they are following their physician's advice.

One way that APS' Health Coaches include the physician in the care management process by sharing clinical information with the participant's consent and in compliance with all HIPAA and confidentiality mandates. Our Health Coaches also work with the Enrollees' providers to obtain history and pertinent information about their patient, including lab values, physical findings, medications, and the treatment goals the physician has established for their patient. Accordingly, the Health Coaches share information they've learned regarding the physician's patient. Sharing clinical information ensures that continuity and care coordination exists for all participants, which better assists them in obtaining the full level of care they need and deserve. Our Health Coaches will also follow up personally to dialogue and coordinate with the physician to address each Enrollee's needs. We have found that our ability to immediately notify physicians of changes in their patients' health status is well received, as physicians are often unaware of such changes until the patient's next office visit. As a result, we support physicians in their care of Enrollees and offer the resources and staff they frequently do not have available to perform continuous health monitoring of their patients.

Our facilitation encourages participants to communicate with their physician, establishing a mutual rapport, as communication between the two parties directly influences decisions in the Enrollee's treatment and care. By promoting communication within the treatment team, we infuse in participants with the importance of communicating with their provider, asking questions and reporting to their provider on progress, problems encountered, and any changes in their condition.

Key ways that we involve and engage physicians include the following examples of methods we have used in our programs.

- Outreach Coordinators – Outreach Coordinators are locally-based clinicians who serve as the liaison between APS' programs and the physician community. Outreach Coordinators provide support and education to physicians.

- Physician Notice of Enrollee Engagement Letter - Physicians are sent a program introductory letter that provides information on APS, the program, its purpose and its anticipated impact on the care the physician is currently providing to an Enrollee who is actively engaged in our program.

- Physician Notice of Member Graduation Letter - Once the program participant has adopted successful self-management skills, made the appropriate healthy lifestyle changes, and achieved an optimal level of health, the participant "*graduates*." The physician also receives a letter informing him/her of the patient's graduation from the program. The letter states the objectives of the program participant's care plan and the actual goals achieved, enabling the physician to stay informed and receive timely clinical information on the patient's current clinical status.

- Clinical Alert Form – The Clinical Alert Form (CAF) is sent to physicians whose enrolled patients have exhibited a significant change in medical status, warranting intervention. The CAF is designed to be a medium for facilitating two-way communication between APS' program and the physician.

- Physician Notice of Program Participant Achievements/Physician Profiles – APS' Health Coaches work with each participant to identify key milestones, which mark individual health goals that the participant has successfully achieved. As each milestone is achieved, the participant's physician is sent a letter informing them of the specific health goal that was accomplished, enabling the physician to stay informed and receive timely clinical information on their patient's current clinical status.

Provider Training

APS is unique among its competitors for its comprehensive experience in training providers. APS has provided training targeted specifically to Primary Care Physicians; hospital staff; nursing home staff; home health staff; state institution staff; MR/DD staff; and behavioral health staff. We offer, not only a full suite of training modules on over 600 different health topics, but proven technology and efficiency in identifying training needs and quickly developing comprehensive trainings to meet those needs. Because of our vast experience providing training to a large number of people and in a variety of locations, we have a variety of tools already at our disposal. APS views trainings on all levels as an opportunity to dialogue and to improve the services that we deliver, and to be relevant to the needs of our providers and customers.

All trainings, whether for our staff, providers, partners or participants, are based on adult learning theory. We utilize a variety of media (visual, audio and practice) to ensure that adult learners have the utmost opportunity to master the information contained in trainings. Much of our traditional learning experience has led us to believe that we learn best by listening to experts. It has also been found that individuals must actively engage in the individual learning process in order for the learning to create self-awareness, changed behavior, and the acquisition of new skills. In particular, adults have been found to learn more effectively by doing or experiencing. All of our trainings are designed to convey the message in several ways and to give attendees an opportunity to practice or rehearse the information that they have learned. This is particularly useful when we approach training on the web-based APS CareConnection® solution.

APS has a comprehensive library of provider training material, including numerous PowerPoint presentations on a variety of clinical topics, all based on nationally recognized evidenced-based guidelines, which we have developed for other state government programs. We also typically request opportunities to link into existing publications of the State provider organizations to reach providers in an efficient and non-burdensome manner.

The following examples demonstrate the outcomes in several of these programs.

APS' serves as the entity responsible to counties/administrative entities related to and supporting providers, support coordinators and self-advocates/families in intellectual and developmental disabilities (I/DD) issues regarding physical/behavioral healthcare. APS' primary role is to educate providers in order to improve the quality of care and train caregivers so that they can better assist persons with I/DD. Activities include assessment of individual health and health systems, data trending, provider education, health related training for providers and consumers/families, assisting with integration of community health care resources, and health advocacy.

Trainings are conducted based on data from a standardized needs assessment survey in which providers indicate their training needs by topic according to urgency of need (the was designed from this survey) and also by special request. Each quarter, the develops an extensive training syllabus comprised of the most requested trainings available. These trainings are held at various locations in the region to provide maximum accessibility for participants.

Since the inception of our contract, we have developed training modules for more than different topics, providing training annually to more than direct care staff, consumers/family members, support coordinators and county staff. In fact, the set a goal to deliver face-to-face trainings in each year. This goal was well exceeded as the delivered over trainings this past year. The also consistently receives the highest rating – Strongly Agrees – on its training evaluations.

In addition, the offers web based trainings that are competency based. Examples of some of the training modules we have developed specifically for this program include:

- Behavioral Manifestations of Physical Illness in individuals with I/DD
- Grief and Loss
- Mood Disorders
- Anatomy of a Behavior Plan
- I/DD, Aging and Dementia
- Autism Spectrum Disorder
- Autism and the Hospital Experience
- Discharge Planning for Providers & Hospital Staff
- Identifying Mental Illness in People with I/DD and Seizure Disorders
- Weight Management
- Consumer's Guide: When to Seek Emergency Care
- Medication Management
- Smoking Cessation
- Psychotropic Medications
- Sexuality and Privacy for Individuals with I/DD
- Positive Approaches
- Aging and Individuals with I/DD
- De-escalation Skills
- The Role of the Psychiatrist in Developmental Disabilities
- Advocacy of an Everyday Life
- Aging: Physical Changes
- Aging: System Challenges
- Anger Management
- Arthritis
- Bipolar Disorder
- Depression
- Generalized Anxiety Disorder (GAD)
- Intermittent Explosive Disorder (IED)
- Seasonal Affective Disorder (SAD)

As a part of our education and training initiatives for this program, APS maintains a -specific website, , where stakeholders can access a variety of information on the program at their convenience such as training schedules, course information, newsletters, evaluation forms and an online

training registration feature. This site also includes a feature where users can ask a [redacted] nurse questions regarding general health information for individuals with I/DD and receive a response within three business days.

[redacted]
In 1999, APS was awarded the [redacted] program by the [redacted] to review and promote the delivery of high quality and appropriate mental health and substance abuse services covering [redacted] lives. Our external review process is focused on facilitating recovery, resiliency and self-determination for adults and children who are affected by mental illness, addictive disease and developmental disabilities. The program includes extensive provider training and technical assistance, on-site audits and a formal quality improvement process driven by consumers and their family members, providers and state policymakers. The [redacted] Program also provides regionally organized care management, individualized technical assistance for providers, detailed quality improvement reporting and staffed community liaison/consumer services.

During the first year of operations, APS conducted needs assessments that indicated serious concerns among providers and participants with the rapid changes in their system of care. While the contract did not contain any required training deliverables during the first year of operations, APS responded to the concerns of the community as rapidly as possible to ensure the customers' needs were addressed first. Specifically, [redacted] staff provided:

- [redacted] hours of face-to-face provider training.
- Over [redacted] telephone assistance contacts.
- [redacted] stakeholder Advisory Council meetings.
- Onsite technical assistance contacts for each of [redacted] comprehensive MH/AD/DD providers.
- Authorization of over [redacted] requests for service, using APS CareConnection®.

Since this was the first experience behavioral health providers and participants had with managed care, APS took great care to address attitudes toward managed care and to establish community-wide ownership of system performance and outcomes. Today, APS has an outstanding relationship with state officials, advocates, providers, and other stakeholders. Most importantly service delivery has significantly changed. Participants have a greater opportunity to live independently with a greater quality of life. Fear of repaying Medicaid is minimized because providers are much more skilled at providing outcome oriented services and documenting their work. Finally, state officials, advocates and other stakeholders have extensive data on which to base policy, training, fiscal, and clinical decisions.

[redacted]
When APS implemented our [redacted] contract, we provided a similar level of training and technical assistance:

- During the first 18 months of operations in [redacted], APS provided [redacted] training sessions in various locations throughout the state. There were [redacted] participants, with many topics addressed in a "train the trainer" format to allow for even wider dissemination at individual agencies.
- During the first 12 months of operations, APS provided [redacted] on-site, individual provider Technical Assistance sessions. Providers requested an additional [redacted] sessions that were conducted by telephone or

at the APS offices in [redacted]. This is an average of [redacted] individual provider Technical Assistance sessions per month.

- Lastly, APS provided [redacted] Recipient and Community Education training sessions in the first 12 months of operations, with [redacted] participants.

With a rating of five (5) representing strong agreement and one (1) representing strong disagreement, the mean training evaluation scores for APS [redacted] are shown in Table 1.

Table 1. Summary of Satisfaction Scores	
Survey Statement	**Overall Mean**
Participant's knowledge of topic improved	[redacted]
Information presented clearly	[redacted]
Information presented was relevant	[redacted]
Feel better prepared to perform my job	[redacted]
Overall, satisfaction with the training	[redacted]

[redacted]

In [redacted], we've learned that providers experience challenges in obtaining [redacted] because of access. It is rare that a sole practitioner who serves multiple rural communities can be away from the clinic for even a day. To that end, APS has exploited available technology to deliver [redacted] via videoconferencing to more than 20 rural communities. The APS [redacted] program has hosted [redacted] on a variety of chronic illness topics specific to the needs of [redacted] providers, including ACE Inhibitor use in heart failure, atypical antipsychotic drug-induced type II diabetes, and new guidelines medication management in asthma patients. Respected physicians with subject matter expertise have been extremely willing to share their experience as well as relevant clinical guidelines. APS has worked extensively with the [redacted], the [redacted], and the [redacted] to determine priorities in provider education and plans to deliver at least one [redacted] videoconference each quarter. Upcoming opportunities include diabetic neuropathy and foot care to prevent exacerbations in patients with multiple sclerosis.

APS views provider education and training, on all levels, as an opportunity to dialogue, improve the services that we deliver, and be relevant to the needs of our providers. Education and training are cornerstones of APS' approach to services that emphasize quality improvement, provider participation, and appropriate and efficient use of services. APS has realized positive outcomes in education and training providers by collaborating with state officials, providers, and Enrollees to address system needs for improvement in clinical, administrative, and fiscal functions. Also, in dedicating provider support staff to the consultation and training function, APS will deliver a thoughtful provider education model which considers the needs and environment of Pennsylvania providers as it works in partnership with the Department to implement a "best in class" program.

APS has been extremely successful in building strong relationships with providers, local community-based organizations and other stakeholders, which have resulted in provider "buy-in" in our programs and ultimately program participation.

Provider Network Development

APS has extensive experience developing provider networks for both our private and public sector customers including engaging both PCPs and Specialists to increase provider participation in our programs. In order to build fully contracted provider networks, our network

development strategy focuses on recruiting those providers who can best support the populations we serve and forming strong alliances with our customers' existing provider networks. We identify potential providers by reaching out to those who have historically served members, as well as locating potentials providers through researching community health directories, hospital outpatient clinics, national provider associations, state provider listings and references from current providers. As we begin developing the network, we also conduct Geomapping analyses during implementation and on an ongoing basis to assess the geographic availability of the network. This analysis compares membership data to provider locations, and yields information regarding the percentage and number of members who meet customer-defined access standards.

This analyses also includes assessing the demographic and clinical needs of the population relative to the current network and identifying additional areas for development (e.g., identifying areas where the network does not sufficiently address the needs of the elderly, child/adolescent and disabled populations). The results of these analyses shape our network development activities, which are led and overseen by Provider Networks staff to ensure contract compliance.

The [redacted] and [redacted] are perfect examples of our proven network strategy in building customized provider networks in short timeframes:

- When APS implemented the [redacted] EAP contract, which was previously administered by another vendor, we contracted with [redacted]% of the existing network in less than [redacted] days.
- For the [redacted], we contracted with [redacted]% of the existing network in [redacted] days.

The table below demonstrates the specific number of providers we successfully contracted with and credentialed for each contract.

[redacted]	[redacted]	[redacted]
Number of Employees/Members	[redacted]	[redacted]
Number of Key Recruitment Sites	[redacted]	[redacted]
Number of Practitioners of Facilities Contracted & Credentialed	[redacted]	[redacted]
Days to Complete Credentialing and Contracting	[redacted]	[redacted]

When we asked our clients in the [redacted] how they would rate APS' network expansion efforts during implementation, [redacted], Contracts Manager for the [redacted] stated:

"Most impressive. Network development was a high priority, since our Plan will require all MH/SA benefits to be rendered within the APS network. APS secured agreements with all of the existing mental health/substance abuse inpatient and outpatient facilities in the State, and its provider recruitment has exceeded the number of providers that were in the existing network. APS has also achieved a high percentage of overlap with those providers identified as the Plan's "high volume" providers. Communications and updates during the recruitment process were timely and informative, so that our office was aware of the progress of network recruitment efforts at all times."

In addition to our experience building contracted networks, APS has been extremely successful in increasing provider participation in our Pay for Participation contracts in both [redacted] and [redacted]. One of key strategies is to collaborate with and engage local professional associations, medical societies, community-based organizations, and other stakeholders in influencing provider participation. From our experience, provider recruitment and participation can be challenging due to lack of provider program awareness, geographic challenges, disconnect between providers and their office managers, etc. As a result, key to our strategy is developing an aggressive provider promotional campaign to create "buzz" within the provider community and generate provider interest in the program. The promotional campaign explains the program and informs providers how to contact APS to participate in the program, and typically includes:

- **Introduction letters** to PCPs in the State to educate them on the commencement of the program, introduce them to APS as the contractor and give instructions on how to enroll in the program.
- **Outreach to providers** and their staff through face-to-face meetings, medical society presentations and through outreach to business office managers to inform them about the program and assist with enrollment.
- **Conducting a series of meetings** across the State to introduce key personnel and our operations to interested providers.
- **Promotion to local media**. APS recognizes the power of the media and uses strategies to harness this influence by engaging in proactive media relations campaigns (e.g., public service announcements on television and radio; press releases in newspapers). These venues allow us to reach providers, as well as members of providers' community—such as local public health organizations, legislators and hospitals—that can help influence provider adoption of the program, and ultimately enrollment in the program.
- **Partnerships with Community-based Organizations and State Professional Associations**. APS recognizes the importance of building valuable partnerships with organizations that can be instrumental in motivating providers about the advantages of the program and the importance of their participation. We have found that organizations such as community health providers and state professional associations have the resources and relationships to motivate providers to enroll in ACCESS Plus. In fact, our work with FQHCs and other community-based primary care systems serving Medicaid and low income recipients—has been of great assistance to us in developing these constructive relationships and successful programs.
- **APS website**. Information on program benefits as well as details on enrollment is posted on the program's website.
- **Establishment of a Provider Quality Improvement Advisory Council**. APS typically initiates a Provider Quality Improvement (QI) Advisory Council within the first few weeks after contract award in an effort to establish an ongoing positive relationship with the provider community as well as to maintain a consistent, high-level of communication throughout the life of the contract.

Once a provider, or group of providers, has expressed interest in participating in the program, APS staff contacts them to set up training and enrollment into the program. APS' Provider Outreach Staff are then responsible for educating providers on the program, and assisting providers with enrollment. A perfect example of our provider recruitment efforts is the [redacted]. For the [redacted] program providers are provided financial reimbursements for treatment plan approvals within APS CareConnection® . and program participation. One of the biggest challenges we faced was reaching providers due to resistant Business Office Managers. As a result, APS presented to the [redacted] to educate them about the program and explained the benefits of program participation ; developed outreach plans that specifically targeted Business Office Managers, positioning them with the knowledge to present program information and benefits to providers within their office; provided

number of local medical and specialty associations with educational materials and language for their quarterly newsletters on our program including the benefits program participation; and designating a team of Provider Outreach Staff, who were extremely knowledgeable about the provider communities in their region, to reach out to Business Office Managers and providers to obtain program buy-in and participation. Due to our efforts, **APS has recruited and trained [redacted] providers in [redacted] from April through December 2008**.

APS will leverage our experience to ensure ACCESS Plus Enrollees have access to an accessible and adequate PCP network as well as an adequate number of Specialists, including dentists. APS' Provider Recruitment Plan ensures that participation is convenient for the provider and that ACCESS Plus Enrollees have access to providers in accordance with the Department's distance and travel time factors. APS will work with the Department to ensure that any network development plans meets all access, availability and network composition requirements.

- **Provider relations**

Provider Relations

In each of our public sector programs, APS advocates for a collaborative, stakeholder-driven model of program design, and thus focuses on building strong partnerships with the provider community. This model encompasses a wide variety of competent provider support capabilities, including the establishment of Quality Improvement Advisory Councils for Providers to ensure that their voices are heard and that the program addresses their needs.

APS' Provider Relations Department is responsible for providing education, training assistance to our provider community. Depending on the specific requirements of the contract, Provider Relations Personnel is either located within the contract's dedicated Service Center or within APS' corporate headquarters. Provider Relations staff are typically responsible for provider outreach, education and training activities. The Provider Relations Manager is responsible for outreach to the professional clinical community, assists the Executive Director as a liaison to providers, provides input into communications to the community, assists with attendance at provider activities, and assists with training for program staff. Provider Representatives serve as liaisons with the local provider community and assist with the development of all provider communications and outreach efforts to educate providers on our programs. They are also typically available for on-site consultation to providers, and technical assistance with APS CareConnection®. Furthermore, these staff members also participate in and provide staff support to the QI Advisory Council.

- **Public Relations**

Public Relations

Public relations is a key element of APS' public programs. We partner with our customers to present a positive and consistent message to the communities we serve regarding the program benefits available to them. This includes partnering with our customers to conduct health fairs, advertising events in local newspapers, on the radio, and on television with public service announcements (PSAs), and handling press releases with local papers for customers. Press releases and contributed articles also may contain information on program highlights and enrollment information. Some examples of public relations activities we've conducted for the [redacted] contract include:

- Technical School Project: The [redacted] presented [redacted] to students at the [redacted]. The [redacted] continues to contact technical schools in the [redacted] region to offer this training to students in medical fields as part of the school's curriculum. Positive comments on evaluations included:

> ***"Thank you so much for your time. What you are doing is really great and eye opening!"***
> ***"Gave me a better understanding on mental retardation and now that I work with them, look forward to the future!!"***

- RN/LPN Outreach: The [redacted] project team has reached out to various nursing schools in the region. [redacted] was presented [redacted] times to a total of [redacted] students at [redacted] area nursing schools. The presentation has received positive feedback from students and instructors and continues to be offered to other nursing schools in the [redacted] region. Positive evaluation comments included:

> ***"We do not learn about mental retardation in school so it was very informative."***
> ***"Keep speaking out because advocacy is what people with ID need! Great job ladies!"***

- Consumer Health/Fun Events: The [redacted] has partnered with a number of counties for health and safety fairs including the [redacted] in May 2008 that highlighted the Arthritis Exercise program and [redacted] for past three (3) years where we operated several booths demonstrating various health/wellness interactive activities (e.g., hand washing, nutrition/healthy lunches, exercise, dental care). We also participated in the [redacted] (consumer event) that focused on ways to incorporate physical activity into the days of individuals, encouraging heart health, weight management and overall wellness.

- Transition Support Project: Two [redacted] nurses submitted a proposal to present [redacted] and [redacted] as part of the Healthy Lifestyles, Community Participation, and Independent Living portion of the [redacted] in July 2008. As a result, the [redacted] training was accepted and presented at the conference.

- Parent Groups: A [redacted] staff member contacted the [redacted], an organization supporting clients with mental illness and mental retardation. As a result, the [redacted] presented information on [redacted] twice to the [redacted]. Feedback received from the sessions included the following:

> ***"Wonderful presentation. Kind and patient."***
> ***"Excellent presentation."***

- Fitness/Personal Trainer Project: The [redacted] project leader contacted the [redacted] and learned that the [redacted] had collaborated with the [redacted] to form an [redacted]. The mission of the [redacted] is to work to improve the US and global health by promoting increasing participation by people with disabilities in physical activity, sports, and recreation. The ultimate goal is to reduce substantially, in this country and

internationally, health problems associated with disabilities and inactive lifestyles. As a result, the [redacted] became a member of [redacted].

- **Analysis of industry trends in PCCM and Disease Management programs**

Analysis of industry trends in PCCM and Disease Management Programs

As a leader in the healthcare management arena, APS is vigilant in our continuous analysis of industry trends related to both disease management and PCCM programs to ensure programs are relevant, reflect best practices and ultimately achieve the client's program objectives of improved clinical outcomes in the most cost-effective manner possible.

Through our experience designing and delivering disease management programs for the past 14 years, APS is more than familiar with the evolution of disease management as well as related industry trends. A significant trend in disease management is the growing awareness of the impact of behavioral health conditions (e.g., schizophrenia, bi-polar disorder, schizo-affective disorder, major depression, substance abuse disorders including and autism spectrum disorders) on chronic medical conditions. These co-morbidities present barriers to chronic condition self-management. They impair the ability of Enrollees to adhere to medications for chronic disease and complicate efforts at treatment of medical conditions. Further, behavioral healthcare medications can increase the likelihood of developing or increasing the severity of a chronic condition (e.g., medications that cause weight gain may result interfere with diabetes management). APS has been at the forefront of discussing the emerging recognition of "mind/body" issues in the management of chronic disease, and introduced screening for depression into our public sector Disease Management programs at their inception. We continue to evolve person-centered interventions that promote recovery and resiliency for people with severe mental illness and children with serious emotional disturbances who also have chronic illnesses, developing special DM techniques for individuals with schizophrenia and outreach techniques for Residential Treatment Facilities and Treatment Foster Care, for example.

At the same time that the DM industry has become aware of the prevalence of chronic condition and behavioral health co-morbidity, there has also been an increased appreciation for total health management for people in comparison to management of discrete diseases. We credit the efforts of the Institute of Medicine (IOM) for this trend. In 2001 the IOM published "Crossing the Quality Chasm: A New Health Care System for the 21st Century." Central to this new health system is the achievement of six key aims for healthcare delivery: safe, timely, efficient, effective, person-centered, and equitable." APS has focused the development of our programming on achievement of these aims for the [redacted] people receiving services through programs we support in [redacted] states and Puerto Rico, resulting in a total population health management program that focuses on people first for integrated and holistic services that achieve dramatic cost containment and high rates of Enrollee and provider satisfaction.

Based on our experience with Medicaid programs on a national level, we have identified key dynamics that continue to be subject to debate and development within the PCCM arena. These includes the growing responsibilities of the primary care provider (PCP) and emergence of the "medical home" as a critical response to health care costs and the burgeoning rate of chronic disease in the overall population as well as Medicaid. Additionally, PCCM programs have grown to include Pay for Performance (P4P) programs to provide incentives for PCPs to deliver specific preventive and primary care services for PMPM payments as early PCCM programs did not feature careful management of service delivery and roster payments. Identified as a significant enhancement to patient safety by the Institute of Medicine, efforts to encourage the adoption of health

information technology (HIT) have also increased with growing interest in healthcare reform to reduce the cost of care. HIT has been defined to include patient disease-specific registries, electronic health records, e-prescribing, and other applications of information technology to healthcare – at the bedside and across communities. The view of HIT as a means to improve quality and patient safety and reduce cost is also a trend in Medicaid.

Given APS' experience in delivering programs to public sector customers and the prevalence of chronic conditions and behavioral health co-morbidities within the Medicaid population, APS is well ahead of the trends, positioning use as a leader within the healthcare market. With our roots in the behavioral healthcare industry, we were one of the first companies that recognized the link between behavioral health and disease management, and adapted our programs to address such issues. Furthermore, we have designed our programs with a total population management approach to care. Through our serving Medicaid populations, we estimated early on that managing Enrollees who have three conditions such as diabetes, hypertension and COPD for example would not be best served through three different disease management programs. Our approach manages the **whole person** – not the singular disease - across the continuum of health and healthcare. Whether the person has diabetes and depression or acute leukemia, APS' knowledgeable and experienced clinicians deliver management services that result in sustained and meaningful improvements in health status and health outcomes. Our holistic approach avoids the duplication of effort that occurs with treating chronic conditions as if they were independent.

Additionally, APS offers an information system, APS CareConnection®, to help facilitate patient management, expectations for medical homes, coordination of care, linkage to community resources, and the management of complex chronic disease across primary and specialty care. APS CareConnection® is available to various providers – from PCPs to BH providers – so that they can access Enrollee plans of care; assessment tools and results; disease registries; patient rosters; EPSDT profiles; evidence-based guidelines; links to community, state, and national resources; and educational Enrollee materials, etc. We also have field and Call Center-based technical assistance who support provider use of this system. Furthermore, Care Coordinators bring the Healthcare Neighborhood to the door of the Medical Home, facilitating communication with specialty providers, the county-based behavioral health system, dentists, and community-based resources.

Strengthening the PCP Medical Home are APS Health Coaches, field and Call Center-based Registered Nurses who bridge the gap between home and office. Health Coaches empower Enrollees for better self-management; they are an "extra set of hands" for hard-pressed PCPs and office staff. With a tool kit of resources that encompasses systems, people, and shared information, we help PCPs realize P4P goals and benefit from this important program. Promoting patient-safety and quality through consistent, positive feedback, we help PCPs with details of care planning, medication management, and coordination. With our significant background in behavioral health, we are a credible resource for PCPs caring for Enrollees with severe mental illness and serious emotional disturbances. From our operational model that ensures we are viewed as insiders from day one to our proactive presence in the community, we strengthen the relationship of Enrollees and physicians – enhancing medical homes.

Put simply, APS' programs are already designed to address such industry trends, with proven program models and strategies that have been implemented successfully in other States – APS will do the same for ACCESS Plus.

- **Local communities**

Strategic Partnerships with Local Communities

APS has a strong record of building community alliances in our work across the United States including grass roots efforts with a wide variety of community health interests, from Federally Qualified Health Centers (FQHCs) and Rural Health Centers to major teaching institutions and health systems. Successful engagement with the provider and social supports systems has been perhaps the strongest of our many critical success factors.

We have developed an approach to establishing and maintaining long-term relationships predicated on respect, collaboration, and partnership among all entities serving our program membership. We believe that the best method of maintaining relationships with different stakeholders such as providers, consumers/families, community based organizations, nonprofit organizations, and other entities of government is to involve key representatives of each of these groups in every step of the process.

Stakeholders – including Enrollees, providers, advocates, and governmental leaders - need an opportunity to be heard and to shape program development and design.

Community Health Partnership Model

One of our key operational practices is to ensure our continual update of our knowledge and understanding of the special needs of a population and to establish close ties to the community of institutions that address their needs. The APS *Community Health Partnership Model* is a collaboration between the Enrollee, his/her health care providers, community stakeholders, and the state or local agency. APS health coaches-- nurses trained in chronic illness management and behavior modification-- and care coordinators-- individuals specially trained in locating social support systems and resources-- provide care and disease management services to Medicaid beneficiaries. They work telephonically and/or on-site alongside health care providers in stand-alone clinics, community health centers and major hospital systems. Our staff members perform assessments and offer educational information and support to encourage the beneficiary's compliance with medications and treatment plans and self-management of his/her health. Health Coaches and Care Coordinators also assist clinic and facility staff members in conducting disease collaboratives, hosting patient education seminars, and by acting as a direct liaison to the state's Medicaid plan.

For example, in [redacted], APS has built successful relationships with the [redacted], the [redacted] and the [redacted]. APS regularly presents program information at their regular meetings, annual events, and in their newsletters, as well as partners on projects to improve outcomes and care. At [redacted] request, APS is working on a project to facilitate more successful transitioning of children and teens in residential treatment centers into group homes.

We have also already reached out to a number of Pennsylvania associations and academic institutions in preparation of the Pennsylvania proposal to increase our capability in responding effectively to local interests and needs. These meetings introduced APS as well as provided an overview of our services and mission, our innovative management system, APS CareConnection®, and our community-based model. These have included but are not limited to the [redacted]

[redacted]. In fact, we have received letters of support from some of these associations, which have been submitted in **Exhibit 27**.

- **Behavioral health services coordination**

Given APS' extensive experience in the behavioral healthcare industry, we are intimately aware of the need for seamless coordination between physical health and behavioral health providers and how such coordination can positively impact an Enrollee's overall health and well-being. APS understands the increased complexity involved in treating concurrent medical and behavioral problems and the necessity to ensure information, referrals and follow up care are closely coordinated among the entire treatment team. The successful management of co-morbidities across multiple Providers is essential in reducing costs and improving outcomes for individuals with behavioral health and/or co-occurring disorders. Lack of coordination of care results in:

- Negative treatment clinical outcomes.
- Contra-indicated medication management.
- Increased utilization of highly restrictive levels of care.
- Lack of long-term stabilization and set backs in recovery.

Achieving this reduction requires significant coordination of care among multiple behavioral health and medical practitioners (both primary care and specialty care providers), as well as important community resources that provide services to program Enrollees.

APS believes that our attention to the full mind-body integration of our services improves the overall health of individuals, reduces total expenditure of health care, and ultimately achieves improved clinical outcomes. We understand and actively manage the interplay between the mind and body through our [redacted] **years of behavioral change experience**. To ensure continuity of care for Enrollees with behavioral health and/or co-occurring disorders, APS establishes policies and procedures that specifically directs the monitoring and improvement of the continuity and coordination of care between behavioral health providers and general medical providers. Monitoring and improvement activities (e.g., medical record reviews, etc.) rely on close collaboration between PCPs, behavioral health practitioners, and APS. Key areas of focus include:

- Exchange of information between behavioral health care practitioners, specialty providers and PCPs.
- Identification and treatment of behavioral health disorders commonly seen in primary care.
- Appropriate use of psychopharmacological medications in the general medical setting.
- Coordination of care for co-existing medical and behavioral health disorders.
- Coordination of preventive health activities with medical delivery systems.

To improve the coordination of care between medical and behavioral providers, APS typically:

- Provides clients with educational materials on medical/behavioral coordination.
- Includes multiple articles on best practices for medical/behavioral coordination and expectations in the APS Provider Newsletter.
- Supports client involvement through emphasizing the importance of medical/behavioral coordination in the APS Client Newsletter.

- **Consumer incentives**

The use of incentives for desired consumer behavior has increased in popularity with Medicaid programs as the benefits to be gained in functional status and cost management have increased. When appropriately designed and administered, consumer incentives for people with chronic diseases can lead to more appropriate utilization of clinically recommended and preventative healthcare services, greater adherence to medication regimens, and increased adoption of healthy behaviors.

In developing consumer incentive programs, APS researches national agency literature such as the Agency for Healthcare Research and Quality (AHRQ), provides a rationale for the selection of the incentive, and identifies the target audience for the incentive program. Articulating goals for the incentive program also helps to ensure that expectations and desired outcomes are explicitly stated and well-understood. Research suggests that consumers will change their behavior when the new behavior is perceived to:

1. Offer benefits superior to those of the existing behavior (*better*).
2. Involve fewer barriers than the existing behavior (*easier*).
3. Be supported by people they value (*popular* with their role models).[2]

Research also suggests that incentives are effective in promoting desired behaviors We believe it is essential that providers be aware of and support consumer incentive programs, as they can reinforce behaviors and may be asked to document delivery of services. Providers can also help prevent an inappropriate focus on incentivized behaviors in favor of other needed services and so can frame desired behavior in the *context* of health improvement. Additionally, the incentive needs to be provided to the Enrollee within a reasonably short timeframe following the desired behavior to ensure they see the link between the action and reward.

APS has developed successful consumer incentive programs for both our public and commercial customers. In [redacted], we developed an innovative consumer incentive program focused on HRA completion described below:

Through our [redacted] APS employed a variety of strategies to reach intended service recipients. One of the contract deliverables for APS was to complete a health risk assessment (HRA) on everyone in the target population. APS used the SF-8 questionnaire, a brief 8-question HRA developed by Quality Metrics.

Originally, APS staff completed the survey exclusively by telephone. An introductory letter was mailed, inviting Enrollees to call our toll-free number to complete the questionnaire over the phone. Within two weeks of the mailing, [redacted]% of the Enrollees on the mailing list called to complete the SF-8 via the telephone. Although this return rate for mailing is comparable to industry standards, APS believed that by offering incentives to individuals, it could increase the response rate. A series of three (3) incentives was established. The first incentive was an offer of a "Free Health Guide Book" upon completion of the questionnaire. An additional [redacted]% of the mailing list called in during those [redacted] weeks.

The next mailing, to the same group of Enrollees, staff included a paper SF-8 assessment with a postage-paid reply envelope and an incentive of a $5 pre-paid phone calling card for each completed questionnaire. This resulted in a [redacted]% response rate – [redacted]% by direct return mail and [redacted]% via telephone.

[2] Ibid., page 30.

The final incentive to the same group again included a paper survey with a reply envelope and an offer of a $5 gas card. Although individuals had already been sent 3 previous mailings, plus attempted to make outbound phone contact multiple times, another [redacted]% mailed in their SF-8 and [redacted]% called to complete it over the phone, for an additional [redacted]%.

Periodically, a new population sample was drawn and our next group of Enrollees, who were completely new to the program, were sent an introductory letter with a paper questionnaire, reply envelope, but no incentive. [redacted] of this group mailed in their S-F8 and [redacted]% phoned us.

The total cost for the incentives, including mailing and staff time, was approximately $[redacted] per completed S-F8, which compares favorably with the estimated cost per SF-8 of $[redacted] for staffing outbound calls and call attempts.

APS discovered that a variety of strategies is needed to effectively complete an HRA with the Enrollee population. Seeing the questionnaire in advance appears to improve the response rate, even if Enrollees choose to complete the questionnaire over the phone rather than mail it in. Incentives are effective, but because some people will respond without an incentive, an efficient use of incentives is in subsequent contacts rather than the initial contact. And finally, although mailings are effective, outbound calls and other strategies still needed to be employed.

Our goal for ACCESS Plus is to develop a transparent and consensus-based incentive program that draws on literature and evidence and has the support of Enrollees' PCPs, the RAC, and the statewide QMC. The guidance of evidence, coupled with the input and feedback of informed stakeholders, will increase the identification of priority health behaviors and meaningful incentives. With this guidance and the approval of the Department, the incentive program will focus on optimal health choices – *better* choices for consumers; engaged communities make it *easier* for Enrollees to participate; and broad support also demonstrates that role models might participate – increasing program *popularity*. APS will leverage our experience developing targeted consumer incentive programs to achieve a consumer incentive program that works for the ACCESS Plus Enrollee population and is consistent with Medicaid regulations.

- **Cultural competency**

Cultural Competency

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes. (US Department of Health and Human Services, Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services: Final Report, page 1. March 2001.). APS is committed to delivering services that are culturally competent and demonstrates our dedication through the following activities:

APS' Provision of Non-English Member Information - APS is recognized for our strong focus on cultural competency and respect for diversity in our communications and educational programs. A critical aspect of working effectively with recipients and families of diverse cultures is to understand the norms and mores of the culture. One's cultural identity and the experience of pursuing that identity within daily society greatly influence how individuals access health care. As a result, APS provides multiple options and media for the

delivery of information based on Enrollees' needs, their health literacy, and their primary language. Our materials are based upon several important foundations of learning theory, social marketing, health literacy, accessibility, and cultural competency. Enrollee materials are provided in alternative languages and formats, as necessary, to ensure Enrollees' full understanding of the information. In general, APS develops written materials in non-English languages where the percentage of the membership meets the Centers for Medicare and Medicaid Services (CMS) definition of a "prevalent" language. Health Coaches also facilitate communication for non-English speaking Enrollees, and we aggressively hire bilingual Health Coaches from the local communities that we serve. We supplement the language capabilities of our Health Coaches with health care certified interpreters and translator services. Additionally, we use web translator services at www.freetranslation.com for e-mail communications.

Cultural Competency Training - APS staff training is addressed from various cultural perspectives, ensuring that care decisions made are not only clinically sound but also sensitive to cultural norms. For example, APS includes Culturally and Linguistically Appropriate Services (CLAS) standards in our staff orientation program. We also require Health Coaches to attend cultural competency trainings offered through the Office of Minority Health (OMH) and obtain nursing credits. Furthermore, we encourage PCPs to also earn CMEs and nursing credits through OMH. APS also consults and listens to local providers and community organizations to ensure our training emphasizes the various skills in working in a culturally sensitive manner such as respecting the unique culturally defined needs of various client populations and viewing natural systems (family, community, faith groups, etc.) as mechanisms of support for minority populations; recognizing that concepts like family and community have different meanings for different cultures and even for subgroups within the cultures; starting with the family, as defined by each culture, as the primary and referred point of intervention; and advocating for effective services on the basis that the absence of cultural competence anywhere is a threat to competent services everywhere, etc.

Serving Special Needs Populations - APS communicates effectively with hearing-impaired and deaf callers through on-site TDD (Telecommunications Device for the Deaf) equipment and State Relay Telephone Services. We also make materials available in Braille upon request for people who are blind. APS' offices are accessible (as required by ADA) and we provide ASL interpreters and other language supports as needed. Furthermore, for Enrollees who are functionally or cognitively incapable of assisting in their treatment plan or attaining self-management objectives, APS provides the Enrollee's family and/or caregiver with education, advice, and support to assist in the understanding of chronic care management objectives and ensuring that they are capable of implementing the recommended treatment regimen and monitoring symptoms.

- **Coordination of EPSDT services**

APS has over 10 years of experience with reporting on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. For example, through the [redacted] (Medicaid) Program, APS provides analysis and reports for EPSDT. Specifically, in 2008, APS, in collaboration with the [redacted], conducted a study to monitor the rate of documented Child Health Checkups provided to [redacted] under the

age of 21 years. This study adapted Healthcare Effectiveness Data and Information Set (HEDIS®) 2007[3] hybrid guidelines for EPSDT, commonly referred to as "Child Health Checkups." APS has provided details of this study:

The period of review covered calendar year (CY) 2006 and four age groups: 0 to 15 months, 3 to 6 years, 7 to 11 years, and 12 to 21 years. Of [redacted] sampled in the 0 to 15 month age group, [redacted]% received the recommended six Child Health Checkups. Among the 3- to 6-year-olds, [redacted]% received at least one Child Health Checkup during 2006. Seven-to 11-year-olds received [redacted]% of the recommended visits, and 12- to 21-year-olds received [redacted]%.

Three of the four age group percentages were significantly lower than the national Medicaid means for the same time period. As HEDIS does not maintain a benchmark for the 7- to 11-year-old group, it could not be compared to a national mean. For the 12 to 21 years age group, the [redacted] periodicity schedule indicates that a Child Health Checkup should be conducted at least once every other year, while the HEDIS measures look for a Child Health Checkup every year for these children. We expect to see lower rates of adherence in this group compared to HEDIS national Medicaid means.

When data for Enrollees ages 0 to 15 months were analyzed according to exact number of documented visits, we saw that for the first three (of the recommended six) visits [redacted] received services at a rate consistent with the national Medicaid mean. However, after the third visit, the percentage of [redacted] who received the recommended number of visits declined significantly more than the national Medicaid means.

Using administrative claims and medical record data, we found the percentage of Enrollees who received the recommended number of Child Health Checkups appeared to increase from 2003 to 2006. However, between 2005 and 2006, there were no significant changes in percentages of Child Health Checkups for any of the age groups. Overall for 2006, the percentage of children who received the recommended number of Child Health Checkups was highest in the 3- to 6-year-old age group ([redacted]%), and the lowest in the 7- to 11-year-old age group ([redacted]%). While there were no significant differences between racial/ethnic groups, the percentage of children who received the recommended number of Child Health Checkups was generally lower for the 7- to 11-year-old and 12- to 21-year-old age groups for each racial/ethnic group.

Medical record reviews indicated that a comprehensive health and developmental history and anticipatory guidance were the two components of a Child Health Checkup that were not identified as often as a physical exam across all age groups. The number of missed opportunities indicated that the rate of children receiving Child Health Checkups could be greatly improved.

Through this study, APS identified many solutions for increasing the number of documented Child Health Checkups among [redacted] children. One solution involves greater provider incentives for providing and documenting Child Health Checkups, as well as fastidiously ensuring that each patient seen (for whatever reason) has the full complement of up-to-date Child Health Checkups. Another solution may be ensuring that opportunities for completing Child Health Checkups are available outside of regular office hours for parents and caregivers who work during the day. Furthermore, given that a majority of [redacted] may be struggling financially, all efforts to make Child Health Checkups as convenient to working parents or guardians as possible should be implemented. For a parent with a child under 15 months of age, the most pressing expense of a Child Health Checkup is time off of work. Parents, particularly mothers, have likely used a good amount of vacation or sick time (if their jobs provide such) with the birth of

[3] NCQA. (2007). *HEDIS® 2007 Audit Means, Percentiles, and Ratios: Medicaid HMO Means, Percentiles, and Ratios*. Available at: http://www.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/MPR/HEDIS_2007_Medicaid_HMO_Means_Percentiles_Ratios.xls. Accessed June 3, 2008.

a child. By the baby's third or fourth Child Health Checkup in a year (out of six recommended in the first 15 months), parents may begin to have problems taking time away from their jobs. Child Health Checkups should be widely available after regular office hours to accommodate and encourage parents who might normally adhere to the recommended number of Child Health Checkups, but find themselves unable due to limited time off and/or uncooperative work situations.

- **Other Commonwealth of Pennsylvania agencies**

Experience Partnering with Commonwealth of Pennsylvania Agencies

Through our current Pennsylvania contract, [redacted], APS has developed a number of positive working relationships with various Pennsylvania agencies as well as local county governments and local provider communities. APS has held this contract since 2002. APS' [redacted] provides collaborative, responsive educational support to an eight-county region in Southwestern and [redacted], and is focused on enhancing the quality of life of individuals with intellectual and developmental disabilities (I/DD) by leading initiatives that facilitate improvements in the delivery of healthcare and services to this population.

APS' [redacted] is currently funded by the [redacted] and has also worked on special projects with other departments including the Department of Health as well as the [redacted]. For example:

- APS interfaces with [redacted] on a quarterly basis to discuss program issues within [redacted] as they impact the scope of work of the [redacted] program and [redacted]-specific initiatives.
- [redacted], the Executive Director of APS' [redacted] program, sits on various [redacted] including the Capability and Capacity Building Committee and the [redacted]. He is also involved in a State-wide effort concerning dental issues for individuals with intellectual disabilities and/or special needs. For example, the APS [redacted] has been extremely proactive in creating an online Regional dental database that is overlaid with Geomapping technology and available via the [redacted] website.
- APS partners with [redacted] and the local county governments to implement [redacted]-specific initiatives. Examples include:
    - When the [redacted] identified a high incidence of choking and deaths related to choking after analyzing its aggregate incident management database, the [redacted] asked APS' [redacted] along with other [redacted] to develop trainings and fact sheets for advocates, providers and family members. These materials were geared at helping them better understand and manage the issue of choking, and ultimately reduce its incidence.
    - Within our [redacted] counties, APS' [redacted] discovered variances among provider agencies regarding medication administration and medication errors. As a result, our [redacted] Nurses worked collaboratively with [redacted] to develop and distribute templates to assist provider agencies in developing their own policies and procedures to ensure uniformity and consistency and reduced medication errors through root cause analysis.
    - Based upon an identified need, APS' [redacted] created Emergency Preparedness resource materials to assist the provider community in increasing their level of emergency preparedness. Furthermore, [redacted] co-chairs the [redacted].

- APS has partnered with County Aging/MR Committees within the [redacted]. For example, APS' [redacted] nurses participated in each of the County Aging/MR Committee meetings in [redacted] and [redacted] Counties. One [redacted] nurse attended the [redacted] Aging/MR special event on Positive Practices, Restraint Reduction, and the Trauma Sanctuary Model. A [redacted] staff member also assisted the [redacted] with the development of a "learning library" of books, CD/DVDs, etc., to be used as reference materials for those involved in the aging/MR community. In addition, [redacted] nurses present annually at the [redacted].
- The recent collaboration with the [redacted] has resulted in the Executive Director and Clinical Manager being asked to sit on the project's Advisory board. APS has worked with [redacted], Medical Home Coordinator, to assist in the projects expansion across the region served by the [redacted] as well as to educate the Physicians offices that participate in the project. APS has participated in several conferences, meetings and telephone conferences over the past two years.
- The APS [redacted] has been involved in a collaborative effort with the behavioral healthcare provider community to discuss challenges and gather data related to the treatment of individuals who have been dually diagnosed with both intellectual disabilities and mental health issues. APS sees this as an opportunity to bring best practices to those providers who treat this targeted population by providing them with meaningful resources and tools, which ultimately will improve Enrollee outcomes.

APS will take the same partnership approach in working with the [redacted] agencies as we have through our current [redacted] contract if selected to administer the ACCESS Plus Program.

- **Interventional Stratification**

Interventional Stratification

APS' programs employ interventional stratification strategies to identify and stratify potential candidate for our programs, and then apply targeted inventions that help them better manage their chronic conditions while achieving and maintain healthy behavior changes. To identify individuals who may benefit from our Disease Management services, APS perform risks stratification through claims-based predictive modeling (PM) and analysis of uncoordinated care on eligible Enrollees. This stratification is based on an analysis of eligibility and claims data, including pharmacy, behavioral health and laboratory data, and total costs. APS' initial stratification process results in each Enrollee being classified along a continuum based on their probability of incurring future costly health care episodes. APS uses the [redacted] which was developed specifically for the Medicaid population. Our expertise with predictive modeling enables APS to identify Enrollees who have a "high risk" potential for costly episodes of care. The combination of risk stratification based on [redacted] and analyses of uncoordinated care allows us to prioritize Health Risk Assessments and Member Baseline Knowledge (MBK) surveys. The MBK was developed to further stratify program Enrollees by gaining additional detail on the Enrollee's functional status, risk for non-adherence to recommended care, risk for poor self-management, as well as several other factors not present in claims data. In the process of filling out the MBK survey, APS collects crucial information on a member's health status, including general health and medical history; recent signs and symptoms associated with the chronic illness; current treating health professionals and medications; individual understanding of his/her disease(s); willingness to learn self-management skills; barriers to care posing risks for non-adherence (e.g., functional limitations, transportation, financial, educational, psychosocial, language/cultural or social isolation issues); and functional and psychosocial status and lifestyle risk factors, co-morbidities, etc.

Although our PM provides the initial screen of eligible Enrollees, the heart of our screening and assessment occurs in one-on-one interactions between Enrollees and Health Coaches. Our Health Coaches conduct a more detailed clinical interview to obtain more recent utilization history and assessment of the Enrollee's ability to manage their disease. Those Enrollees at highest risk receive holistic health assessments by APS Health Coaches first. Highest-risk Enrollees are pursued as a first priority, while secondary efforts are focused on Enrollees with moderate or lower risk factors.

For those customers who choose to offer HRAs, APS offers a flexible, yet aggressive, approach to distributing and collecting HRAs, as traditional channels do not capture all eligible high-risk Enrollees. APS typically distributes and collects HRAs through a variety of mechanisms, including telephone, in person meetings at community provider and partner settings. In addition, APS' flexible approach to the administration of the HRA allows Enrollees to complete HRAs at all stages along the Enrollee identification, enrollment and engagement continuum. The HRA may also be completed by Health Coaches or Case Managers.

HRAs and holistic assessment information are entered into our proprietary APS CareConnection® community health record information system, which is predicated on national guidelines and the Health Outcomes Institute, a recognized leader in the process of outcomes management. All Enrollee assessments are made available to the Enrollee's treating providers via the Internet-enabled APS CareConnection®. In addition to sharing these assessments, APS communicates with the providers about how to make updates and changes in the results of the assessment via the web-based APS CareConnection® solution. APS CareConnection® gives providers a powerful tool for facilitating a quick, ongoing review and discussion cycle. Rather than pushing faxes with scribbled margins back and forth, providers are able to sign online, view the existing assessment results, and indicate their acceptance or changes based on additional information the provider may have. This gives the provider instant access so if additional information becomes available, the provider can update the assessment. In addition, this assessment information is now available to other treating providers without delay.

This broad-based, technology-enabled, exchange of assessment information allows APS' clinical staff to support planned, structured interactions for the Enrollee's long-term care needs as well as identifying potential acute episodes which help us work proactively with the Enrollee's providers to respond to patient's treatment needs. In this respect, APS' assessment tools contained within APS CareConnection® help to continually identify Enrollees at risk for higher utilization of health care services and greater medical costs. Based upon this information and subsequent program engagement, Health Coaches evaluate the existing treatment regimen and adherence to confirm or adjust the Enrollee's acuity level. Enrollees are then given an acuity rating, ranging from Low to Severe – the first level (low) constitutes Medical Care Management while level II thru IV represent acuity levels within the DM program.

Additionally, APS develops a Plan of Care, which includes various interventions tailored to specifically meet each Enrollee's needs and their risk level. The APS information and interventions are customized and tailored according to each Enrollee's disease severity, risk status, co-morbidities, current level of self-management skills, and readiness to change. Education is provided telephonically, by mail, or through the web. APS has structured our program in this way to provide low/moderate risk Enrollees with a myriad of resources and tools that will help them achieve their goals, while simultaneously allowing us to focus most of our coaching efforts on individuals with greater complexity, which requires a higher degree of attention. For example, a 37 year old with Hyperlipidemia with regular PCP visits and a Plan of Care is considered low-risk, and does not require a high frequency of contact from an APS Health Coach. These individuals are typically self-motivated

and already making healthy lifestyle choices that will ultimately impact their health and do not necessarily require the help of Health Coaches to identify barriers and set attainable goals. For examples, interventions for high-risk Enrollees may include home visits, Coordination of providers/services, discharge planning for inpatient episodes, and education on medication management. All Enrollees, regardless of their risk stratification have access to the same resources. The available resources have been listed below:

- Access to a Health Coach. The Health Coach is Enrollees' personal health advocate and works closely with them to provide an in-depth understanding of the impact of the chronic illness on overall health and well-being; discuss their action plan for lifestyle changes; assist the Enrollee in the identification of barriers and/or issues impacting effective self management and strategies to overcome the barriers; and facilitate navigation of the Enrollee's healthcare benefits and provider relationships.
- Access to clinicians 24/7 via a toll-free number for questions and concerns.
- Access to online information to increase the Enrollee's knowledge and assist in self management (e.g., diets for diabetics, exercise advice for parents of children with asthma, newsletters, smoking cessation tips, etc.).
- Distribution of educational materials to help them understand their condition and ways to improve their health.
- Access to health fairs and other wellness related events during which Enrollees can complete "Interest Postcards" requesting that they be contacted by a Health Coach and/or receive specific educational materials.

Whether stratified as *low/moderate* or *high* risk, the disease management coaching an individual receives is *"holistic"* and focused on providing the individual with proactive, ongoing support and education for their identified health risk(s) and all co-morbid conditions and issues that are impacting their overall health.

Program Contact Information

Contact Information for the aforementioned programs are provided below:

Program Contact Information	
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]

Program Contact Information	
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
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Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]
Customer Name	[redacted]
Address	[redacted]
Contact Name & Title	[redacted]
Contact Phone Number	[redacted]

II-6 Financial Capability

Offerors must submit information about their financial condition in this section. In its sole discretion, the Department may disqualify any Offeror for failure to include this information. Information pertaining to cost of an Agreement that might result from this RFP is not required and should not be included in RFP Part II-6, Financial Capability, or anywhere else in the Technical Submittal. For ease in assembling the submittal, the Offeror may append its financial documentation rather than including it in the body of the document.

a. Include information on the identity of any related party proposal. Compliance with this requirement does not require an Offeror to seek out information that it does not already have. Explain how the other party meets the definition of a related party. Once the Department announces the Offerors it has selected, each selected Offeror must promptly notify the Department if it is a related party to any other Offeror whose proposal was selected.

Not applicable. APS is not submitting any related party proposal.

b. Identify each entity that has an ownership interest of at least five percent (5%) of the Offeror. Provide, in an Appendix, the information described below on the Offeror and on each entity that owns at least five percent (5%) of the Offeror. If any information requested is not applicable or not available, explain why. Appropriate documentation may be submitted to support information provided. Please provide, as applicable:

Please see **Exhibit 30** for the requested information.

i) Audited generally accepted accounting principles (GAAP)-basis financial statements for the most recent fiscal year for which the statements are available. The statements MUST include a balance sheet, statement of revenue and expenses, and a statement of cash flow. Statements must include the auditor's opinion and notes to the financial statements. If no audited financial statements are available, explain why and submit unaudited financial statements.

Please see **Exhibit 30** for the requested information.

ii) The latest report from Moody's, Standard & Poor's or similar agency.

Please see **Exhibit 30** for the requested information.

iii) Lines of credit that are available, including maximum credit limit and amount available. Provide documentation.

Please see **Exhibit 30** for the requested information.

iv) State of Incorporation

Please see **Exhibit 30** for the requested information.

v) Type of Incorporation, as profit or non-profit.

Please see **Exhibit 30** for the requested information.

vi) Company Tax Identification Number

Please see **Exhibit 30** for the requested information.

vii) Company Dun & Bradstreet Number

Please see **Exhibit 30** for the requested information.

viii) Bond rating.

Please see **Exhibit 30** for the requested information.

c. Explain how the Offeror's response provides proof of fiscal soundness.

APS continues to be a financially sound, well-positioned company in the industry and has provided our Audited Financial Statements as **Exhibit 31**. However, we would like to provide some background regarding our company and our financial statements. Innovative Resource Group, LLC d/b/a APS Healthcare Midwest is a wholly owned subsidiary of APS Healthcare Bethesda, Inc. GTCR Golder Rauner, LLC (GTCR) is the ultimate parent company of APS Bethesda through Partners Healthcare Solutions Holdings, LP. GTCR is a leading private equity investment firm and long-term strategic partner for outstanding management teams.

The Chicago-based firm pioneered the investment strategy of identifying and partnering with exceptional executives to acquire and build companies through a combination of acquisitions and strong internal growth. One of the firm's top priorities is responsible fiscal management. GTCR currently manages more than $8 billion of equity capital invested in a wide range of companies and industries.

APS and its related entities were purchased by [redacted], Inc. on [redacted]. The statements included in the RFP response include the period from acquisition, [redacted], through December [redacted] For this period, the company incurred [redacted]). Included in this [redacted]. Therefore, on a cash basis, [redacted]

Since the purchase of APS by Partners Healthcare Solutions, Inc. more than a year ago, the senior leadership team has made a significant investment in improving financial projections for 2008 and beyond. [redacted]

d. If the Offeror plans to subcontract responsibility to administer substantially all of its responsibilities under the Agreement, and if the subcontract provides for financial risk on the part of the subcontractor, provide items listed in RFP Part II- 6.b above, as they relate to the potential subcontractor.

APS does not plan to subcontract responsibility to administer substantially all of our responsibilities under the agreement. APS will be the prime contractor and retain responsibility for the majority of responsibilities under the agreement. A list of our subcontractor partners and their functions are detailed in Section II-3.27, Contracts and Subcontracts.

e. The Offeror shall explain how it will fund development and start up costs, including the source of funds. Provide information and documentation to enable the Department to conclude whether sources have and are committed to providing the expected funds.

All costs associated with the implementation of this program will be covered through a

APS has a fully integrated budgetary and financial accounting system. Each contract has its own cost center, and management monitors and analyzes revenues and expenses on a monthly basis. Funds expended for a particular contract must be compared against the contract budget and approved by management depending on the dollar amount.

f. A statement as to whether there are any outstanding legal actions or potential claims against the Offeror over services related to those being sought in this RFP and a brief description of any settled or closed legal actions or claims against the Offeror in the past three years.

APS has provided a listing of outstanding legal actions or potential claims against APS over services related to those being sought in the ACCESS Plus RFP. Additionally, we have provided a brief description of any settled or closed legal actions or claims against APS and its parent company, APS Bethesda in the past three years.

Person or Entity	Date of Inception	Caption of the Action	Brief Description of the Action	Current Status/ Disposition

Person or Entity	Date of Inception	Caption of the Action	Brief Description of the Action	Current Status/ Disposition
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

II-7. Objections and Additions to Standard Contract Terms and Conditions

The Offeror will identify which, if any, of the terms and conditions contained in Exhibit O (Standard Contract Terms and Conditions) of the draft ACCESS Plus Agreement (Appendix A) it would like to renegotiate and what additional terms and conditions the Offeror would like to have included in the terms and conditions. The Offeror's failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Department may consider late objections and requests for additions if to do so, in the Department's sole discretion, would be in the best interest of the Commonwealth. The Department may, in its sole discretion, accept or reject any requested changes to the standard contract terms and conditions. The Offeror shall not request changes to the other provisions of the RFP, nor shall the Offeror request to completely substitute its own terms and conditions for the draft ACCESS Plus Agreement (Appendix A). All terms and conditions must appear in one integrated Agreement. The Department will not accept references to the Offeror's, or any other, online guides or online terms and conditions contained in any proposal. Regardless of any objections set out in its proposal, the Offeror must submit its proposal, including the Cost Submittal, on the basis of the terms and conditions set out in Exhibit O (Standard Contract Terms and Conditions) of the draft ACCESS Plus Agreement (Appendix A). The Department will reject any proposal that is conditioned on the negotiation of the terms and conditions set out in Exhibit O (Standard Contract Terms and Conditions for Services) of the draft ACCESS Plus Agreement (Appendix A) or to other provisions of the RFP.

APS has read Exhibit O (Standard Contract Terms and Conditions for Services) of the draft ACCESS Plus Agreement (Appendix A), and will comply with such terms and conditions.

April 15, 2009

Jennifer Basom
Project Officer
Department of Public Welfare
Division of Procurement
Room 525 Health & Welfare Building
Commonwealth Avenue and Forster Street
Harrisburg, PA 17120

Re: Request for Proposal (RFP) 44-08 Re-issued ACCESS Plus

Dear Ms. Basom:

On behalf of Innovative Resource Group, LLC d/b/a APS Healthcare Midwest (APS), we thank you for the opportunity to submit our proposal in response to the above-referenced RFP re-issued by the Commonwealth of Pennsylvania's Department of Public Welfare (the Department) for Enhanced Primary Care Case Management and Disease Management Services. APS provided separately bound Appendices as a part of our prior technical submittal. We do not wish to change the Appendices; and ask that the previously submitted Appendices be included in our current submission.

The ACCESS Plus Program delivers exceptional value to the people of the rural counties it serves, and this RFP builds on that value with coordination, information and Disease Management support for Enrollees and Primary Care Providers (PCPs).

APS has carefully read the Department's RFP and we applaud the holistic and comprehensive vision that the Commonwealth has presented in this RFP – an innovative Total Health Management approach to care for the ACCESS Plus population. The mission of APS is to deliver Total Health Management services to our customers, and we welcome the opportunity to fulfill our mission in partnership with the Commonwealth of Pennsylvania as part of the ACCESS Plus Program.

A leader in the field of Medicaid care management, APS develops and delivers effective strategies to engage providers and Enrollees in the challenge of improving healthcare and achieving meaningful and sustainable improvements in the quality of care delivered to Enrollees. Our proposal is aligned with the goals and objectives of the ACCESS Plus Program to:

- Improve access to primary care and provide a medical home for children and adults.
- Improve access to health care services for Medical Assistance (MA) recipients.
- Improve the quality of health care available to MA recipients.
- Provide access to care management.
- Stabilize Pennsylvania's MA spending.
- Support the principles and strategies of the Prescription for Pennsylvania (Rx for PA) initiative.

Should APS be selected for this important program, the Commonwealth will realize key benefits as a result of APS' advantages:

- An existing presence in Pennsylvania through our Southwest Pennsylvania Health Care Quality Unit (HCQU) Program. This program has been acknowledged by CMS as a *"promising practice"* and APS has delivered on this promise for people with intellectual and developmental disabilities. APS has also developed strong ties with many of the Commonwealth's counties and agencies, such as the Office of Developmental Programs (ODP) and the Office of Mental Health and Substance Abuse Services (OMHSAS).
- A full-service office already in Harrisburg, Pennsylvania. This office will serve as an implementation base for our ACCESS Plus Program, to be expanded for our office-based staff, affording a high level of access for, and coordination and communication with, the Department and other Commonwealth agencies.
- Experience managing healthcare programs serving more than 20 million people. Our administrative and Disease Management expertise is an ideal mix for enhanced ACCESS Plus Program performance. We have over 14 years of disease management and lifestyle behavior change experience, and currently support 41 Medicaid Programs in 20 states and the Commonwealth of Puerto Rico.
- APS has relevant Pay for Performance (P4P) experience through our Medicaid contracts with the State of Wyoming (EqualityCare) and the State of Missouri, and offers innovative ideas to promote the ACCESS Plus P4P Program.
- Partnerships with Pennsylvania-certified Disadvantaged and Enterprise Zone businesses such as Adept Consulting, Black Consulting Services, BT Consulting LLC, and ProgenyHealth. These experienced small businesses add value to our solution and will support enhanced services for Enrollees and PCPs in education, technology training and support, coordination of the Regional Advisory Committees, and case management for fragile populations.
- Fulfillment support from PRWT Services, Inc., a former Pennsylvania-certified disadvantaged business and now one of the premier minority enterprises in the nation.
- Exceptional ability to address healthcare needs and interests in the ACCESS Plus area through our partnerships with the Pennsylvania State University Center for Health Care and Policy Research and the Pennsylvania Association of Community Health Centers. Through these relationships, APS can access expert clinical insight for

conditions new to the Disease Management Program, and assure access to Pennsylvania's network of Federally Qualified Health Centers and others.

- Health information technology with APS CareConnection® and My Health Direct® to support PCP Medical Homes and facilitate diversion from medically unnecessary emergency room utilization.
- Experienced support for the Department's SMI Innovation Project, through our expertise in behavioral health (especially with pharmacy issues), our Care Management system, field-based Health Coaches and Care Coordinators, and through APS' partner Southeast Consultants, who bring specialty expertise in analysis of pharmacy patterns and trends.

Furthermore, in accordance with the RFP requirements, APS:

- Certifies that neither APS nor any of our proposed or current subcontractors are currently under suspension or debarment or are precluded from participation in any federally funded health care program by the Commonwealth, any other state or the federal government.
- Certifies that no conflicts of interest exist between APS and our proposed subcontractor(s) and the requirements of this RFP. APS will also abide by the conflict of interest standards identified in the RFP's Exhibit O (Standard Contract Terms and Conditions for Services) and Exhibit P (DPW Addendum to Standard Terms and Conditions) of the draft ACCESS Plus Agreement (Appendix A).
- Will comply with all of the requirements outlined in the RFP, our proposal and the Agreement if selected.

I will serve as the primary contact for the Department's RFP Project Officer. My contact information is provided below:

	Primary Contact
Name & Title	[redacted]
Address	44 South Broadway, 12th Floor White Plains, NY 10601
Telephone	[redacted]
Fax	[redacted]

We welcome any questions or ideas you have regarding our proposal and we look forward to forging a successful partnership with the Commonwealth, to serve your ACCESS Plus Enrollees, their providers and the Pennsylvania community.

Thank you for your consideration of our proposal, and if further information is needed, please do not hesitate to let me know.

Sincerely,

[redacted]

II-2 Statement of the Problem

The ACCESS Plus Program is a primary care case management (PCCM) system that features a "medical home" – a designated Primary Care Provider (PCP) – for each ACCESS Plus Enrollee in the 42 county ACCESS Plus area where mandatory managed care programs are not offered. ACCESS Plus is an *enhanced PCCM* program, delivering greater value to Enrollees, Providers, and the Department. These enhancements – for example, care coordination; disease and case management; Enrollee education and outreach; provider enrollment, management, and education; and an integrated information environment to manage and improve the quality and medical necessity of care – are designed to improve access to appropriate primary, specialty, dental, and behavioral healthcare for over 300,000 program Enrollees. These enhancements will be delivered by the ACCESS Plus vendor – a contractor that will be responsible for building the infrastructure to empower Enrollees, facilitate coordinated care through a high quality provider network, and speed actionable information throughout the system so that Enrollees, providers, and the Department can make informed decisions at all levels – personal, professional, and program-wide. This infrastructure creates a *healthcare neighborhood* for the PCP medical home that strengthens both performance and accountability – a context for medical professionals that is rich in timely information delivered to the point of care and a context for Enrollees that is rich is caring support, motivation for self- care, and is above all person-centered and holistic. This context is the public program environment in which APS has excelled for more than a decade. In this section we describe our organization, current trends we have observed in the industry, and our comprehensive approach to meeting the requirements of ACCESS Plus with exemplary customer service.

APS will advance ACCESS Plus goals to:

- **Improve primary care access and provide medical homes for children & adults**
- **Improve access to health care services for MA recipients.**
- **Improve the quality of health care available to MA recipients.**
- **Provide access to care management**
- **Stabilize Pennsylvania's MA spending**
- **Support the principles and strategies of the Prescription for Pennsylvania (Rx for PA) initiative**

Provide an overview of the proposing organization that highlights the Offeror's key strengths that are relevant to this project.

APS received its first public program contract in 1999 to provide External Review services to the State of Georgia's Division of Mental Health, Developmental Disabilities, and Addictive Diseases. From this single state we have grown to a national company supporting 41 Medicaid programs in 26 states and the Commonwealth of Puerto Rico – facilitating the delivery of high quality medical and behavioral healthcare services across the continuum of people served by public programs. In the 10 years since we began serving Medicaid agencies, we have developed three key strengths that have made us successful and are highly relevant to this project: information technology, location, and people.

State of the Art Information Management: APS CareConnection®. APS CareConnection® is a proprietary, web-based, and HIPAA compliant information system. It enables sharing of health data among APS clinicians, patients, network providers and customers, through a person-centered data system that consolidates clinical data, integrating multiple data sources such as claims data, pharmacy data, Health Risk Assessment results, symptoms reported by Enrollees and providers, and embedded screening tools such as the PHQ-2 and PHQ-9

screening tools for depression. Patient assessments documented within APS CareConnection® support comparisons of condition progress and transitions between risk status, with integrated predictive modeling scores, interactive secure email between providers and the APS team. The system prioritizes patients and tasks for APS Health Coaches and Care Coordinators. APS will configure this system to meet the requirements of the ACCESS Plus Program and will auto-populate the care plan with a model care management plan that PCPs can use to manage the care of ACCESS Plus Enrollees –**ALL** ACCESS Plus providers will have access to this state-of-the-art system with no purchase of additional hardware or software beyond existing office systems and Internet service providers. In addition, the Department will have read-only access to Enrollee records through APS CareConnection® for monitoring and reporting.

Dedicated Service Center Model. The Department requires that staffing for this program be based in Pennsylvania, with key personnel located in Harrisburg when not in the field. This requirement is an APS best practice: clinical and management staff members are based in the state and in close proximity to our clients. This operational model has been field tested in 26 states – including Pennsylvania, where our well-respected Southwestern Pennsylvania Healthcare Quality Unit (HCQU) delivers training on crucial healthcare issues for healthcare providers serving people with intellectual and developmental disabilities. We know that all healthcare is really local – and so therefore are our people, who bring their knowledge, experience, and relationships with them to the benefit of our programs. This approach brings acceptance among the provider *and* consumer communities because we know these communities – after all, we live there, too.

The APS Team. APS CareConnection® supports the science of our award-winning Disease Management Programs; the APS Health Coach is the heart and soul of our success. Registered Nurses with backgrounds in community health and chronic care, Health Coaches work in the field and at the Call Center to provide 24/7 sympathy and supportive advice to the Enrollees we support. APS pioneered the community-based Health Coach because we know it takes more than a telephone voice to empower Medicaid Enrollees to adopt successful self-management skills – it takes a real person reaching out to help people gain the courage and determination it takes to manage chronic illness. Our Health Coaches are supported by Care Coordinators – staff members with health education, social work, and behavioral health backgrounds as well as Peer Specialists, consumers who have been program recipients and who therefore understand the concerns and questions Enrollees have. Our management teams support these front line staff members and our dedicated Executive Directors have the responsibility and authority to deliver the exemplary customer service that our clients expect.

Our corporate approach leverages APS core capabilities, and we recruit key local and other partners to complement our strengths. With APS providing our core capabilities of contract management, information systems, care coordination, and disease management, we have recruited a team that provides significant resources for the ACCESS Plus Program and the Department – resources to ensure we can meet the needs of today and the challenges of tomorrow. We are proud that our team features four businesses certified as Disadvantaged Businesses by the Pennsylvania Bureau of Minority and Women Business Opportunities (BMWBO); two are also Enterprise Zone businesses:

- **BMWBO-certified Disadvantaged Businesses:**
  - *Adept Consulting Services: A certified Minority Business Enterprise, Adept currently supports the Department's information systems.

- *Black Consulting Services: A certified Women-owned Business Enterprise, BlackCS provides training and documentation services.
- BT Consulting LLC: BTC is a certified Minority-owned business and professional staffing company, with technology and project management expertise.
- ProgenyHealth: ProgenyHealth is a certified Women-owned Business Enterprise specializing in case management of high risk neonates, with documented reductions of re-hospitalizations and Emergency Room utilization for these fragile babies.

- **Analytic and Information Technology Partners**
  - Pennsylvania State University Center for Health Care and Policy Research (CHCPR): CHCPR joins APS to provide significant clinical and research resources for ACCESS Plus.
  - Southeastern Consultants, Inc. (SEC): SEC brings their innovative profiling algorithms to the critical task of identifying Enrollees whose care and health status can be improved through better coordination of services, including pharmacy, medical, and behavioral health services.
  - My Health Direct®: A revolutionary approach to Emergency Room diversion, My Health Direct® will be available to ACCESS Plus vendors at no charge to use for resource scheduling.
  - WB&A: An NCQA-accredited CAHPS vendor, WB&A has participated in the accreditation program since its inception.

- **Outreach and Communication Partners**
  - Pennsylvania Association of Community Health Centers (PACHC): PACHC's members provide a significant proportion of primary care to ACCESS Plus enrollees, and PACHC joins APS to assist with provider outreach and education. CME credits will also be provided through PACHC.
  - PRWT Services, Inc.: A Pennsylvania company and former certified-MBE, PRWT is now one of the nation's outstanding minority enterprises, providing communication and distribution services.

Discuss current trends or challenges associated with Primary Care Case Management (PCCM) and Disease Management, and specifically, key issues and considerations for the Commonwealth's ACCESS Plus Program. Include how the Offeror proposes to incorporate these advances in services delivery.

Based on our experience with Medicaid programs on a national level, we have identified key dynamics that continue to be subject to debate and development: responsibilities of the primary care provider (PCP); emergence of the "medical home" as a critical response to health care costs and the burgeoning rate of chronic disease in the overall population as well as Medicaid; the role of pay for performance and/or participation; and the impact of health care technology on primary care/medical homes. In the DM field there are two prominent trends that we see emerging: acknowledgement of the impact of behavioral health issues on physical health and chronic disease care and the shift from condition-centric Disease Management to person-centered total health management. We discuss the DM trends first as they form part of the larger context of primary care case management and relate directly to emerging views of the primary care medical home within the healthcare neighborhood of specialty, pharmacy, dental, institutional, community-based, and behavioral health services.

* Also Enterprise Zone businesses.

With recent information from the Substance Abuse and Mental Health Service Agency concerning the impact of behavioral health on physical health, greater attention is being given to implications of these findings for DM. DM providers are searching for ways to deliver chronic care management that addresses the impact of behavioral health disorders *and* their treatments. For example, a side effect of some behavioral health medications is the development of metabolic syndrome – a precursor of diabetes if not addressed. With adherence to medication and medical regimens a critical component of successful self-management of chronic illness, severe mental illness presents an even greater burden on individuals with medical co-morbidities. At the same time as the industry struggles with the extremes of mental illness and chronic disease, it also acknowledges the gains to be achieved through programming that succeeds with body/mind integration. This type of programming addresses physical health and recognizes that mental health contributes significantly to its achievement – and combines programming that delivers interventions strengthening both mind and body.

The shift from a fragmented focus on individual diseases to a holistic health management emphasis – as required by the current RFP – is aligned with the trend we see toward mind/body integration. Aside from the expensive overlap of services that a fragmented approach entails, it can also be bewildering to Enrollees who are not sure which program does what, and infuriating to providers who receive multiple mailings about different programs for the same Enrollee. Our analyses found over [redacted] DM eligible Enrollees with two or more co-morbidities. For these Enrollees, a "single disease state" approach becomes operationally incoherent. APS has been a pioneer in the effort to develop holistic, person-centered programming, and we present a holistic approach in our proposal for integrated and comprehensive interactions with program Enrollees, providers, and the Department. Trends in primary care case management show similar shifts in thinking about a comprehensive and integrated approach.

The Role of the PCP. In 2000, Rosenbaum and her colleagues reported that almost 50% of Medicaid recipients were enrolled in some form of managed care.[1] In 28 states, managed care programs included Primary Care Case Management. These programs included provisions that were common across all state programs concerning the responsibilities of primary care case managers:

- … the contracts are highly similar in the broad scope of both clinical and administrative duties assigned to PCCMS in patient care, coverage determinations, and specialty care management.
- While all contracts exclude one or more classes of benefits from either provision of care or case management responsibilities, many contracts contain important ambiguities regarding what is "in" and what is "out," particularly in the area of EPSDT services.
- The contracts require service to all sub-populations... clinical primary care responsibilities as well as varying degrees of responsibilities for the management of clinically complex cases, including oversight of specialty coverage and use of resources by specialists.[2]

The Connecticut Health Project noted in 2006 that almost 25% of Medicaid enrollees were served by PCCM programs in 26 states. On January 1, 2009, Connecticut became the 31st state to offer a primary care case management program for Medicaid enrollees with pilot enrollment for Husky A members.[3] Goals include

[1] Rosenbaum, S.; Stewart, A.; Sonosky, C. (2000). Negotiating the New Health System: Findings from a Nationwide Study of Medicaid Primary Care Case Management Contracts. Washington, DC: Center for Health Services Research and Policy, The George Washington University.
[2] Ibid., page 4.
[3] State of Connecticut, Department of Social Services, August 25, 2008.

improving overall medical outcomes while reducing unnecessary emergency room visits. This increased expectation for the PCP role is a trend in Medicaid.

The Person Centered Medical Home. Early efforts in performance measurement identified the importance of a usual source of care for the delivery of primary and preventive healthcare. With a growing percent of Americans without health insurance – and without a usual source of care – the medical home concept gained importance in the national debate about healthcare improvement. HRSA reported in 2008 that women with a medical home are more likely to receive preventive care, to receive continuous care, and to have lower hospitalizations and healthcare costs. In 2007, the American Academy of Family Physicians issued principles to guide dimensions of "medical home:"

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** – the personal physician is responsible for all of the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, including care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

As this description indicates, the characteristics of the PCP in a PCCM program are significantly aligned with the concept of a medical home. This alignment – viewing the PCP as a "medical home" is a significant trend in PCCM programs, and one that is promoted by the physician community.

Pay for Performance/Pay for Participation. While PCCM programs offer considerable benefits for Medicaid recipients, their effectiveness has not been broadly documented in literature – and early programs did not feature careful management of service delivery and roster payments. Pay for Performance (P4P) programs provide incentives for PCPs to deliver specific preventive and primary care services for PMPM payments. P4P programs link additional premiums to improved performance on selected performance measures, as does Pennsylvania ACCESS Plus.

Health Information Technology. Identified as a significant enhancement to patient safety by the Institute of Medicine, efforts to encourage the adoption of health information technology (HIT) have increased with growing interest in healthcare reform to reduce the cost of care. The view of HIT as a means to improve quality and patient safety and reduce cost is also a trend in Medicaid.

Challenges and Opportunities. Each of these trends offers great promise for Medicaid programs in general and PCCM programs in particular. In the ACCESS Plus region as in many other areas, many offices are single or small practices. In a presentation at the 2008 Disease Management Leadership Forum, Deloitte reported that HIT could cost as much as $100,000 for each practice. Without the benefit of an information system to facilitate patient management, expectations for medical homes, coordination of care, linkage to community resources, and the management of complex chronic disease across primary and specialty care is a daunting task for the family physician – especially in rural areas where clinical and other resources may be scarce and widely distributed. How does APS propose to advance the benefits of these trends in the face of such

challenges? We start with the IOM's focus on health information technology, with APS CareConnection® serving as the information highway in the ACCESS Plus healthcare neighborhood.

We then enhance our foundation of technology with communication and coordination skills; our lay educators, behavioral health professionals, and administrative personnel. Care Coordinators bring the Healthcare Neighborhood to the door of the Medical Home, facilitating communication with specialty providers, the county-based behavioral health system, dentists, and community-based resources. Strengthening the PCP Medical Home are APS Health Coaches, field and Call Center-based Registered Nurses who bridge the gap between home and office. Health Coaches empower Enrollees for better self-management; they are an "extra set of hands" for hard-pressed PCPs and office staff. With a tool kit of resources that encompasses systems, people, and shared information, we help PCPs realize P4P goals and benefit from this important program. Promoting patient-safety and quality through consistent, positive feedback, we help PCPs with details of care planning, medication management, and coordination. With our significant background in behavioral health, we are a credible resource for PCPs caring for Enrollees with severe mental illness and serious emotional disturbances. From our operational model that ensures we are viewed as insiders on day one to our proactive presence in the community, we strengthen the relationship of Enrollees and physicians – enhancing medical homes.

Describe the Offeror's experience and familiarity with the project area in general, including its understanding of the medical, educational, social and economic needs of the target population and the communities in which they live.

APS has conducted extensive out reach to regional stakeholders to understand the environment in which ACCESS Plus performs. As Lisa Davis, Director of the Pennsylvania Office of Rural Health explained, "Pennsylvania is considered to be one of the most 'rural' states in the nation, with almost 2.8 million residents living in areas that are designated as rural. The economic, cultural, social, geographic, and demographic characteristics of rural communities are sufficiently different from those of urban and suburban communities to require special consideration."

With county ACCESS Plus populations varying from 855 in Forest to over 43,000 in Luzerne (according to our analysis of SFY 2007 data) the ACCESS Plus region includes small, rural counties as well as larger population centers. Access to care can be challenging. With approximately 80 hospitals in the region, county-based hospital listings indicated that eight of 42 counties (Monroe, Pike, Snyder, Potter, Juniata, Montour, Forest, Cameron, and Sullivan) do not have inpatient hospitals. According to a report distributed to the Consumer Sub-Committee in October, 2008, as of September 30, 2008 almost 66% of ACCESS Plus provider sites were restricted or closed, possibly accounting for anecdotal concerns about access submitted to that Committee and the Regional Advisory Committees. However, the highest Provider Site to Enrollee ratio documented in that report was 572 to 1 in Mifflin County; the lowest was in Sullivan County, with a ratio of 250 to 1. This indication of relatively good access can be misleading; depending on availability of specialties and site restrictions, access varies significantly between regions.

In the current economic environment, the small businesses that are characteristic of rural areas are under even greater employment pressure, and we can expect the unemployment ranks to grow in the next contract period, bringing with them greater membership in ACCESS Plus that has already been observed. Medical homes will also be stressed and individuals with chronic disease will need greater social and medical support. As rural hospitals struggle to keep beds filled, interest in diverting emergency room utilization will wane; this

resource will seem a viable option to meet extended office hour and location needs. A resource historically playing a key role in rural communities – the county Extension Office – can play an even greater role in health education for poor, rural communities. Similarly, school systems and churches will also provide a focus for community activation and a resource for communication to the broader community. The distribution of providers, the age of Enrollees, and the rural character of the ACCESS Plus region also suggests that community-based organizations and even retailers will be valuable partners – churches, volunteer organizations, WalMarts, grocery stores, and drug stores will serve as "point of sale" locations for APS to reach Enrollees. With the average age of all enrollees at 22, customary communications methods will have to be extended to YouTube, Facebook, and Twitter. APS lay educators will have accounts, and be reachable by young Enrollees through Instant Messaging and social network sites – our experience is that although ACCESS Plus Enrollees may be young and poor, they will be more like their counterparts in the private sector in terms of their communication preferences and messaging.

APS knows rural healthcare and has been part of helping Medicaid agencies address rural issues for over a decade. We currently support programs in rural states such as Arkansas, Georgia, Maine, Oklahoma, Vermont, and West Virginia. To know these areas and serve them well companies have to be *in* them and their people have to be *from* them. We pioneered dedicated, local service centers and field-based Health Coaching precisely in response to the needs of rural areas and under-served populations.

Describe the Offeror's understanding of the selected Offeror's role in furthering the Department's goals and overall mission for the ACCESS Plus Program, including plans to improve the quality of care and improve the health outcomes of ACCESS Plus Enrollees while controlling costs.

We understand our role to be that of a dedicated partner to the Department in furthering the mission and goals of the ACCESS Plus Program – providing flexible and cost-effective solutions as the program evolves to keep pace with changing needs in the ACCESS Plus region. We are the voice of the Department in the local community, relentless in our compassion for people who are struggling with chronic disease, mental illness, or special needs and just as focused on helping people achieve their goals of self-empowerment, wellness, recovery, and community inclusion. As a [redacted] Enrollee wrote us in 2008, "In summary, what has involved years of dealing with illness resulting in needless frustration is remedied within a couple of months since my call to the Chronic Care Improvement Program." For providers, we are experienced professionals and a trusted source of information for themselves and their patients. In the 2008 survey conducted by The Myers Group for the Wyoming HealthyTogether! Program, **87.5%** of individual physicians said they were satisfied or very satisfied with the "overall benefit of HealthyTogether! to support treatment plans, provide 24/7 education and help patients make positive behavior changes to improve their health." Across our health management programs, APS improves quality and controls cost – helping our clients remove the excessive cost of poor quality and uncoordinated care.

The Department can expect no less of APS for the ACCESS Plus Program. For the PCCM population as a whole, we will focus on healthcare neighborhood development: strengthening the network and increasing rates of essential primary and preventive care, and increasing coordination between system components, especially between medical and behavioral healthcare. In the Disease Management program, our emphasis will be on identifying Enrollees with *uncoordinated care* and working closely with Enrollees, providers, families, and their communities to improve care coordination. This approach facilitates a shift from medically unnecessary and expensive care to more effective and efficient settings; provides feedback to providers; includes one-on-one

health coaching with Enrollees, and engages the community in health and wellness initiatives to improve population health as a whole.

Describe the Offeror's understanding of the role of the program's advisory committees, specifically the Regional Advisory Committees and the Quality Management Committee.

APS is accustomed to working with advisory committees, a feature of most our Medicaid programs. In this proposal we suggest a new role for regional committees – as Regional Ambassador Councils. Too often, Medicaid recipients are asked for their opinions but not their contributions to the advancement of important program goals. We believe that county-based Enrollees and Providers have the most at stake in the quality of the ACCESS Plus Program and can make significant contributions to peer education, activation of the local community to identify and provide needed resources – such as childcare and supplementary transportation, and outreach to both new Enrollees and potential ACCESS Plus providers. We have planned to support the Regional Ambassador Councils with training resources, a full-time Coordinator, and on-going support to make this new approach successful.

In the same way, we see the Quality Management Committee (QMC) as both a significant resource for local provider feedback and a clearinghouse for clinical quality improvement opportunities. We propose to present our ongoing quality and other reports to this group. In addition, the QMC will help us develop the provider survey and interprets its results, offering insight into findings that is needed to make those findings *actionable*. APS is a strong supporter of learning collaboratives, and proposes an adaptation of the IHI collaborative model in our approach to provider education. We will enthusiastically staff the QMC, and this effort will be the responsibility of the ACCESS Plus Medical Director and QI Manager.

Describe the Offeror's ability to work closely with stakeholders, including local Providers, local resources and governmental programs.

APS embraces collaboration with stakeholders, and has conducted outreach to many in Pennsylvania:

- The Hospital and Health System Association of Pennsylvania.
- The Mental Health Association of Pennsylvania.
- The Pennsylvania Osteopathic Medical Association.
- The Pennsylvania Association of Community Health Centers.
- The Pennsylvania Office of Rural Health.
- Pennsylvania Health Law Project.
- Pennsylvania State University School of Medicine.
- Pennsylvania Medical Society.
- The Academy of Pediatrics, Pennsylvania Chapter
- Individual Pediatricians in Warren, Lackawanna, Tioga, and Potter Counties.
- Geisinger Health System.
- The Academy of Family Practice.

APS also attended the Medical Assistance Advisory Committee meetings and the Consumer Sub-Committee meetings as part of our efforts to identify stakeholders and become familiar with the interests and concerns of these committees. In our discussions with stakeholders we identified organizations with the mission and capability to provide exceptional value to the ACCESS Plus Program. We are therefore proud that the Pennsylvania Association of Community Health Centers and the Pennsylvania State University, Center for Health Care and Policy Research have joined us as partners.

As we explain in our technical proposal, we also understand the resources needed to engage stakeholders and maintain a positive, interactive relationship. During implementation, and with the Department's direction, we will identify stakeholder organizations and agencies relevant to the ACCESS Plus Program. The APS Management Team will be responsible to contact these organizations and establish on-going meetings, identify areas where collaboration and coordination are needed, and also identify other stakeholder organizations with which we should communicate. Also with the knowledge and approval in advance of the Department, we will gladly participate in meetings, attend presentations, and provide support for the ACCESS Plus constituency – for example, attending local health fairs. This approach is yet another benefit of the APS dedicated service center model – with decision-making located in the community, we are able to develop the close relationships that are needed to promote program interests and achieve ACCESS Plus goals.

Describe how the Offeror will incorporate principles from Governor Rendell's Prescription for Pennsylvania (Rx for PA) into the ACCESS Plus Program.

Rx for PA is a set of integrated strategies to eliminate inefficiencies in the health care system, better manage chronic conditions, expand access through inclusion of new providers, implement common sense insurance reforms, and offer access to affordable health care insurance to the uninsured. These concepts are the foundation of our proposed approach to the ACCESS Plus Program, and are exemplified in APS team proposal features addressing key principles of the Prescription for Pennsylvania:

- **Rx for Quality: Prescription for Pennsylvania changes how we pay for health care to focus on improving quality, enhancing patient safety and promoting wellness.**

From the decades of experience APS and its people bring to our programs, our constant focus is on quality of care – care that meets the six aims of the Institute of Medicine for the 21st century healthcare system: safe, efficient, effective, timely, person-centered, and equitable. Enrollees can promote this "prescription" through self-efficacy – the courage to take charge of healthcare and health status. Providers promote this goal through adoption of evidence-based medicine, efficient management of workflow, and strategic use of information to improve care for underserved populations. APS will promote the Rx for Quality through a consistent person-centered approach, proactive education programs for both Enrollees and Providers, and intelligent, actionable, timely, and evidence-based feedback that Enrollees can use to increase their self-management skills and Providers can use to reduce variation in their application of evidence-based guidelines. As active members of the ACCESS Plus clinical community, the APS Medical Director, Health Coaches, and Quality Improvement staff will be present in the day-to-day delivery of healthcare in the ACCESS Plus region, helping to close the gap between evidence and practice and serving as the infrastructure for ACCESS Plus – creating a close-knit healthcare neighborhood as the environment in which primary care medical homes will flourish.

- **Rx for Access: Prescription for Pennsylvania expands access for all Pennsylvanians to the right kind of health care, from the right provider, at the right time, in the right place, for the right cost.**

Our commitment to this principle starts with a rigorous program of recruiting eligible primary care, medical, and dental providers to join the ACCESS Plus Program. Enhancing the required field-based Provider Representatives, APS has augmented its approach with a specialized Call Center Help Desk dedicated to the provider community (in addition to the overall provider resources in the Call Center). With enhanced levels of customer service, a world-class integrated care management information system – available to all ACCESS Plus providers – and information-based practice supports available in a variety of formats, APS has planned the

information, education, and outreach resources to ensure that both Providers and Enrollees recognize and promote the right care, from the right provider, at the right time, and in the right place. Working together, the ACCESS Plus community can achieve this vision for all ACCESS Plus Enrollees. Key to achieving the goals of quality and access is chronic disease care.

As the diagram in Table 2-1 shows, the Total Health Population Management approach that APS proposes is consistent with the Chronic Care Model – supporting self-management and enhanced chronic illness care. This model also shows *in italics* elements that are essential to recovery and resiliency for Enrollees with mental illness, which we address with understanding and support.

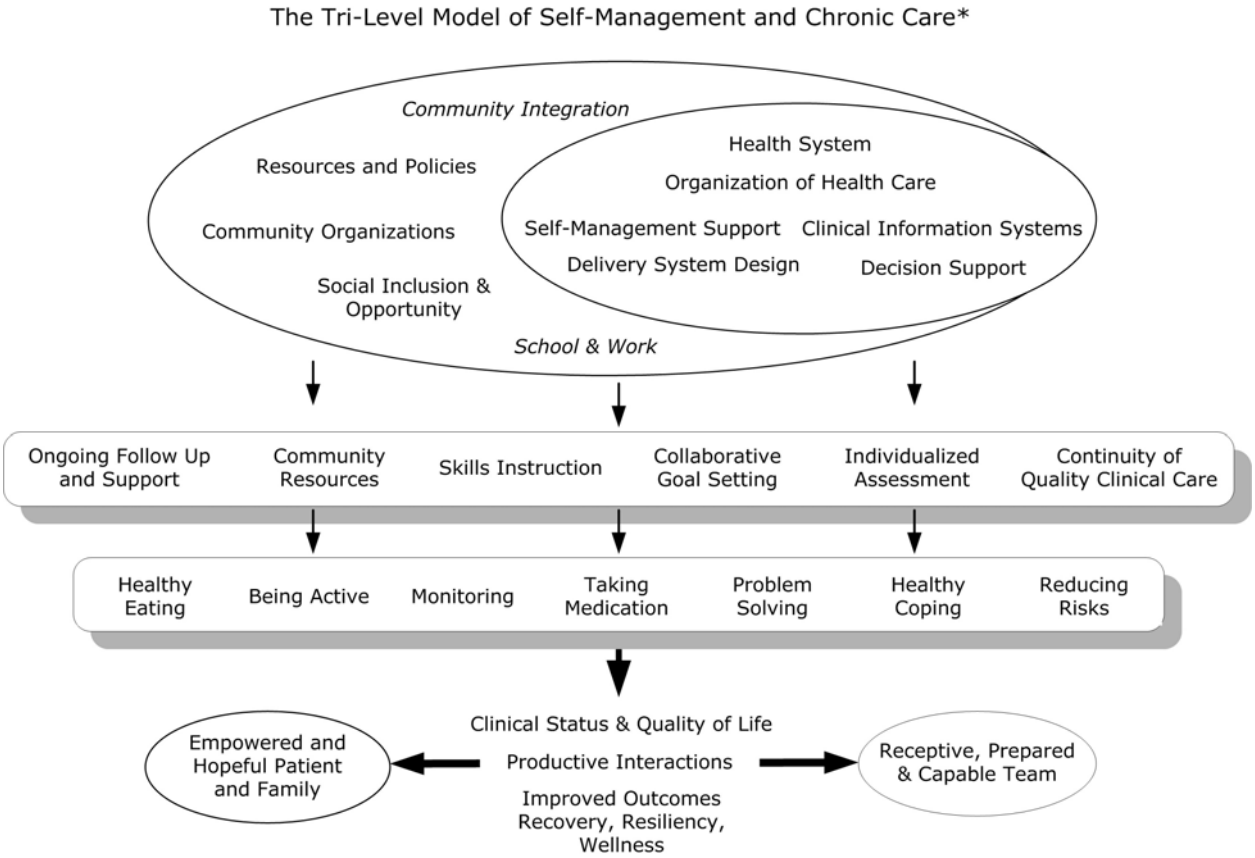


Table 2-1. Chronic Care Model Adapted from Improving Chronic Illness Care
(*Developed by Dr. Ed Wagner and adapted by APS to show behavioral health factors and interventions)

- **Rx for Affordability: Prescription for Pennsylvania provides that uninsured Pennsylvanians will have access to affordable health insurance.**

For each dollar spent on medically unnecessary, ineffective, and uncoordinated care, Pennsylvania sacrifices a dollar for coverage of Pennsylvanians without healthcare insurance. APS works to preserve scarce public resources by decreasing the tragic burden of uncoordinated and wasted care – on Medicaid Enrollees who are underserved, on Medicaid providers who struggle to serve this often difficult population, and on Medicaid agencies, who strive on a daily basis to ensure that vulnerable populations receive the healthcare, social service, and community-based programs they need. Our focus on uncoordinated care is a key strategy to lessen its burden on the Medicaid system – improving quality and stabilizing cost to create resources that can

then be used to expand coverage. As we demonstrate throughout our proposal, the people of APS – across the country and in Pennsylvania – are ready to help the Department achieve that success for ACCESS Plus.

In his recent budget address, Governor Rendell acknowledged that Pennsylvanians have learned to "do more with less." In this light, the Department has proactively adopted efficiencies for greater cost effectiveness. The ACCESS Plus Program is also poised to do more with less – less fragmentation of care, more holistic focus on achievement of healthcare goals, more visibility to ACCESS Plus Enrollees and providers through community partnership, and more effective delivery of healthcare services. APS is ready to join the Department in this effort and do more for the people of Pennsylvania and ACCESS Plus.

II-3 Work Statement

10. EPSDT SCREENS

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is a required benefit for all "categorically needy" children under the age of 21, i.e., those with poverty-level income, who receive Supplemental Security Income (SSI) or who receive federal foster care or adoption assistance. Health risks intended to be addressed by EPSDT highlight these concerns: "Low-income children covered by public insurance are more likely to be born at low birthweight, which increases the risk for lifelong disability,[1] and more likely to be in fair or poor health, to have developmental delays or learning disorders, or to have medical conditions (e.g., asthma) requiring ongoing use of prescription drugs.[2]" Serious health conditions affect 80 percent of children in foster care. For these children, Medicaid is essential to ensure access to preventive and developmental services.[3] For ACCESS Plus, ensuring the delivery and reporting of EPSDT services are major elements of responsibility. As the discussion in this section indicates, they are also areas of major focus for the APS team. We propose innovative approaches that draw on the core capabilities of APS and its expert partners with active participation from local communities.

The EPSDT Program covers essential services for children in ACCESS Plus. APS will engage Enrollees *and* local communities through outreach and education to increase awareness and provide PCP-friendly tools to track services.

A. Describe in detail the Offeror's operational procedures for coordination and monitoring of EPSDT services. Include detail about how the Offeror will:

1. Conduct Enrollee outreach to educate Enrollees about EPSDT and follow up with Enrollees who do not remain current with the periodicity and immunization schedule.

APS proposes an innovative approach to Enrollee outreach and education about EPSDT that will improve utilization of program benefits by ACCESS Plus Enrollees under the age of 21. In our experience with the [redacted] million Medicaid Enrollees we serve through our URAC-accredited case, disease, and utilization management programs, Enrollees are more likely to become engaged and stay engaged when they have an active role in their health, healthcare, and public programs. For this reason, we propose to form Regional Ambassador Councils to provide not only local input into program design, management, and operation but to also be active in outreach to enrollees at the county level. Helping to educate Enrollees, their family members, and PCPs about the importance of EPSDT services will be a major focus for the Regional Ambassador Councils. APS' partner Black Consulting Services, a certified woman-owned and Enterprise Zone located small business, will create Enrollee-friendly training materials that "translate" clinical descriptions into information to be delivered by Enrollees and community-based organizations at the county level. For example, rather than expect lay Council members to explain the "periodicity schedule of immunizations" required by the Department, we

[1] Hack, M, Taylor, HG, Drotar, D., et al. (2005). Chronic Conditions, Functional Limitations, and Special Health Care Needs of School-Aged Children Born with Extremely Low-Birth-Weight in the 1990s, *Journal of the American Medical Association*, 294(3), p. 318–25.
[2] Ku, L, Nimalendran, S. (2004). *Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP* Washington, DC: Center on Budget and Policy Priorities.
[3] Markus, A, Rosenbaum, S, Stewart, A, et al. (2004). *How Medical Claims Simplification Can Impede Delivery of Child Developmental Services*. New York: The Commonwealth Fund.

would train them to explain that children need more than one set of shots to be protected against childhood diseases.

The purpose of this approach is to provide multiple and alternative outreach efforts to all components of the population – Enrollees, PCPs, and the healthcare neighborhood – to increase awareness of the span and importance of EPSDT benefits. This comprehensive and integrated approach reaches all population segments with a unified message about EPSDT.

As important as it is to create this understanding and awareness at the theoretical level, it is just as important to ensure that parents are alerted when their eligible children have not received services to which they are entitled. Using the Department's Billing Guide for EPSDT Services (in **Exhibit 8**) to identify EPSDT services in claims data, APS will track delivery of these services on a monthly basis. We explain how we will conduct tracking in our response to Section II-3.10.A.2 below. When we identify gaps in service, we will first notify the PCP that claims data may be incomplete for that Enrollee. The purpose of this step is to provide the PCP with the opportunity to validate the gap and address it through billing or actual service delivery. After the initial notification to the PCP, APS will follow up with Enrollees' parents by issuing an "ACCESS Plus Parent's Letter" from the APS Medical Director that recommends parents contact their child's PCPs to ensure that services are both documented and delivered. The PCP letter will also reference the Parent's Letter so that PCPs are aware that parents will receive information about EPSDT services that should be delivered.

In addition to notifying parents and the PCP, APS will also update the Enrollee's record in APS CareConnection® so that we can monitor the delivery of service after these notifications have been complete. Using the PCP tracking report and APS CareConnection® Enrollee queues to identify Enrollees, APS Care Coordinators will work with individual PCPs and Enrollees to ensure that EPSDT services are delivered, billed, and documented. We will prioritize Enrollees according to the number of services that are pending as well as the length of time that service gaps have been identified. For example, APS would follow up first with Enrollees (and their PCPs) with service gaps involving multiple immunizations and developmental screenings that have been profiled for more than 30 days.

2. Develop and maintain an electronic system to track Enrollees' EPSDT screening and immunization status to confirm Enrollees have received all required EPSDT screens.

APS understands PCPs and other providers need easy to use tools that help offices identify Enrollees with EPSDT screening and immunization needs and then manage the scheduling process to ensure all Enrollees receive EPSDT services on a timely basis. Such a tool would enable office staff members to quickly sort Enrollees by Access Plus number, age, gender, and services that need to be scheduled, for example, so that staff members could identify Enrollees with age-specific immunization needs or developmental service needs. Across our 41 Medicaid programs in 20 states and Puerto Rico, APS strives to reduce administrative burdens on providers and their offices so they can focus on delivering high quality, person-centered care to Medicaid Enrollees. We will bring this same commitment to EPSDT service tracking.

APS will integrate eligibility, claims, and provider data in our information system, to create an electronic tracking system that will enable us to notify both PCPs and Enrollees about missing EPSDT services. EPSDT profiles will list the Enrollees (including Enrollee identifiers) as well as categorizing the immunization and screening services that need to be scheduled and delivered. Profiles will be available through the provider portal on the ACCESS Plus website so that providers can download them with their rosters on a monthly basis.

The profiles will be created in Microsoft® Excel Spreadsheet format so that offices can sort the listing by any field and quickly group Enrollees for notification and follow up. To make it easier for offices to generate notifications, we will provide model letters in Microsoft® Word that can be created by mail-merging selected spreadsheet rows. These letters will also be distributed in a format for printing without mail merge as well as in hardcopy format so that offices without relevant software/hardware can still use the model letters to notify Enrollees of needed services. Because we know some PCPs may have limited access to the Internet to download files, we will make the monthly profiles available on CD-ROM to PCPs as well. We will ask PCPs to select a format as part of their enrollment process and then deliver monthly profiles in that preferred format.

This initial approach will create a low-burden system that PCPs can use to improve their own EPSDT tracking and increase delivery of timely services. As step two in our system, APS will implement an EPSDT tracking system that is integrated with APS CareConnection®. This more advanced tracking system will feature an EPSDT tab as part of the provider dashboard that PCPs can use to view, sort, or print their EPSDT queue of Enrollees with pending services. The queue will link to an Enrollee-specific EPSDT service screen that can be used to view and enter EPSDT services for that Enrollee. APS will populate the service screen using claims data and data from the immunization registry; providers can then review each Enrollee's services at the individual level. The system will also create the spreadsheet for providers to download and use with their mail merge letters. We understand that the Department is working on an electronic screen for providers to use for EPSDT, and we will work with the Department to ensure that APS resources complement this approach. Should providers not use APS CareConnection®, we will continue to create the spreadsheets for them to access through the ACCESS Plus website. With complete and timely data about utilization of EPSDT services, APS will assist with the annual CMS-416 form for reporting to the Centers for Medicare and Medicaid Services (CMS).

3. Assist Enrollees by coordinating referrals and medically necessary follow-up treatment resulting from an EPSDT screen.

APS Health Coaches (Case Managers) will use our electronic EPSDT tracking system to identify Enrollees with follow-up needs. In addition, the Enrollee Handbook will also inform Enrollees who need assistance with referrals and medically necessary follow up that APS is available for this purpose on a 24/7 basis through the toll-free Enrollee line. To ensure that providers are also aware of this service, we will include a similar statement in the Provider Handbook.

APS Health Coaches and Care Coordinators will be available to facilitate referrals and follow up after EPSDT screening. As with all our procedures, APS provides a caring and flexible resource that Enrollees can depend on for help with locating physicians and scheduling services. This approach is especially important when screening results indicate a potential problem. APS helps to coordinate referrals and medically necessary follow-up through:

- **APS Call Center:** APS Call Center staff – Health Coaches and Care Coordinators – will work individually with Enrollees and their parents to help families understand EPSDT screening results and discuss their options for follow-up. With Social Workers and Behavioral Health Professionals as part of our Care Management team, APS staff members are well-versed in the services that Enrollees will need as a result of EPSDT screening.
- **My Health Direct®:** My Health Direct® is an Internet-based coordination system that organizes available medical and resources within geographical and schedule parameters. Using My Health Direct®, APS can quickly locate PCPs with open appointments in proximity to Enrollees. After securing a referral from the

PCP office either by telephone or email, APS staff can then select a convenient appointment and notify the provider by fax. A reminder note is also sent to the Enrollees' parents with information about the appointment, and APS CareConnection® is updated to show the referral so the PCP is aware.

- **PCP Offices:** APS resources are also available *directly* to the PCP offices – including APS CareConnection® and My Health Direct®. We strengthen the Medical Home with provider-friendly tools that promote communication, coordination, and follow-up, especially of important EPSDT screening results.

APS has been recognized by the industry for our success with care management programs, where we routinely coordinate referrals to medically necessary care, but the real reward for our success comes from the people we help:

> **"I think it is all great. Now there is someone to talk to who understands."** –
> [redacted] Client.

4. Monitor PCP compliance with appointment standards and EPSDT screening requirements, including a description of what the Offeror will do if it identifies PCPs who do not meet the performance standards.

As appointment standards are defined in Appendix A, PCPs must meet the following requirements for access to care: (a) Emergency Medical Condition cases are immediately seen or referred to an emergency facility; (b) Urgent care appointments are scheduled within twenty-four (24) hours; (c) Routine appointments are scheduled within ten (10) Business Days; and (d) Health assessment/general physical examinations are scheduled within three (3) weeks of Enrollment. APS uses a multi-faceted approach to evaluate the extent to which PCPs comply with appointment standards, and in particular with EPSDT screening standards.

Identifying and Resolving Concerns

We first establish and emphasize the standards through the Provider Handbook and on-going training. We cross-walk standards between the Provider Handbook and the Enrollee Handbook to ensure expectations are consistent between Enrollees and their PCPs. Provider tip sheets will be available for offices that summarize appointment standards as well as EPSDT services (for example, the Billing Guide). During orientation we alert Enrollees to appointment standards as well as the availability of preventive and screening services for ACCESS Plus Enrollees under the age of 21. These efforts create a common ground of understanding concerning appointment standards and EPSDT requirements – which are complex and numerous.

We then monitor PCP compliance with the ACCESS Plus Supplemental Agreement and PCP Handbook at a systems level through regular audits of PCP offices as we propose in II-3.22. We also evaluate the results of CAHPS® surveys for feedback about access to care. On a detail level, we monitor Enrollee access through complaints and grievances, calls to APS for assistance in making appointments, and other related activities, such as requests to change an Enrollee's PCP. We consolidate these different sources of information into an overall assessment of PCP accessibility – especially in complying with follow up to EPSDT screening results by scheduling additional tests, prescribing medications, or referring Enrollees to developmental services.
When we identify and document an access concern with a PCP the ACCESS Plus Medical Director will call the office to discuss the concern directly with the provider. We follow up this step with a site visit by the area Provider Services Representative and a Health Coach or Care Coordinator to verify that the office has appropriate policies and procedures to ensure timely compliance with appointment standards. We also validate that the office is aware of and has procedures to address follow-up to EPSDT screening results. Often, appropriate follow-up fails when offices do not have timely access to test results. In these circumstances we

also recommend corrective action for office and the laboratory communications to improve information flow between the entities. We then monitor on-going activities through multiple measures, including claims profiles for the provider to monitor patient throughput, follow-up calls to both the PCP and Enrollees, and documenting referrals in APS CareConnection® so that Health Coaches can remind Enrollees of upcoming appointments that have been established.

APS will compare data regarding individual provider performance to identify providers who have patterns of non-compliance. For providers with consistent patterns of non-compliance, we notify the agency so that more rigorous action can be taken, for instance, freezing the roster or suspending the supplemental agreement. These are actions of a serious nature and would not be contemplated by APS without significant discussion with the Department.

B. Describe in detail the Offeror's plan and operational procedures for EPSDT Enrollee outreach. Include in the description how the Offeror will:

1. Educate Enrollees about procedures.

EPSDT program benefits are a complicated set of services at varying timeframes through childhood and adolescence. Enrollees will need frequent reminders about services, as well as other supporting information to help them understand what this benefit involves.

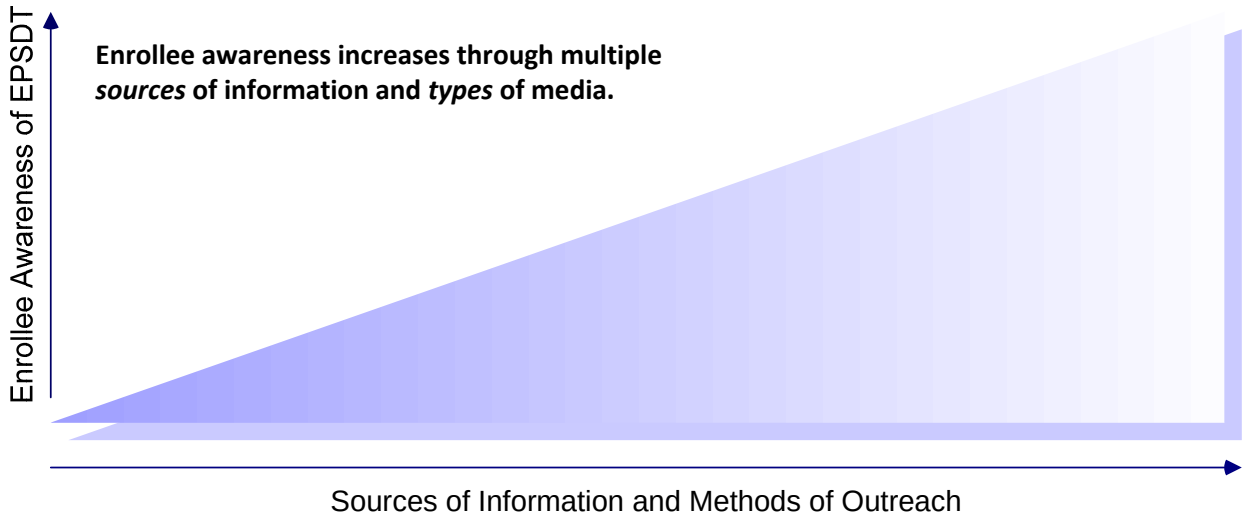


Table 12-1. Communication Model for EPSDT

The APS outreach plan is designed to use comprehensive and complementary outreach procedures through APS Health Coaches, Enrollee stakeholders, and PCPs to increase awareness and utilization of these important services.

APS will comply with all requirements listed in the **Draft ACCESS Plus Agreement, Section A.12 – EPSDT Screens** including ensuring that new Enrollees under the age of twenty-one (21) will have a scheduled

appointments for EPSDT screens within thirty (30) days of their enrollment and that a minimum of 3 attempts (by phone, home visit, and/or mail) will be made to schedule their initial appointment.

As the illustration in **Table 12-1** indicates, Enrollee awareness cannot be created with a single effort at communication of EPSDT benefits to Enrollees only. Our plan for Enrollee outreach therefore takes into account a variety of media available in the ACCESS Plus region, the context of community stakeholders, and a program that continues through the life of the contract.

Table 12-2 below presents our plan for Enrollee outreach and communication for EPSDT benefits. As this plan indicates, APS will target specific segments of the stakeholder community with relevant information to increase awareness of EPSDT services; the importance of follow-up after screening; the need to conduct services across childhood and adolescence; and the roles of relevant stakeholders (primarily parents and PCPs) in this effort. By reaching related segments (Community, PCPs) of the target audience (parents) with easy to use information (tips, checklists), APS creates a shared understanding of what EPSDT entails; why it is important; how to access EPSDT services; and what to do if there is a positive result on a screening test.

Table 12-2. APS Plan for EPSDT Outreach & Communication

Activity/Audience		Focus/Goal
Enrollees	Initial Care Coordinator call to parents of new Enrollees.	Confirm age of EPSDT-eligible Enrollee; explain EPSDT services – "Every Parent Should Do This"; confirm knowledge of PCP assignment. Set appointment with new PCP, identify and address questions and concerns. **Goal:** Ensure parents of newly enrolled children know what services to expect for their children.
	Welcome packet to parents, including CDC "Positive Parenting Tips" in English or Spanish.	Provide basic information about expected age-specific level of functioning with practical suggestions for healthy parenting; Enrollee Handbook about EPSDT services. **Goal:** Establish expectations at beginning of enrollment for utilization of EPSDT services, with information parents can use to assess development.
	EPSDT Monitoring for parents to alert them to gaps in EPSDT services or follow-up.	Quarterly "parent update" to remind parents that their children are behind on recommended immunization and screening services. **Goal:** Parents will call an APS Health Coach for assistance making an appointment for EPSDT services.
Providers	Provider Handbook with EPSDT insert for both medical and dental providers.	Alert providers and office staff to the need to engage Enrollees' parents about EPSDT services, with "Positive Parenting Tips" that offices can download or order; service expectations for providers and Pennsylvania billing guide for EPSDT services. **Goal:** Ensure documentation on provider responsibility for EPSDT.
	EPSDT Monitoring to identify gaps in service at the patient level.	Notify PCPs with easy to use information about gaps in EPSDT services for Enrollees on their roster. Identify follow-up to screening results; help providers use schedule referral appointments. **Goal:** Ensure PCPs actively promote EPSDT services.

Table 12-2. APS Plan for EPSDT Outreach & Communication		
	Activity/Audience	**Focus/Goal**
Community-based	Regional Ambassador Council (RAC) Outreach to Communities	Enrollee focused Outreach and communication efforts to activate community- and faith-based organizations with information about EPSDT services and benefits to constituencies. **Goal:** Create community awareness of the important of EPSDT services and follow-up referrals.
	Quality Management Committee Outreach to local PCPs	Ensure program-wide focus on EPSDT; alert PCPs to RAC activities, availability of provider information and materials PCPs offices can have for Enrollees. **Goal:** Activate clinical community around delivery of PCP services.
	Outreach to adjunct stakeholders – pharmacies and other high-traffic retailers	Calls and notices to CVS, Walgreen, Rite Aid and other standalone pharmacies; Wal-Mart and Kmart stores; grocery stores, etc. to explain "Every Parent Should Do This." **Goal:** Create environment of awareness and support for delivery of EPSDT services.

As we have emphasized throughout the proposal, we believe that a medical home functions best in the context of a healthcare neighborhood with a strong information infrastructure. EPSDT is a program that delivers essential services to a population that, if well-served in the present, may better achieve its future potential. APS is a proactive partner for the Department to realize this important goal for low income ACCESS Plus children.

2. Follow-up with Enrollees who do not remain current with the periodicity and immunization schedule.

As we explain throughout this section, APS Health Coaches, Care Coordinator, and especially Peer Specialists will reach out directly to parents and Enrollees who are not current with the EPSDT service schedule. Beginning with an overall campaign during the initial enrollment period, when Health Coaches or Care Coordinators will conduct an orientation call with parents about membership in ACCESS Plus, we will provide detailed information that will help parents schedule appointments and keep their children's immunization schedule up to date. An example of the CDC Positive Parenting Tip for Children Age 0-1 Year old is included in **Exhibit 9** in both English and Spanish. Materials such as the Positive Parenting Tips will be included in parents' welcome packages. This information will be echoed in the Enrollee Handbook as well as in materials distributed through the PCPs and community organizations and businesses.

Complementing this general awareness campaign will be specific follow up for individual Enrollees who are not current with the immunization schedule. Using the Pennsylvania Children's Checkup Program Periodicity Schedule and Coding Guideline (**Exhibit 8**) to identify expected immunizations for specific age groups, the electronic tracking system we discuss in this section will compare immunizations that have been administered to those expected. This comparison will identify missing immunizations (to the extent that providers bill consistently with this Guideline). As we state Item II-3.12.A.1, APS will notify the PCP to indicate missing immunizations. We will also reach out to parents to let them know that their children should be scheduled for certain immunizations. The first step in this process is for a Peer Specialist to call the parent. This Specialist has

been recruited for Enrollee Outreach as a Peer of enrolled consumers. The Peer Specialist will call the Enrollees' parents to let them know there is a gap in immunization.

APS will continue to monitor the immunization status of the Enrollee on a monthly basis. If after the first 30 day period the gap remains, an APS Care Coordinator will place a call to the Enrollee to schedule an appointment and also call the PCP office to confirm the appointment. If necessary, APS will continue reminding parents and PCPs concerning the need for immunizations until the gap is closed or the parent declines the service. During this time, APS will also continue to notify the PCP about gaps in immunizations so that PCP offices can work with APS to ensure Enrollees receive the full schedule of immunizations.

3. Use data to enhance outreach efforts.

APS uses a data driven approach to inform Enrollees and PCPs about opportunities to improve the delivery of evidence-based services. For example, the 2007 HEDIS measure for Use of Appropriate Medications for People with Asthma was 85.7%, an increase of 8.1% over 2006. An outreach card to parents of Enrollees with Asthma, in this instance, might ask their help to ensure their child with asthma is one of the nearly 90% of children who receive the right medications. It can also be useful to share information about the percentage of services that have been delivered. The illustration in **Table 12-3** presents an example of this approach. It provides a color-coded immunization "map" that shows immunizations by birth age and highlights where documentation of services indicates a possible gap. The Important message is for the parent to contact the PCP rather than try and explain the individual immunizations.

The extent to which Enrollee reports such as the one in **Table 12-3** below can be completed for Enrollees will depend on the nature and availability of Enrollee-level immunization data. Where possible APS will blend data into our communications to explain gaps between services recommended and those received; to help parents and guardians understand how individual enrollee records compare against the general population, and to engage parents and guardians in the effort to increase utilization of medically necessary services.

All communications should also encourage parents (or older Enrollees) to call the ACCESS Plus Enrollee line for help they may need – scheduling an appointment, interpreting the results, or finding out more about EPSDT.

You've Got a Green Light for Your Baby!

Our records show your baby is between 2 and 4 months of age, and might be missing some shots. Talk to your PCP about shots your baby needs to be safe from childhood illnesses – your PCP knows what to do! Or, call ACCESS Plus at 800-555-1212 - we can help make sure your new baby is safe and healthy.

Every Parent Should Do This!
The Right Vaccinations for Your Child

Vaccine▼ Age▶	Birth	1 Mo.	2 Mo.	4 Mo.	6 Mo.	12 Mo.	15 Mo.	18 Mo.	19-23 Mo.	2-3 Yrs	4-6 Yrs
Hepatitis B	●	↔	↔		↔	↔	↔	↔	↔		
Rotavirus			●	●							
Diptheria, Tetanus, Pertussis			●	●	●		↔	↔			●
Haemophiles influenza type b			●	●		↔	↔				
Pneumococcal			●	●	●	↔	↔			Some Children	
Inactivated Poliovirus			●	●	↔	↔	↔	↔			↔
Influenza					↔	↔	↔	Every Year	↔	↔	↔
Measles, Mumps, Rubella						↔	↔				●
Varicella						↔	↔				●
Hepatitis A						↔	↔	2 Doses	↔	Some Children	
Meningococcal											

● - Shots are Up to Date! ● - No Records for these shots! ● - Not Due Yet

Table 12-3. Enrollee-Specific Immunization Reminder

As with all communications to Enrollees, language should be at a 6th grade level; messages should be positive and linked to actions Enrollees can easily take.

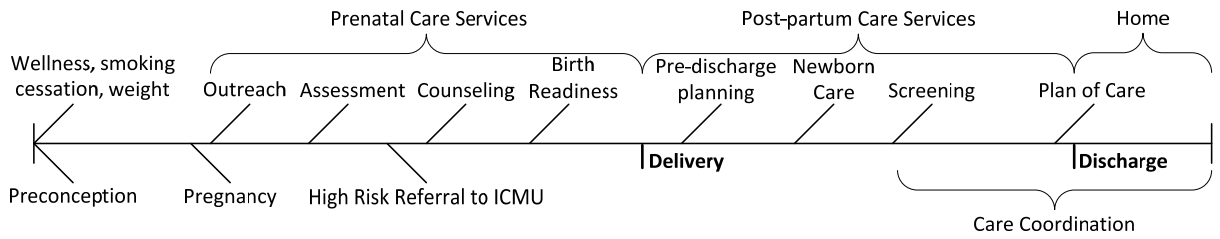
C. Describe whether the Offeror currently links or will link to the Department of Health immunization registry.

APS will link to the Department of Health immunization registry. For APS, linking to the immunization registry means that our Internet care management system, APS CareConnection® will be configured to accept an extract from the immunization registry. The extract will be formatted according to Department specifications, and will include Enrollee identifiers (name, address, parent/guardian, Medicaid number, Social Security Number, date of birth) as well as immunization data. APS will then use these data in conjunction with claims data to profile the Enrollee's immunization status for the PCP and the Department. The use of these data will contribute to efficiently completing the relevant HEDIS® measures as well as allowing APS to create more detailed and timely communications for providers and Enrollees.

II-3 Work Statement

13. SERVICES TO PREGNANT WOMEN

APS views services to pregnant women as a continuum of integrated support that begins at preconception and extends through the post-partum period for successful transition from pregnancy to parenthood – a total maternal-newborn solution.[1] This continuum is illustrated by the figure in **Table 13-1**. We explain our comprehensive approach in this section.



Please note that APS will comply with the requirements listed in the **DRAFT ACCESS Plus Agreement (Appendix A), Section B.15 – Services to Pregnant Women**.

A. Describe how the Offeror will coordinate with non-MA enrolled Providers through which women are already receiving prenatal or postpartum care at the time of enrollment.

To ensure that women can benefit from all of the services available to them, APS Health Coaches will reach out to Enrollees' Non-MA enrolled Providers regarding the maternity services offered as part of the HBP Program, encourage them to apply for enrollment, and act as the liaison between the Non-MA Provider and the Department to ensure an efficient enrollment process as well as continuity of care for their patients.

APS recognizes that some women may already be receiving prenatal or postpartum care from Non-MA providers at the time of enrollment. When Care Coordinators become aware that Enrollees are pregnant or have recently delivered a newborn (either through contacting the Enrollee during initial orientation or upon notification that the Enrollee is pregnant) they will update the eligibility file and identify the Enrollees' current physicians. To ensure that women can benefit from all of the services available to them, Health Coaches will reach out to Enrollees' non-MA enrolled Providers on the maternity services within the Commonwealth's Healthy Beginnings Plus (HBP) Program. This effort includes encouraging Non-MA Providers to apply for enrollment in the HBP Program and become HBP "qualified" providers so they are eligible to bill the Department for qualifying services. For those Non-MA providers who wish to participate in the HBP Program, our role will be to act as the liaison between the Non-MA Provider and the Department to ensure enrollment occurs as quickly as possible to ensure continuity of care for their patients. For those Non-MA providers who do not wish to participate in the HBP Program, our Care Coordinators will refer Enrollees to the EAP Contractor following

[1] Fetterolf, DE, Stanziano, G, Istwan, N. (2008). Application of Disease Management Principles to Pregnancy and the Post-partum Period. *Disease Management,* 11(3), p. 161-168.

procedures for obtaining a new PCP established for this reason.

B. Describe innovative strategies the Offeror intends to implement to encourage pregnant women to seek prenatal and postpartum care services. Describe how the Offeror will optimize the likelihood that Enrollees who are pregnant will initiate prenatal care in the first trimester, comply with scheduled prenatal visits and return for postpartum checkups. Identify potential challenges the Offeror anticipates when facilitating prenatal care for Enrollees and explain how the Offeror will mitigate those challenges.

There is evidence that specific factors are associated with delayed initiation of prenatal care. Beckman, Buford, and Witt reported in 2000 on results from a study of 110 women that wait times for appointments were a reason to defer care, along with both race and age as significant factors.[2] Rogers and Schiff found in their study that women who were not aware of their pregnancy and who disliked going to the doctor were less likely to initiate timely prenatal care.[3] Two larger studies help to confirm factors associated with delayed entry to primary care. In a 2000 study of 3,000 women with Medi-Cal coverage, researchers found that women who feared disclosure of their pregnancy were 47% more likely to delay care; women with unwanted pregnancies were 41% more likely; and those with unplanned pregnancies were 35% more likely to delay care. Participants not having a regular source of care were 35% more likely to defer care. Women with transportation barriers were 68% less likely to begin care in the first trimester. An additional factor was the age of the woman, with 18-19 year olds significantly more unlikely to not be aware of the pregnancy.[4] In this study, only 38% of women initiated care early in their pregnancy. A study of women in the New Jersey HealthStart program also found that when the pregnancy was unplanned, or women were ambivalent about their pregnancies, only 18% of women received timely care.

The cited figures indicate that both innovative solutions and "old-fashioned" outreach strategies are needed to help ensure women receive the prenatal care they need. We propose a set of information, outreach, and incentive strategies that begin at preconception and extend through the post-partum period for women who become pregnant to: (a) continue the strong performance of the ACCESS Plus Program for initiation of prenatal care in the first trimester (with a reported HEDIS measure of 89.54% in 2007); (b) increase the percent of women receiving greater than 81% of expected prenatal visits (72.02% in 2007); and (c) regain rates for post-partum visits (at 65.21% in 2007 down 8.24% from 2006).

APS is experienced in promoting a medical home in the Enrollees' healthcare neighborhoods – successfully linking Enrollees to a usual source of care, customary pharmacy, dental, and specialty care. APS will also work with the Department to identify and implement on-going strategies and incentives to healthy behaviors and lifestyles. For example, for Wyoming Medicaid's ***Healthy Together!...*****Healthy Additions** maternity health management program, we provide pregnant Enrollees with various types of educational materials including pregnancy books that discuss general pregnancy experiences if they attend expected prenatal visits. We also provide calendars to track the baby's growth, as well as tip sheets and booklets that are targeted to the

[2] Beckmann, CA; Buford, TA; Witt, JB. (2000). Perceived Barriers to Prenatal Care Services, *The American Journal of Maternal Child Nursing*, February, p. 43-46.
[3] Rogers, C; Schiff, M. (1996) Early versus Late Prenatal Care in New Mexico: Barriers and Motivators, *BIRTH*, 23 (p.l)
[4] Guttmacher Institute. (2000). Family Planning Perspectives, Volume 32, Number 5, 2000.

Enrollee's specific needs and concerns (e.g., breast feeding, nutrition, gestational diabetes, postpartum depression, etc.). Educational materials help Enrollees understand their pregnancy and the period after the baby's birth, and encourages Enrollees to adopt healthy lifestyle practices. We highlight examples of innovative strategies for ACCESS Plus in Table 13-2.

Reach young adults with educational messages through social marketing media.	
	Enrollee-focused: • Develop messaging for young adults on healthy lifestyles (preconception health). • Develop informal YouTube videos with APS Peer Specialists* talking about important health concepts (e.g., diet, smoking cessation, or visits to PCPs). • Establish Facebook membership for Peer Specialists to communicate with Enrollees. • Include email/cell phone signup on ACCESS Plus website for Enrollees 18-21 for text messages and emails. • Conduct screening campaign to identify substance abuse among Enrollees, conduct Peer Specialist and Health Coach outreach with motivational interviewing based on stages of change to evaluate readiness and facilitate movement along continuum of change. • Identify Enrollees turning 21 and ensure selection of and visit to adult PCP. • Select incentives (e.g., passes to local movies) that are attractive to young adults in exchange for well-visits to PCPs (for Enrollees without a visit in 12 months) or Enrollees who sign up to quit smoking.
	A specific at risk segment of the Enrollee population, young adults, will receive a focused campaign to promote healthy behaviors, establish a relationship with their PCP, and select one if they are turning 21. *Peer Specialists are a specific category of Member Services Representatives, selected for their socio-economic and demographic similarities to ACCESS Plus Enrollees.
Significantly improve continuity of post-partum care, include screening for depression.	
	Facility-focused: • Work with hospitals in the ACCESS Plus region to strengthen discharge planning, including using My Health Direct® to make an appointment for follow-up with their physicians *before they leave the hospital*. • Recruit and train Discharge Planners to use APS CareConnection® to set goals with new mothers for recommended post-partum care, including identifying transportation and child care needs. APS CareConnection® will queue Enrollees for follow up by Health Coaches. • Reach out to regional hospitals to include post-partum survey, such as the Edinburgh Postnatal Depression Scale, in post-natal discharge packets. • Recruit facilities not using APS CareConnection® to notify APS by telephone or email so that APS clinicians can work with women to establish follow up appointments, identify and resolve barriers, and screen Enrollees for post-partum depression.
	PCPs have concrete information about barriers to postnatal care and identify specific Enrollees for whom barriers may exist (e.g., age, transportation, childcare). Joint interventions by APS and PCPs address both clinical and community-based barriers.

The rapport built between Enrollees and their designated Health Coaches is essential to optimizing the likelihood that we can successfully encourage Enrollees to initiate prenatal care in the first trimester, comply with scheduled prenatal visits and return for postpartum checkups. Our Health Coaches are responsible for reaching out to Enrollees in the most supportive and compassionate manner. They act as the Enrollee's sounding board for any issues or concerns they may have, providing the Enrollee with advice, prenatal and postpartum education, identifying both barriers to care and risk factors, and locating appropriate resources to meet Enrollee needs. These needs include, for example, coaching mothers to reduce smoking and discontinue substance abuse; advising them on healthy lifestyle decisions; educating Enrollees on the signs of infection; advising Enrollees on reducing work hours and stress; helping Enrollees recognize the signs and symptoms of premature labor; and counseling Enrollees about family planning options. Through these on-going interactions, Enrollees build trust with their Health Coaches, which enables us to reinforce healthy pregnancy behaviors.

Mitigating Potential Challenges Regarding Prenatal Care

In addition to strategies we propose in this section, it is also important to recognize that leveraging community resources will enable us to reach a much broader audience than by our efforts alone. For example, we will develop relationships with Women, Infants and Children (WIC) Program providers throughout the ACCESS Plus region and ask them to encourage Enrollees to contact the ACCESS Plus hotline to self-identify. We will reach out to family planning providers with tools and information about ACCESS Plus so that they can encourage self-identification upon positive pregnancy tests. Identifying and leveraging family or additional support systems (e.g., churches, etc.) to ensure healthy prenatal behaviors are being reinforced by those closest to the Enrollee is another strategy to activate community resources. We will also analyze pharmacy claims data to identify women who have recently filled a prescription for prenatal vitamins, so that Health Coaches can conduct outreach calls. At enrollment and reenrollment (e.g., annually), APS will also identify women of childbearing age and provide education and written information, including the link to the ACCESS Plus Enrollee website, about the importance of pregnancy planning, folic acid, family planning availability and interconceptional/preconception care, as well as self-identification.

C. The selected Offeror will be responsible for managing care for low-risk pregnant Enrollees. The Department's Intense Medical Case Management Unit will manage high risk pregnant Enrollees. Describe how the Offeror will assist pregnant women with their health care needs, including providing case management services and information on the Department's Healthy Beginnings Plus (HBP) Program. Also, specifically describe the Offeror's approach for coordinating high-risk pregnancy case management services with the Department's Intense Medical Case Management Unit.

Under the ACCESS Plus Program, APS understands that we will be responsible for providing maternity case management services to low risk pregnant Enrollees. Each Enrollee will be assigned a Health Coach throughout their pregnancy, delivery, and the post-partum period. APS will identify pregnant Enrollees during welcome calls for new Enrollees by asking the Enrollee about her status. We will also profile pregnancy indicators on the eligibility file and create a roster of Enrollees for follow up. Once identified, an APS Health Coach will contact the Enrollee within five (5) business days of her enrollment (or within five (5) Business Days of when APS is notified that an Enrollee is pregnant) to identify or assist in identifying a maternity care provider for the Enrollee. The Health Coach will also communicate regularly with the Maternity Provider to ensure they complete the required Obstetrical Needs Assessment (OBNA) Form on schedule. We will then submit the OBNA forms to the Department's Intense Medical Case Management Unit (IMCMU) for risk level

determination. Please note that we will provide a monthly panel list of maternity care Enrollees to Providers indicating the Expected Date of Confinement (EDC) as well as the due dates for the OBNA Form updates.

On notification from the Department of low risk Enrollees, APS clinical staff will be responsible to call Enrollees within 10 Business Days of notification. During this call we will provide information about the HBP Program and identify Enrollees' preferences for on-going contact during their pregnancy. We will follow up the call with our "expecting mother" kit. The kit includes our self-care handbook, "Planning a Healthy Pregnancy," and "Caring for Your Baby" which have been included in **Exhibit 11**. For low-risk pregnant Enrollees, our Health Coaches typically call them on a monthly basis about appointment compliance, general maternity health education (the importance of prenatal vitamins and getting rest; balanced nutrition and increasing fluid intake; what food to avoid during pregnancy, including certain fish, cheeses, etc.; appropriate weight gain; and physical activity), ensure all appropriate procedures are occurring (e.g., ultrasound around week 20, glucose screening between weeks 24-28), and answer any other questions or concerns the expectant mother may have. We also work to ensure pregnant Enrollees are taking necessary medications (if applicable) and educate pregnant Enrollees on labor and delivery during the third trimester (e.g., what to expect, signs of infection and premature labor, when to call their OB provider, preparing for a child, breast feeding, post-partum depression, etc.). We also provide counseling about family planning options following delivery.

Pregnant Enrollees initially stratified as low-risk who become high-risk will be transferred to the Department's IMCMU. During implementation, we will develop interface policies and procedures to ensure our coordination is supportive of the Enrollee. This approach includes identifying a liaison at the Department's IMCMU for contact about high-risk cases to ensure IMCMU staff can access clinical information. APS CareConnection® will be available to all IMCMU staff for the Enrollees' clinical history and notes made by APS during routine interactions. APS will also collaborate with the Department's Division of Quality Management/ACCESS Plus and the IMCMU to develop and provide comprehensive reports that include reporting criteria for both high and low risk Enrollees in the maternity program as described in the RFP's Exhibit D, Required Vendor Reports. These reports will be developed with the assistance and expertise of APS' Health Intelligence Department, which is further explained in **Section II-5 Personnel**.

D. Describe how the Offeror will encourage follow-up and treatment of postpartum depression and related conditions such as drug and alcohol dependence and other mental illnesses. Include in the description how the Offeror will encourage Provider identification of postpartum depression and related conditions, and optimize follow-up surveillance, referral and/or treatment. How will the Offeror coordinate with BH-MCOs to provide services for postpartum depression and related conditions?

During the third trimester, our Health Coaches will begin educating pregnant Enrollees on expectations for the birth experience and the potential for postpartum depression: symptoms, prevalence, and how and when to notify their physicians. We will encourage facilities to notify APS concerning discharge and schedule appointments for follow up care through My Health Direct®. After discharge, Health Coaches will continue to talk with Enrollees on postpartum issues: depression; drug and alcohol abuse and second hand impact on children; and HBP benefits such as the availability of a postpartum home health visit. APS can also schedule the home visit through My Health Direct® if needed.

To encourage Provider identification of postpartum depression and related conditions, APS will obtain the OBNA Form from the Maternity Provider again during the postpartum period and submit information to the

Department. Health Coaches will also contact maternity providers serving HBP Enrollees to identify postpartum depression for low and high risk Enrollees. Providers will have a validated tool to facilitate screening, such as the Edinburgh Postnatal Depression Scale, specifically developed to assist PCPs in identifying postpartum depression.

APS will offer Providers a perinatal depression consultation line/email forum to assist them in identifying depression and managing medications; conduct ongoing Provider training and technical assistance to identify these issues; develop a CME on perinatal depression through multiple avenues (e.g., in office training, web based training and grand rounds) and involve medical organizations and associations, such as the Pennsylvania Psychiatric Society, in our provider training initiatives. We will also distribute medication guidelines to providers; identify behavioral health resources; assist in tracking referrals with provider feedback; and engage pediatricians in screening as they are more likely to see the mother during the postpartum period than other providers. We will work directly with Providers to remove the "stigma" against encouraging Enrollees to contact the ACCESS Plus Enrollee hotline. We will identify child-bearing age women through the eligibility and claims files who have been previously diagnosed with a mental health issue, and follow up with them when they become pregnant, as they may be at a higher risk for perinatal depression.

Health Coaches will reach out to Enrollees identified with post-partum depression on at least a bi-weekly basis for the next 60 days. Frequency of outreach calls may increase depending on the severity of the postpartum depression. Health Coaches will conduct additional postpartum depression screenings; ensure postpartum appointments are made and kept; assess if Enrollees were prescribed medication and if so, educate the Enrollee on the importance of medication compliance; reinforce providers' treatment recommendations; and answer additional questions or concerns. Health Coaches will follow-up with Providers, with the Enrollee's consent, to ensure appointments are kept and assist Enrollees to obtain transportation via MATP if needed.

Health Coaches will also assist Providers with referrals to the BH-MCO for behavioral healthcare services. Given APS' extensive experience in the behavioral healthcare industry, we are intimately aware of the importance of coordinating behavioral healthcare services to make the greatest impact in a member's overall health and well-being. As a result, APS will establish a single clinical point of contact for each BH-MCO, and conduct quarterly meetings with the BH-MCOs to identify and resolve both individual and general coordination and communication issues.

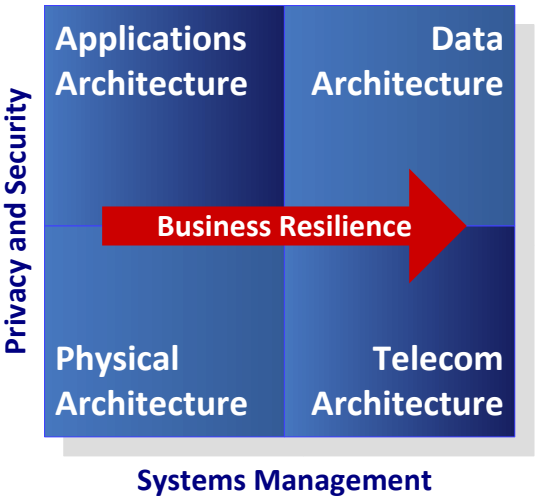
II-3 Work Statement

1. INFORMATION SYSTEMS

A. The Department wants assurances that the planned management information system has the capabilities to meet all Departmental requirements. Provide a general systems description and a systems diagram that describe how each component of the management information system will support the major functional areas of ACCESS Plus.

General Systems Description

The rationale for our approach and methods is based upon the successful launch of Medicaid care management programs in multiple states. As the systems diagram in **Table 1 – 1** at the conclusion of Item A illustrates, our MIS is closely tied to the APS dedicated service center model, which is ideally suited to meet the program and systems needs of ACCESS Plus. APS will implement an ACCESS Plus MIS with a combination of locally deployed systems solutions and cost-effective corporate infrastructure. APS CareConnection® is an essential feature of our approach, and is highly integrated into the APS care management architecture. It is a sophisticated, integrated care management system that has been successfully implemented in multiple sites with widespread provider adoption and client satisfaction. My Health Direct® is an essential feature of our MIS solution for ACCESS Plus. In this section we discuss our general systems approach as well as describing our applications, APS CareConnection® and My Health Direct®.



The APS IT environment is mature and robust relative to industry benchmarks. The technology infrastructure in use throughout APS is based on industry standards and best practices.

The chart in Figure IT-1 illustrates the overall architecture organization of the APS infrastructure. An enterprise architecture team maintains ownership over the enterprise frameworks in use, regularly updating, measuring and improving the infrastructure to enable IT to meet customer requirements quickly and economically. APS uses an enterprise architecture framework that incorporates best practices from numerous leading frameworks, including FEAF and TOGAF. Using defined measurements and metrics as the guide, the IT environment has the following attributes:

- Utilizes industry standards based in all sub-architectures.
- Adheres to best practices and frameworks, including TOGAF, ITIL, COSO, CobiT and CMMI.
- Managed with discipline including adherence to governance processes and performance of routine controls and reviews.
- Builds on an architecture that emphasizes collaboration and knowledge management.
- Focuses on agility and scalability to keep customers costs down.
- Contains a strong commitment to risk management, privacy and security.

Applications Architecture

The applications architecture is the heart of the IT delivery engine, consisting of the applications, integration and delivery processes for IT-based solutions. The development and delivery process is based on industry standards that enable APS to deliver services quickly and cost effectively. These attributes describe the applications architecture:

- Multi-platform: The delivery team has the capability to support the best platform for the customer, from desktop to Windows Server to Unix-based server solutions.
- Agile: The solutions developed are built with significant self-service configuration, allowing APS to configure the solution to meet customer requirements, thereby reducing the amount of IT investment needed. Additionally, by following industry standards and technologies, APS has the ability to quickly integrate solutions.
- Methodology: The IT organization operates on defined, industry-standard processes and methodologies, selecting the appropriate process for the situation. Example methodologies including the use of a Project Management Office (PMO), PMI-based project management methodology, RUP-based waterfall development methodology, and SCRUM-based iterative development methodology.
- Quality Assurance: All processes and release go through a discipline quality management process, including the use of a dedicated QA organization.

Data Architecture

APS has a world-class data architecture, leveraging the extensive skills of experienced data architects. All data is managed through an enterprise information architecture, which is focused on movement, management, enrichment, and consumption of data. APS employees use data quality management (DQM) for ensuring, maintaining, and improving the quality of data as it flows throughout the organization. The following attributes describe the data architecture:

- Architected: Data and information flows through applications using a purposeful, managed approach that takes the enterprise into account to maximize the value and structure of data. Data is fed into an Operational Data Store using ETL tools and applying semantic resolution, then structured in Data Warehouses for analytics and reporting.
- Security: Given our commitment to Enrollees and patients, privacy and security information is managed by service level agreements (SLAs), auditing, and metrics development. These appropriately measure confidentiality, integrity, and availability. Preventive, detective, and corrective security controls are used to assure security of information.
- Performance: The APS data architecture is architected to support very high volumes of data with excellent performance.

Telecommunications Architecture

APS has sufficient telecommunication capabilities, including electronic mail, to meet the requirements of the Department's Agreement. The telecommunications infrastructure consists of industry standard equipment and providers (e.g. CISCO, Avaya, AT&T, etc.). The overall telecom infrastructure is built on a high availability, fault tolerance framework on top of an MPLS. The architecture supports multiple protocols as necessary to support customer needs, such as FTP, S-FTP, S-MIME, Web-SSL, VPN, etc. Redundancy and fault tolerance is implemented per defined Service Level Agreements. All APS sites are connected via the MPLS to a high-speed backbone-based server infrastructure.

Physical Architecture

APS supports a multi-platform physical architecture at the server level. All servers are rack-mounted with managed interfaces in a controlled environment. The APS infrastructure focuses on maintaining a low total cost of ownership and high business resilience. Industry standard technologies are deployed, including virtualization, blade centers, distributed power management, enterprise storage management, and enterprise backup. The vendors of choice are IBM and Dell for Intel and Unix-based systems. The data center is located in Brookfield, Wisconsin, a suburb of Milwaukee.

Privacy & Security Architecture

APS is obsessive about security and privacy. APS maintains awareness and training programs around privacy and security. All employees are trained on privacy and security fundamentals, including HIPAA and relevant state and federal regulations/laws. APS has extensive documented policies governing processes that deal with all types of information, including protected health information. A security organization staffed with certified security professionals develops and maintains policies, audits compliance, and oversees implementation based around the National Institute of Standards and Technology (NIST) Standards. All internal and external systems are hardened with industry standard security solutions. Example security safeguards are highlighted below:

- Organizational Requirements:
  - Maintaining business associate agreements with third parties.
  - Development and continual updates of HIPAA and confidentiality policies and procedures.
- Technical Safeguards:
  - External systems are protected with perimeter and internal firewalls and intrusion detection systems.
  - Mobile devices are encrypted with remote wipe capabilities.
  - Active directory group policy is used to manage appropriate administration and security policies by user by device.
  - Two-factor authentication is used for remote access and laptops.
  - All sensitive data is appropriately protected through applicable mechanisms, such as encryption and access control.
  - Applications operate with tiered security role-based model. Employees can only access customers they support. Customer data is logically and/or physically separated (data from multiple customers is not integrated). Additionally, level of data visibility is limited by role.
  - Remote access is carefully controlled through VPN, PKI, and regular auditing.
- Physical Safeguards:
  - Physical security – badges, cameras, and guards.
  - Strong password rules with aggressive expiration and timeouts.
  - Desktop protection via port control, encryption, anti-virus, limited desktop rights, and desktop firewall.
  - Asset tracking and media reuse procedures.
  - Continual maintenance of physical locations and equipment.
- Administrative Safeguards:
  - Internal and external audits are conducted regularly.
  - Continual awareness and training program based on updated federal and state regulations.
  - Assigned Chief Security and Chief Privacy Officers.
  - Ongoing impact analysis in development of contingency plans.
  - Security incident procedures that include ongoing documentation and quarterly review.

- Clearance procedures in hiring new workforce members.
- Ongoing audit and corrective action process including sanctions.

Systems Management

The systems management architecture for APS is based on Information Technology Infrastructure Library (ITIL) best practices. The data center employs best practices for security, operations, and resilience. Numerous industry standard technologies are deployed in the data center, including environmental control systems, Tivoli systems management solutions, business continuity and site recovery, and monitoring and alerting. Relevant management practices are also implemented at the local levels.

Business Resilience Framework

APS has implemented a business resilience framework (BRF) to address the typical concepts of business continuity plans and disaster recovery. The objective of the framework is to align the resilience of the infrastructure with the SLAs and operational risk of the business and its customers. The goal of resilience is to ensure availability of the infrastructure, with solutions and processes that either absorb incidents without fault or apply secondary measures to address unavoidable faults.

The BRF plan addresses the three core aspects of business impact, including emergency response (e.g. bomb threat), crisis management (e.g. theft) and business continuity (e.g. telecommunications failure). The ultimate goal of the plan is data continuity for customers. SLAs are extracted from customer commitments to provide the operating guidelines for all aspects of the infrastructure. Plans are defined, maintained, and regularly tested to address the various incidents which may occur. After incidents occur and are resolved, groups meet to perform an analysis of the situation, with the focus on continually improving the BRF based on actual results.

Business continuity plans are defined and implemented in every office. These plans address a people, process and tool approach for the various types of incidents. The plans are regularly updated to keep current with changes in the business.

With respect to the worst-case-scenario, a total location outage due to catastrophe, a disaster recovery plan is in place. The plan consists of industry standards processes and techniques (e.g. a disaster recovery hot-site, documented resumption procedures, etc.). The disaster recovery plan is tested semi-annually.

APS CARECONNECTION®

In addition to our general management information system structure described above, APS would also like to describe our innovative system solution, known as APS CareConnection®, for the ACCESS Plus Program. As no state public program is like its neighbor, APS CareConnection® offers our public sector clients a highly developed and HIPAA compliant platform that is configurable to specific state requirements, effectively meeting each client's program needs.

APS specializes in program management services to public sector and commercial customers and is without conflict of interest in offering APS CareConnection® to *all* ACCESS Plus providers to:

- **Manage patient care plans.**
- **Alert APS to Enrollee concerns.**
- **Access data and reports.**
- **Interact with APS program staff.**

APS Care Connection® is our proprietary, integrated care management system. APS CareConnection® debuted in 1999 as the first web-based authorization tool used in

a statewide Medicaid program. APS CareConnection® is now deployed with [redacted] applications in [redacted] states. APS will adapt this innovative web-based system for use with the ACCESS Plus Program. We can assure the Department that this system *currently* provides functionality that meets the PCCM and DM scope of work as specified in **Appendix A, Section A.8**. We will configure this system during implementation to include specific ACCESS Plus PCCM and DM eligibility specificiations, claims data for all PCCM Enrollees, condition-specific plan of care algorithms for the DM program, and links to the Department's sites. Most importantly, this system makes it possible to integrate information across medical, behavioral, and non-medical providers. APS CareConnection® also offers capabilities such as decision support, patient registries, online evidence-based guidelines, integration with Preferred Drug Lists (PDLs), and other tools for the provider community. APS CareConnection® is linked throughout all of our internal departments and is able to seamlessly integrate eligibility, clinical claims, encounter claims, pharmacy claims, information gathered from Enrollees and providers, quality improvement efforts, and supplemental data we receive from the Department (i.e., PROMISe™, Medicaid Medical Review System, etc.).

The unique capabilities of APS CareConnection® serve as the infrastructure of the healthcare neighborhood, supporting the primary care medical home with a comprehensive, integrated, person-centered database. One of the most significant benefits to APS CareConnection® is that it represents a single source of information that houses all relevant care management tools – data, guidelines and criteria, Individual Treatment Plans, health status assessments, communications, and interventions – in a single site that is accessible to all providers and APS clinical staff. This integrated resource promotes the type of *productive interactions* that are essential in the Chronic Care Model and support provider teamwork.

APS CareConnection® combines quality management, data collection and care management tools, receiving and transmitting data through both file imports ("data-streaming" from community practice management systems) and/or direct data entry via our secure APS website. An important characteristic of "medical homes" for accreditation by the National Committee for Quality Assurance (NCQA) is the extent to which health information technology is integrated into providers' workflow. APS CareConnection®, with its integrated plan of care, represents an important resource for medical homes in the ACCESS Plus region, and will be made available to all ACCESS Plus providers free of charge. No sophisticated software or hardware needs to be purchased for APS CareConnection®. APS supports provider use of this resource with on-line help, a dedicated provider Helpdesk, and onsite regional Provider Representatives. We will provide training via multiple touches to ensure providers know how to use the system and are comfortable with the technology. During implementation and at the start of the program, we want the opportunity to meet with providers face to face to collaborate and identify what they need and to align our efforts with the Pennsylvania Medical Home Project and its intentions. Just as importantly, the Institute of Healthcare Improvement in Boston recognizes a plan of care for every patient as a key patient safety mechanism. The APS CareConnection® plan of care can be maintained by both APS and providers and can be printed for signed, hardcopy storage if needed.

APS CareConnection® has always been code-set compliant with HIPAA standards. We use standard ICD9 codes, and work closely with customers to resolve issues regarding the use of long-standing local code anomalies. APS will work with the Department and the providers in the state to assure that all code set needs are met. Our experience with our large base of providers and customers has taught us that the HIPAA standards are not completely uniform; one trading partner's definition and use of fields may vary significantly from another's. Many trading partners use optional fields to transfer information not covered in the standard, but needed to successfully transact the business. APS has a strong tool set and development team ready to successfully

address these issues. Using BizTalk and custom programming, APS is confident we can meet the Department's needs while complying with the federal standards and guidelines.

As a system that is currently in use in [redacted] states with [redacted] configurations, APS CareConnection® complies with state information technology standards. We are confident the APS information system also complies with the Department's IRM standards, including compliance with the IRM Business Partner Network Connectivity Provisioning Standards for connectivity to the Commonwealth's network. APS will comply with any changes made to the IRM Standards. We understand that whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of any MIS or IRM changes and that every effort will be made to provide earlier notice for complex changes.

APS CareConnection® currently interfaces with every major MMIS vendor, including EDS, ACS, and Unisys.

As a result, APS assures the Department that we will support data exchange with PROMISe™, CaseNET CaseManager™, Client Information System, and the Medical Management Review System.

APS CareConnection® is currently interfaced with every major MMIS vendor, including EDS, ACS, and Unisys. APS' information system will interface with the Department's data systems to exchange information and will transmit and retrieve all electronic data using a connection approved by the Department and CMS. APS assures the Department that we will support data exchange with PROMISe™, CaseNET CaseManager™, Client Information System (CIS), and the Medical Management Review System (MMRS).

Supporting major functional areas of ACCESS Plus, APS CareConnection® will feature the following advantages:

- **Outreach policies and procedures** will be documented in APS CareConnection® and record each contact with Enrollees, providers, and community resources regarding program information and operation.
- **Assessments** performed by the APS' Health Coaching team that can be viewed by any providers on an ongoing basis as treatment and progress ensue.
- **Enrollment/Disenrollment status** will include enrollment qualification data and reason(s) for disenrollment.
- **Enrollees' Individual Treatment Plans**, which include goals and interventions based on assessments and clinical progress reports, allow providers and their staff to review, approve care plans, and closely monitor Enrollee patterns.
- **Enrollee Education Services** include instruction given to Enrollees on appropriate use of health care services; risk-reduction and healthy lifestyles; self-care and management of health conditions; and advanced directives.
- **Enrollee Reminders** serve as tools to signal office staff to follow-up on laboratory work, schedule appointments and can be based on long-term patient goals.
- **Enrollee Profiles and an Automated Drug Use Review Alert Program** notifies providers as to whether a patient is actually refilling his/her medications as instructed and utilizing appropriate sources of health care service.
- **Links to Clinical Guidelines**, **Protocols and Enrollee educational materials** are offered in several locations on APS CareConnection® (We will also have links to Department regulations as well as nationally recognized associations such as the American Diabetes Association, the American College of Cardiology, etc.). In addition, providers will be able to see ACCESS Plus branded health education materials, as well as

links to information from nationally-recognized clinical organizations to support providers' own office-based disease management projects and general Enrollee education initiatives.

- **Provider Feedback Reports and Enrollee Record-Keeping Tool** show how each participating provider is performing on chronic illness measures such as HbA1c and lipid levels. Information also includes differences between recommended care, actual care and care by other providers with a similar population. The Patient Record-Keeping Tool includes data on drug therapy compliance, utilization of emergency rooms and hospitals, laboratory assessments, and other trend data on the Enrollee's health status.
- **DM Registry Look-Up Tool** enables providers to be able to view, print, and download a list of active DM program Enrollees who have chosen the provider as their PCP. Our ability to collect eligibility data will facilitate this process.

My Health Direct®

Building on our experience with providing care, APS understands the system and care management needs of primary care providers. Just as importantly, we understand the system-wide needs of ACCESS Plus and will provide innovative tools for PCPs and other ACCESS Plus providers, local APS staff, and the Department. APS CareConnection® is one of those tools – providing the care management infrastructure for medical homes. My Health Direct® is another tool that APS will offer through a license agreement with Global Health Direct (which we discuss in Section II.27, Contracts and Subcontracts).

Designed to facilitate emergency room diversion for hospitals, My Health Direct® will be deployed for this purpose in ACCESS Plus counties. My Health Direct® is an Internet-based, searchable resource matching system that allows users to locate available appointments within specific geographic boundaries and time parameters, assign appointments to Enrollees, print an appointment page for Enrollees in any of 70 languages, link to transportation resources to schedule transportation for Enrollees, and fax an appointment confirmation to the clinical provider. For example, if hospital emergency room triage nurses identify non-emergent visitors that still require care, they can conduct a look up for the patient, identify available times and locations at the patient's preference, schedule the appointment, arrange for transportation, and fax the appointment confirmation to the provider. We will populate My Health Direct® with ACCESS Plus Enrollees and PCP assignments so that ER Departments can schedule a visit to the PCP. APS Provider Technical Specialists will work with providers to populate the system with primary care provider resources. This resource will also be used by APS Health Coaches and Care Managers to work with providers on behalf of Enrollees to schedule appointments for providers without Internet access as well as resolve issues with both PCP authorizations and accessibility of PCP appointments. My Health Direct® is an important community-based resource that facilitates access to care for ACCESS Plus Enrollees. It will reduce inappropriate utilization of emergency rooms and decrease the percentage of Enrollees who fail to keep appointments. In doing so, it will address some of concerns that make providers reluctant to treat Medicaid patients and help build network capacity.

Dedicated Access Plus Website

As the adoption of the Internet continues to expand, APS efficiently and cost-effectively delivers our materials via our program-specific websites. Hosting our own, program-specific material allows APS and our partners to distribute information that is relevant to the chronic conditions we support, as well as reinforces the evidence-based clinical guidelines we communicate to providers.

APS will establish and maintain a program specific website for ACCESS Plus Program Enrollees and their providers with separate web pages for each. The site's Enrollee Home Page will provide various types of educational information about the ACCESS Plus Program and will be written at no higher than a sixth (6th)

grade reading level. Educational materials will be available to Enrollees via printed copy documents in addition to its web page. ACCESS Plus Program Enrollees will have open access to program information, contact numbers, community resources and information related to their primary disease and other co-morbid conditions through a dedicated website. Please note that APS will submit all materials that it proposes to post to the website to the Department for prior approval. Other features of the ACCESS Plus website will include:

- PCP directories, including limited English proficiency (LEP) and ADA accessibility for PCP offices.
- ACCESS Plus Enrollee and PCP handbooks and newsletters.
- Disease Management Program materials, including a brief description of each program and information about how to access services.
- "What's New" items and frequently asked questions and answers.
- Regional Advisory Committee meeting materials (e.g., agendas, meeting minutes, etc.).
- Information about how consumers with LEP and consumers who are deaf can access interpreter services to obtain medical care and treatment.
- Information on ACCESS Plus Quality Improvement Efforts, including but not limited to:
    - Chart Review Data; Clinical Quality Measures
    - Provider and Enrollee Satisfaction Surveys and Results
    - Quality Improvement Initiatives and Results
    - Select Reports Regarding Provider Network and Participation
- A secure provider portal that provides real-time panel roster data, including adult preventive care screenings and EPSDT screening information.
- Other information as requested by the Department.

The secure site will not only post important program information, but it will also offer the capability for Enrollees and providers to submit questions to the APS Health Services Team at any time. With the exception of questions and comments related to MA Program regulations or Claims, APS will respond to questions and comments related to ACCESS Plus and the Disease Management program within one (1) Business Day of receipt. APS will also refer questions related to regulations or claims to the Department for response. In addition to email communication regarding scheduling of care management interventions and other education needs, Enrollees will be able to participate in a survey, available on our website. Complaints, grievances and suggestions can also be submitted through the program website.

Providers throughout Pennsylvania will also have open access to program information, contact numbers, and resources information related to chronic care management through the dedicated ACCESS Plus Program website. Training modules will also be adapted and posted. These web resources are particularly valuable in assisting providers in their own internal quality improvement efforts. Providers preferring to email APS staff can do so through the website, in addition to receiving telephonic access and support.

APS' program specific website also offers sophisticated technical solutions for promoting quality improvement. In addition to a wealth of educational material, community resources, publications, links to national and state-specific sites and other information available through the dedicated program website, APS has developed an extensive network of resources and web-based applications for training providers and consumers. These web-based trainings can be accessed and used by anyone who registers, and are free of charge. Features include electronic registration for Enrollees, online testing following the training, and a training certificate that can be awarded (with print capability) through the website. We highlight our Pennsylvania Health Quality Unit (HCQU) website in **Exhibit 1**, particularly because of our proposed approach to web-based training applications. Other

program specific websites for our Wyoming Health Management program and Maryland Administrative Service Organization (ASO) program are also provided in **Exhibit 1**.

APS will review and update the ACCESS Plus website on a monthly basis or more frequently as needed to ensure accuracy of information displayed on the website. We will also work closely with the Department to ensure the website complies with all Department requirements for information systems and webpage development.

APS will rely on the latest technology to communicate with providers and Medicaid Enrollees for the ACCESS Plus Program in a way that allows rapid updates incorporating new Pennsylvania policies and Medicaid program mandates. We are eager to deploy our system so that providers and Enrollees themselves have efficient access to information and resources to enable appropriate management of high-risk chronic conditions.

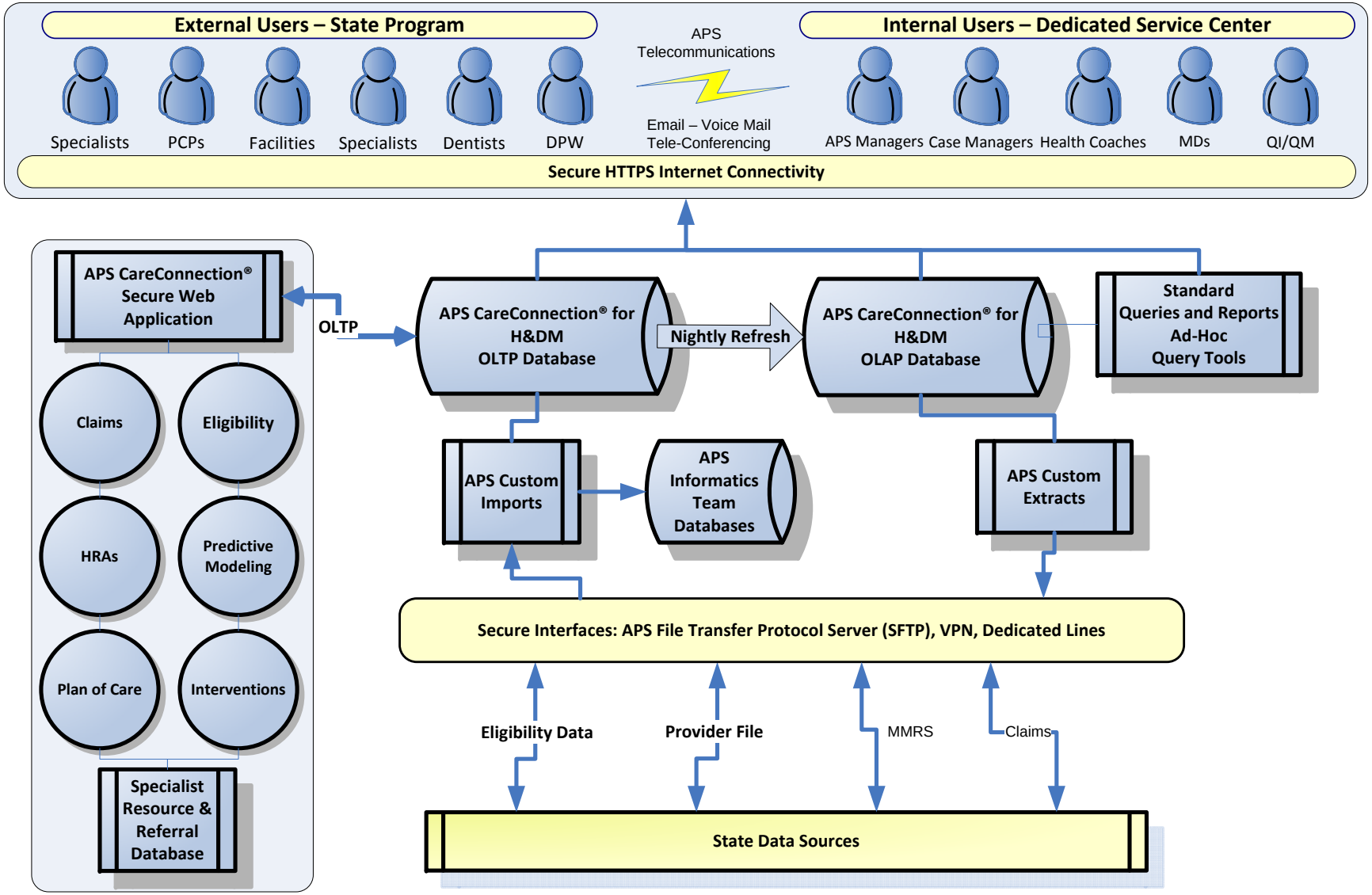
APS MIS – Dedicated Service Center Deployment

Over the past five years APS has emerged as a leading provider of program management solutions to state Medicaid agencies, serving programs for behavioral health, medical care, managed care, 1915(b) and 1915(c) waiver programs, and programs for people with intellectual and developmental disabilities. We attribute our success with this field to two critical factors: our culture of exemplary customer service, of which our flexibility and responsiveness are hallmarks, and our dedicated service center model, which we have identified as an APS best practice. Our MIS is integral to these two factors.

APS establishes dedicated service centers for virtually all of our state public sector business. The benefits are obvious: close proximity to our customers; reduction in learning curve through our employment of local staff who are experienced with the programs we serve; accountability to customer interests and requirements through de-centralized decision-making; and integration with the community of stakeholders because we are part of that community on a daily basis. A key part of our dedicated service center is deployment of Health Coaches and Provider Representatives in field locations where they are accessible to providers and Enrollees. The characteristics of our dedicated service center model are directly related to our reputation for proactive customer service, patient-centeredness, and our provider-friendly systems and staff. The combination of corporate resources and local program staffing is a cost-effective approach that our MIS exemplifies.

We present the system diagram in **Table 1-1** that outlines MIS functionality compared to the Draft ACCESS Plus Agreement (Appendix A), Section A.8, with comments on the modifications and timeframes for full configuration to Department requirements. As this diagram illustrates, the APS corporate information systems center in Brookfield, Wisconsin houses the main infrastructure and data in a secure, HIPAA-compliant location. The APS Health Intelligence Unit in Madison, Wisconsin accesses the Online Analytic Processing Database through a secure data line. Internal and external users at the local program level have access to the integrated patient-centered database through APS CareConnection®, which includes access to the website as well as download sites for standard reports. Users can access telecommunications for voice mail and teleconferencing, with Microsoft Office applications (Word, Excel, Project, Outlook, PowerPoint, SharePoint) for email and document creation and management.

Table 1 – 1 APS CareConnection® for Health and Disease Management Architecture



APS HEALTHCARE
Healthy Together

B. Describe how the Offeror will:

1. Utilize the Primary Care Provider (PCP) and membership files sent to the Offeror by DPW.

APS can accept PCP and membership file updates from the Department on a daily basis after an initial load of the membership file. Our system has the capability to receive, update and maintain the Department's eligibility files consistent with information provided daily and monthly by the Department in the PROMISe™ 834 file format. APS also has the capability to provide daily updates of membership information to subcontractors, although it is important to note that APS will not subcontract care or disease management responsibilities. Eligibility files will be installed during configuration and then updated on a daily basis. APS recommends the use of SFTP (secure FTP) for data transmission. APS also recommends daily updates of add/change/delete records from the Department using SFTP for file transfers. We will also accept tapes, CDs or other mutually acceptable media, providing appropriate precautions are taken to encrypt and track the data in transit. APS will work with the Department to clearly define the nature of Add/Change/Delete transactions, and test to be sure they are correct. We recommend an annual reconciliation file, or "true-up" file, of all eligible individuals and their eligibility history to cross-check the systems, and also that large feeds occur during evenings or weekends, allowing the fastest loading with no degradation or conflicts with the Department's activities.

APS will also establish an eligibility verification system with files from the Department's eligibility system at least one month prior to implementation, and will update the eligibility file on a nightly basis. APS will download the file and update the APS CareConnection® Enrollee eligibility file using the Department's membership data. We will then create a load report that identifies the number of records that were updated and/or added and the number of discrete Enrollees and submit the report to the Department for validation.

Any discrepancies in the record counts will be examined and addressed by APS, working with the Department. **Table 1-2** illustrates our experience with system interactions such as we propose for the current project. APS and its related entities use a proven methodology of both unit and system testing, in coordination with our trading partners. We find that each state partner has different IT capabilities and processes. While we maintain internal standards, we coordinate our efforts to ensure compliance and easy integration for our partners. With Nineteen (19) DM and UR systems deployed nationally to support public sector programs, we manage a wide variety of data exchange formats and protocols.

In addition to our own resources, APS will work with Adept Consulting Services during implementation. Adept Consulting is a Pennsylvania certified Disadvantaged Business that has extensive experience with the Department's data. Their expertise will enable us to quickly configure APS Care Connection® for efficient data exchange with all Department systems. The Department's data management is a *core capability* of Adept Consulting that will enable APS to implement data exchange with the Department for accurate and complete population of APS CareConnection® datasets.

Table 1-2. APS' DATA EXCHANGE EXPERIENCE

Type of Data	Client	Frequency of Update	Covered Lives
Eligibility	[redacted]	Daily (Update)	[redacted]
	[redacted]	Daily	[redacted]
	[redacted]	Weekly Import (Full)	[redacted]
	[redacted]	Daily (Update)	[redacted]

Table 1-2. APS' DATA EXCHANGE EXPERIENCE			
Type of Data	Client	Frequency of Update	Covered Lives
	[redacted]	Monthly	[redacted]
	[redacted]	Monthly	[redacted]
	[redacted]	Daily	[redacted]
Provider Files	[redacted]	Weekly	[redacted]
	[redacted]	Daily	[redacted]
	[redacted]	Weekly	[redacted]
	[redacted]	Monthly	[redacted]
Authorizations	[redacted]	Daily	[redacted]
	[redacted]	Daily	[redacted]
Claims	[redacted]	Daily	[redacted]
	[redacted]	Monthly	[redacted]
	[redacted]	Weekly	[redacted]
	[redacted]	Weekly	[redacted]

We are also able to comply with key requirements of Appendix A.8:

- Create and submit to the Department provider data related to the ACCESS Plus network utilizing PROMISe™ Provider ID numbers in a format determined compatible by the Department.

- APS currently submits provider data to state MMIS systems, using a variety of unique provider identifiers. During implementation, we will configure and test the specific format and process to update PROMISe™ provider data, including corrections to provider numbers when we identify an error through provider and/or Enrollee interactions. The correct number will be documented in APS CareConnection® and we will create an exception report that notifies the Department of incorrect provider numbers.

- Create and submit to the Department the required reports outlined in Exhibit D, Required Vendor Reports.

- APS has proposed dedicated reporting analysts for this important program. The organizational structure is documented in **Section II-5, Personnel**. APS has capacity in its Health Intelligence Unit to support these positions with experienced health analysts. Resumes for these individuals are shown in **Exhibit 2**. We also supplement the standard reports outlined in **Exhibit D** with the creation of ad hoc reports at the Department's request through the reporting analysts as well as APS team members and the Pennsylvania State University Center for Health Care and Policy Research (CHCPR). Information about CHCPR is provided in **Section II-3.27, Contracts and Subcontracts**, and the resume for the key senior researcher at CHCPR who will be involved in this project is included in **Exhibit 2**. Standard reports and special purpose reports will be accessible through the ACCESS Plus website.

- Report on assigned quality measures outlined in Exhibit W, Quality Management Performance Measures, and Exhibit X, Financial Performance Measures.

- These measures will be calculated as standard reports that can be accessed from the ACCESS Plus website as well as through APS CareConnection® by individual providers (for their own practices). These reports

will be developed and tested for approval by the Department during implementation and will then be produced as scheduled for submission to the Department.

- Analyze paid claims data to determine when Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and adult preventative services are needed for each Enrollee.

APS has over 10 years of experience with reporting on EPSDT service utilization. We discuss this experience in **Section II-4, Prior Experience**. The key to these analyses – since EPSDT services are complex and varied – is to provide actionable feedback at the individual Enrollee level to individual providers. EPSDT profiles can be voluminous if not organized properly. A key process during implementation will be to work with providers, the Department, and the Quality Management Committee to develop a reporting instrument that can be used by providers to easily identify categories of Enrollees in need of EPSDT and adult wellness services, as well as categories of service that are needed by multiple Enrollees. In our discussions with ACCESS Plus stakeholders, a number of individuals suggested that a simple spreadsheet that could be sorted by multiple columns, such as Enrollee identifier or service gap, would be a useful format. This spreadsheet can then be downloaded through the providers' logon to APS CareConnection® or distributed on CD-Rom by mail service. As we demonstrate here, we understand what providers need and are both flexible and innovative in meeting those needs.

- Identify the Enrollees as potential candidates for the Disease Management Program.
- Using claims data updates that are distributed weekly, we will evaluate the claims against the Disease Code set to identify newly diagnosed Enrollees as early as possible. We will then work with the Department and the PCPs to confirm the diagnosis, notify Enrollees, assign a Health Coach, and begin the process of Health Risk Assessment and disease management.
- Incorporate the Department's pre-established eligibility identification criteria as discussed in Exhibit C, Disease Management Program: 2008 Disease Codes or other criteria recommended by the Vendor and approved by the Department.
- APS has used the pre-established eligibility identification as presented in Exhibit C to evaluate the dataset distributed to interested vendors, and therefore have already programmed the 2008 Disease Codes into our analytic and reporting systems. Criteria used by APS in the past differ somewhat from Exhibit C and we present information about our criteria in **Section II-3.23, Disease Management**. We will work with the Department to identify and use criteria that provides the most reliable identification of DM candidates, and will update that criteria as additional information becomes available that improves screening performance.
- Receive and process claims history provided by PROMISe™ consistent with requirements identified in the Department's agreement.

APS will maintain claims history with sufficient detail to meet all Department reporting requirements set forth in Exhibit D, Required Vendor Reports. APS currently uses a three year claims history for predictive modeling and other analytic purposes, and a rolling two year history for the APS CareConnection® integrated Enrollee Dashboard (screen shots of this Dashboard are included in **Section II-3.23**). We will work with all parties and their respective systems (i.e., the Department, the EAP contractor and PROMISe™, CaseNET Case Manager™, CIS and MMRS) to ensure the electronic exchange of data is accurate, efficient and seamless.

2. Receive PCP selection information from the Enrollment Assistance Program (EAP) contractor and submit PCP files and authorization information to DPW daily.

APS can support the receipt and transfer of various types of data, as indicated in **Question B.1** above, through many different electronic formats at varying frequencies. We can receive PCP selection information from the Enrollment Assistance Program (EAP) contractor as well as transfer PCP files and authorization information to the Department on a daily basis. With regard to provider data, APS will comply with the PCP file submission process, including creating and submitting provider files utilizing PROMISe™ Provider ID numbers in a format determined compatible by the Department. The provider file will:

- Contain information on all providers participating in the ACCESS Plus Program, including both PCPs and Specialists.
- Identify whether the provider is a PCP or a Specialist.
- Detail which PCPs and Specialists are accepting ACCESS Plus Enrollees as new patients to the EAP contractor. This will allow the EAP contractor to identify PCPs and Specialists for new and potential ACCESS Plus Enrollees.
- Contain detailed information on each provider that is sufficient to meet the Department's reporting requirements set forth in Exhibit D, Required Vendor Reports.

APS will also provide a file via PROMISe™ of PCP assignments for all Enrollees on a daily basis, if requested by the Department, to the Department's Eligibility Verification System (EVS) contractor. This includes PCP assignment information consistent with all requirements specified by the Department as set forth in **Section C.1, PCP Selection** of the RFP.

Lastly, APS will verify whether the provider information in the Department's PROMISe™ system is accurate. If the provider information is not accurate, APS will notify the Department's Provider Services Division to correct any errors. Furthermore, APS will submit a provider file to the Department that is consistent with all requirements specified by the Department at least weekly or more frequently, if requested.

3. Share information between the Department's systems and its own systems to avoid duplication of effort.

APS is a proactive partner for State Information Systems Departments. Our Information Technology Department works collaboratively to identify opportunities with our State partners to consolidate and share information to avoid rework, duplication of effort, and the data inconsistencies that result from duplication. Depending on the complexity of the situation, project timelines typically range from thirty (30) days to six (6) months with both APS and the State as responsible parties in the process. For example, when we implemented the Administrative Services Organization for the State of [redacted] Behavioral Health System, we quickly identified a source of duplication in maintaining authorization information in APS CareConnection® and entering that information directly into the State's own MMIS. We worked closely with the system vendor and the State to develop and implement an interface to share information and eliminate duplication of effort. In the State of [redacted] Medicaid QIO program, APS created an interface between provider billing and management systems to remove duplication of entry for the plan of care and authorization data, implementing a seamless data exchange process between systems that populated APS CareConnection® for prior authorization, submitted authorizations to the MMIS, and returned authorization numbers to the

provider systems. We will be equally active in identifying ways to remove duplication through shared data for the Department.

4. Communicate information from the Specialist Resource and Referral Database to the Department.

The Specialist Resource and Referral Database contains information that identifies Specialist members of the ACCESS Plus network so that PCPs, the Department, and APS can locate Specialists when referrals are needed. We understand that Specialists will include not only medical Specialists, but also dentists and orthodontists. We recommend the following data elements for the Specialist Resource and Referral Database:

- Specialist Demographic Information: Name, address(es), county, specialty.
- Practice Type: Individual, clinic, multi-practitioner site; multi-specialty location, number of years at each location.
- Office hours and days open (with encouragement for evening hours and Saturdays).
- Panel Information: open, closed, restricted (including nature of restriction), current number of ACCESS Plus Enrollees.
- Languages available in the office other than English, point of contact for arranging assistive supports (e.g., sign language interpreter) if available. (If not, APS will coordinate this function.)
- If a dental specialty, availability of sedation dentistry.
- Referral limitations.

We will work with the Department to finalize these data elements prior to implementing the database, which will then become accessible on the ACCESS Plus website as well as through APS CareConnection®. The database will be maintained directly with data collected from the Supplemental Agreements, and additional data entry conducted by APS Coordinators in our Harrisburg office. The database will be uploaded to the Department on a regular schedule. The Department's staff will also be able to create a downloadable spreadsheet from the database on an ad hoc basis. APS has proposed additional functionality to support referrals to Specialists, as we explain in II-1.C below.

C. Explain whether the Offeror's current information system is ready to operate according to the requirements of the Agreement. If it requires modifications and/or updates, describe the necessary modifications and/or updates and the Offeror's plan for completion.

APS' information system currently includes many components of the Draft ACCESS Plus Agreement listed in **Appendix A, Section A.8**. Consistent with our dedicated service center model, APS proposes custom configurations based on our standard platform. Therefore, much of the clinical management and reporting functionality required by Section A.8 is already available. We then customize this standard platform to meet the specifications of each program – providing a flexible, innovative, and responsive information system that is tailored to contract requirements. Please note that prior to any major modifications to our system, including upgrades and/or new purchases, APS will inform the Department in writing of the potential changes and develop and submit a work plan detailing recovery effort and use of parallel system testing. We currently maintain a demonstration system that is populated with model eligibility, provider and claims information, and this system is also used for testing purposes. **Table 1-3** presents the phased implementation of the information from implementation to full deployment across the 42 county ACCESS Plus area and provider population.

Table 1-3. Phased Implementation of APS Information Systems			
Phase	Functionality	Modification	Timeframe
I	Fully configured with ACCESS Plus eligibility, provider, and claims files. DM and CM Enrollees loaded with risk strata for plan of care development and management by APS internal users. The Department has read-only access. File interfaces functional for updates to data. Reporting requirements completed. ACCESS Plus website fully functional.	Cross-walk data sets to APS OLTP database to populate APS CareConnection®; establish file interface timeframes and formats; establishing reporting formats and other deliverables. Program Department-specific reports and measures. Train providers to use My Health Direct®. Create ACCESS Plus Enrollee and provider website; populate APS CareConnection® with ACCESS Plus-specific links.	10/01/2009
II	ACCESS Plus PCCM Enrollees added to APS CareConnection® with automated plan of care for voluntary PCP use. My Health Direct® fully functional with Enrollee, and PCP data loaded.	Predictive modeling using CDPS for all PCCM Enrollees. APS Provider Representatives and Field Technicians responsible for provider training and technical assistance to use APS CareConnection®; and to populate My Health Direct® with appointments and transportation resources.	03/01/10
III	Provider Satisfaction Survey site accessible to providers, with survey scheduled for completion 2nd quarter 2010.	Set up provider survey questions in APS CareConnection® notify providers of survey timeframes.	05/01/10

II-3 Work Statement

2. REGIONAL ADVISORY COMMITTEES

A. Describe innovative strategies the Offeror will implement for recruiting and increasing Enrollee participation in the Regional Advisory Committee meetings. In the description, identify any challenges the Offeror anticipates in facilitating Enrollee participation in committees such as the Regional Advisory Committee.

APS proposes a model for the Regional Advisory Committees that transforms Enrollees contributions from passive to participating – from advising to contributing – and from listening to actively representing the program in their communities.

APS commends the Department for establishing Regional Advisory Committees (RAC) to facilitate communication between the Department, APS, and ACCESS Plus Enrollees. As a "people first" organization, APS has always worked with Enrollees in the public programs we support to inform our programs in ways that best serve the people they are intended to benefit. With our background and commitment to people with severe mental illness, chronic disease, and intellectual or developmental disabilities, APS promotes resiliency, recovery, and empowerment of consumers throughout our total health management programs. These characteristics also contribute meaningfully to our culture of inclusion and exemplary customer service – and it is these characteristics that we will draw upon, with approval from the Department, to *transform* involvement in the Regional Advisory Committees into full participation in the Regional Ambassador Councils. In this section we describe our approach to accomplishing this evolution. In all activities, APS will comply with all requirements listed in the **Draft ACCESS Plus Agreement, Section A.9 – Regional Advisory Committees**.

Our approach starts with a recruiting effort that is community-based and creates interest in, and commitment to, ACCESS Plus goals. During implementation, and with guidance from the Department, we will meet with regional organizations, including faith- and community-based organizations, school systems, county Extension Offices, and health systems, providers and provider organizations. These organizations can make major contributions to identifying potential members. Current members who wish to continue serving will be welcome to do so. We will ensure that these members are recognized for their contributions and are involved in development of the Regional Ambassador Councils and recruitment of new members.

With consumer and provider councils as a routine component of our total health management programs, APS is familiar with challenges to participation. These challenges include, for example, concerns over time commitments from consumers and others, the need for travel assistance and child care, uncertainty about the impact of reimbursement on continued Medicaid eligibility, as well as reluctance to assume public roles. We have found that nothing succeeds like a successful council – positive group process, implementation of recommendations from council members, well-planned meetings that are conducted efficiently, and a genuine interest in the contributions of people who are stakeholders in the program. In addition, assistance with expenses, convenient scheduling and local meetings on a regular basis, a consistent resource for planning and communication, and an active effort to assure the ability of individuals to participate - these factors all contribute to the development of active and positive community councils.

B. Describe any suggestions the Offeror has for modifying the Regional Advisory Committees' structure and meetings. Provide suggestions for how the Offeror would encourage Regional Advisory Committees to take a more active role in developing meeting agendas, suggesting topics for discussion and providing input on various aspects of the ACCESS Plus Program.

With 41 programs serving over 20 million Medicaid enrollees, we have found that stakeholders take an active role when there are supports and resources to facilitate that role and expectations the role will be active and not passive. We propose a change in the meaning of the RAC acronym from "Regional Advisory Committee" to "Regional Ambassador Council" – which signals a dual role for Council members. We envision participants as both ambassadors of the program to their communities and ambassadors of those communities to the ACCESS Plus Program. Our proposal goes beyond a change in name alone. We have also allocated a full-time RAC Coordinator to facilitate and support the Council, focusing on working directly with the Regional members on the development of agendas, scheduling outreach and education initiatives, and helping to implement recommendations from Council members for improvements in Council functioning and structure. APS team member, Black Consulting, will staff this position, as well as being responsible for working with APS to develop sound and practical training programs, maintaining comprehensive documentation of Council activities, and providing meeting support through communications and scheduling.

Working with the full-time RAC Coordinator, each Council will make outreach plans for the quarter, targeting community and faith-based organizations and schools to deliver materials and engage in activities that are relevant to Enrollees. APS will facilitate these activities by identifying community-based organizations that might be interested in offering programs, making introductory calls if necessary, providing materials and support to members, answering specific questions about the program and its features, as well as helping to coordinate and support the activities of Council members.

Linking health and lifestyle programs offered via county level Extension offices to Enrollee interests and needs will leverage local resources and build support for ACCESS Plus.

We will also recruit county level Extension Office staff in the ACCESS Plus regions (with assistance from the state level Extension system at the Pennsylvania State University) to work with Council members to provide health and lifestyle programs that are relevant to ACCESS Plus Enrollees. Extension offices are invaluable sources of information and include consumer education in their mission. Linking these programs to Enrollee interests and needs will leverage local resources and build support for ACCESS Plus.

By reframing the RAC, we believe we will empower and inspire Enrollees to become engaged in ACCESS Plus. With a "grass roots" approach to program improvement, members are active participants with significant expertise in the needs and interests of their counties and Regions. We appreciate that this vision is an ambitious one and subject to approval by the Department. Based on our attendance at Pennsylvania Consumer Sub-Committee meetings and our review of RAC materials, however, we are confident that with information and commitment from the APS team the Regional Ambassador Councils can become active champions of healthy lifestyles, informed health choices, and improved health status for all ACCESS Plus Enrollees.

II-3 Work Statement

3. MATERIALS DEVELOPMENT AND DISTRIBUTION

A. The selected Offeror must develop ACCESS Plus Program materials as set forth in the Agreement. Describe how the Offeror will design, develop, print and distribute materials that are culturally sensitive, easily understood and written with a text no higher than a sixth grade reading level.

APS is adept at designing, developing, and distributing Enrollee materials that are customized to our Medicaid populations. With 41 Medicaid programs in 20 states and Puerto Rico APS has an extensive library of materials already developed that we will adapt for use with the ACCESS Plus Program as approved by the Department. These materials are culturally and linguistically appropriate and written with text no higher than a fourth or sixth grade reading level depending on the intended audience and the state requirements. We will review ACCESS Plus Enrollee materials annually and make changes as needed according to **Appendix A, Section B.2 Materials Development and Distribution**.

APS currently has an extensive library of customized materials for the Medicaid population.

From our experience, we have found that services must be appropriate for the many audiences to which they are delivered, and thus, we have made a significant investment in ensuring that the content of written materials is appropriate for our audiences. Information is conveyed in a manner in which the program Enrollees can trust and will adopt. Our literature takes into consideration the importance of culturally and linguistically appropriate health services to ensure positive health outcomes. There is evidence documenting the benefit of cultural competence on health outcomes. For example, several studies found significantly improved results associated with diabetes outcomes, and one study found significant results associated with cultural competency at sites providing services for children with asthma.[1] As a result, we base our Enrollee materials on important foundations of social marketing, learning theory, health literacy, accessibility and cultural competency. Cultural and linguistic competence is a characteristic of materials that are respectful of and responsive to culture and language needs.[2] Our materials utilize culturally diverse images and examples and are available in alternative languages and formats (such as Braille). We use the Flesch-Kincaid method to score reading level and reading ease, with our materials typically written for reading levels between fourth and sixth grade and a reading ease score between 80 and 90 (easily read by 10-11 year olds).

We will develop a distribution plan for the ACCESS Plus Program that specifically addresses the needs of Enrollees and providers. The plan will use a multi-pronged approach to increase awareness and enrollment in the program; promote the benefits of our program; be approved by the Department prior to implementation; and be updated with the Department's approval on an annual basis. We rigorously review materials to ensure they are clear and reader-friendly, and present accurate and appropriate information about ACCESS Plus and the APS team. Materials for ACCESS Plus will comprise both APS standard literature and new material. A sample Strategic Marketing Provider Plan used for the Georgia Medicaid Management Program (GAMMP) in

[1] Goode, T.D., Dunne, M.C., Bronheim, S.M. (2006). *The Evidence Base for Cultural and Linguistic Competency in Health Care.* Washington, DC: The Commonwealth Fund.
[2] Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Healthcare.* Washington, DC: US Department of Health and Human Services.

Georgia has been included in **Exhibit 3**. An excerpt of our proposed Provider Promotion Plan for the ACCESS Plus Program has been provided in **Exhibit 4**.

During implementation, we will select materials from the APS library that are relevant to the ACCESS Plus Program for adult health and wellness as well as disease management (DM) and case management literature. New material, such as new DM literature, will be developed by APS. Our Development Department assists with this activity under direction from Vice President, Clinical Product Development, Megan Cormier, RN, MSN, with oversight from our Chief Medical Officer, Dr. Steven Saunders. The ACCESS Plus Medical Director and Health Services Director will also participate in the development effort to update the Member Handbook and Provider Manual as needed. These materials will be reviewed and approved internally within APS and submitted for review to the Department. With approval from the Department, we will then present consumer materials to members of the Medical Assistance Advisory Committee and Consumer Sub-Committee for review and comment. Clinical and provider materials will be submitted for review and comment by the Quality Management Committee. This process is an important part of developing culturally appropriate materials – garnering input from individuals who will use the materials and identifying their cultural perspectives and reactions to the information which enables us to make modifications that are effective, targeted, and responsive to the interests and perspectives of the audience.

ACCESS Plus materials will be provided in alternative languages and formats, as necessary, to ensure Enrollees' full understanding of the information. In general, APS develops materials in non-English languages where the percentage of the membership meets the Centers for Medicare and Medicaid Services (CMS) definition of a "prevalent" language. The current standard defines a language as prevalent if [redacted] or more of the Medicaid population uses it as a primary language. In this light, APS will develop materials in other prevalent languages in the region and in alternative formats for those Enrollees who are visually impaired.

Enrollee materials (e.g. educational materials, preventative and clinical guidelines, quality improvement information, website information, provider information, audit tools and check lists, etc.) will be available via hardcopy as well as online. Specifically, we will distribute Enrollee materials using the following methods at a minimum:

- Direct mail (APS will use the Department's name, APS' return address, and receive the Department's approval for the design of all envelopes and mailers prior to use).
- In person distribution by Field Care Coordinators and Health Coaches.
- Distribution through provider locations.
- Distribution through faith, cultural and community-based organizations.
- Distribution at community and clinic health fairs.
- Download from the APS ACCESS Plus website.
- Distribution through Regional Advisory Committee (Regional Ambassador Council) members.

APS' partner, PRWT Services, will provide mailing support for Enrollee and provider materials. Fulfillment is a *core capability* of PRWT and their "Simply the best" service provides an efficient resource to ensure mailings are conducted on a timely basis.

II-3 Work Statement

4. CARE COORDINATION AND INTENSE MEDICAL CASE MANAGEMENT

Definition of Care Coordination: A set of Enrollee-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, and timely manner. Care Coordination emphasizes prevention and wellness, continuity of care, and appropriate planning and communication between levels of care, settings of care, and providers of care.

The ACCESS Plus Program creates a "medical home" for each Enrollee through the assignment of a Primary Care Provider (PCP). APS creates a coordinating context for this medical home, linking primary and specialty care, behavioral healthcare, pharmacy, and community services in a "neighborhood" that promotes community integration, resiliency and recovery, and a continuum of safe, high quality healthcare from preventive care through chronic care and intense case management – a "healthcare neighborhood" for enrollees and their PCPs. This process is total population health management and *seamless coordination of care is its hallmark*. As the illustration in Table 4-1 indicates, we maintain a focus on the Enrollee across the complex environment of agencies, organizations, and entities that Enrollees encounter.

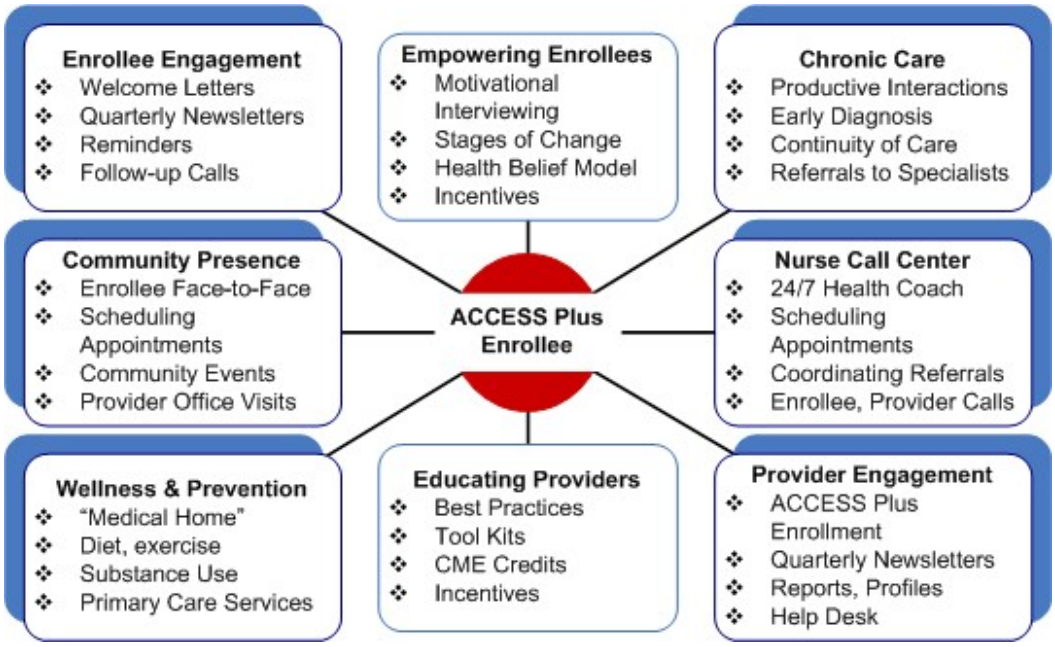


Table 4-1. ACCESS Plus Enrollee-Centered Program

In this section we describe our approach to the requirements of the **Draft Access Plus Agreement, Section B.5 – Care Coordination; Draft Access Plus Agreement and Section B.6 – Intense Medical Case Management**.

A. Describe the Offeror's plan for seamless and continuous care coordination and case management for Enrollees being served by a variety of systems, such as children in substitute care. Describe how the Offeror will identify and outreach to populations such as persons who are homeless, persons receiving HIV/AIDS targeted case management services, HIV/AIDS waiver services, school-aged children and pregnant women. Identify potential challenges the Offeror anticipates in coordinating care for the populations identified and explain how the Offeror will mitigate these challenges.

APS' Care Management approach incorporates evidence-based models of care management, addresses all co-morbidities, enhances coordination of care among Providers, creates a forum for open communication and information-sharing, and strengthens the management infrastructure to provide a continuity of care to achieve better health outcomes for ACCESS Plus Enrollees. We will improve the health of Enrollees by providing coordinated care management services based on an Individual Treatment Plan (ITP) that utilizes evidence-based practice guidelines and includes promoting collaborative relationships with Providers, providing Enrollees and Provider education, and reporting and feedback loops with Providers and Enrollees.
In this section we outline first outline our plan for care coordination, explaining the functions and tools that APS Health Coaches and Care Coordinators will employ to successfully coordinate services for Enrollees and provide case management for severely at risk Enrollees. As we describe in Section II-5, Personnel, our care coordination teams will include Registered Nurses, Lay Educators, and licensed Behavioral Health Professionals. These skill sets enable us to transparently blend wellness health education, clinical interventions when needed, and effective integration of behavioral health into a person-centered care coordination system for Enrollees.

Plan for Coordination and Case Management

Our approach to care coordination and case management builds on four essential functions, discussed in order of their priority for successful coordination:

Planning. The planning function begins with establishing relationships with agencies, managed care organizations, community-based organizations, Enrollee advocates, provider organizations, school systems, and individual providers. An established relationship involves identifying formal points of contact between entities and more importantly, trigger events that require notification to the ACCESS Plus vendor, and an appropriate set of actions that result from these events. During implementation we will establish Letters of Agreement with the Behavioral Health Organizations and the Single County Authorities, for example, that outline our respective roles and which detail events and information that will require intervention by APS. APS will also establish formal points of contact with Commonwealth agencies, hospitals, Area Agencies on Aging, Waiver authorities, medical associations, and enrollee advocates.

The purpose of formally identifying a point of contact and the context for communication is to ensure that all entities involved with the transition of Enrollees between public systems, providers, or settings understand their roles in notifying APS concerning Enrollee status changes. As we document the environment in which coordination will be conducted, we will also document appropriate steps and timeframes for intervention. Assisting us with this important documentation will be APS partner Black Consulting Services, a woman-owned and Enterprise-zone disadvantaged business. Our coordination guide will be formally maintained to document updates and changes, as we do with APS policies and procedures, and our agreement with entities will establish the means of notifying us of a change in policy and/or point of contact. In addition to updates from other entities, APS will also update our documentation on an annual basis to ensure that it is current. UM-12 Coordination of Care, in **Exhibit 5** is an example.

The Enrollee Handbook, ACCESS Plus website, and outreach materials will also include information for Enrollees on how to obtain assistance in coordinating care and receiving case management. Community- and faith-based organizations will also receive materials that outline care coordination and case management resources to assist us with Enrollee needs.

Identification. This function entails the recognition of situations in which Enrollees need assistance with coordination. As we mention in our discussion of barriers, however, identifying when coordination and case management are the most appropriate approaches for Enrollees can be difficult when information is diverse and fragmented. Planning communication with entities is one way to identify Enrollee needs. For example, we will initiate coordination when an organization notifies its APS point of contact that a specific event has occurred, such as admission to an acute psychiatric facility, or admission to one of the Commonwealth's waiver programs. This type of notice will enable us to *respond* to events in a timely and appropriate way. We will also respond to the requests of Enrollees, family members, providers, and other stakeholders when coordination needs are identified. APS is committed to *proactive* coordination of services for enrollees, and therefore does not depend only on notification by another entity to identify opportunities to improve coordination.

Our most powerful tool in this effort will be quarterly data profiling to identify Enrollees with characteristics of *uncoordinated* care, such as poly-pharmacy, duplication of services, utilization of multiple providers, emergency room utilization that is not medically necessary, and admissions for ambulatory-sensitive conditions. We present examples in Table 4-2.

Table 4-2. Examples of APS Data Mining Tools for Coordination of Care
Uncoordinated Care Profile: This quarterly profile incorporates the proprietary algorithms developed by Southeast Consultants to integrate pharmacy, medical, and behavioral health data to identify utilization occurring among multiple providers, settings, specialties, and systems. Enrollees identified through this profile are not successfully linked to a medical home and may be receiving services that are not evidenced-based for their diagnoses, occurring among a variety of providers and settings.
Outlier Utilization Report: This monthly profile identifies statistical outliers in terms of specific utilization of services. APS uses a metric of 3 standard deviations from the mean in outlier identification. Not all outliers will benefit from care coordination or intensive case management; additionally, information in this category has also been useful to identify waste and abuse of services by Enrollees and providers.
Patient Health Briefs: These monthly reports highlight areas of concern for individual Enrollees so that PCPs can address opportunities to close gaps in service and manage medications. An example of a Patient Health Brief is in **Exhibit 6**.
Medically Unnecessary ER Utilization: The results of this report identify potentially unnecessary services. It helps to identify non-adherent Enrollees and those who are not receiving a usual source of care from PCPs.
Admissions for Ambulatory-sensitive Conditions Profile: Opportunities to avoid inpatient care by improvement in ambulatory and outpatient care. ▪ Hypertension (high blood pressure). ▪ Short-term complications of diabetes (such as diabetic ketoacidosis or hyperglycemic coma). ▪ Bacterial pneumonia. ▪ Urinary tract infections.

Table 4-2. Examples of APS Data Mining Tools for Coordination of Care
▪ Angina (chest pain) for which no procedure was performed.
▪ Uncontrolled diabetes without complications.
▪ Pediatric gastroenteritis.
▪ Perforated appendix, which can result from delays in treatment for acute appendicitis
▪ Congestive heart failure.

There are opportunities for improvement in the Commonwealth. Pennsylvania was ranked 15th among all states in the Commonwealth Fund 2007 State Scorecard for all measures. However, Pennsylvania was ranked in the third quartile for medically unnecessary care and in the fourth quartile for the measure of "healthy lives" (which is taken from the Center for Disease Control survey that measures healthy days in a population). In data APS examined, we compared average inpatient and outpatient claims for cost and utilization outlier Enrollees with Congestive Heart Failure (CHF) to all outlier Enrollees and to Enrollees with no outlier costs or utilization. Outlier Enrollees averaged [redacted] inpatient claims and [redacted] outpatient claims for 2006/2007. Non-outlier Enrollees average [redacted] inpatient claims and [redacted] outpatient claims. Enrollees with CHF averaged [redacted] inpatient claims – more than twice as many as for other outlier Enrollees. Enrollees with CHF averaged [redacted] outpatient claims; less than [redacted]% more than Enrollees with other outlier utilization. The proportion of inpatient to outpatient utilization suggests that there are opportunities to improve care for Enrollees with CHF because of much higher inpatient utilization and much lower outpatient utilization.

This outlier analysis also indicates other areas of concern. Our analysis of claims provided for response to the RFP indicates that in 2006/2007 there were [redacted] ACCESS Plus Enrollees with outlier utilization and/or costs. For this time period, the outlier Enrollees had an average of:

- [redacted] prescriptions; $[redacted] in pharmacy costs; [redacted] medical claims; $[redacted] in medical costs and $[redacted] in total costs.

In comparison, non-outlier Enrollees had an average utilization of:

- [redacted] prescriptions; $[redacted] in pharmacy costs; [redacted] medical claims; $[redacted] in medical costs and $[redacted] in total costs

Total costs for the group of [redacted] Enrollees were $[redacted] Of the total outlier Enrollees, Enrollees with severe mental illness (Psychotic Illness/Bi-polar Disorder) accounted for [redacted]% of the population. Their utilization included [redacted]% higher inpatient care; [redacted]% higher professional claims, [redacted]% higher pharmacy utilization with pharmacy costs [redacted]% higher for this group compared to the outlier cohort. However, claims for outpatient care were [redacted]% lower than the group, and costs for outpatient care were [redacted]% lower. Figures such as these are not actionable by themselves. They are *indicators*, however, to opportunities where information sharing, careful monitoring by informed clinicians, and communication between providers could improve overall utilization and potentially shift costs from more expensive inpatient and emergency room care to outpatient care as appropriate. It is important to note, however, that controlling cost is not a function of reducing medically appropriate and necessary care. Rather, it is a function of eliminating wasted, uncoordinated, and medically unnecessary care.

Some Enrollees with outlier status are individuals with severe conditions. For example, there were seven Outlier Enrollees with a diagnosis of Hemophilia/von Willebrands, and these Enrollees accounted for almost

[redacted]% of the total cost (averaging $[redacted] in total costs) in a population of [redacted] Enrollees with hemophilia. We also identified [redacted] Alzheimer patients with one or more of the targeted DM conditions or a behavioral health diagnosis. Increasing coordination and case management *may not* produce a significant impact on costs for this fragile population. Coordinating care, providing intense case management services, and enhancing support from community-based resources *can* increase quality of life for Enrollees and their caregivers, as well as avoiding even greater impact in terms of cost and health-related quality of life.

Evaluation. Effective coordination is timely, person-centered, and comprehensive in its integration of care settings, providers, systems, and stakeholders. For example, an effectively coordinated discharge from inpatient care is one in which hospitals plan discharges with Enrollees and family members far enough in advance to ensure that caregivers will be available as needed; durable medical equipment is planned, authorized, and delivered; home health is planned and coordinated with the agency; prescriptions are filled before discharge and reviewed with the patient; transportation is scheduled if needed; the PCP has reviewed the patient's record and discharge plan, and all follow up appointments are scheduled and documented in an organized packet for the patient and family (if needed). Coordination to this extent seldom occurs, but to achieve it an evaluation of coordination needs must occur and it must be comprehensive. This effort can be significantly improved with the interventions of APS Health Coaches and Care Coordinators, and the next step in coordination is the evaluation of needs so that interventions are responsive and efficient. This process does not need to be lengthy or complicated, but it cannot really occur without effective planning and identification. When we identify an opportunity for care coordination, Health Coaches and Care Coordinators will efficiently evaluate what coordination should entail by using established procedures, clinical and program guidelines, and experience and training to determine effective steps. This process also includes communication among providers who will or should be involved, Enrollees and family members, community-based organizations, and the Department as needed.

Intervention. The timeframes for activation become compressed as interventions begin. Planning and identification are on-going processes that continuously prepare and scan the environment for coordination needs and stakeholders. Evaluation of needs can then occur quickly and interventions are expediently deployed when needed. Oversight of interventions occurs with APS' management team in close collaboration with PCPs, and Health Coaches and Care Coordinators conduct interventions – sharing information, identifying and bringing resources to bear on the need, and ensuring that follow up occurs throughout the extended care team. APS CareConnection® is aptly named for this process – an integrated and person-centered care management system, it efficiently collects and organizes information that APS, providers, and the Department have to have in order to ensure that Enrollee care is well-coordinated.

The successful management of chronic illness across multiple providers and systems is essential to reduce costs and improve outcomes. Achieving reductions requires significant coordination of care among multiple medical practitioners (both primary care and specialty care Providers), as well as important community resources that provide services to program enrollees. APS' plan for seamless and continuous care coordination and case management for Enrollees emphasizes:

- Coordinating care so that ongoing courses of treatment are not interrupted or delayed.
- Facilitating information transfer of medical record information to new providers or systems in a timely fashion.
- Development and implementation of an enrollee disease registry within APS CareConnection® for providers and systems to quickly identify care coordination needs.

- Monitoring the referral and follow-up of enrollees in need of specialty care and routine health care services.
- Documentation of referral and follow-up services in enrollees' records.

APS will develop and follow policies and procedures in accordance with Section B.1, Policies and Procedures, for the identification and referral of an Enrollee with Special Needs and those needing coordination between disparate systems. The process will include a description of the information APS will capture on the Enrollee file.

APS CareConnection® - the essential tool for care coordination and intense case management:

- **Integrated diagnostic and service database.**
- **Plan of care for every Enrollee.**
- **Available to *ALL* ACCESS Plus providers.**
- **Secure, HIPAA-compliant communications.**
- **Health Coach and Care Coordinator alerts from PCPs to initiate interventions.**

Identification and outreach to special populations. APS will employ several approaches to indentify and outreach to special populations:

- Using claims diagnosis data to identify persons with HIV/AIDS, pregnant women and those enrollees with special needs, such as autism spectrum disorders.
- Using principles of social marketing to outreach to potential enrollees who are homeless (such as working with staff in shelters, posting materials in clinics, etc.), those who are or may become pregnant (through WIC clinics and medical providers), and school-aged children by working with school nurses and school district leaders.
- Establishing close working relationships with waiver program and intensive case management program staff to refer eligible enrollees between programs.
- Collaborating with the county-based behavioral health system to improve coordination between medical care, dental care, and behavioral healthcare.

Answering challenges: APS understands that in addition to clinical issues surrounding Enrollees with chronic illnesses, there are very complex challenges to coordinating care:

- Fragmented delivery system, including funding sources, differences among provider practices and training.
- Differences in professional styles of providers; information-sharing is essential but difficult.
- Perceived (or real) access to care; cultural and ethnic stigmas impede access.
- Fear and stigma within a Medicaid population about seeking medical care.

Below we describe the use of targeted interventions, innovative staff models, and APS CareConnection® to answer common challenges to coordinating clinical and social services for ACCESS Plus Enrollees. As with the development of Enrollee clinical activities, APS focuses the development of our coordination activities that have the most impact in improving Enrollees' health status. For example, simply by coordinating transportation for Enrollees on atypical antipsychotic medications so they can visit physical health providers on a quarterly basis for glucose levels monitoring, we may help that Enrollee avoid metabolic syndrome or diabetes. Similarly, by providing physical and mental health providers within Enrollees care teams with actionable information traditionally not available – such as pharmacy data demonstrating poor adherence to antipsychotics – we can alert clinical and social services to Enrollee's perceived barriers to taking medications and work to close gaps in care, potentially avoid emergency care.

Within ACCESS Plus DM and PCCM programs, we included staff to focus on coordinating care, including referring enrollees to mental health and chemical dependency service providers, as well as other social services such as homeless shelters, food banks, etc. These professionals help Enrollees navigate multiple system complexities by establishing and maintaining effective relationships with behavioral health and other specialty providers. APS CareConnection® enables *21st century* care coordination by integrating data at the person level; documenting a plan of care for every Enrollee, making care planning and delivery *transparent* to the provider community, and providing a secure and HIPAA-compliant communication system between APS and the provider community so that PCPs can alert APS to care coordination needs and concerns.

Finally, an important aspect of the APS' model is the creation of linkages between Enrollees, Providers, and community resources. These resources, such as chronic illness support groups, supplement Provider capabilities in important ways by offering information, additional services—such as transportation, counseling, food and shelter—and support for the Enrollees through interactions with professionals and other individuals with the same chronic disease. APS CareConnection® will include a comprehensive resource directory so that provider offices can easily access the directory. Through this approach, our Health Coaches and providers will have community resources information at their fingertips. APS has already begun the process of building relationships with providers and community organizations in Pennsylvania.

B. Describe how Case Managers will facilitate communication and coordinate service delivery between primary care, specialty, ancillary and behavioral health Providers to ensure Enrollee's timely access to care, improve health outcomes and eliminate barriers to accessing services.

APS' Care Managers will facilitate communication delivery between primary care, specialty, ancillary and behavioral health Providers using several vehicles, including paper-based reports, electronic alerts and telephonic communication. We will use APS CareConnection® patient alerts and secure messaging and Plan of Care/Individual Treatment Plan tools to notify providers of Enrollees' health status as well as issues needing immediate attention. In addition, we plan to distribute patient-level data identifying treatment gaps, medication adherence and prescribing practice issues through our Patient Health Brief. Our staff will also make calls to practice staff to coordinate appointments, facilitate translator services if necessary, and answer questions about ACCESS Plus Program benefits. Finally, nurses will communicate with providers when an Enrollee's health condition changes or presents an emergency (i.e., CHF patients who have sudden weight gain and increased risk for acute emergency/ heart attack). APS Health Coaches, Care Coordinators, and Provider Representatives staff will for example:

- Assist the PCP, the Enrollee, or his or her family members in contacting the Area Agencies on Aging (AAA) to initiate the OPTIONS assessment and work with the PCP or Enrollee to obtain information regarding the need for and outcome of OPTIONS assessments.
- Promote use of evidence-based guidelines as foundation for educational interventions.
- Provide education on screening/monitoring for new-onset of symptoms and co-morbidities.
- Provide complimentary patient education material (co-branded with state program, Provider office information –for high volume practices) relevant to diseases, risk factors, medication adherence and preventative measures (immunizations, cancer screenings), importance of family involvement in treatment/techniques for family involvement.
- Link patients being discharged from acute care and psychiatric hospitals and their PCPs.
- Facilitate relapse prevention plans for Members with depression and their PCPs/Community Mental Health Clinics (e.g., patient education, extra clinic visits, and follow-up phone calls).

- Partner with Provider practices having higher medication adherence rates to identify best practices and leverage tools/education to support practices with lower rates of adherence.
- Educate office staff about symptoms of exacerbations and how to communicate with patient. Develop speaking points and triggers for making emergency appointments.
- Development of specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors or unmet needs.

Our community-based efforts also reduce barriers to access that Enrollees with special needs can experience by identifying resources, strengthening the medical home, and monitoring Enrollee care to identify disparities and unmet need:

- Provide list of community resources (for referral) including Medicaid PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.
- Identify providers with special accommodations, e.g., sedation dentistry.
- Educate staff about barriers Enrollees experience in making/keeping appointments. Assist with possible ergonomic changes to office.
- Facilitate group visits to encourage self-management of various physical and mental health conditions/diagnoses such as pregnancy, diabetes and tobacco use.
- Communicate on a patient-by-patient basis on gaps/needs in order to assure patient has baseline and periodic medical evaluations from primary care provider.

C. Describe how the Offeror will coordinate with and determine when to refer high-risk Enrollees who are not enrolled in the Disease Management program to the Department's Intense Medical Case Management Unit.

APS understands that the Department's FFS Intense Medical Case Management Unit will, at least at the outset of this Agreement, continue to provide Intense Medical Case Management services for high risk Enrollees who do not have one or more of the diseases selected for the Disease Management Program. APS, if engaged, will in turn provide Case Management services for all high risk Enrollees who are enrolled in the Disease Management Program.

APS understands that the Department will identify individuals eligible for Intense Medical Case Management through Predictive Modeling. APS will also refer to the Department individuals it identifies as high risk Enrollees who may be eligible for Intense Medical Case Management.

APS will work with the Department's Intense Medical Case Management Unit to establish a common set of triggers based on our health risk assessments and claims-based utilization information. This set of triggers will include Enrollees who we assess and identify a Severe Mental Illness, those with frequent ER use (more than 3 visits in a 6 month period), and/or poor medication adherence. Triggers will also include psychosocial needs we identify through assessments and referrals, including those Enrollees that:

- Require care and/or services of a type or amount that are beyond what is typically required.
- Have been diagnosed with an autism spectrum disorder.
- Require extensive rehabilitative, habilitative or other therapeutic interventions to maintain or improve the level of functioning for the individual.
- Due to the nature of the condition, may require a Specialist to manage primary care.

- May incur higher morbidity without intervention and coordination in the care of the individual.
- Require care and/or services that necessitate coordination and communication with public and private community service organizations.
- Require coordination of care and/or services between acute inpatient settings and other facilities and community Providers.
- Require assistance to schedule or arrange for appointments or services, including arranging for transportation to and from appointments.
- Need language, communication or mobility accommodations.
- Need to be accompanied or assisted by an individual who may act on the Enrollee's behalf when seeking or receiving care.

If a Special Need is indicated, APS will place a Special Needs indicator on the Enrollee's record or file and must outreach to that Enrollee to identify his or her Special Need or circumstance. APS will assure that Enrollees' needs are adequately addressed, and refer Enrollees identified as requiring additional assistance to the appropriate care coordinator, Disease Management case manager or to the Department's FFS Intense Medical Case Management Unit, as necessary.

D. The Department will initially conduct predictive modeling to identify high-risk Enrollees, but, in the future, may require the selected Offeror to conduct predictive modeling. Describe the Offeror's experience conducting predictive modeling and how it would use predictive modeling results. List and describe the predictive modeling products the Offeror uses or has used.

APS uses a comprehensive suite of powerful predictive modeling tools – both public domain and propriety – to identify high-risk clients. Our approach analyzes demographic data, historical medical, behavioral, and pharmaceutical claims data using statistical algorithms that take into account all major disease diagnoses, since high-risk cases are generally comprised of multiple diagnoses. Claims-based analyses are supplemented by Health Risk Assessments (HRA). The approach is based upon research conducted by a member of APS' HI team indicating both sources of information can independently contribute to identifying appropriate clients for a care management program.

Step 1: University of California – San Diego's Chronic Disease and Illness Payment System

APS has provided predictive modeling services for over a decade and currently conducts such analytics for Medicaid programs that cover over 4 million members. Predictive modeling is a component of each *Healthy Together!* disease management (DM) program.

For our commercial care management accounts we use the Johns Hopkins ACG (originally "Ambulatory Care Group") Case-Mix System. ACGs have a long history and continuous development and improvement make it one of the most widely used systems on the market today. For our Medicaid accounts, however, we prefer to use the Chronic Disease Payment System (CDPS). CDPS has been shown to have greater predictive power over the ACG model when applied against a Medicaid population.[1] It has the added advantage of including an Aid Category which assigns diagnoses to CDPS groups slightly differently by eligibility category (SSI vs. TANF) and

1 Kronick, Richard, et al., Improving Health-Based Payment for Medicaid Beneficiaries: CDPS, Health Care Financing Review, Volume 21, Number 3, Spring 2000.

by age group (children vs. adults.) This distinction recognizes that effects of diagnoses on expenditures are different for persons with disability than for TANF recipients.

Our expertise with predictive modeling will guide APS in identifying clients who have a "high risk" potential for costly episodes of care. This initial claims-based identification also sets priorities for conducting HRAs and baseline knowledge surveys, as well as outreach and enrollment activities.
For Claims-Based Predictive Risk Modeling, APS Proposes to use:

- Chronic Disease Payment System (CDPS) to stratify Enrollees by risk.
- APS' Proprietary Treatment Gap Analysis to identify unmet care needs.
- APS team member Southeast Consultants to identify uncoordinated care.
- The output of these powerful informatics tools are creatively combined to define and identify clients who will be targeted for the disease management.

Step 2: Application of Predictive Modeling

CDPS includes 20 major categories of diagnoses, which correspond to body systems or type of diagnosis. (For prospective estimation of payment weights, it excludes the categories for infants, leaving the model with 19 major categories). Most of the major categories are further divided into several subcategories according to the degree of the increased expenditures associated with the diagnoses. For example, diagnoses of the nervous system are divided into three subcategories for high-cost, medium-cost, and low-cost conditions. CDPS assigns each member to one or more of 67 possible medical condition categories based on diagnosis codes.

Each member is also assigned to one of 16 age/gender categories. For each member, the model predicts total medical costs based on the medical condition categories and age/gender category assigned. The model has been calibrated to identify patients at high risk for using large amounts of health care resources in the future, and to estimate potential expenses. Before their health care situation worsens and service use increases, the CDPS scores can help to identify persons who could benefit from intensive disease management, case management, and other types of interventions. CDPS can also be used to estimate future resource use for sub-groups within a population and the method has many applications within the quality improvement domain. By assigning each individual to a single grouping which permits the effects of a clustering of morbidities to be captured in estimates of resource use based upon a unique pattern of co-morbidities, the program identifies individuals with complex conditions that can benefit from care management. In adopting the CDPS system, APS recognizes the congruence of this approach to capturing the multidimensional nature of an individual's health over time.

Below is an example of how we used CDPS risk scores for our [redacted] State Wellness Program. The member risk scores were used to stratify individuals into 4 risk bands:

- High ([redacted]% of population) = Percentile average [redacted]
- ModHigh ([redacted]% of population) = Percentile average between [redacted] and [redacted]
- ModLow ([redacted]% of population) = Percentile average between [redacted] and [redacted]
- Low ([redacted]% of population) = Percentile average [redacted]

Our past experience providing care management services to Medicaid members has taught us the importance of assisting those members with multiple co-morbidities. Based upon the stratification process above we produced the following co-morbidity count in [redacted]:

Count	Strata	Comorbid Count	Average Risk Rank Percentile
[redacted]	High	[redacted]	[redacted]
	ModHigh		
	ModLow		
	Low		

We will conduct a similar analysis for the ACCESS Plus Program to identify member at high risk and multiple co-morbidities. APS believes that a predictive analytic approach increases the effectiveness of chronic care improvement. Predictive modeling serves to identify individuals who are at-risk for intensive service utilization but who have not yet received the appropriate services or guidance to recognize the important signs and symptoms that can lead to a worsening of their condition. We will apply our predictive modeling to the entire enrolled ACCESS Plus population to identify those members most in need of in-depth Health Coaching. Outreach to and early intervention with identified individuals both alleviates future suffering and promotes entry into service at a lower intensity, and more cost-effective level of care.

APS' Treatment Gap Analysis. Treatment Gap Analysis is a proprietary APS clinical data mining tool used to analyze medical and pharmacy claims to identify chronic care conditions that can be measure against applicable standards of care to address instances of sub-optimal clinical care. Treatment Gap Analysis involves the identification and then stratification of patients who have gaps between actual care and evidence-based practice guidelines. This application also matches participant and provider interventions to the Enrollees' level of risk and measures outcomes.

Uncoordinated Care Profiles. SEC has developed proprietary, criteria-driven algorithms which are applied to claims data to identify and target patients exhibiting patterns consistent with uncoordinated care. These patients could most benefit in cost efficiency and quality of care from improved coordination of care provided through focused care and disease management interventions. While these uncoordinated care patients represent a small percentage of enrollees ([redacted]%), they account for significant percentages of program costs ([redacted]%). Enrollees are screened for patterns of uncoordinated care, for over and under utilization of prescriptions, therapeutically duplicative and contraindicated drugs, frequently changing drug therapies within class and subclass, using multiple prescribers and multiple pharmacies concurrently and in random patterns, accessing the ED frequently and/or for non-emergent care, and numerous other access patterns often indicative of uncoordinated care.

Step 3: Stratified Assessments Using More than the Data

Subsequent to developing initial risk stratification, APS' Health Coaches will contact ACCESS Plus identified participants to confirm enrollment and perform assessments of Enrollees utilizing APS CareConnection®. During these assessments, APS Health Coaches focus on the "whole person," delving beyond their immediate need and assessing their potential physical and mental health care needs. We recognize that a "cookie cutter" approach to chronic care is not effective because each participant is different in terms of the way they view their circumstances, needs, disease, the resources available to them, the way they learn, the way information is processed and how they respond to assistance in seeking health care. Highly customized, APS CareConnection® includes:

- Automated, customized assessment tools – for ACCESS Plus, these tools will incorporate a validated depression screening instrument (PHQ-9).
- Assessment-driven, automated stratification to clinical pathways and care strategies.

- A proprietary clinical impact tool (exceeds URAC case management standards).
- Assessment driven, auto generated care plans which include goals, interventions, and monitoring and evaluation timelines that are based on national standards and practice guidelines and have been highly customized to meet the needs of public programs.
- Automated prompts and updates to the Care Management Team to facilitate on-going clinical decision-making and intervention.

E. Recommend additional innovative case management strategies the Department may want to consider for the ACCESS Plus Program.

As part of the coordination activities with the Department's Intensive Case Management Unit, APS will implement outreach and education programs co-developed with DPW, which focus on health initiatives that target Enrollees with Special Needs including, but not limited to, smoking cessation for pregnant women, childhood obesity, HIV/AIDS, developmental disabilities, cervical cancer screening, and other services available to Enrollees with Special Needs as directed by the Department in coordination with APS. APS will include a discussion of services to Enrollees with Special Needs as an agenda item and address Special Needs issues during the Regional Advisory Committee meetings, as directed by the Department.

APS understands that office staffs are the gatekeepers to patients reaching their providers and thus have a great impact on access. Enrollees diagnosed with Severe Mental Illness (SMI) encounter difficulty accessing primary care. APS will provide training for office staff within primary care practices about methods to facilitate behavioral health referrals. Training will also include a description of symptoms of SMI exacerbation, how to communicate with patients who experience exacerbations and other symptoms, and speaking points and triggers for making appointments. In addition, APS will educate staff about the barriers SMI patients report when making and keeping appointments, such as noisy reception and waiting rooms. Similarly, APS proposes to facilitate communication between primary care providers and the mental health team, realizing that psychiatrists may not always be available. This facilitation may include training behavioral health office staff to be receptive to medical needs the primary care provider communicates, necessary data elements when receiving referral from providers and even modifying workflows to ensure immediate feedback and appointment setting. APS will engage primary care and mental health providers as partners to develop and test these strategies for enhancing communication and coordination.

Focused High Risk Neonatal Case Management

Analysis of claims data for 2006 and 2007 indicated [redacted] neonatal cases that were in the top [redacted]% of total costs. Pharmacy cost for this group was $[redacted] and medical costs were $[redacted] for total costs of $[redacted]. Inpatient costs represented the greatest percentage of costs – [redacted]%. Of equal concern is the well-being of these fragile infants after discharge.

APS is aware that the Intense Case Management Unit handles these cases, along with other very high cost/high risk cases. Because of the exceptional cost associated with their delivery, and in recognition of high inpatient costs and emergency room utilization, APS recruited our small business partner, ProgenyHealth to join the APS team to work with the Department in caring for these babies and supporting their family members. ProgenyHealth brings an exceptional case management standard to the Department's support. President Ellen Stang, MD, is a Board-certified Pediatrician licensed in the Commonwealth of Pennsylvania. Dr. Stang's team of Neonatal Intensive Care Unit (NICU) Registered Nurses brings decades of experience in the care of high risk neonates. The ProgenyHealth Case Management Toll Free number will be available as a selection on the calling

tree of the ACCESS Plus 24/7 Toll Free number to Enrollees with NICU babies from discharge for a period of *12 months*. This extended specialty intense case management service will support young families in making good decisions for their fragile babies, offering nurse advice 24 hours a day, 7 days a week. An additional focus of this service will be to promote the delivery of EPSDT services to children enrolled in this service.

We propose that the Department's ICM Unit will refer babies into this service. ProgenyHealth will conduct an intake assessment and implement case management services. APS will support ProgenyHealth with data extracts for claims and eligibility, and will integrate ProgenyHealth's case management documentation into APS CareConnection®. The Department will also be able to access case files on a read-only basis through ProgenyHealth's secure website. ProgenyHealth will also work with APS to support the PCPs of these Enrollees for comprehensive and integrated services that are seamlessly transparent to families and providers.

F. Recommend innovative emergency room diversion strategies and capabilities the Department may want to consider for the ACCESS Plus Program (e.g., PCP scheduling software in emergency rooms and other strategies to address inappropriate use of emergency rooms).

Inappropriate use of emergency room services is a particularly significant problem for Medicaid programs. According to Center for Healthcare Strategies, a small percentage of Medicaid recipients are disproportionately driving costs; approximately 5% of Medicaid beneficiaries account for up to 50% of total Medicaid spending in states across the country. Currently, state Medicaid programs are reimbursing for ED visits that could be prevented through less costly medical services and care coordination.

Medicaid beneficiaries often have multiple needs and confront difficulties navigating the health care system. These individuals face barriers in accessing primary care, mental health care, substance abuse treatment, housing and other services, contributing to their frequent ED visits. Hospital emergency departments and primary care clinics in the community have a vested interest in providing Medicaid beneficiaries with alternatives to use of ED services for non-emergent care. However, these community providers may not always have the means to adequately address this issue, absent broader systems reforms.

APS proposes to use an innovative strategy - a web-based scheduling and referral system application. APS has partnered with My Health Direct. Inc. (MHD) for use of their system in the ACCESS Plus Program proposed by APS. MHD is healthcare information technology that offers a comprehensive, community-wide solution for real-time searching, comparing and scheduling of health care services. The tool is accessible through a secure Internet portal, requiring only an internet connection and an Internet Explorer browser. ED staff can search and schedule appointments with PCPs and the MHD system then prints documentation of the appointment for the Enrollee in any of 70 languages, and also faxes an appointment document to the PCP office that staff can then quickly record in the patient scheduling system. Emergency Department staff can effectively reduce overcrowding caused by the presence of Enrollees without emergency needs by scheduling appointments with their PCPs. APS will work with hospitals and PCPs in the ACCESS Plus area to adopt and use this system.

G. Describe how the Offeror will coordinate services for Enrollees with long-term special needs (e.g., cerebral palsy) and ensure that these Enrollees are able to access ACCESS Plus benefits and services.

The approach APS takes in coordinating services for Enrollees with long-term special needs is consistent with our overall care management philosophy. APS' plan for seamless and continuous care coordination and case management for Enrollees with long-term needs will include:

- Becoming familiar with ACCESS Plus benefits and covered services (including waiver services) and identifying opportunities where Enrollees may not be maximizing their benefits.
- Identifying when Enrollees may become eligible for Medicare-covered services, including nursing home care and hospice services.
- Identifying dentists who will serve MA recipients with special needs, including children.
- Ensuring continuity of care for Enrollees with Special Needs who transition from children's' services to adult services, including educating Enrollees on the adult services available and how they compare to the services available to children.
- Communicating Information from the Enrollee handbook about how and where to access behavioral health, Family Planning, OB/GYN, dental and vision services, and services for Enrollees with Special Needs, including autism spectrum disorders.
- Coordinating care with providers (and systems) so that an ongoing course of treatment is not interrupted or delayed.
- Assisting with the transfer of medical record information to new providers or systems in a timely fashion.
- Communicating coordination activities to all members of the care team, as well as the Enrollee and the Enrollee's caregivers.
- Assisting with the development and implementation of an enrollee disease registry within CareConnection® capable of being shared with providers and systems.
- Monitoring the referral and follow-up of enrollees in need of specialty care and routine health care services.
- Facilitating, when necessary, the re-assignment of a PCP: contacting the Enrollee and PCP to understand the reason for PCP request for re-assignment, gaining approval through the Department, and contacting the EAP contractor to initiate the reassignment.
- Documentation of referral and follow-up services in enrollees' records.

APS also responds to issues concerning continuity of care (Section II-3.8) describing our support for children with special needs who transition into adult services. Our outreach and communications for Enrollees with special needs is addressed in Section II-3.16, Enrollee Outreach and Education. With five programs that serve people with special needs, and DM programs that support over 200,000 Medicaid Enrollees in Medicaid Aged, Blind, and Disabled waivers, APS is one of the most experienced vendors in providing DM and administrative services for people with special needs. The Department can be ensured that APS understands special needs and is prepared to support people with these needs – with our hallmark exemplary customer service and person-centered approach.