Request for Proposal

SOLICITATION # YH19-001

AHCCS Complete Care Contract for Contractors

Proposal Due Date:
January 25, 2018
at 3:00 p.m. Arizona time

- Submitted Electronically -

SUBMITTED BY:
Arizona Complete Health, Complete Care Plan
1230 W. Washington Street
Tempe, Arizona 85281

TO:
Meggan Harley, CPPO, MSW
Chief Procurement Officer
AHCCCS
701 E. Jefferson, MD 5700
Phoenix, Arizona 85034

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complete health

January 24, 2018

Arizona Health Care Cost Containment System Administration (AHCCCS)
Procurement Office
Attn: Meggan Harley, CPPO, MSW
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

Re: Request for Proposal # YH19-0001

Dear Ms. Harley:

We are pleased to submit our response to the Request for Proposal (RFP) # YH19-0001 from the Arizona Health Care Cost Containment System Administration Complete Care Program. The legal entity submitting this bid is Health Net Access, Inc., and as such, Arizona Complete Health-Complete Care Plan (AZCH) will be the DBA for that legal entity with Cenpatico Behavioral Health of Arizona, LLC as the Affiliated Organization.

AZCH is the fully integrated, single comprehensive plan formed by our Arizona Health Net Access and Cenpatico Integrated Care Regional Behavioral Health Authority (RBHA) programs. Our experience with ALTCS, RBHA and acute plans in AZ has informed the development of AZCH to create a highly integrated health plan with a commitment to serve communities and deliver whole-person health care. We are committed to the goals AHCCCS has brought forward in this program transformation, and throughout our response, we have presented innovation and experience that we believe will carry through that vision.

We look forward to the continued opportunity to work with AHCCCS and provide high quality, integrated care to beneficiaries. Should you have any additional questions, please feel free to contact us by the information listed below.

Sincerely,

Paul D. Barnes, Ph.D.
Arizona Plan President
Arizona Complete Health
1870 W Rio Salado
Tempe, AZ. 85281
Phone: (480) 567-9011

James V. Stover
Medicaid President
Arizona Complete Health
1870 W Rio Salado
Tempe, AZ. 85281
Phone: (520) 809-6516

EXHIBIT A: OFFEROR'S CHECKLIST

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

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

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
Offeror's Bid Choice Form	RFP Section I, Exhibit B Refer to Bidders' Library	4
Offeror's Completed and Signed RFP Solicitation and Offer Page	RFP Section A Refer to Bidders' Library	5-6
Offeror's Signed Signature Page(s) for **each** Solicitation Amendment	Refer to Bidders' Library	7-8
Capitation Non-Benefit Costs Bid Submission		
Signed Agreement accepting capitation rates	RFP Section H, Instructions to Offerors	9
Non-Benefit Costs Bid Submission workbook	RFP Section H, Instructions to Offerors	10-15
Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	16-29
Executive Summary and Disclosure		
Executive Summary	RFP Section H, Instructions to Offerors	30-32
Moral or Religious Objections	RFP Section H, Instructions to Offerors	33
Narrative Submission Requirements		
1.	RFP Section I, Exhibit C	34-35
2.	RFP Section I, Exhibit C	36-42
3.	RFP Section I, Exhibit C	43-47
4.	RFP Section I, Exhibit C	48-54
5.	RFP Section I, Exhibit C	55-59
6.	RFP Section I, Exhibit C	60-64
7.	RFP Section I, Exhibit C	65-71
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9.	RFP Section I, Exhibit C	77-81
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11.	RFP Section I, Exhibit C	87-91
12.	RFP Section I, Exhibit C	92-96
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	97-101
14.	RFP Section I, Exhibit C	102-106
15.	RFP Section I, Exhibit C	107-111
16. A (North) *If applicable*	RFP Section I, Exhibit C	112-114
16. B (South) *If applicable*	RFP Section I, Exhibit C	115-117
17.	RFP Section I, Exhibit C	118-122
18.	RFP Section I, Exhibit C	123
Oral Presentations		
Names and Titles of Participating Individuals	RFP Section H, Instructions to Offerors	124
Resumes of Participating Individuals	RFP Section H, Instructions to Offerors	125-148
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit D Refer to Bidders' Library	149
Affiliated Organization Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	150
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	151-153

GENERAL SUBMISSION REQUIREMENTS

OFFEROR'S BID CHOICE FORM
EXHIBIT B

EXHIBIT B: OFFEROR'S BID CHOICE FORM

AHCCCS COMPLETE CARE RFP YH19-0001 OFEROR'S BID CHOICE FORM

BID CHOICE FORM - PART 1

Health Net Access, Inc.
OFFEROR'S NAME

is bidding on the AHCCCS Complete Care Program in the GSA(s) checked below:

Offerors bidding in all three GSAs shall also identify below GSA priority preferences for award by indicating (1st choice, 2nd choice, 3rd choice) in the Priority Choice by GSA Column.

	GSA	Priority Choice
☒	**Central:** Maricopa, Gila, and Pinal Counties	1
☒	**North:** Mohave, Coconino, Apache, Navajo and Yavapai Counties	3
☒	**South:** Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties	2

Authorized Signature

1/24/18
Date

Paul Barnes
Print Name

Plan President and CEO
Title

BID CHOICE FORM - PART 2

Offerors requesting to participate in the evaluation for expansion of services as described in *RFP Section H, Instructions to Offerors, Paragraph 20*, shall indicate their request for participation below. An Offeror must complete the Bid Choice Form - Part 2 in order to be considered for participation in the future expansion of services. **Failure to complete the Bid Choice Form shall preclude the Offeror from participation in the future expansion of services.**

Health Net Access, Inc.
OFFEROR'S NAME

is requesting to participate in the evaluation for expansion of unique services in the GSA(s) checked below:

	GSA
☒	**Central:** Maricopa, Gila, and Pinal Counties
☒	**North:** Mohave, Coconino, Apache, Navajo and Yavapai Counties
☒	**South:** Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties

Authorized Signature

1/24/18
Date

Paul Barnes
Print Name

Plan President and CEO
Title

OFFEROR'S COMPLETED AND SIGNED RFP SOLICITATION PAGE SECTION A

AHCCCS Arizona Health Care Cost Containment System	NOTICE OF REQUEST FOR PROPOSAL
	SOLICITATION # YH19-0001
	AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

SECTION A: SOLICITATION AND OFFER PAGE

Chief Procurement Officer
Meggan Harley, CPPO, MSW
Chief Procurement Officer
AHCCCS
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

Telephone: (602) 417-4538
E-Mail: ICRFPYH19_Questions@azahcccs.gov
Issue Date: November 2, 2017

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (AHCCCS)**
Procurement Office (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: **AHCCCS COMPLETE CARE PROGRAM CONTRACT FOR CONTRACTORS**

PROPOSAL DUE DATE: **January 25, 2018** **AT 3:00 P.M. ARIZONA TIME**

A Pre-Proposal Prospective Offerors' Conference has been scheduled for Wednesday, November 8, 2017 starting at 9:00A.M. Arizona Time. The Conference will be held in the following location:

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

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE PROCUREMENT OFFICER NAMED ABOVE, IN WRITING, VIA E-MAIL, AS SPECIFIED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE RFP YH19-0001 QUESTIONS AND RESPONSE TEMPLATE LOCATED IN THE BIDDERS' LIBRARY. ANSWERS TO QUESTIONS WILL BE POSTED IN THE AHCCCS WEBSITE IN THE FORM OF A SOLICITATION AMENDMENT FOR THE BENEFIT OF ALL POTENTIAL OFFERORS.

In accordance with A.R.S. §36-2906, which is incorporated herein by reference, competitive sealed Proposals will be received by AHCCCS in accordance with the instructions in this solicitation document until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read.

Proposals must be in the actual possession of AHCCCS on or prior to the time and date in accordance with the instructions in this Solicitation document.

Late Proposals shall not be considered.

All Proposals must be typewritten. Additional instructions for preparing a Proposal are included in this solicitation document.

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the person named above. Requests should be made as early as possible to allow time to arrange the accommodation.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

AHCCCS Arizona Health Care Cost Containment System	NOTICE OF REQUEST FOR PROPOSAL
	SOLICITATION # YH19-0001
	AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

OFFER

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

NPI No. (*optional*)

None

Federal Employer Identification No.: 46-2616037

Dun and Bradstreet (DUN) No. 80-924-5525*

E-Mail Address: pabarnes@centene.com

Health Net Access, Inc.
Company Name

1870 W. Rio Salado Parkway
Address

Tempe | Arizona | 85281
City | State | Zip

For clarification of this offer,

contact: Name: Paul Barnes

Title: Plan President and CEO

Phone: 480-567-9011

Signature of Person Authorized to Sign Offer

Paul Barnes
Printed Name

Plan President and CEO
Title

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§41-1461 through 1465.
3. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. The Offeror ___ is / X is not a small business with less than 100 employees or has gross revenues of $4 million or less.
5. The Offeror is in compliance with A.R.S. §18-132 when offering electronics or information technology products, services, or maintenance; and
6. The Offeror certifies that it is not debarred from, or otherwise prohibited from participating in any contract awarded by federal, state, or local government.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

This Contract shall henceforth be referred to as Contract No. YH19-0001

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

OFFEROR'S SIGNED SIGNATURE PAGE(S) FOR EACH SOLICITATION AMENDMENT (1 – 2)

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #1		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: **January 25, 2018** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

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

This Solicitation is amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Paul Barnes	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Plan President and CEO	TITLE: Chief Procurement Officer
DATE: 1/23/18	DATE:

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #2		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: **January 25, 2018** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

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

This Solicitation is amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Paul Barnes	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Plan President and CEO	TITLE: Chief Procurement Officer
DATE: 1/23/18	DATE:

EXECUTIVE SUMMARY AND DISCLOSURE

EXECUTIVE SUMMARY

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

1. The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant…

OVERVIEW OF ORGANIZATION

Arizona Complete Health-Complete Care Plan (AZCH) is honored to have the opportunity to respond to the Request for Proposal for AHCCCS Complete Care Program YH19-0001. Functionally, AZCH is the fully integrated, single comprehensive plan formed by our Health Net Access and Cenpatico Integrated Care Regional Behavioral Health Authority (RBHA) programs. The legal entity submitting this bid is Health Net Access, Inc., and as such, Arizona Complete Health-Complete Care Plan will be the DBA for that legal entity with Cenpatico Behavioral Health of Arizona, LLC as the Affiliated Organization. Our experience in Arizona as a RBHA, an Acute Care plan, and an ALTCS plan has informed the development of AZCH to create a highly integrated health plan with a commitment to serve communities and deliver whole-person health care. Throughout this response, ***AZCH will*** demonstrate how we meet or ***exceed contractual requirements*** and are committed to the following tenets as described in the Contract:

- AZCH is dedicated to AHCCCS' Mission and Vision that is founded on providing comprehensive quality healthcare, supporting member choice, and ensuring continuity of care to reduce fragmented services.
- AZCH understands the importance of continuously adding value to the AHCCCS Complete Care Program through our integrated delivery system for physical health (PH) and behavioral health (BH) services. We have and will continue to recognize the critical importance of our care management and care coordination processes evolving to improve our performance for members and providers.
- AZCH supports and will adhere to all AHCCCS System Values and Guiding Principles to guide our organizational and operational processes for comprehensive service delivery to members.
- AZCH will provide and support integrated care that focuses on improving member health outcomes, enhancing coordination of care, and increases member satisfaction.
- AZCH will collaborate with AHCCCS in terms of initiatives that focus on continuous system improvement to build a more cohesive and effective health care system in Arizona.
- AZCH will continue to provide leadership in the Arizona Association of Health Plans to ensure engagement and collaboration with other plans.

RELEVANT EXPERIENCE

We bring over 13 years of experience serving Arizona's Medicaid program. AZCH currently provides managed care services for over 500,000 members through our Acute Care and RBHA contracts. Through our HealthNet Access experience, we provide fully coordinated health care to members in Maricopa County that includes medical and coordination with the local RBHA as well as fully integrated services for our GMHSA duals. Through our RBHA experience, we provide integrated health care for individuals with SMI and coordinated BH services to members in Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma counties. Additionally, we bring historical experience serving members under the Acute Care Program in Yavapai County and fully integrated services to ALTCS members in Maricopa, Pinal, Gila, Cochise, Graham, and Greenlee counties.

LEVERAGING NATIONAL EXPERIENCE. AZCH is a wholly-owned subsidiary of Centene Corporation (Centene), the largest Medicaid managed care company in the country. Centene has diversified, multi-national healthcare expertise, and for more than 34 years has served complex and underserved members through government-sponsored healthcare programs. AZCH will leverage both our Arizona and national integrated experience to support AHCCCS Complete Care.

PROPOSED APPROACH TO MEETING REQUIREMENTS

AZCH and our strong local Arizona leadership team, are committed to meeting and exceeding Contract requirements using our **combination of national Medicaid focused best practices and resources, with locally tailored approaches, investments, decision making and control**. With 7.1 million Medicaid member lives nationwide, Centene continues to invest in integrated technologies such as Centelligence®, our proprietary and comprehensive family of integrated decision support and health informatics solutions, includes a combination of proprietary algorithms, risk stratification, and advanced predictive analytics to improve care and achieve quality, clinical, and financial goals in integrated care.

Together with our affiliate health plans AZCH participates in Centene's national best practice forum for sharing evidence based practices, performance improvement projects, and other successful interventions. This allows AZCH to learn from the experience of 29 Medicaid plans and health programs across the country, benchmark against and compare our experience in AZ, spot national trends, and be proactive and successful in our initiatives. We are committed, and invested in Arizona--***AZCH and Centene together employ approximately 2,100 staff across the state of Arizona.***

LOCAL LEADERSHIP AND EXPERTISE. Complementing this national experience is our local leadership, expertise and infrastructure. In our progression toward integration, we have assembled an ***expert core leadership team with an average of 16 years' experience in Medicaid, 13 years specific to AHCCCS.*** This AZ Medicaid experience has translates into trusted and credible relationships with PH and BH providers, stakeholders, and AHCCCS. We have an established Customer Service and Medical Management team trained to assist members in accessing needed services. Our local approach enables us to provide accessible, high quality and culturally/linguistically sensitive and integrated health care services to members. Our managed care model uses integrated programs that can be delivered effectively only by local staff, providing a strong connection with the communities we serve. This approach ensures that members, providers, state agencies and community resource agencies are able to partner with trusted individuals from their communities and that stakeholders have direct access to local, accountable health plan staff. Our proposed approach begins with effective member engagement and a robust, well-supported and engaged provider network. ***We have a fully credentialed, statewide, network of nearly 30,000 AZ providers today, including a significant network of PH, BH, and 17 integrated health homes-with over 90 integrated clinic locations.*** We provide the support and empowerment for members to take charge of their health and access services, through a member-centric, whole health approach. A dynamic health care system requires frequent changes and we recognize the need to continually re-focus to make the necessary adjustments that will result in the most beneficial quality outcomes for our members. It is through this veteran team, integrated infrastructure, and proven approach that we can confidently meet the requirements of the Complete Care Contract.

BRINGING ADDED VALUE TO THE PROGRAM

AZCH has implemented multiple innovative programs and strategies to bring added value to the program and deliver exceptional services to members. As demonstrated throughout this response, the following are examples of our innovations that will bring added value to members.

- We recognize the complexity of the transformation of the AHCCCS delivery system and the large number of members impacted by this transition. To make this successful, our ***multi-disciplinary Rapid Response Team and Transition Coordinator will meet twice daily beginning mid-2018 through transition to operations.*** Monitoring data on key implementation factors such as authorization readiness, stress testing of the computer systems, outreach to relinquishing health plans and RBHAs, updated provider lists, and updated PA lists. Lead by the Director of Quality Management, quality staff will conduct real-time monitoring for potential quality of care concerns and immediate health and safety issues, which will trigger immediate action by the Quality of Care team.
- By July 2018, per AHCCCS guidelines and AHCCCS approval, AZCH will launch our CentAccount member incentive program which incentivizes members for participation in preventive services, especially those associated with healthy birth outcomes and EPSDT services, such as regular prenatal care and well-child visits. In addition, we are ***aligning provider incentives with member incentives*** to support a collaborative approach for preventive care.
- Through our pilot project in Yuma we are ***expanding use of Community Health Workers/Promotoras*** and will partner with other network providers to expand/enhance culturally responsive outreach and engagement efforts for improvement on goals or barriers, such as health literacy, stigma reduction (BH/SUD), prenatal care, breastfeeding awareness, well-child care (EPSDT), and domestic violence risk.
- We have partnered with The University of Arizona College of Nursing (UA CON) to ***fully fund a Developmental Pediatric Nurse Practitioner Certificate Program to increase provider capacity*** to conduct screenings and identify developmental delay sooner.
- AZCH is implementing a ***Quality-Based Pay for Performance Program that rewards Primary Care Providers and integrated health homes*** with a bonus payment when they achieve target quality results in reducing Emergency Department use, acute hospital admissions/readmissions, and length of stay.

- AZCH ***goal to have 80% of AZCH spend made to high value, integrated providers under VBP by 2020.*** We will accomplish this through VBP strategies like our "no provider left behind" P4P program for all PCPs and BH providers, Centene's customized FQHC VBP Model, specialized VBP programs for the medical specialties of OB, endocrinology, GI and cardiology – all by October 2019.
- AZCH is holding ***monthly provider forums in each urban and rural county we are awarded for 60 days pre- and 90 days post-go live to support a successful transformation of the delivery system***. These meetings will be structured to hear concerns, brainstorm solutions, and introduce our Provider Engagement Specialists and leadership team.
- In Q1 2019, we will begin ***offering three versions of a Navigating American Indian Health Care with AHCCCS packet***. Each packet will be tailored to engage, educate, and bring awareness about Contract changes and how the changes differ from current services and options related to receiving or providing BH/PH services for members, providers, and Tribal Nations.
- Beyond the contractual requirements, ***we are investing in Arizona to improve member experience and provider alignment***. Investment areas include practice transformation (Care Accountability), needs of homebound members (Healthy Together), early identification of Autism Spectrum Disorder and developmental delays (Southwest Autism Resource and Research Center), homeless population (Circle the City/Engage) and technology (Zoom Visits).
- Through Centene's ***Outcomes Improvement Central,*** AZCH brings a searchable, enterprise wide library of initiatives available to leadership and staff through our Intranet, with over 450 pilots and programs for Medicaid populations.

MEETING SPECIFIED REQUIREMENTS

AZCH will meet all requirements as specified in paragraph 7, section Participation as a Medicare Advantage Dual Special Needs Plan (D-SNP), and RFP Section D, paragraph 70 within the Contract.

ACCOMMODATING AHCCCS MEMBERS. AZCH is committed to providing covered services to members without regard to race, color, national origin, sex, sexual orientation, gender identity, age, and/or disability. We will not use policies or practices that discriminate in any circumstance [42 CFR 438.3(d), 45 CFR Part 92]. AZCH develops processes and programs that are focused on meeting the member's individual needs regardless of their personal background. In fact, AZCH celebrates and embraces diversity as demonstrated by our diversified hiring practices and emphasis on learning from others to develop new programs. One example of this commitment is supported by our strong relationships with Tribal Nations in our GSAs. Our relationships with Tribal Nations and what we have learned from these relationships, have been instrumental to program and network development that meets the specific needs of the Tribal community.

PARTICIPATION AS A MEDICARE ADVANTAGE DSNP AND MEDICARE REQUIREMENTS. AZCH will implement Medicare DSNPs effective January 1, 2019 in all awarded counties. AZCH will maintain and operate AHCCCS-contracted DSNPs as per the requirements of respective existing MIPPA Agreements with the State through the designated contract term of December 31, 2018. AZCH acknowledges the requirement to offer a Medicare Advantage DSNP in all awarded counties and have submitted our Notice of Intent to Apply to CMS for expansion of our DSNP program, for any potentially counties awarded under this RFP. As part of the application process, AZCH has been actively developing provider networks in service expansion counties in accordance with CMS and AHCCCS adequacy standards to file in February 2018. In our current D-SNP (H5590), we achieved a Medicare 4 Star rating in 2016 and retained that 4 Star rating in 2017. We believe this to be a remarkable achievement given that the population was made up of dual eligible members under our ALTCS program. The challenges of meeting HEDIS, CAHPS and HOS measures for the Elderly and Disabled population under Long Term Care were considerable. The key to our success was the fact that every part of our organization committed to the quality and member satisfaction outcomes measured by the Medicare Star methodology, not just our Medicare quality department. We are bringing that same total organization commitment to our current H5590 members who are dual eligible members under our Health Net Access contract and expect the same result.

In summary, AZCH brings more than 13 years of experience serving Arizona and a commitment to transforming the service delivery system for integrated, member-centric health care that improves whole-health outcomes.

MORAL OR RELIGIOUS OBJECTIONS

arizona complete health

EXECUTIVE SUMMARY AND DISCLOSURE

Moral or Religious Objections

The Offeror shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service [42 CFR 438.102(a)(2)]. The Offeror shall submit a Proposal addressing members' access to the services [Section 1932(b)(3)(B)(i) of the Social Security Act, 42 CFR 438.102(b)(1)(i)(A)(2)]. AHCCCS does not intend to offer the services on a Fee-For-Service basis to a Successful Offeror's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored. In the event the Proposal is not approved, AHCCCS will notify the Offeror. In these circumstances AHCCCS may disenroll members who are seeking these services from the Successful Offeror and assign members to another Successful Offeror. AHCCCS also reserves the right to withhold assignment of new members until such time as there is an approved Proposal [42 CFR 438.56]. The Proposal must:

1. Place no financial or administrative burden on AHCCCS,
2. Place no significant burden on members' access to the services,
3. Be accepted by AHCCCS in writing, and
4. Acknowledge an adjustment to capitation, depending on the nature of the proposed solution.

If AHCCCS approves the Offeror's Proposal for its members to access the services, a Successful Offeror must immediately develop a policy implementing the Proposal along with notification to members of how to access these services. The notification and policy must be consistent with the provisions of 42 CFR 438.10 and shall be approved by AHCCCS prior to dissemination. The notification must be provided to newly assigned members within 12 days of enrollment, and must be provided to all current members at least 30 days prior to the effective date of the Proposal [42 CFR 438.102] [42 CFR 438.102(b)(1)(i)(B), 42 CFR 438.10(g)(4)].

Arizona Complete Health – Complete Care Plan has no moral or religious objections to covered services; will provide or reimburse for covered services; and is not submitting a Proposal to address members' access to the services.

NARRATIVE SUBMISSION REQUIREMENTS

NARRATIVE SUBMISSION REQUIREMENTS

NARRATIVE SUBMISSION
RESPONSE #1

NARRATIVE SUBMISSION
RESPONSE #1

arizona complete health

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

Unless otherwise specified, responses to each submission requirement must be limited to five (5) pages

1. The Offeror must identify no more than two contracts, in addition to Arizona Medicaid contracts, that represent its

Arizona Complete Health-Complete Care Plan (AZCH) is the fully integrated, single comprehensive plan formed by our AZ Health Net Access and Cenpatico Integrated Care RBHA programs. AZCH is a wholly-owned subsidiary of Centene Corporation (Centene), a national leader in Medicaid Managed Care providing services for approximately 7.1 million Medicaid beneficiaries in 24 states, including complexity of integration of physical health (PH) and behavioral health (BH). Centene has strong experience with managing integrated Medicaid programs in 19 states, and coordination for PH and BH benefits in all markets. Over the past 34 years, Centene's local approach to integrated health care, service delivery, and innovative strategic partnerships have saved millions of dollars and improved health outcomes. AZCH is able to leverage both proven national best practices from our parent company as well as local best practices through our integrated experience in AZ to support AHCCCS Complete Care. For example, with AHCCCS' approval and guidance, we have tailored Centene's proven best practices to AZ, such as Start Smart for your Baby®, our award winning pregnancy management program supporting educational and social needs. This customized program has achieved enterprise-wide savings of more than $10M (annualized). The following tables represent our experience managing health care delivery systems similar to AHCCCS Complete Care through our comprehensive, local Arizona experience and affiliate experience in Texas and Mississippi.

ARIZONA MEDICAID CONTRACT EXPERIENCE

Arizona Program	Geographic Coverage	Populations Served	Enrollment (Oct. 2017)	BH/PH Integrated Status	Years in Program	Current Contract Status
Arizona Regional Behavioral Health Authority (RBHA) – Cenpatico Integrated Care	Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma counties	TANF, CHIP,	429,829	Not integrated	13	Active
		Adults with SMI	13,372	Integrated for SMI	13*	Active
AHCCCS Health Plan - Health Net Access, Inc.	Maricopa County	TANF, CHIP, SSI	59,225	Integrated for GMH / SA Duals	5	Active
Arizona Long Term Care System - Bridgeway Health Solutions	Maricopa, Pinal, Gila, Graham, Greenlee, Cochise counties	ABD, LTC, DSNP	0	Integrated	11	Inactive as of 9/30/17

**Adults with SMI have been in Cenpatico contracts for 13 years, however, management of integrated services for Members with SMI went live in 2015—3 years in program.*

TEXAS – SUPERIOR HEALTH PLAN

Texas Program	Geographic Coverage	Populations Served	Enrollment (Oct. 2017)	BH/PH Integrated Status	Years in Program	Current Contract Status
STAR	Bexar, El Paso, Nueces, Lubbock, Travis (48 Counties)	TANF	312,889	Integrated	19	Active
CHIP /CHIP Perinate	Bexar, El Paso, Nueces, Lubbock, Travis (48 Counties)	CHIP	33,562	Integrated	17	Active
STAR+PLUS	Bexar, Dallas, Nueces, Lubbock (44 Counties)	ABD	71,913	Integrated	11	Active
Medicare Advantage DSNP & MAPD	Bexar, Collin, Dallas, Nueces and Rockwall (5 Counties)	Medicare	951	Integrated	10	Active

STAR Health	Statewide (254 counties)	Foster Care	33,630	Integrated	10	Active
STAR+PLUS MRSA	MRSA Central and West Texas Service Areas (130 counties)	ABD	35,948	Integrated	4	Active
MMP	Bexar, Dallas, Hidalgo	Duals	9,118	Integrated	3	Active
STAR Kids	Bexar, El Paso, Hidalgo, Lubbock, MRSA West, Nueces, Travis	SSI	28,795	Integrated	2	Active
CHIP RSA/CHIP RSA Perinate	174 rural counties	CHIP	70,135	Integrated	14	Active
STAR & STAR MRSA	Hidalgo and MRSA Central, Northeast, and West (221 counties)	TANF	422,858	Integrated	6	Active
STAR+PLUS	Hidalgo (10 Counties)	ABD	31,884	Integrated	6	Active

MISSISSIPPI – MAGNOLIA HEALTH PLAN

Mississippi Program	Geographic Coverage	Populations Served	Enrollment (Oct. 2017)	BH/PH Integrated Status	Years in Program	Current Contract Status
Medicaid/ CHIP	Statewide	TANF, ABD (Non-Duals), Foster Care, SSI/ABD, Breast/Cervical and Cancer Patients	248,000	Integrated	7	Active
		CHIP	17,828	Integrated	3	Active

VALUE PROPOSITION

As experienced at-risk managed care plans with integrated PH and BH services, AZ, TX and MS contracts all represent markets with significant rural and frontier communities, cultural diversity, and social determinants of health (SDOH) in complex populations. Our success in managing the contracts referenced above and similar contracts across the country is rooted in robust programs, technology, training, and best practices delivered locally and specifically built for the holistic needs of complex Medicaid populations. Throughout our response, we focus primarily on our local experience in Arizona, drawing as appropriate from our affiliate Medicaid plans in Texas and Mississippi. We selected Texas for a variety of reasons including managed care program maturity, covered populations, and presence of multiple MCOs. Our TX affiliate recently completed an administrative integration to create a seamless care management/coordination and network management experience. Many of the program offerings that AZCH is introducing or enhancing, such as Start Smart for Your Baby®, have been implemented in Texas with successful outcomes, which we will share in our response. Our Mississippi affiliate's Medicaid Managed Care program began as separate PH and BH programs with integration then occurring under a single contract in 2012; we will replicate their successful initiatives for EPSDT in Arizona. Both Texas and Mississippi have extremely rural/frontier communities like Arizona, with Texas also sharing the similarity of Arizona's larger metropolitan areas and border communities. Both Texas and Mississippi have diverse populations and cultures within their membership and have addressed the importance of SDOH. Both programs have grown over the years through expansion of eligibility categories and expansion of services covered, similar to the Complete Care contract.

NARRATIVE SUBMISSION
RESPONSE #2

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

2. AHCCCS has a comprehensive behavioral and physical health benefit package and strives for high quality services…

AHCCCS' behavioral health (BH) and physical health (PH) benefit package provides a foundation of services and supports that enables transformation of the health care delivery system for members, providers, and communities. Arizona Complete Health-Complete Care Plan (AZCH) is the fully integrated, single comprehensive plan formed by our AZ Health Net Access and Cenpatico Integrated Care RBHA programs. AZCH will leverage our integrated experience from across the state to support AHCCCS Complete Care.

AZCH VISION FOR SUCCESSFUL INTEGRATED SERVICE DELIVERY

AZCH fully supports and ascribes to all AHCCCS System Values and Guiding Principles as defined in the Contract. Applying our hands-on experience, lessons learned, and direct member, provider, and community feedback, we are well prepared to implement these key elements across the entire Complete Care population. In the words of our stakeholders and providers, collected during provider and community forums, keys to successful integrated service delivery include: flexible financial models, funding/resources for practice transformation, culture change in practices, removing stigma around BH, workforce development, education across the system, and navigation support. By implementing these collective values, principles, and components, we will create a seamless, easy to navigate, coordinated and dynamic system; facilitated through the programs and innovations described below and monitored by our quality program. ***Our integrated service delivery goals are to increase the percentage of members who experience fully integrated health care by 25% in Year 2 and 50% in Year 3 over baseline Year 1 percentages; achieve a 10% increase on AHCCCS Integrated Care Screening Metrics in Year 1; decrease Emergency Department (ED) utilization for members receiving integrated care by 10% in Year 2; and achieve a 4 Star Rating of Health Plan on the child (in Year 1) and adult (in Year 2) CAHPS member satisfaction surveys.***

INTEGRATED SERVICE DELIVERY UNDER AHCCCS COMPLETE CARE

We will fully implement the critical components and principles of integrated service delivery through a dynamic work plan that includes: 1) a proactive Integrated Care Management and Care Coordination (ICMCC) program; 2) member education and engagement; 3) proactive, high touch provider education, practice transformation, and support; 4) automated population health management (PHM) and other technology tools; 5) value based purchasing (VBP) and other financial incentives; 6) community engagement, collaboration, and investment; and 7) robust quality management and process improvement (QMPI) procedures. We understand this transformation will be multidimensional and we have established an AZCH Lean Six Sigma Staff Training Program to maximize our capacity to operate as a learning organization, create efficiencies, monitor service delivery and continually improve the delivery of integrated care. We have organized this response by our work plan initiatives to demonstrate how we will implement integrated care service delivery and address *AHCCCS' 18 System Values and Guiding Principles* which we have adopted and refer to throughout this response as *Core Components (CCs)* of our Complete Care implementation.

1) PROACTIVE ICMCC PROGRAM. Everything we do centers around the health and wellness of our members and families. We connect members to the appropriate level and intensity of resources and improve ease of navigation through *identification of the need for and provision of comprehensive care coordination and integration of BH, PH and non-clinical health care related services (CC #3 and 4)*. Our person-centered, holistic ICMCC program is designed to facilitate this coordination and integration, as well as identify and intervene early. ICMCC is available to all members, with more intensive services, engagement, outreach, and education for members enrolled in care management.

Identification and Matching Resources and Services to Needs. We start with early identification, including predictive modeling, leveraging all available data to stratify members daily, such as: assessments and screenings; Blind Spot data; PH, BH, and pharmacy claims/authorizations; registries, e.g. the Homeless Management Information System (HMIS) and AZ State Immunization Information System; Health Current Health Information Exchange (Health Current); and jail feeds. Employing our comprehensive ***PHM Solution,*** we identify members faster and at more complex levels, recognizing holistic and compounding symptoms, conditions, and needs. Based on identified needs, members are matched with services and providers best suited for them, factoring in PH, BH, co-morbidities, and social determinants of health

(SDOH) with respect for member choice. For example, children receive developmental screenings; members with chronic conditions are eligible for health coaching; members with acute needs may access care coordination and assistance with system navigation; and members identified as high risk may receive intensive care management and transitional services. All members are systematically tracked to identify new or emerging needs and we intervene as appropriate. As part of our PHM, our ***Integrated Care Managers (ICM)*** receive daily, member and population specific, insights to action that support targeted and rapid response interventions, while also measuring outcomes. For example, receiving real time alerts when a member presents at the ED allows ICMs to proactively outreach the member, identify root cause for the visit and assist in identifying a more appropriate level of care. Through proactive engagement, we have ***reduced ED utilization by 6% in our integrated membership in the past year***.

Coordinated and Integrated Service Delivery. AZCH *maintains, rather than delegates, key operational functions to ensure integrated service delivery (CC #16).* Applying a team-based approach, our integrated teams of BH and PH professionals work as cohesive units, with each member of the team taking responsibility to provide whole person care. Each team is staffed to address BH, PH, and SDOH through a single, integrated lens. For members in care management, an ICM serves as the personal navigator to help facilitate integration and connect members to holistic services. For these moderate to high risk members, the ICM leads a member-driven planning process. The ICM engages members, family/caregivers, PCP/health home providers, specialty and BH providers, including regional crisis providers, and community agencies, and supports integrated care through ***Integrated Care Team (ICT)*** meetings (including Child and Family (CFT) teams), a shared ***Integrated Care Plan (ICP),*** weekly care rounds, and sharing actionable data. We facilitate coordination through facilitating and maintaining member releases of information, encouraging the sharing of medical records, and assessments, ICPs, and other care planning and clinical information through our secure Portals.

Specialized Programs. Members are also engaged through our *chronic disease management programs (CC #6)*, including training in self-management, and *preventive and health promotion and wellness services (CC #7),* with targeted outreach and initiatives to close care gaps and engage in screenings. For example, our chronic pain program includes peer to peer contact and has ***reduced the number of high risk benzodiazepine utilizers by 72% and the number of high risk Opioid utilizers by 54%*** over a six-month period. To ensure *adherence with the Adult BH Service Delivery System-Nine Guiding Principles and the AZ Vision-Twelve Principles for Children (CC # 8 and 9)*, all AZCH ICMs and support staff are trained in these principles as a framework for engagement in shared decision-making toward whole person health and recovery. AZCH also utilizes community-based treatment teams and CFT Coaches, Fidelity monitoring, and offers CFT provider education and certification, all designed to support integrated service delivery for our members with BH needs. Other programs for members with special health care needs include targeted efforts to support Children's Rehabilitative Services (CRS) children, members with autism spectrum disorder (ASD), and our Opi-End program to prevent and treat opioid abuse. This includes specialized health homes that can manage children with complex PH and BH conditions, including BH Residential Facilities and Home Care Training for the Home Care Client. We have an ASD COE, Children's Clinics Tucson. In fall 2019, COEs will support all awarded GSAs through our hub and spoke model, extending COE expertise to non-urban communities through telemedicine and provider consults. Our innovative Opi-End program is aligned with AHCCCS' strategy and Governor's executive action memo and includes prior authorization guidelines for long and short acting opioids; member identification for our pharmacy home program; prescription for Naloxone with all approvals for high dose opioids; provider requirements around documentation of tried or planned non-opioid modalities and a tapering plan; and provider alerts related to medical risk based on medication review.

2) MEMBER EDUCATION AND ENGAGEMENT. Our programs for health literacy and promotion are multi-faceted to appeal to all member preferences and learning styles, including in-person visits, newsletters, online education, phone outreach, texting (Q1 2018), and social media. Sample topics include Mental Health Awareness, Living with Co-Morbidities, and How to Talk to Your Providers (BH and PH). Enhancing the education and *engagement of members and families at all system levels (CC #14)*, we have a rich network of ***almost 600 Peer and Family Supports*** and share care planning information with authorized family members through our Caregiver Portal, described below. An example of how we utilize Peers is in care transitions, meeting members in the hospital or working with individuals transitioning out of jail to increase engagement and help with connection to a PCP or health home, follow up appointments, and social services (e.g. housing, employment). Based on our 2016 pilot study of members participating in peer support services

participants in peer support decreased arrests by 28% and decreased ED visits by 22% over 12 months. Finally, we leverage ***Community Health Workers (CHWs) and Promotoras*** to connect members with culturally sensitive community resources and help promote health literacy and *reduce stigma* associated with BH. Peers and outreach staff will be critical in helping members *embrace transformation (CC #17)*, explaining not just the availability of benefits, but how those benefits are best delivered for the individual (e.g. through a health home), what they need to do, what we will do, and who is their one stop for support at any time. AZCH staff have been trained in best practices including Person-Centered Care Planning, Integration, Motivational Interviewing, Trauma Informed Care, and Mental Health First Aid (MHFA) to enhance their ability to engage members.

3) PROACTIVE, HIGH TOUCH PROVIDER EDUCATION, PRACTICE TRANSFORMATION, AND SUPPORT. A robust, highly trained, and accessible provider network is a critical component of integrated service delivery. AZCH takes several steps to *ensure timely access to care (CC #1)* and that *providers receive education and guidance on service integration and care coordination (CC #5),* starting at initial provider orientation. Integrated practices must work differently than a traditional clinical model and members should feel the difference. AZCH supports system integration training and bi-directional integration, including transforming into integrated health homes (IHH) and bringing BH resources to PCPs, including through telemedicine. For example, we are implementing Project ECHO in 2018. ECHO is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live. The ECHO model™ increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions.

Provider Education. Through our experience assisting providers deliver integrated services, we have learned there is a high level of stigma in many PCP offices that do not pursue information about their patient's BH conditions. We also found EDs not addressing a PH condition due to BH symptoms and staff in BH practices not comfortable talking about PH conditions. We continue to address these situations through system education, monitoring, and the use of Peers. Our scalable provider education program is built on proactive identification of providers based on profiling, quality and other metrics to indicate educational opportunities. AZCH educates providers through: monthly Essential Provider Communication Calls with IHHs, specialty providers, and PH providers; our online Care Coordination certificates program developed in partnership with the UA College of Nursing (UA CON); Train the Trainer programs, ***as of March 2017, 76 IHH staff trained and are now trainers in ICMCC***; regional integrated care trainings with CMEs for medical professionals; traveling lunch and learns on integrated care and ICMCC for PCP offices, e.g. "Championing the Vision of Integrated Care", Value-Based Care, and Medication Assisted Treatment; and online trainings, e.g. BH and PH co-occurring and connected conditions, the use of BH/PH screening tools, and how to refer for BH/PH services. In collaboration with the Arizona Health Plan Association, AZCH will lead efforts in streamlining provider education statewide by October 1, 2018. To promote *culturally competent and linguistically appropriate care (CC #2)*, all network providers and AZCH staff are trained on cultural, disability, and poverty sensitivity, offered as part of all provider and employee orientations and available online. In 2017, ***7,384 users completed 216,834 online/live courses***. Since 2015, we ***have trained 52,686 providers on integrated care topics***, such as Diabetes for BH Professionals, The Overlap of Mental Illness and Respiratory Disease, and Visions of an Integrated Life. Our provider network training compliance ***completion rate for 2017 was 95.4 %,*** exceeding the AHCCCS AMPM 1060 requirement of 90%. We monitor effectiveness of our trainings through our practice transformation and QMPI programs. We design trainings around provider feedback. For example, we heard from community partners that there is a lack of understanding in assessment of ASD as well as providers who will treat. We hosted a provider forum on the use of the assessment tools and are working with the UA CON to develop a Nurse Practitioner (NP) program for the treatment of children with developmental delays by fall 2019.

Practice Transformation. A critical feature of our current system has been working with community mental health centers (CMHC) to become fully functioning IHHs providing PH and BH services through fully integrated care teams. As the RBHA, we provided practice transformation support, from assessment to implementation for every CMHC/intake agency in the network. Technical assistance and resources included comprehensive education; timely, actionable, meaningful, and easy to use data and dashboards (e.g. Care Gaps and visibility to authorized services and utilization history); and forums to review, such as daily touch points and monthly Joint Operating Committees. Today, our RBHA network includes 17 IHHs with ***90 integrated clinics locations,*** up from 60 in October 2015. We will expand integrated

service delivery, assessing and providing tailored support for PH and BH providers across the Complete Care network. For example, funding ***Population Health Administrators (PHA)*** in the practices to directly facilitate and support integration. Since October 2015, we have ***funded over $3.3 million*** in PHA support and are engaging an outside practice transformation firm, Care Accountability, to support transformation across the network in 2019.

Other Provider Support. We recognize and enhance our network through *evidence-based practices and innovations (CC #10).* For example, we promote ***AHCCCS' Targeted Investment Program*** *and* ***Centers of Excellence (COE).*** AZCH promotes high value providers, including COEs, using data analytics to identify members and target outreach, such as member calls, newsletters, provider meetings, our public website, member and advisory councils, and health fairs. A COE logo was created for providers to utilize on their websites and marketing materials. AZCH auto assigns members who do not choose a PCP to a high value provider and utilizes ICMs and Customer Service staff to communicate high value providers and COEs to members not already assigned or requesting a change. We also provide actionable information to support provider success under the new program, including a ***customized monthly VBP/payment dashboard*** with data on payments, shared savings potential, outcome trends, risk stratification, penetration rates, service type, quantity and a potential payment tool to determine future payments if outcome metrics are met.

4) AUTOMATED PHM AND OTHER TECHNOLOGY TOOLS. Key to our success is our significant investments in technology and *innovation (CC #10),* including *health information technology to link services and facilitate improved communication (CC #18)*. The following describes key systems supporting integration.

PHM Solution. While other organizations use predictive analytics in the medical field, few, if any, offer our PHM Solution which includes a combination of proprietary algorithms, risk stratification, and advanced predictive analytics to have real time line of sight to the whole person. Our solution combines technology, clinical information, SDOH, and our integrated health informatics platform (described below) to improve care and management of individuals with complex care needs through the delivery of clinical, financial, and experiential insights. For example, with complex populations, a trip to the ED is likely to have more than one contributing factor, such as CHF, anxiety, and housing. Through our PHM Solution we can see the whole picture and come up with effective interventions designed to tackle all presenting issues, not just the primary diagnosis. Our PHM Solution was designed with the knowledge that effective ICMCC and delivery strategies require the ability to work in real time, proactively identifying needs daily, intervening at the member or population level, and continuously monitoring outcomes.

Health Informatics Platform. Centelligence® is our proprietary and comprehensive family of integrated decision support and health care informatics solutions. Our Enterprise Data Warehouse supplies the data needed for all of Centelligence's analytic and reporting applications while simultaneously orchestrating data interfaces among our core applications including claims, authorizations, customer service, ICMCC, PHM, and our web and mobile offerings, and pulling data from external and other program sources such as AHCCCS Blind Spot data, high risk/high cost program data, Health Current/HIE data, HMIS, and jail feeds. Since inception of the Statewide HIE Integration Plan (SHIP), we have been an integral participant in connecting high volume providers to Health Current. With over 40 provider organizations participating in the SHIP today, our intent is to expand participation through VBP. We are the first health plan to implement the HMIS, connecting our members who are chronically homeless to community resources and housing.

Web Portals. We facilitate information sharing across the system through our online, secure portals. Through our Member and Provider portals, authorized ICT participants or approved users can access member clinical and care planning information such as completed assessments; shared ICPs; PH and BH service history and screenings; lab results; and other clinical data, while maintaining the security and privacy of the member's personal and protected information. Beginning in October 2018, our Caregiver Portal will allow caregivers, often times the most important natural supports to our members on a day-to-day basis, access to otherwise unavailable health information for their loved one.

Real-Time, Online Appointment Scheduling. Also supporting *access (CC #1),* ***MyHealthDirect*** facilitates urgent online appointment setting, including PH and BH intake, crisis, and discharge follow-up. Member Services and ICMs can instantaneously schedule appointments; schedule appointment reminders; and securely attach documentation to the appointment for specific care gaps (e.g., EPSDT or preventative screening needs) to assist providers during the visit.

5) VBP. A key strategy in the implementation of integrated service delivery is *VBP,* supporting *improved health outcomes and cost containment and/or reduction of health care costs without compromising quality (CC #12 and 13)***.** We use VBP

to align and incentivize providers to deliver integrated care. We have been very effective in driving membership to high value providers, *72% of members with an SMI and 86% of our CMDP BH members are receiving care from a high value provider*. From CY16 to CY17, our acute plan has seen a *5% increase* in membership under value based contracting. In preparation for moving 12 health homes to a VBP payment model, our RBHA embarked on an effort to move specialty providers from a Block Payment Model to a Fee for Service (FFS) Payment Model. We **successfully *transitioned 36 block providers to FFS and on April 1, 2017, implemented an enhanced VBP program with 12 of our health homes*** with incentives connected to integrated quality outcomes. A major success of the VBP implementation was the development of a highly robust and sophisticated VBP Dashboard. The intention behind the monthly dashboards is to assist IHHs in developing interventions to move the needle on their outcomes. **Our goal is to have 80% of AZCH spend made to high value, integrated providers under VBP by 2020.**

6) COMMUNITY ENGAGEMENT, COLLABORATION, AND INVESTMENT. AZCH cannot transform the delivery system alone. We need *collaboration with the greater community (CC #15)*, including local community participation, input, and engagement. We accomplish this through creating forums for communication and direct community feedback, such as our Stakeholder Advisory Committee; participation in local hospital and county community health assessments, serving on workgroups and community collaboratives; and supporting our community resources to better serve the integrated needs of our members through education, training and workforce development.

Community Education and Engagement. AZCH is experienced in supporting and engaging communities. To increase health literacy across the system, we ***trained over 1,080 community resources in 2017***, including first responders and community agencies. Education topics include MHFA, Trauma Informed Care, and BH/PH Integration. We also connect with our communities through ***social media campaigns***. In July we launched a Suicide Prevention Awareness social media campaign that ran through October and reached 61,750 people with a total of 86,139 Facebook impressions. Specific initiatives to better engage the community and bring value and meaning to integrated service delivery include our ***community engagement and reinvestment program*** which ***has awarded $366,000 throughout Southern AZ in 2017*** and our ***Re-Entry and Justice programs***. We receive daily booking and release files from five County Detention Centers. Utilizing the daily feeds, we identify members booked into detention and share this information with our network providers to begin discharge and release planning, including network providers sharing medication information with the detention health provider. When asking providers how we can improve whole person care, we heard from our rural providers that access to dental care was an issue. In response we ***funded a mobile dental unit, working together with a rural agency and providing $175,000 to implement***.

Coordination and Collaboration. Engaging communities also includes coordination with community agencies to address *SDOH*, such as housing, employment, food, and utilities. Examples of community organizations AZCH partners with to promote whole person care include El Rio FQHC, Catholic Community Services, and Tucson Homeless Program. Through SDOH partnerships we have become a leader in ***improving employment and housing*** for our members. Our RBHA has ***led all 3 RBHA/MCOs for 10 consecutive quarters*** with the highest percentage of members (all populations) competitively employed. Our goals for housing for FY17 included a reduction in the overall number of members homeless by 20%. At the end of September, ***the number decreased by over 20% and the rate of homelessness decreased by over 5%***.

7) ROBUST QMPI PROCEDURES. Ensuring clinical and operational efficiency and a high standard of care are core functions of our QMPI program. Our QMPI program is overseen by our QMPI Committee (chaired by our CMO) and directed and evaluated by our annual approved QMPI Work Plan. Our program is fully integrated and in compliance with AHCCCS requirements, including those described in Section D.22 of the RFP and specified in AMPM Chapters 400 and 900. Our program provides the infrastructure and activities to provide better health outcomes at lower costs, improve the quality and safety of clinical care and services provided, and optimize the member and provider experience.

Tracking and Monitoring. As described above, AZCH has data collection, analytics, and reporting processes in place to measure and monitor clinical and operational performance, including all AHCCCS measures and reporting specified in Section F, Attachment F3, Contractor Chart of Deliverables. Quality metrics from functional areas across the organization are monitored, tracked, and trended via our integrated care subcommittee structure, with oversight and strategic

direction provided by our local QMPI Committee. This process informs our quality activities and performance improvement projects.

Culture of Continuous Quality Improvement. Developing a new program requires specific attention to quality. This includes a process and culture of *continuous quality improvement (CC #11),* applying evidence-based approaches such as PDSA (Plan-Do-Study-Act) Cycles, Rapid Cycle Improvement, and Lean Six Sigma. To support these efforts, we have an ***in-house Lean Six Sigma black belt*** who trains staff members, resulting in 8 green belts and 12 yellow belts (green belt in process) in 2017. AZCH commits to offering Lean Six Sigma training twice per year, training up to 50 staff per year.

Clinical Guidelines and Best Practices. Supporting consistency, efficiency, and improved outcomes, we promote the use of best practices spurred by innovation and accepted by the community. AZCH clinical practice guidelines (CPG) are evidence-based, consistent with national standards for prevention and management, and reflect recommendations published in peer-reviewed literature and by nationally recognized organizations (such as the American Academy of Family Physicians and Centers for Disease Control and Prevention). We ensure that UM criteria, coverage decisions, clinical programs, education materials, and benefit information are consistent with adopted CPGs, and monitor compliance with all AHCCCS, state and federal requirements for CPGs. We will coordinate the development of CPGs and other best practices with willing plans to present our provider partners with consistent CPGs. For example, we are committed to working with AHCCCS and other MCOs to ***develop CPGs for peer support services in CY19***. AZCH ensures providers are notified of new or revised CPGs, and monitors implementation through audits and systematic reporting.

PARTNER FOR SUCCESS

EXPERIENCE INTEGRATING CARE. AZCH has direct experience integrating care for members through our RBHA and management of the GMHSA Duals. As of November 2017, AZCH is serving the BH and PH needs of ***13,432 Medicaid eligible adults with SMI*** under our RBHA and the integrated needs of ***3,167 GMHSA Dual members*** under our acute health plan. Through this experience and implementation of our ICMCC, along with the development of IHHs, we have seen positive outcomes in utilization, quality and other member outcomes, satisfaction, employment, and housing.

Integrated Care Outcomes	
Utilization	From 10/16 to 10/17 we saw a ***6% decrease in ED use*** and an ***8% reduction in adult psychiatric readmissions.***
Quality Outcomes	From 07/16 to 05/17, ***improvements in HEDIS***, included Diabetes A1c Testing (16%); Diabetes Eye Exams (23%); Diabetes Screening for Member Using Antipsychotics (11%); Adult Access to Preventive Care (4%); Monitoring for Members on Persistent Medications (10%); Breast Cancer Screening (4%); and Chlamydia Screening (11%).
Other Member Outcomes	For Cochise, Graham, Pima and Yuma counties, the percentage of our members booked into detention centers from 10/16 to 09/17 was 52.9%, ***a 24% reduction***. Through our Brief Intervention Program, we increased community stabilization from 51% to 71%, or a ***39% increase in stabilization*** from 10/16 to 10/17.
Satisfaction	We have enhanced how we measure member satisfaction including a Monthly Member Survey, distributed at our health homes, measuring patient experience, outcomes and improved functioning, social connectedness and social well-being, and quality of interaction/communication. The most recent survey ***showed statistically significant increases in all measures related to patient experience and outcomes and improved functioning***.
Employment	As reported by AHCCCS, our RBHA has led all 3 RBHA/MCOs for 10 consecutive quarters with the ***highest percentage of members competitively employed*** for all population types, averaging 50% of members employed. In FY16-17, 1,500 RBHA members obtained employment, making just under ***10,000 of our members employed***.
Housing	Our goals for housing for FY17 included a reduction in the overall number of members homeless by 20%. ***At the end of September, the number decreased by over 20% and the rate of homelessness decreased by over 5%***.

INTEGRATION INNOVATIONS AND INITIATIVES. Sharing AHCCCS' vision, we have listened to our stakeholders and responded through current (described above) and future (described below) initiatives and innovations to support our collective ability to meet AHCCCS' goals.

Continuously Improving Member Experience and Outcomes. Building on the programs and experiences described, we will implement a combination of programs and innovations to improve engagement and access, such as:

- Working with providers and facilities to offer ***alternative levels of care*** that address holistic needs. This will include increased access to IHHs for children with significant BH and PH issues, including facilities that can address the needs of our adult GHMSA population with a high rate of opioid use which contributes to exacerbated PH conditions.

- Addressing the needs of our homebound members through our ***Healthy Together Medical Home Visit Program*** that will provide integrated home clinical visits beginning 10/1/2018.
- Expanding our reach through technology, we will utilize virtual visits using secure, encrypted, video technology that bring together the member, ICM, and member-directed ICT in in Q1 2019.
- Addressing SDOH, we employ models such as Housing First. To help identify member needs early, we have invested $10,000 in El Rio to expand the use of ***PRAPARE***, a provider assessment tool to screen for and help address SDOH. We will introduce the use of PRAPRE to all contracted FQHCs and HHs by 7/1/2019. Data will be integrated into our PHM solution and actionable information pushed back out to ICMs and providers.

Continuously Improving Provider Experience and Member Access. A key to success, many of our current and future innovations focus on providers and improving their ability to effectively deliver integrated care and services, including:

- Additional ***practice transformation*** and technical assistance to improve bi-directional integration and other evidence-based practices, such as the Collaborative Care Model. AZCH will engage an outside practice transformation firm, Care Accountability, to further support transformation across the network in 2019.
- Utilize ***Project ECHO*** and telemedicine resources to bring PH and BH expertise to point of care beginning 6/2018.
- Expansion of VBP including incentives for PH/BH coordination, whole person care, screenings, Health Current participation, care coordination, and targeted member outreach by Q1 2019, ***driving 80% of spend to high value providers by 2020.***
- Expand ***Second Responder Crisis After Care*** services to effectively engage members into care and reduce dependency on EDs and crisis services by 11/1/2019; including a Second Responder service specifically designed to serve children with ASD and collaborating with AZ Connections to develop a Transition Program that provides BH and PH clinic based crisis aftercare coordination and stabilization services. AZCH has four second responder service programs; including, Peer Crisis Aftercare, Foster Care Stabilization, IDD and Behavior Management, and Housing Support. We will implement a fifth second responder service specializing in ASD in awarded regions.

Transforming the Delivery System. 2018 community efforts are focused on workforce development and transformation:

- Funding a Developmental Pediatric NP certificate program. The UA CON will partner with a Developmental Pediatrician with Banner University and CRS, to develop the curriculum and practicum that will be offered to practicing NPs who are specialized in Pediatrics and Family Practice available fall 2019.
- Partnering with Central AZ College and Pima Community College on their CHW program. Planned activities include adding a BH component to the curriculum; using those who complete the program as Community Engagement Specialist in our network; providing MHFA training to students; and ***sponsoring 40 students (tuition and books=$2000/student)*** in completing program by 10/1/2019.
- We have been selected to participate in four ***SAMHSA HRSA Innovation Communities in 2018***. Innovation Communities are expert facilitated groups of up to 15 organizations who come together to focus on an area of BH and PH integration innovation. Organizations learn from experts and each other during an intensive four-month period. Based on our award, AZCH will participate in the following Innovation Communities: Preparing for Value-Based Payment in BH and Primary Care; Building Integration in Pediatric Care; Implementing Pain Management Guidelines in Integrated Care; and Team Based Care. Projects will be completed in 2018.

NARRATIVE SUBMISSION
RESPONSE #3

NARRATIVE SUBMISSION
RESPONSE #3

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

3. The implementation of the AHCCCS Complete Care Program is a transformative and complex change to AHCCCS…

COMPREHENSIVE SELF-MONITORING TO ENSURE ACCESS TO SERVICES POST-IMPLEMENTATION

Arizona Complete Health-Complete Care Plan (AZCH) recognizes the complexity of the transformation of the AHCCCS delivery system and the large number of members impacted by this evolution. Through our rapid-response approach discussed throughout this response, we are committed to ensuring members are able to access and receive services and minimize member and provider abrasion by facilitating a seamless transition. We will resolve issues with urgency while maintaining high standards, program integrity, and transparency. We will drive this through our Quality Management and Performance Improvement (QMPI) program and deliberate continuous quality improvement self-monitoring efforts. Our proactive monitoring is based on an informed and continuous feedback loop utilizing data and information from all sectors of the integrated delivery system.

VETERAN TEAM AND PROVEN APPROACH. Our parent organization, Centene, is the largest Medicaid managed care organizations in the country, successfully launching or transitioning over 20 markets since 2013. From this proven track record, we will use tested tools and processes that encompass the complexities of Medicaid transitions. Complementing this national experience is our local expertise and infrastructure. We have a fully credentialed, statewide, network of nearly 30,000 AZ providers today, including a significant network of physical health (PH), behavioral health (BH), and integrated providers. We have an established Customer Service (CS) and Medical Management (MM) team trained to assist members in accessing needed services. In our progression toward integration, we have assembled an expert core leadership team with expertise in Executive Management, Operations, Network Development (ND), Compliance, CS and MM. At least one member of the team has participated in every Medicaid transition since 2003 and in aggregate have successfully transitioned over one million lives. They have an average of 16 years' experience Medicaid, 13 years specific to AHCCCS. They have established relationships with local providers, stakeholders, and AHCCCS. It is through this veteran team, integrated infrastructure, and proven transition approach that we can confidently transform the delivery system while ensuring the basics – getting member's timely access to care, providers timely payment and prior authorizations (PA) determination; addressing questions with urgency; and proactively communicating across the system.

LEVERAGING AHCCCS' EXPERIENCE. From our experience in transitions for all types of AHCCCS' programs, we have amassed critical lessons and information we will use to tailor our systems, processes, and procedures for AHCCCS Complete Care. During pre-implementation, critical issues include working with relinquishing health plans, including RBHAs and AHCCCS to transition open authorizations, identify treating providers, and identify continuity of care needs. We will also develop and implement a proactive communication and education plan, featuring ***monthly provider and community forums in the 60-days pre go-live and three months post implementation*** in each county we are awarded to introduce AZCH and Complete Care, solicit input and direct feedback, and address questions and concerns. Regardless of the amount of pre-implementation work completed, we recognize that we will receive an increased call center volume from members and providers. Members will request plan information, transportation services, PCP changes, urgent prescription fills, and formulary exceptions. Provider offices will request assurance of circumstances when PA are not needed, as well as inquiries about billing and plan processes. This will be followed by increased claim payment inquiries, identified network gaps, and the need to quickly add providers through contracting and single case agreements. We are prepared for this increased activity through proactive staffing (ramped up for go-live) and effective training. Supporting our ability to self-monitor, we will deploy specific strategies, best practices, and technology solutions based on proven success and integrated into our ***Go-Live Rapid Response Plan and processes***. Using these foundational components and additional elements described in more detail below, AZCH will ensure uninterrupted service delivery for members. AZCH understands that transition services and activities are anticipated to begin on March 8, 2018, and will adhere completely to the requirements listed in Exhibit G of the RFP.

CONTINUITY OF CARE. In order to ensure access to services post implementation, we must have a proactive way to identify and engage members, as well as, coordinate with providers pre go-live and monitor to ensure they continue to

receive services post go-live. AZCH recognizes that many of our new members will come to us with established provider relationships, including medical specialists and BH providers. We will outreach to complex members in August and September to ensure care needs have been identified and continuity of care is maintained during the October 1, 2018 transition. We ensure continuity of care and service delivery for AZCH members, including DSNP members, transitioning from other plans (whether Acute plans or RBHAs) and providers through the following components:

- Identification of the member via the eligibility file, transition file (DEF) transmissions, and Blind Spot data
- Identification of existing services and providers
- Outreach to providers and plans to obtain current treatment needs and existing authorizations when necessary
- Coordination of a transition plan and outreach to members with special needs and coordination of care needs
- Identification and coordination to address social determinants of health
- Completion of a comprehensive assessment and development of a care plan
- Establishing communication with providers to maintain continuity of care

As the receiving Complete Care plan, AZCH is committed to exceeding AHCCCS transition requirements for the benefit of members. We will use historical information received prior to go-live to proactively identify and risk stratify members and ensure they are receiving services in the best possible setting for their needs. Specifically, we will aggregate disparate pieces of healthcare data from multiple sources, including PH, BH, pharmacy claims, ED and hospital ADT notices, jail feeds, Housing Management Information System (HMIS), and assessments, into a single registry. We also integrate the AHCCCS Blind Spot data, DEF files from the relinquishing contractor, and Health Current HIE data feeds. With this comprehensive analytics and reporting, we will identify and address our members' PH, BH, and social needs prior to implementation. While recognizing member choice, our proactive identification system will help us to identify members with un-coordinated care and will enable targeted outreach to educate about options and choices for integrated care in the new delivery system. We will use this information to identify existing member/provider relationships and ensure that members can retain their current providers for continuity of care through AZCH contracts or single case agreements as needed. We will waive certain PA requirements for the first 60-days post implementation.

High Risk and Members with Special Needs. Starting in August 2018, we will reach out to the relinquishing health plans and RBHAs regarding members identified as having high risk and special needs to ensure continuity of care. Members who have gaps in care and members with special healthcare needs are identified immediately upon receipt and analysis of the DEF file. These members are assigned an Integrated Care Manager (ICM) based on their primary need and will follow them post transition. The ICM will be the member's primary point of contact and will work with other members of the Integrated Care Team to coordinate care and implement a member-directed Integrated Care Plan. Based on historical claims data and PA information, AZCH will coordinate with transitioning members' existing providers to ensure that existing services are continued and will monitor to ensure services are provided post go-live.

Pharmacy. Our team of pharmacists and pharmacy staff, with expertise in PH and BH, are a critical resource during this transition. During go-live, we proactively review pharmacy claims data and compare it against our network and formulary edits. Members identified as higher risk are forwarded to an ICM to provide additional assistance during the transition. We work with our pharmacy benefits manager during go-live to identify non-network pharmacies for potential contracting opportunities. We code the pharmacy system during the continuity of care period to allow members to bypass certain edits at point-of-sale including network edits and then work with members and their prescribing provider to transition their medications in-network. We have a command center that monitors rejection reports daily to ensure proper coding and set-up. We also monitor PA reports during go-live to ensure policies and procedures are followed correctly. Both the claims and PA data help identify additional high risk members for care management outreach and support. Proactive communication with pharmacies during go-live helps to establish important feedback loops that support continuity of care and inform our self-monitoring efforts.

Transportation. We will work with the prior plan and RBHAs to ensure all scheduled transportation needs are met. If we do not use the same transportation vendor, we will provide an electronic file of all scheduled appointments to our transportation vendor, and outreach to affected members to confirm the appointment and notify of the change in vendor. Additionally, for those members with routine transportations, for example members on dialysis or needing MAT

services, we will have a special process where a dedicated team member will manage the transition of these members to ensure there are no transportation delays. We will monitor transportation through a daily report that will indicate number of members scheduled for transportation, number of trips completed, reason for missed trips and timeliness of pick-ups. We will monitor complaints daily to intervene immediately.

SYSTEMATIC SELF-MONITORING THROUGH THE QUALITY IMPROVEMENT PROGRAM

Our QMPI program serves as the core structure and feedback loop for all self-monitoring activities. Quality Management (QM) oversight will serve to ensure that critical issues impacting member care are addressed with urgency, and that cross-departmental data collection, evaluation, and intervention occurs seamlessly throughout the care delivery transition. The QMPI monitoring structure will include both real-time (daily) monitoring as well as regular retrospective monitoring including tracking and trending of key implementation metrics. The go-live dashboard will be utilized daily by the Rapid Response Team (described below) ***to identify and address issues in real-time***, and will feed through the QMPI Committee which will oversee implemented interventions to ensure fidelity to the PDSA process, and will have ultimate responsibility for evaluating the efficacy of interventions and directing refinement as needed.

KEY DATA FOR CONTINUOUS QUALITY IMPROVEMENT MONITORING. AZCH will monitor, at least monthly during the first 6-months of transition, a comprehensive set of data to promote early identification of service delivery issues and gaps and for reporting to QMPI. Data is tracked and trended to identify systematic issues that require correction. Monitoring data will include:

- Prior authorization volume and timeliness during transition
- Continuity of care: PH, BH, pharmacy, and transportation, including referrals to specialists
- Daily census for all facilities: identifying timely discharge planning
- Care plan review and updates, particularly for vulnerable populations
- Care management and care coordination for active episodes of care
- Network gaps: current network, necessary additions; access and availability standards, Credentialing timelines
- Vulnerable member populations, e.g. CRS, HIV/AIDS, opioid use, transplant, AzEIP, transition age youth, transition from CMDP, SMI, children with a CASII core of 4+, children at risk of removal, seriously emotionally disturbed, SEN newborns, Severe Combined Immunodeficiency, and members with or at risk for autism, high risk OB
- Members residing in rural/frontier areas
- Members aged 16 and older with a case plan indicative of aging out of foster care
- Over and under-utilization metrics, e.g. admits, ED visits, ED holds, preventive visits, EPSDT services
- Missed appointments
- Complaints, disputes, appeals and grievances trends, on a daily basis
- Call Center metrics including call volume, average speed to answer, call abandonment, and first call resolution
- Justice involved members, especially those with an SUD diagnosis of opioid use and engagement in MAT services
- HMIS to ensure members experiencing homelessness are connected to RBHA housing resources
- Quality of Care trends

ENSURING SERVICE DELIVERY THROUGH A GO-LIVE RAPID RESPONSE MONITORING AND ACTION PLAN. The goal of our Go-Live Rapid Response Plan is to maximize the success of this system transition through vigilant monitoring and swift issue resolution. The Go-Live Rapid Response Plan is an operating procedure for key leaders and staff to monitor activity before, during and after the system transition and is modeled upon previous transitions at AZCH. This integrated and systematic approach provides a standard procedure for program oversight that is focused on issue triage, escalation and resolution. We aim to maximize program success by minimizing confusion in the pre- and post- go-live periods with an emphasis on prioritization and speed to remediation.

While QMPI will have ultimate oversight, to ensure immediate resolution, our go-live rapid response approach will employ a multi-disciplinary ***Rapid Response Team*** led and driven by our Medicaid President, facilitated by the Transition Coordinator, and comprised of the *Contract Compliance Officer, Chief Medical Director, VP of Medical Management, Adult Healthcare Administrator, Children's Healthcare Administrator, Director of Utilization Management, Director of Integrated Care Management, Director of QM, Director of Pharmacy, Justice System Liaison, Housing Administrator, VP*

of Operations, VP of Network, VP of Government Affairs and Communication, Director of Member Services/Call Center, Dispute and Appeal Manager, Individual and Family Affairs Administrator, Member Advocacy Administrator, and other clinical and non-clinical staff as needed. Starting August 27, 2018 and through at least the first quarter of the new contract, the team will ***meet twice daily*** to monitor data on key implementation factors such as authorization readiness, transition plans for high need members, stress tests of the computer systems, outreach to relinquishing health plans and RBHAs, updated provider lists, and updated PA lists. The team will prioritize issues by urgency/magnitude with member access and continuity having highest priority, and resolves issues as they arise. Led by the Director of QM, quality staff will conduct real-time monitoring for potential quality of care (QOC) concerns and immediate health and safety issues, which will trigger immediate action by the QOC team.

Communication and Escalation. On a daily basis, leveraging the Daily Dashboard described below, a communication specialist will draft a communication to all internal staff to ensure they are aware of issues, prioritization, and resolution. We adhere to standardized procedures for escalation of appropriate issues to the Medicaid President as the executive lead for immediate resolution, facilitated by appropriate staff. The Rapid Response team uses a dedicated, specific email account through which all staff can send inquiries regarding the transition. The Transition Coordinator or other designated members of the Rapid Response Team will monitor, log, and resolve all inquiries received via email.

Daily Dashboard. Daily, the Rapid Response team will monitor a specialized set of measures created to assist with immediate identification of potential access to care issues, some of which are the same measures QMPI will monitor. The metrics are generated on a daily dashboard that flags metrics which fall below established performance thresholds. The Rapid Response team will review the dashboard, identify root causes for metrics that fall below thresholds, and resolve individual member and system issues. QM and Contract Compliance staff work with each department on an ongoing basis to ensure contract compliance by monitoring for process improvement opportunities, identifying defects in processes, and working with teams to improve procedures. Issues that arise are analyzed, prioritized, and resolved daily. The go-live dashboard feeds into the AZCH data warehouse for data aggregation and reporting into standardized systems and processes such as the QMPI program. The Transition Coordinator will be tasked with generating a daily summary of the dashboard highlighting key information such as high priority issues for the day, issues by type and volume, key resolutions, and issues to monitor for the next day. The go-live dashboard includes the following metrics:

- PA requests by type of service and response times
- Missed appointments
- Member requests to change PCPs
- Call Center metrics: call volume, call reasons, ASA, abandonment, and service level for providers, members, pharmacy, vision, and dental
- Claims received, pended
- Information obtained from RBHA/Crisis contractor
  - *Number of members accessing crisis 24 hour and sub-acute services*
  - *Crisis Mobile Team response times*
  - *After hours crisis line utilization*
  - *Rapid Response Assessments within 72 hours*
- Staffing ratios
- AzEIP time from referral to first service
- Pharmacy metrics: transition fills, formulary exception requests, out of network pharmacy requests, and denials
- Grievances and appeals related to appointment availability, access to care, coordination of care, transportation, clinical decisions, plan changes, and system navigation
- Facility census
- ED Utilization and ED hold times
- QOC's concerns with an emphasis on those categorized under *Availability, Accessibility and Adequacy*
- Jail Feeds for increased incarceration
- Transportation metrics described above

The Rapid Response team reviews each metric with operating departments to ensure access to care for all members and to identify potential process issues.

Demonstrated Experience. The Rapid Response approach has been used by AZCH during multiple transitions in AZ over the past several years. As an example in the 2015 SMI integration transition, it was reported in daily meetings that we had a network adequacy deficit for contracted skilled nursing facilities (SNFs). There were more members in SNFs than anticipated, including members in non-contracted facilities. Single case agreements were immediately executed for members in non-contracted SNFs. ND collaborated with all non-contracted skilled nursing facilities to initiate the

contracting process and provide a comprehensive orientation to the health plan. Using the rapid cycle improvement methodology, the issue was identified and solutions implemented which avoided gaps or barriers in care delivery.

CAPACITY BUILDING. AZCH will monitor operational staffing, network capacity, processes, and reports to ensure appropriate resources and service delivery. AZCH has proactively worked to optimize our organizational design in anticipation of transformation. We have enhanced our staffing and structure to ensure continuity and coordination of PH and BH services for all of our members. Additionally, we have transformed our network contracting approach to offer fully-integrated contracting and value based payment (VBP) models for integrated health.

Building a Quality, High Value Health Network. A crucial precursor to ensuring service delivery post-implementation is presenting a comprehensive provider network from the onset. As such, AZCH has a robust, currently contracted network of PH, BH, and integrated care providers throughout the state. The current contracted and credentialed network has nearly 30,000 unique providers speaking over 90 different languages across all counties in AZ. We will use AHCCCS transition information, DEF file, Blind Spot data, member and provider complaint history, and quality benchmarks to identify gaps in the pre-go-live network. We will leverage our credentialed, contracted providers from all of our AZ products to include AHCCCS Complete Care. After go-live, we will monitor the network for gaps daily to ensure network adequacy and access during the transition. Our process for determining network sufficiency starts with obtaining the number of members within a given geographic region and comparing the total number of members against the total number of in-network primary care providers by specialty type serving the same geographic region. We will monitor time and distance standards and appointment availability against established thresholds, along with any member and provider complaints to identify access issues. Any newly identified network gaps are immediately shared with the ND team to take the necessary steps to fill the gap or coordinate single-case agreements for out-of-network services in collaboration with our care management teams until the gap is filled. Through all these efforts, AZCH will ensure that access to providers is available and accessible and that all members receive needed care.

AZCH Approach to Provider Engagement and Education. The focus of our Provider Engagement program is to provide initial onboarding and continuing education, share data in support of closing care gaps and VBP arrangements, and coordinate issue resolution. Each provider has a Provider Engagement Specialist (PES) as the single point-of-contact, and we provide direct access to senior leadership for escalations. This ensures that providers have access to a reliable resource within AZCH that can serve as their advocate and ensure timely resolution and support for any service delivery issues. Recognizing that provider communication is paramount during a transition, AZCH will augment ongoing provider communications prior to go-live through a series of six workshops to facilitate a seamless transition. AZCH recognizes that provider abrasion and apprehension to change is impacted by their claims experience. Topics for the six workshops include: comprehensive orientation, introduction to provider representative, integration of PH and BH, utilization management and prior authorization process, claims process, electronic data interface, and joint operations committee. Supporting these training opportunities, we will hold monthly provider forums in all urban and rural counties from 60 days pre-go live to three months post implementation. Forums will include senior leadership and introduce providers to our leadership team and PES staff. Sessions will be designed to hear concerns, share and collectively develop potential solutions, answer questions, and include a feedback mechanism to close the loop on any suggestions or open items.

Front Load Staffing for Transformation. AZCH has developed a comprehensive staffing strategy to ensure that all key personnel and departments are staffed for additional members prior to go-live. Our experience reinforces the importance of ramping up call center staffing, including use of trained temporary employees during implementation which we will do both before and after October 1, 2018 go-live. AZCH's staffing plan has been established to maintain capability for performing and carrying out all functions, requirements, roles, and duties required by the Contract. Because staffing plans are tailored to enrollment levels and service areas, we will aggressively monitor enrollment, staffing ratios to ensure appropriate staffing levels. AZCH will closely monitor performance metrics against established thresholds, prior to and during the go-live period and during the first year of operations. When enrollment increases or performance does not meet established thresholds, we will recruit additional experienced and/or licensed staff in a timely manner. If needed to maintain a high level of service, we may leverage temporary staff, Centene health plan and corporate staff, who can step in on an interim basis to supplement staffing.

NARRATIVE SUBMISSION RESPONSE #4

NARRATIVE SUBMISSION RESPONSE #4

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

4. Integrating the delivery of behavioral and physical health care under a single entity is a significant step forward in…

Arizona Complete Health-Complete Care Plan (AZCH) whole heartedly endorses the integrated care vision, guidelines, and goals of AHCCCS, as outlined in Section D.1 of the RFP. Our vision for integrated care is a dynamic system that recognizes and treats the interplay of social determinants of health (SDOH), physical health (PH), and behavioral health (BH) conditions for all members, at all treatment settings and at all levels of care. Our role as an AHCCCS Complete Care plan is to equip our members, families, caregivers, providers, and community partners with the knowledge and tools to meet our shared vision. Our value is not only our direct experience integrating care for complex populations and scalability of our operations, it is our significant investment in tools, technology, training, and technical assistance that has been tested and evaluated through an existing integrated membership base of over 16,500. ***Our integration and care coordination goals focus on improving individual health outcomes, enhancing care coordination and increasing member satisfaction by; increasing the percentage of members that receive fully integrated services by 25% in Year 2 and 50% in Year 3 over Year 1 baseline, and reducing the health care costs of members in care management by 10% in Year 2 through reductions in inappropriate utilization, including a 10% reduction in Emergency Department (ED) use.***

INTEGRATED OPERATIONS TO PROMOTE INTEGRATED CARE

AZCH is a single, integrated plan, organized to administer benefits across all provider types for all members. Beyond co-location of disciplines and functions, integrated care must break down silos at the provider clinic level and at the health plan operational and administrative level. It is not just structure, it is thinking differently through training, integration champions, and overcoming BH stigma. AZCH achieves this through experienced staff working together as ***one integrated team viewing every member, every provider, and every process through a single integrated lens***. Our entire organization is structured to continually advance integrated care. Member services, network and provider engagement, and clinical programs, are all organized to deliver holistic benefits using a seamless, person-centered approach. All AZCH staff are trained in whole person care through our integration champions with subject matter experts providing specialized support. This includes staff and provider training through the UA College of Nursing (UA CON) ***Integrated Care Coordination certificates program*** co-developed in 2017 with AZCH. Our integrated quality structure, including our Quality Management and Process Improvement (QMPI) Committee, monitors the health plan and delivery system for effective integration and opportunities for improvement. Supporting these efforts, we have written policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated services and a single integrated health informatics platform that automates actionable data. ***It is this structure and culture of integration that drives our practices and promotes transformation of the delivery system.***

FOUNDATIONAL ELEMENTS OF SUCCESSFULLY ADMINISTERING INTEGRATED CARE

Leveraging our local integration experience and infrastructure, we have identified the following foundational elements that will support successful administration of integrated benefits and achievement of our goals.

- ***Holistic Whole Person Care***: PH, BH, SDOH, and emotional wellness facilitated through our integrated clinical, administrative, and operations infrastructure
- ***Preventive and Proactive Care***: Timely prevention and validated screenings, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and early identification of developmental delays and chronic conditions, leveraging real time data feeds
- ***Coordinated Bi-directional Care***: Effective communication and coordination across the continuum, including discharge planning and transitions in care, supported by secure, web-based data sharing
- ***Empowering Members***: Tools and insights to support healthy choices, personal responsibility, and develop health literacy and self-management skills, accounting for level of readiness and engagement, meeting members where they are, and promoting recovery, choice, and respect
- ***Team-Based Care***: Partnership and collaboration across all levels of care and disciplines facilitated through case rounds, technology, training, and a team-based care management model
- ***Robust Provider Support***: Facilitate and support provider delivery of integrated care and coordination at all levels of care and treatment settings through technical assistance, training, and ease of referrals

- ***Accessible Member Centric Care***: Timely access to appropriate care and services delivered by a comprehensive, highly trained, integrated and robust network with ongoing monitoring
- ***Leveraging Public Health***: Collaborate to promote healthy lifestyles, health promotion, public health, and address SDOH, including participation in community needs assessments ***Value Based Care***: Pay for value to align integrated delivery, promote quality outcomes and bend the cost curve

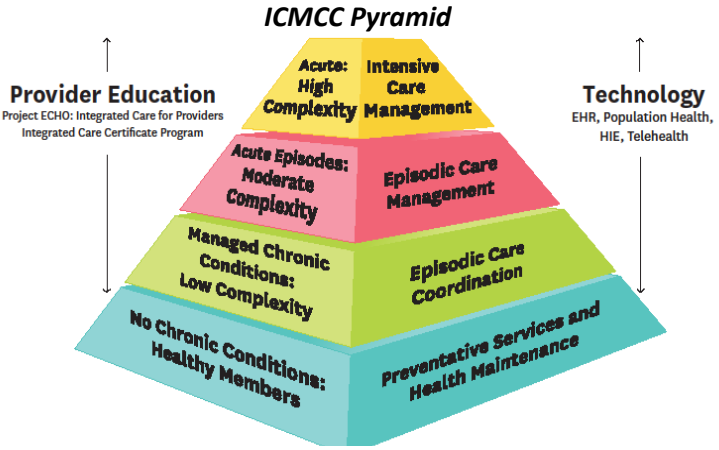
AZCH INTEGRATED CARE MANAGEMENT & CARE COORDINATION ROLE

From preventive care and health maintenance to intensive care management and transitional services, AZCH takes full responsibility for coordinating and managing care for all of our members and collaborating with and supporting providers and system partners to ensure members receive timely and effective services. A key component of our approach is our Integrated Care Management and Care Coordination (ICMCC) program. At the foundation of our model is population health management (PHM), delivering relevant and meaningful health promotion and health literacy activities across the population. Differentiating AZCH is how we bring innovation to this process. Using our integrated PHM solution, described below, we ***identify PH, BH, and SDOH needs in real time and intervene quickly and proactively***. This allows us to apply the appropriate level and intensity of resources to maintain members in the least restrictive setting and promote recovery, wellness and quality of life while honoring member voice and choice. We employ daily risk stratification to identify members for timely intervention in accordance with the following levels:

ICMCC and PHM				
Level of Support	**Intensive Care Management**	**Episodic Care Management**	**Episodic Care Coordination**	**Preventive Services and Health Maintenance**
Member Characteristics	High Complexity: Episode of serious illness or injury; complex social needs; co-morbid, complex, or unstable chronic condition; symptomatic and at risk for admission	Moderately Complex conditions; mostly stable with no complex social needs; may be previously assigned as high acuity but making progress; episodic acute need requiring support to prevent escalation	Low Complexity: Assistance with navigation and/or coordination across the delivery system; stable chronic conditions; risk mitigation	Healthy members: All populations, including healthy members with no chronic or acute conditions; population health management
Method of Delivery	Telephonic with face-to face and /or telemedicine visits as needed		Telephonic, targeted mailings, mobile and other technology	
Minimum Frequency	Minimum weekly until stable then at least monthly	Minimum quarterly, tailored to the needs of the member	Episodic based on member need	At least annual and as needed per data analysis

AZCH is staffed with local, trained, and qualified ICMCC teams available to perform all levels of ICMCC and support and monitor providers/community agencies to ensure members receive the right services at the right time. Staffing is based on member and provider need, accounting for clinical and cultural needs.

ICMCC AND PHM OVERVIEW. In full compliance with the RFP, including Section D.23, we will leverage our current experience, infrastructure, and expertise to ***engage members and providers*** in ICMCC programs that fully capture the principles of integrated care and progressively transform the system to accomplish whole person health. The *ICMCC Pyramid* illustrates how all members, regardless of ICMCC enrollment, are stratified and ***cared for according to need, moving up and down the spectrum of health and wellness***. Supporting the process and aligning resources with needs, AZCH supports providers and staff with targeted data, training, tools, and technical assistance to optimize service delivery based on a person-centered, team-based model. ***Key functions of ICMCC include:***



- Member identification, screening, assessment, stratification, hot spotting, and predictive modeling
- Member and provider education, outreach, and engagement, leveraging and sharing actionable data

- Development, monitoring, and oversight of member-driven Integrated Care Plan (ICP) for members in care management
- Coordination across the full continuum of care, including PH, BH, and SDOH
- Facilitation of prompt access to appropriate care and services, transportation, interpreter services and other accommodations

In addition to proactive member identification, any member can request or be referred to ICMCC and have access to an Integrated Care Manager (ICM) and Integrated Care Team (ICT) to assist with coordination and system navigation.

ICM. Our ICMs, supported by an ICT, carry out ICMCC functions as required in AMPM Chapters 500 and 1000. Members in intensive or episodic care management are assigned an ICM to facilitate and perform all ICMCC functions in accordance with the member-driven ICP and in partnership with the ICT. ICMs have expertise in person-centered care planning, self-management skill development, health promotion and literacy, member advocacy, navigating complex systems, and communicating across disciplines. ICMs bring all involved providers and community agencies together to address PH, BH, and SDOH needs in an integrated approach, educating and holding each party responsible, and following up to close the loop.

ICT. At the center of the ICMCC model is the member. The member-directed ICT includes subject matter experts reflecting member desires, needs, and conditions. AZCH staff include AZ licensed RN and BH clinicians, trained in integrated care. Teams are supported by Program Specialists, e.g. justice, child welfare, housing, employment, veterans, peer support; ICT and CFT Coaches; Health Coaches; PH and BH providers; pharmacists; and community resources, such as Community Health Representatives from across all tribes, Promotoras/Community Health Workers (CHWs), Peer Support Specialists, and SDOH agencies, such as local HUD Continuums of Care. The member-driven ICP (member stated goals and member approved interventions) is shared with members, authorized caregivers, treating providers, and external ICT participants through our secure Web Portals. The ICM initiates and facilitates ICT meetings including internal and external parties as appropriate to meet member needs.

LEVERAGING TECHNOLOGY AND HIGH TOUCH ENGAGEMENT. Technology. Supporting our ICMCC process is our continued investment in integrated technologies. Our real time ***PHM Solution***, supported by Centelligence®, our proprietary and comprehensive family of integrated decision support and health informatics solutions, includes a combination of proprietary algorithms, risk stratification, and advanced predictive analytics to improve care and achieve quality, clinical, and financial goals in integrated care. These integrated tools collect, analyze, and distill comprehensive data sets, such as BH, PH and pharmacy claims/authorizations; AHCCCS Blind Spot data; PRAPARE (SDOH) and other assessment results; real time ED, admission, discharge, and transfer data; HIE and jail feeds, maximizing staff time and accelerating results. Most PHM models have a lag time and require more than six months of data over time. Our PHM solution combines time-sensitive, short term/real time data with member history to identify needs and stratify our population in real time, pushing daily insights and care gaps to the attention of ICMs immediately. For example, identifying pregnant women prescribed opiates, members due for preventive screenings, and care transition period insights to ensure appropriate follow up after discharge. As a proactive system, we don't wait for events to spark action, we predict and prevent. For example, a member with schizophrenia experiencing increases in both chronic disease medication and specialty visits triggers an elevation in complexity from moderate to high. This trend would initiate an ICM referral for immediate outreach and assessment. As another example, a change in housing stability in a member with a justice-involved history would trigger an immediate assessment and connection to appropriate housing resources. From these proactive insights, we can identify barriers to integration, including addressing SDOH, and provide targeted training and education, technical assistance, and actionable data delivered at the point of care.

High Touch Engagement. AZCH employs innovative and effective strategies to maximize member engagement opportunities. Our high touch, personal engagement includes the use of field-based engagement specialists, such as CHWs and Peer Support Specialists, who deploy into the community to locate members, leveraging last known contact information provided by the PCP or health home, EDs, Health Current, the Homeless Management Information System, and other providers and pharmacies, and following member patterns, such as going to homeless shelters. Members can be met at hospitals, EDs, jails and other

Our field-based engagement specialists reached over 10,080 members in 2017.

facilities. We will be using Peer Supports to engage members in the hospital to help with connection to a health home, follow up appointments, and connecting high risk members with a free cell phone. In our peer support pilot with justice-involved members, members of the pilot who received peer support services during the pilot period had a ***decrease in arrests of 28% from 1,111 to 795. ED Visits for the pilot group decreased by 22% from 799 to 620***. AZCH engagement staff are trained in evidence-based practices such as Motivational Interviewing, Patient-Centered Care, nationally recognized Question/Persuade/Refer suicide prevention training, Trauma Informed Care, and Mental Health First Aid. These trainings are made available in the community.

ICMCC FOR SPECIAL POPULATIONS AND PROGRAMS. AZCH's added value to AHCCCS and the unique and complex populations that will be served through Complete Care are our specially trained staff, external relationships, and innovative programs and resources. **Special Populations.** We employ and engage subject matter experts on our ICTs that are familiar with the resources and complexities of each subgroup identified in Section D.23 of the RFP. This is coupled with specific protocols for how to best serve different populations and meet contract requirements. For example, our ICMCC team outreaches to all members/guardians identified by the Arizona Child Abuse Hotline (ACAH) as victims of sex trafficking for assessment and appropriate enrollment into ICMCC. Interventions include the provision of trauma-informed resources and referral for BH and PH screenings and services. We systematically track all activities to ensure communication and follow up, sharing outreach results with ACAH within 30 days of referral. Other interventions include our Tribal Clinical Services Coordinator that helps ensure the ICMCC process includes appropriate tribal providers; our ICMs trained as Veteran Navigators to provide support and appropriate referrals to Veteran agencies to coordinate PH and BH services for our Veteran members; and the addition of a CRS Advocate who is a CRS family member by 10/1/2018. **Special Programs.** We have targeted member engagement programs, such as:

ED Diversion. Timely identification and outreach utilizing daily Health Current alerts; meeting high risk members in the ED to engage in ICMCC; a review of ED visit and health care needs; education on alternatives to ED for non-emergent needs; assistance scheduling appointments or finding a suitable PCP and/or health home; home visits by a CHW; referral for assessment/treatment/community resources; and coaching on use of our 24/7 nurse assist line and other resources.

Care Transitions & Placement Teams. Key components include developing a post discharge care plan, partnering with Health Homes, PCPs and other providers, and Peer and Family Supports to coordinate and ensure continuity and prevent gaps in care, and communicating with members and families/caregivers to ensure members receive necessary and timely post discharges placements, services and supports and that all needs impacting their health have been satisfied.

Disease Management (DM). Members with chronic conditions benefit from a concerted approach to improve health, self-management skills, and health literacy. DM programs include: COPD, asthma, diabetes, chronic pain, SUD (including our Opi-End opioid program described below), depression, CHF, CAD, and anxiety.

Reach-In Justice Program. AZCH contracts and funds Jail Liaison positions, currently co-located in five County Detention Centers, and provides coordination of care for members in corrections. These Liaisons serve as the bridge between detention and community providers, coordinate with all justice system partners including the Courts and Probation Offices, assist in completing and submitting AHCCCS applications prerelease, scheduling appointments and arranging for transportation. We have provided education to our community providers on working with Justice System Partners and the importance of considering criminogenic factors when developing a treatment service plan.

MONITORING SUCCESS AND OUTCOMES. The goal of all programs and processes is to improve outcomes, promote integration, enhance coordination, and improve member satisfaction and experience. We evaluate ICMCC effectiveness and engagement through ICP monitoring, real-time monitoring of member satisfaction, daily data reviews and continuous monitoring of success through our QMPI program. For example, we measure member satisfaction in real time at the conclusion of every member contact with an ICM by asking the member if they are satisfied with the service they received. That feedback is documented in our ICM system and reviewed and acted upon by our Communication, Access, Respect, and Education (CARE) Task Force that monitors and improves member and provider experience. ***For the first six months of the Complete Care program, we will expand our post contact survey to ask the member to rate their overall satisfaction with AZCH***, and use the results to improve care and service. Our annual QMPI and Medical Management Plans are the foundation on which our integrated care approach is established, operationalized, and

measured. In addition to department-based daily, weekly, and monthly reviews of member progress, outcomes data, and trends, our quarterly QMPI Committee monitors and evaluates ICMCC services and whole person care, identifying opportunities for improvement. Measures align with AHCCCS performance measures and include HEDIS; member and provider satisfaction; utilization data, including pharmacy utilization and recidivism; plan performance, including timeliness of assessments; and other specific focus goals. Some focused examples include reducing ED and inpatient utilization in members with anxiety and reducing the percentage of pregnant members with substance use.

DEMONSTRATED EXPERIENCE AND OUTCOMES ADMINISTERING INTEGRATED CONTRACTS

LOCAL EXPERIENCE. AZCH is a leader in integration, successfully aligning members and providers with integrated care. As the RBHA in Southern AZ, we have successfully integrated BH and PH for adults with SMI. Our experience includes development of Integrated Health Homes (IHHs); supporting practice transformation with ***funded Population Health Administrators (PHAs)*** who work on site at provider practices; comprehensive training targeted for PH, BH and Integrated providers, e.g. Managing SUD in Primary Care, Screening for PH, Person-Centered Care; timely, actionable, meaningful, and easy to use data, e.g. Care Gaps, shared ICP, visibility to authorized services and utilization history; and meaningful forums, such as Joint Operating Committees. In October 2015, there were 60 integrated clinics which we have ***increased to 90 IHH clinics*** through 17 IHHs that will continue to serve and improve the outcomes of our GHMSA adult and child members. In 2017, we were selected to participate in four ***SAMHSA HRSA Innovation Communities***; including, Preparing for Value-Based Purchasing (VBP) in BH and Primary Care; Building Integration in Pediatric Care Settings; Implementing Pain Management Guidelines in Integrated Care Settings; and Team Based Care. Our acute plan has direct experience integrating care for our GMHSA/Dual members and have built partnerships with PH and BH providers such as our IHHs, Crisis Preparation and Recovery, Crisis Response Network, Southland Home Health, Terros, and Community Bridges. In collaboration with providers, unique payment approaches have been developed that support providers achieve quality outcomes for shared members. From this experience we have the ability to effectively transition new providers on to our current payment models to effectively manage whole person care. As both a RBHA and acute plan, we have experience coordinating care for shared members, such as through the AHCCCS High Need/High Cost program, ensuring a seamless, integrated experience for current members. Finally, AZCH will glean integrated care experience from the 10 plus years of experience of Bridgeway Health Solutions, with direct experience as a DSNP and ALTCS plan, serving the integrated needs of members in AZ's first fully integrated plan model.

25% more members are receiving fully integrated care through IHHs in 2017 over 2016

NATIONAL EXPERIENCE. In addition to local experience, we have extensive national experience through our affiliate health plans that have ***successfully administered integrated contracts in 19 states***. For example, our Texas affiliate implemented an initiative to increase the use of Cognitive Adaptive Therapy services to address readmission rates for high utilizing members and provide intensive behavioral-oriented community support, including accompanying members to medical appointments and environmental supports such as calendars, pillboxes, and alarms. As a result, ***BH admissions decreased from 19 to 12 (30 days pre and post) and inpatient costs decreased from $32,206 to $18,818.***

QUALITY OUTCOMES. In addition to the many successful outcomes described above, through our integrated programs, we have seen decreased ED utilization, decreased costs, and positive changes in member behaviors. For example, from October 2016 to October 2017 we saw a ***6% decrease in ED use*** and an ***8% reduction in adult psychiatric readmissions.*** In addition, from July 2016 to May 2017, we saw ***improvements in HEDIS***, including Diabetes A1C Testing (16%); Diabetes Eye Exams (23%); Diabetes Screening for Member Using Antipsychotic Meds (11%); Adults Access to Preventive Care (4%); Annual Monitoring for Members on Persistent Medications (10%); Breast Cancer Screening (4%); and Chlamydia Screening (11%). Also demonstrating success through integration are our achievements in employment and housing. As reported by AHCCCS, our RBHA has led all three RBHA/MCOs for 10 consecutive quarters with the ***highest percentage of members competitively employed*** for all population types combined, averaging 50% of members employed. In FY16-17, 1,500 RBHA members obtained employment [new jobs], making just under 10,000 of our members employed. ***Our goals for housing for FY17 included a reduction in the overall number of members homeless by 20%. At the end of September, the number decreased by over 20% and the rate of homelessness decreased by over***

5%. Nationwide, we have demonstrated success through ICMCC programs. For example, an internal analysis of Centene members in ICMCC during 2014 found that, on average, our ICMCC program resulted in ***significant savings in inpatient hospital and ED PMPM costs ($226 and $19 PMPM, respectively).*** This study included a comparison of 2015 (CY14) HEDIS compliance rates. ICMCC members were found to have significantly higher compliance rates for several HEDIS measures compared to the control group, for example ***18.43% higher in breast cancer screening, 12.16% in cervical cancer, and 13.15% in comprehensive diabetes care-eye exam***.

IMPLEMENTING SUCCESSFUL STRATEGIES AND INNOVATIONS IN ARIZONA

Leveraging our experience, we will work with AHCCCS and our communities to adopt and adapt the described strategies to facilitate successful integration. Locally, we have identified several barriers to integration that we continue to address, including PH providers reluctance to coordinate care with BH providers; BH providers unwilling to address PH conditions; stigma related to BH conditions; inadequate information exchange and electronic health records (EHRs) that don't communicate; lack of training in integrated care; outreach and coordination activities that aren't billable; and availability of integrated services at the time the member needs them. Examples of programs to address include:

WORKFORCE DEVELOPMENT AND TRAINING. Enhanced integrated training programs will focus on whole person care, training BH professionals on PH conditions and PH professionals on BH conditions. Our jointly developed UA online Integrated Care Certificate program is available to all providers and community supports. Training topics include delivering integrated care through ICMCC, including facilitation and staffing of ICT meetings and maintaining release of information on file to facilitate information sharing and coordination of care. We will provide system-wide technical assistance (TA) to promote screenings for BH and PH conditions in all settings, including access to free, evidence based screening tools; PCP TA to facilitate the integration of BH consultation, screening, and treatment, including the use of best practices such as Collaborative Care; TA to assist BH providers integrate PH and treat the whole person; and TA to maximize the use of Health Current, supporting clinical information at the point of care. Other workforce development activities will include training CHWs/Promotoras; collaborating with Medical Societies, medical schools, and nursing schools to provide stigma reduction training; and focus groups and culture change interventions.

BEST PRACTICES. Bi-directional integration models such as ***Collaborative Care*** and Project ECHO empower clinicians to provide better care to more people, at the point of service. In June 2018 we will partner with AZ Telemedicine Program (ATP) to offer ***Project ECHO*** on Integrated Care to enhance clinical competency across the delivery system. We will also support our home bound and complex members through integrated home clinical visits through our ***Healthy Together*** partnership in October 2018. We will continue to expand the number of IHHs by funding ***PHAs*** to directly facilitate integration. Since October 2015 we have ***funded over $3.3 million*** for PHAs and are engaging an outside practice transformation firm, **Care Accountability**, to further support transformation across the AZCH network in CY19.

VALUE-BASE PURCHASING. AZCH will continue to expand VBP incentives for PH/BH coordination, whole person care, and screenings, HIE participation, care coordination for members with high needs, and member outreach.

OPIOID EPIDEMIC INTERVENTION. Leveraging national experience and addressing the Governor's executive action memo, our Opi-End Program is designed to approach the opioid crisis in a more targeted fashion, developing and implementing specific policies and protocols to improve the way opioids are prescribed. This is coupled with alternative pain management strategies; prescriber profiling; use of state PDMP; and expanding access to Medication Assisted Treatment (MAT). For example, we collaborated with providers to develop ***three 24/7 MAT clinics*** in Pima County that provide integrated care, which we will expand statewide as applicable. Through chronic pain DM we have ***reduced high risk benzodiazepine utilizers by 72% and high risk Opioid utilizers by 54%*** over a six month period. Through these efforts, our goal is to reduce the mortality rate for AZCH members due to opioid overdose by exceeding the state's aim of reducing overdose deaths by 25% in the next five years.

PROVIDER AND MEMBER RESOURCES. In addition to training and technology tools described throughout, we ensure members and providers have access to information when they need it. For example, we staff a ***24/7 nurse assist line and 24/7 psychiatric and primary consultation access line***, going beyond the traditional advice lines and connecting members and providers with services and real time resources.

arizona complete health

MEMBER ENGAGEMENT AND IMPROVED OUTCOMES THROUGH TECHNOLOGY

Based on feedback obtained by our members through our Member Advisory Council, we found a large majority of our members have smart phones and prefer to connect with us through social media and mobile devices. We recognize this shift in how information is exchanged and are following the communication patterns of our members by investing in mobile and online technology and social media. We leverage our ***Proactive Outreach Manager***, a coordinated member outreach system that orchestrates, tracks, trends, manages, and refines targeted outreach campaigns using the channel most likely to lead to engagement and action. As specified in the AMPM and Section F, Att. F3, we will define and engage at least 10% of our members using web and mobile-based applications, which we expect to far surpass. As a part of our strategy, we will equip high risk members that are without a phone, with a smartphone, free of charge, pre-programmed with phone numbers and mobile apps that will connect them with AZCH. To increase the value to all of our members, we will identify meaningful web and social media content and engaging web applications. Members will earn rewards for appropriate preventive care and healthy behaviors through our CentAccount program and use those rewards at approved retail stores throughout AZ and through their mobile device. We will educate and train members on the use of these resources through our new member welcome calls, member handbook and newsletters; when members call in to our Call Center; through forums designed to train and raise awareness of technology; and through the use of peer and family organizations. Web/mobile apps in development or being utilized are described below.

MOBILE APPLICATIONS. Our ***Member Mobile App*** is a comprehensive, integrated mobile resource, available in English and Spanish, offering a variety of health education resources, including Care Gap Alerts; Find-a-Provider feature; electronic member ID card and screening tools. ***Start Smart Mobile*** is an interactive and personalized app for new and expecting mothers. This solution proactively identifies pregnancy milestones and helps our members take action and access resources, such as care management and 24/7 nurse assist line. These integrated apps will be available Q4 2018. Available by January 2019, the ***Noda Capture App*** will be developed in partnership between AZCH and SAARC. Noda Capture assists with early diagnosis for autism and connects members to ASD resources. We will continue to work with our members and stakeholders to identify other meaningful member apps. Using county-provided tablets in the jails, we upload important PH and BH benefit and plan info and education for inmates soon to be released.
SOCIAL MEDIA. We will continue to use social media to connect to our members and improve health literacy and prevention**.** Over 12-months (11/16-11/17) our Facebook page ***reached 215,600 people***, compared to 43,981 in the prior 12 months.
TEXTING. Upon AHCCCS approval, anticipated mid-2018, AZCH will utilize text technology. Start Smart® for Your Baby Texting sends members 18 and over who opt-in texts with prenatal education, tracking maternal weight, promoting breastfeeding, and encouraging timely postpartum and well child visits. For AZCH affiliate plans, ***frequency of prenatal care improved 6.6%, and timeliness improved 3.2% at the 90-day mark following member enrollment***. In addition, our online appointment scheduling through MyHealthDirect gets members in to see providers quicker and includes mobile access and text appointment reminders.
WEB PORTALS AND RESOURCES. Secure ***Web Portals*** include self-service features and clinical data needed to empower members and authorized family/caregivers to manage their health, including ICP access. Our ***online health library***, powered by Krames, is a flexible, web-based solution for delivering patient education at the point of care, with more than 3,400 HealthSheets explaining conditions, procedures, and specialty areas and 2,000+ drug information sheets on prescription and over the counter products. ***myStrength*** is an online consumer directed mental health resource that helps members take responsibility for their health care and learn more about their diagnoses, track their symptoms, and receive motivational ideas and information. During FY17 through October 31, 2017, ***285 people have accessed and completed the screening tool***. ***7 Cups peer support*** is an online tool that anonymously and securely connects members to trained, diverse, and compassionate peer listeners, providing support in 140 languages on issues such as depression, anxiety, financial hardship, and substance abuse.
TELEHEALTH. We are actively expanding telehealth options to support care in all settings, such as retinal cameras for members going in for diabetes checks or an app to take a picture of the eye and send in. ***Teladoc*** (available Q1 2019) provides members with 24/7 access to doctors by phone or video to diagnose, treat and prescribe medications for non-emergency conditions. ***Virtual visits*** **(**available Q1 2019) are encrypted, care management visits between members and the ICT. ***OnDemand*** is our real-time diabetes home monitoring and clinical support program providing remote monitoring of glucometer, phone based clinical support, and diabetes management coaching.

NARRATIVE SUBMISSION
RESPONSE #5

NARRATIVE SUBMISSION
RESPONSE #5

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

5. The Offeror has a member who is a 54 year old female with schizophrenia, opioid use disorder, brittle diabetes …

BACKGROUND AND APPROACH

Our member, Kate, is faced with a series of interrelated challenges - lack of safe/stable housing, opioid use, inconsistent food source, schizophrenia, neuropathic pain, brittle diabetes, and lack of familial support. We recognize the connection between Kate's behavioral health (BH) and physical health (PH) conditions, including the impact of each social determinant of health (SDOH). We are dedicated to providing Kate with a fully integrated, holistic, member-driven, culturally responsive and strength-based approach to care management and coordination that is recovery-oriented. We train all staff on this approach and on the *Adult Behavioral Health Service Delivery System-Nine Guiding Principles,* which in our role as a RBHA since 2005, have successfully implemented to transform BH and integrated care delivery. Our local Integrated Care Manager (ICM) acts as a clinical single point of contact for care management functions and to engage and advocate directly with Kate. We will build on Kate's strengths and natural supports, addressing her integrated health and related social needs through our person-centered Integrated Care Management and Coordination Model (ICMCC). We will work with Kate to obtain a safe living environment, engage her in the care planning process, identify and manage appropriate interventions, coordinate care transitions, ensure effective services and supports based on her goals, strengths and preferences to reduce risk and help achieve better health care outcomes. In this response, Kate is in Safford, AZ, the anchor town of a micropolitan area of about 37,000 people and the number one "hot spot" for opioid use in Southern AZ. In this rural environment, options for treatment are limited as opposed to Maricopa or Pima Counties with more options for housing and available services. Regardless of location, our care management process would be the same. Upon Kate's enrollment with us, we would have immediate knowledge of her and procedures in place to ensure we meet all program requirements. We support infrastructure and processes to facilitate integrated health information and care coordination through our Population Health Management (PHM) solution, secure Web portals, Shared Integrated Care Plan (ICP), Integrated Care Teams (ICT), ICMs and Quality Management Team.

PREVENTING POTENTIALLY AVOIDABLE ACUTE CARE

Kate has spent three days in the Emergency Department (ED) which, given her homeless status, might be considered an ED hold due to constraints on options for safe discharge. AZCH has an established process designed to prevent extended tenure in the ED, resulting in a better disposition for members like Kate, with our Rapid Response ICM process ensuring ICM staff are available seven days a week to engage members or provide onsite/telephonic disposition planning support for members that have been in the ED >24 hours, or who are difficult to locate or engage.

IDENTIFICATION OF MEMBER AND RISK STRATIFICATION. Our ICM is a nurse and/or licensed BH clinician that is the clinical single point of contact for Kate and her ICT. Upon receipt of the transition files from her previous health plan (prior to October 1), our ICM will have identified Kate as a high priority for initial outreach. Risk levels are assigned using daily risk stratification and predictive modeling of all current and new members contained within our PHM solution. Our PHM risk stratification tool uses all available information (eligibility file, transition file, (DEF) transmissions, Blind Spot data, authorizations, PH, BH, pharmacy claims, assessments, care plans, housing status, etc.) to identify high needs members. As she is transitioning from another plan, we would conduct a clinical review with her previous care manager and the RBHA to ensure we have complete information, last known or commonly frequented addresses, and any previous ICPs. Our ICM initiates outreach efforts using multiple strategies as the RBHA would have indicated that Kate is homeless and has no known working phone or address. Our ICM would enlist Engagement Specialists (leveraging Peer Support Specialists [PSS], Community Health Workers, Community Health Representatives, and/or Promotoras from the community) to contact or go onsite to shelters and other likely sources to locate her. The ICM would also be proactively monitoring for hospital presentation, ED alerts or other trigger events using daily feeds from the Health Current HIE and hospital inpatient census data. Our ICMs proactively check for these alerts through our PHM solution which systematically monitors, captures, and pushes notifications to the ICM daily. Providers that do not currently utilize Health Current notify us of ED visits through our 24-hour nurse assist line. A hospital or ED alert/notification is trigger to action for response from our ICM who is able to quickly engage the member at the ED. Our AZCH ICM would have

worked to find and engage Kate prior to her presentation in the ED due the complexity of her health diagnosis and SDOH challenges. Should we have failed to find her before presentation, our proactive approach and real-time alerts would have enabled our ICM to connect with her in the ED within 24 hours of her presentation. As the transition to a new Complete Care plan has just occurred and Kate is homeless, it is possible that she may not have known that her health plan changed, which could have delayed notification from the hospital. While AZCH would have made every attempt to prevent this scenario from happening, our ICM will be there to support Kate as she is being discharged after three days spent in the ED.

MEMBER ENGAGEMENT: RAPID RESPONSE AND ASSESSMENT

INITIAL OUTREACH AND ASSESSMENT. Through our HIE alert, ICM locates Kate at Mt. Graham Regional Medical Center in the rural community of Safford. Just as she is being prepared for discharge from the ED, our ICM immediately calls the ED social worker and requests permission to meet Kate prior to her discharge. Given Kate's significant issues, our ICM meets Kate onsite at the ED to quickly identify her current PH, BH, and SDOH needs, conduct a Health Risk Assessment, obtain her consent to release information, and begin to establish a trusting relationship to develop aligned short-term and long-term goals. The ICM provides Kate with a Member Welcome Packet, talks with her about the ICM program and gets her permission to help her through care management. The ICM documents the assessment and the conversation in our PHM solution and accesses the Prescription Monitoring Program (PMP) data reflecting Kate's history of medication use and Kate's service history in the HIE including information on her current ED visit. The ICM consults directly with the ED social worker for additional treatment history, including potential illegal substance use. The ICM reviews the information about Kate's health conditions, treatment history, medications and all information related to Kate's ability to care for herself upon discharge, including housing status, substance use, family contacts, or other sources of support.

ASSESSMENT RESULTS. Our ICM notes that there is no record of Kate receiving a SMI determination and she has not been assessed for or received MAT services prior to the ED encounter. Kate also confirms what previous claims data suggested, she has not seen her PCP, or any medical provider for her diabetes and neuropathic pain, or refilled her psychotropic medication prescription. From the ED physician, we learn that Kate uses IV heroin, and that she was kept in the ED to stabilize her blood sugars and restart her psychotropic medications. The ICM is concerned about the potential of Kate experiencing a non-medical detox while in the ED for three days. Without transitional support, MAT services and engagement into SUD treatment, she is at risk for heroin use upon discharge and increased risk for overdose. Kate's complex clinical history and presentation requires immediate connection to services and with Kate's input and approval, the ICM will initiate contact and planning with providers before she leaves the ED.

All of our ICMs are trained in Trauma-Informed Care, Person-Centered Care Planning, Active Listening, Motivational Interviewing, Housing First and the Transformational Stages of Change model.

PERSON-CENTERED ENGAGEMENT. Kate is likely to have a history of trauma due to its correlation with mental illness, substance use, and homelessness. Kate's ICM works to understand her past experiences and potential trauma that may have led her to mistrust people and the healthcare system so the ICM can respond with a respectful person-centered, trauma-informed approach to engage her in care. A trauma-informed approach is key as we engage Kate, to address her homelessness and lack of social/familial support. It is important to establish a safe transition from the ED and maintain her engagement in care to stabilize her PH/ BH conditions and prevent avoidable ED utilization in the future. The ICM creates a context for Kate to be comfortable expressing her needs and goals, using Active Listening and Motivational Interviewing to hear the primary concerns Kate has for her health and safety, and relay the ICM's concern about the danger of overdose Kate faces, as well as the risks from her unmanaged diabetes and inappropriately managed chronic pain. The ICM then works with Kate to jointly identify the steps she can take to avoid these adverse outcomes.

MEMBER-DIRECTED CARE PLANNING AND COORDINATION

HOUSING FIRST AND MEDICAL HOME. As the ED has indicated, Kate is medically stable for discharge and our ICM's first priority is to ensure that she has a safe housing option that supports her continued engagement in her treatment. Our ICM wants to coordinate the transition from the ED to a setting that will meet Kate's immediate needs for shelter, safety, consistent food source, and PH and BH stabilization, while addressing her substance use diagnosis (SUD). The ICM

tells Kate about some options for care that would enable her to get her PH, BH and SUD services on site. One is Southeastern AZ Behavioral Services (SEABHS) and the other is a Brief Intervention Program (BIP), a brief residential step-down program for stabilization, in nearby Globe at Community Bridges, Inc. (CBI). Our ICM tells her that both SEABHS and CBI are integrated health homes (IHH) with programs that can treat all of her care needs, including immediate assessment for MAT, addressing her SDOH needs and providing care for her brittle diabetes. After listening to the service options available to her, Kate expresses a readiness to change and elects to go to the CBI BIP and enroll in SEABHS as her health home. The ICM is able to secure immediate availability at CBI BIP. The ICM then follows up with a call to connect to the Health Care Coordinator (HCC) at SEABHS. With solutions for the immediate needs for safe housing and follow-up care identified, the ICM coordinates with the ED social worker and the HCC at SEABHS to ensure a smooth transition to the CBI facility. The ICM also informs Kate that even though her PCP is not in our network, we will coordinate with her current PCP if Kate is interested in re-engaging with him. AZCH could reinstate her PCP without authorization for 90 days, or employ a single case agreement if necessary for continuity of care. However, Kate states she does not want to go back to her previous PCP because he discontinued her Percocet. The ICM would forward this complaint to our Quality Department for investigation as a possible quality of care concern if Kate did not receive an alternate pain management service when the Percocet was discontinued. Since Kate has selected SEABHS as her new IHH, her ICM will ensure that SEABHS receives copies of her medical records within 10 business days from request, and has a PCP appointment scheduled for within three days of discharge from the BIP.

EFFECTIVE AND EFFICIENT TRANSITIONS OF CARE. The ICM arranges for transportation for a safe arrival at CBI. The ICM assists Kate in her transition from the ED by obtaining Kate's medications from the hospital pharmacy for transport with her. Though the ICM has arranged transportation to CBI, the possibility of Kate using heroin and being at risk for overdose between the ED and the BIP remains, so with Kate's permission, the HCC from SEABHS meets her at the ED and rides with her. Prior to leaving the hospital, the ICM ensures that Kate is provided with a Naloxone rescue kit and is taught how to use it. If Kate does not have a cell phone, we provide her with a pre-programmed Safe Link smartphone that contains contact information for SEABHS, CBI, her other health care providers, the ICM, AZCH nurse assist line, and local 24/7 crisis response line. SEABHS will be able to access the discharge information and Kate's previous health history through our secure Provider Portal, however, to ensure coordination and reduce the information Kate has to repeat to intake staff at SEABHS and CBI (which was just shared at the ED) the ICM has gathered Kate's ED discharge information, obtained a CFR42 Part 2 and HIPAA compliant consent for release of information, and provided a written copy to the HCC, while also providing an in-person status update. The ICM will work with the HCC and Kate to set a time for the first ICT meeting, which is the collaborative interdisciplinary treatment team that will meet with Kate and her chosen supports, to establish her ICP. The ICM ensures that an immediate Vulnerability Index - Service Prioritization Decision Assistance Tool screening is conducted by SEABHS to prioritize Kate's housing needs. This information informs ICP development to ***support a smooth transition from the acute setting to the community and provide a foundation for ongoing continuity of care*.**

MEMBER-DRIVEN ICP.

With assessment information and Kate's own voice, the ICT will establish an ICP that incorporates Kate's needs, goals, and self-management, seeking Kate's input to update the ICP to reflect her evolving status and evaluate her progress towards goals. For members with complex needs, the ICT initially includes Kate, her ICM, the AZCH Medical Director and Pharmacist, and her chosen community treatment team: the HCC, PCP, BH provider, PSS and other supports identified by Kate. The ICP accounts for any identified SDOH, is developed through a culturally responsive lens, and incorporates resiliency factors including social supports and spiritual tradition. The ICP is updated at least annually or upon any change in status or condition, including lack of progress toward goals. For a high needs member like Kate, the ICT would meet at least monthly to review the ICP. During Kate's first ICT meeting, Kate identifies some high level goals and the team works together to identify short-term/long-term steps to help address her goals. Additionally, the team discusses the best options for care. The ICT discusses the need for SMI and ALTCS eligibility assessments as the complexity and severity of Kate's PH and BH conditions could make her eligible for both programs. Kate says she is more interested in feeling good now and having a safe place to live, but would consider those assessments in the future. During the discussion, with Kate's goals in mind, Kate and her team discuss her transition out of the CBI BIP and into permanent

supportive housing (PSH), they also discuss how she can best engage in outpatient services. SEABHS offers comprehensive BH services including Trauma Focused-Cognitive Behavioral Training and is partnered with Canyonlands FQHC to create a fully integrated health home for her for ongoing outpatient care. Canyonlands can conduct a PRAPARE assessment to better address all of Kate's SDOH needs and is able to support Kate's PH needs and MAT services. Through SEABHS she can continue to access PSH services. Our ICM will ensure alignment of our ICP with the IHH's Individual Service Plan which includes Kate's crisis prevention plan to ensure all services delivered support Kate's ICP goals, this information is documented within our PHM technology solution. ***The following ICP, created with and approved by Kate, is available to Kate and authorized ICT participants through our secure Web Portals, is developed to address short term and long term care and service needs, capturing and directly responding to Kate's self-determined goals.***

Goal	Short Term Planning	Longer Term Planning
I want a safe place to live	• Obtain immediate shelter to attain stability – transitional placement at CBI • Monitor and support SEABHS with PSH services • Obtain PSH through SEABHS • Obtain assistance with disability benefits via SOAR, or supported employment services, to attain and maintain housing, per Kate's choice	• Provide support at her established housing with PSH and work with IHH to participate in home visits to understand Kate's needs • Connect Kate with an Employment resources to provide employment training and placement if she is ready to take that step.
I want to reduce my pain	• Develop safety plan that provides support, treatment and recognizes triggers to prevent inappropriate opioid use • Immediate MAT need assessment by CBI • Management of pain with non-opioid treatments at CBI • Establish pharmacy home with one location for meds • Connect with Peer Recovery Support • Arrange transportation to appointments as needed	• Ongoing MAT at CBI with provider support for evidence based MAT, SUD treatment • Engage in AZCH Chronic Pain Disease management program • Health home coordination for pain management referrals if needed • Continue Peer Recovery Support
I want to feel good	• Stabilization of symptoms of schizophrenia at CBI BIP and with transition to SEABHS and Canyonlands • Monitor and support medication treatment with consideration to effectiveness and side effects at SEABHS • Participate in Peer Support Services (PSS) either in-person, or through virtual PSS with Seven Cups—our secure online PSS provider • Monitoring BH/PH symptoms such as but not limited to depression, mood changes, dental health changes, and weight gain concerns and intervening/providing referrals as appropriate • Monitoring suicidal ideation, homicidal ideation, and symptoms of hallucination and intervening/providing referrals as appropriate	• Support medication adherence at SEABHS with recommendations for medication therapy, i.e. Consideration of a Long Acting Injectable Antipsychotic • Inclusion in Medication Therapy Management for ongoing pharmacist review of medications for contra-indications and effectiveness • Provide BH provider with evidence-based practices for medication management for members with comorbid diabetes • Continue Peer Support • Assess for SMI determination/ALTCS eligibility • Assess need for longer-term BH residential treatment facility (BHRF) such as CBI in Benson or The Haven.
I don't want to worry about my diabetes	• Nutritional support and education at SEABHS and then through Canyonlands FQHC • Review medications and monitoring for least invasive approaches • Identify and address barriers to medication adherence • Increase awareness through enrollment in AZCH's Diabetes DM program to provide self-management and education coupled with OnDemand's high-tech, easy to use devices to monitor glucometer activation, daily	• Access to Nutrition – arrange for food boxes • Patient education on disease management (DM) and self-monitoring • Support of health homes's diabetes DM program • Supporting IHH PCP with referral to endocrinology and podiatry as needed through telehealth connection

	compliance and glucose readings to ensure recommended ranges are maintained	• Monitoring for and assuring appointments with providers are kept • Ongoing monitoring of care gaps through PHM Solution related to Kate's diabetes, i.e. HA1C, eye exam, and kidney screening
I want to establish supportive relations-hips with friends and family	• Develop communication and relationship skills through work with counselor • Identify family and friends to re-connect • Work with PSS to develop positive social supports • Assist Kate with understanding what supports she has and provide education on community resources	• Engage with support entities • Support connection to community based and natural supports • Consider family counseling if appropriate to re-establish positive relationships

ONGOING COMPLEX CARE MANAGEMENT. Kate's ICM will follow-up with her at least once a week, and probably more frequently until Kate has made significant progress towards her recovery goals. Our priority is to ensure that Kate receives person-centered integrated services that wrap around her, rather than expecting her to navigate multiple providers. We would encourage Kate to engage in our DM programs and education including Diabetes DM and our Chronic Pain DM, which has successfully ***reduced the number of high risk benzodiazepine utilizers by 72% and the number of high risk Opioid utilizers by 54%*** over a six month period. Kate will continue to be closely monitored by her ICM and the ICT to optimize Kate's recovery during her journey through the healthcare system. Our ICM will actively participate in Kate's ongoing treatment team meetings that include Kate and her other chosen participants, bringing in additional experts from our ICT to support the process. For example, our housing specialist to help identify and secure PSH, or our pharmacist to monitor Kate's medications. If Kate were in an urban setting with additional services, the ICM may have suggested that Kate consider Assertive Community Treatment services, an evidence-based practice of intensive wraparound service and supports for high needs members that may help her to maintain her PSH. The ICM and ICT will continue to systematically and personally monitor on an ongoing basis the status of Kate's medical conditions and treatment approaches, ensuring that the care she receives meets her goals and supports her recovery and stability.

NARRATIVE SUBMISSION
RESPONSE #6

NARRATIVE SUBMISSION
RESPONSE #6

arizona complete health

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

6. The Offeror has a member who is an 18 year old female who was diagnosed with sickle cell anemia at the age of…

BACKGROUND AND APPROACH

Our member, Carmen, is navigating through several challenges. She has been impacted by sickle cell disease (SCD), a qualifying condition for Children's Rehabilitative Services (CRS), since she was a toddler. She is now an adolescent who is pregnant and trying to complete high school, though her depression and health conditions are making that difficult. While she is resilient – as evidenced by her commitment to completing high school – she must now overcome the negative impact of incarceration and opioid use. We will build on Carmen's strengths and natural supports, addressing her integrated health care and related social needs through our person-centered, Integrated Care Management and Care Coordination (ICMCC) model, and our nationally recognized Start Smart for Your Baby® (Start Smart) program. We will ensure Carmen has stable housing and other transitional supports as a recently transitioned youth, and is established with an OB/GYN and PCP that can adequately deliver whole person health care, understanding and recognizing her physical health (PH), behavioral health (BH), and social determinants of health (SDOH) needs, including supporting her chosen providers with the tools and resources they need to ensure optimal outcomes. With Carmen's SCD qualifying her for both CRS and as a member with special health care needs (SHCN), we would have immediate knowledge of her upon enrollment with us, and procedures in place to ensure we meet all program requirements, including contracting with all Multi-Specialty Interdisciplinary Clinics (MSIC) in awarded GSAs. We support infrastructure and processes to facilitate integrated health information and care coordination through our Population Health Management (PHM) solution, secure Web Portals, shared Integrated Care Plan (ICP), Integrated Care Teams (ICT) and Quality Management teams.

MEMBER IDENTIFICATION

We engage Carmen at the Pima County Adult Detention Complex where she was incarcerated. Arizona Complete Health-Complete Care Plan (AZCH) funds Jail Liaisons co-located within the County Detention Centers to partner with Jail Health Services (JHS) and community providers to identify and respond to detainees with health care needs. On a weekly basis, the county detention centers send AZCH a file of inmates scheduled for release and we utilize this report to identify members meeting Reach-In program criteria. To date, over 68% of our members identified for the program have opted to participate. In addition, our Integrated Care Managers (ICM) carefully review the records of all members identified as a Level 1 (Priority Population) on the Detention Center report, prioritizing them for the highest level of support. In Carmen's case, because she is pregnant with a CRS condition and a Level 1 priority member, we assign an ICM from our Maternal Child Health (MCH) team to work with her and coordinate her integrated care and psychosocial needs.

AZCH will work to replicate our daily information feed from Pima County regarding members that are incarcerated in awarded GSAs.

MEMBER ENGAGEMENT: PRE-RELEASE AND TRANSITION TO COMMUNITY

For Level 1 members like Carmen, we begin member engagement and coordination prior to release. Our Jail Liaison receives notification about Carmen from the AZCH Reach-In Team. Given Carmen's pregnancy and other SHCN, we seek written approval from the Pima County Jail for the ICM to join Carmen and the Jail Liaison in an in-person meeting while still incarcerated. After the Jail Liaison engages Carmen to explain AZCH resources available to support Carmen in planning a successful transition back to the community, they introduce the ICM. As a way of introduction, the Jail Liaison describes to Carmen AZCH's MCH program which includes a certified Women's Health Nurse Practitioner and ICM, who is also a certified postpartum doula and will provide Carmen's ICMCC services and lead the ICT. Supporting this member engagement, Jail Liaisons and ICMs are trained in Trauma-Informed Care, Person-Centered Care Planning, Active Listening, Motivational Interviewing (MI), Housing First, and the Transformational Stages of Change model. At this time, the ICM determines Carmen has no history in the BH system, therefore does not have an existing Child and Family Team (CFT) and refused any Transitional Age Youth (TAY) services when offered them at age 17. Carmen now opts into the Reach-In program, signs a 42CFR Part 2 and HIPAA-compliant Release of Information, and the ICM completes an assessment. The ICM leads the multidisciplinary ICT which begins meeting prior to Carmen's release to discuss and plan for care post-release. This community based team includes Carmen and all providers and agencies involved in her care

and services. The ICT for all justice involved members includes the Probation Officer and County Attorney who support the team in understanding the justice system. Because Carmen has a high-risk pregnancy, our AZCH Medical Director who is a Board-certified OB/GYN will provide additional monitoring of and consultation to Carmen's treatment. The level and type of involvement of each ICT participant is driven by Carmen and her needs, preferences, and desires.

MEMBER DIRECTED ASSESSMENT AND CARE PLANNING

Carmen will be supported with integrated care management and care coordination services pre- and post-delivery and throughout the first year of her baby's life. As a first time mother and teen, she is eligible for other community resources. Together with Carmen, the ICM and ICT develop an ICP based on her goals that fosters a healthy delivery and addresses her PH, BH, and SDOH needs. Carmen's immediate needs are locating stable housing, establishing relationships with providers to address chronic pain, depression, and prenatal care, securing transportation, and developing family or informal supports. As Carmen and the ICT evaluate her options upon release, they consider and discuss the elements described below.

HOUSING FIRST. It is critical prior to release to determine where Carmen will live and understand what natural supports she may have. As part of Carmen's assessment while still incarcerated, a Vulnerability Index-Services Prioritization Decision Assistance Tool determines Carmen's housing needs, including options for family support. Carmen will be returning to her family home, living with her mother and siblings. As a participant in the Reach-In program, Carmen is offered a Peer Support Specialist (PSS) accessible to her upon her request. The ICT also includes a PSS and/or Adult Family Partner, available upon Carmen's request, to work with Carmen to identify and engage familial and other natural supports. For example, we ask Carmen about the baby's father. If Carmen wants him to be involved, the PSS could help her to identify positive ways to engage him in care for her and/or the baby. The ICM would coordinate with the baby's father as requested by Carmen. The PSS and ICM can work with the member to prepare for her transition back home, addressing any trust issues or fall out from Carmen's arrest. Though she is already 18, Carmen may be interested in our TAY specialty team that provides comprehensive community wraparound services and supports, such as employment support. In addition, Carmen's goal to complete high school requires determining the best option for her continued education, given her health and psychosocial needs, in addition to transportation, future child care needs, and other accommodations.

CRS ELIGIBILITY AND MEDICAL HOME. Carmen is CRS-eligible and prior to being incarcerated she was served at our contracted Pima County's Multi-Specialty Interdisciplinary Clinic (MSIC), Children's Clinics. As an adolescent who has been involved with the justice system, Carmen is likely to mistrust helping professionals, including medical providers. This mistrust may create a barrier to Carmen receiving the health care that is so important for her safety and well-being, as well as for her unborn child. Using MI, the ICM talks with Carmen about the importance of connecting to medical care when she is released from jail. The ICM explores options with Carmen, which include returning to the MSIC or transitioning to a new provider. Our ICM explains the purpose and approach of an integrated medical home so that Carmen is fully informed in making a choice about her ongoing health care. The ICM offers to schedule Carmen's initial appointment with her chosen medical home through our online provider scheduling system, MyHealth Direct, which helps support timely access and improves member compliance through appointment reminders. The ICM helps with arranging transportation and can be available or arrange for a PSS to attend appointments with Carmen if preferred.

PAIN MANAGEMENT FOR SCD. Hydroxyurea, the primary treatment for pain with SCD, is contraindicated in pregnancy, therefore we can anticipate that Carmen will need to be prescribed opioids for SCD-related pain during her pregnancy. Given her history of opioid use, Carmen was assessed when incarcerated for clinical appropriateness for RBHA-funded Medication Assisted Treatment (MAT) by a community MAT provider in the detention center health services, and MAT would not have been initiated for Carmen since the primary reason for her opioid use is pain management for her SCD. Carmen is prescribed Naloxone upon release from jail as she is at risk for an opioid-related overdose. Our ICM would work with Carmen to develop safety and contingency planning in her ICP that would involve pain management strategies, and identifying warning signs of an impending SCD pain crisis. The ICP will include best practices for pain management alternatives to opioids and considers treatment contraindications for her pregnancy. To mitigate crises and prevent relapse, a safety plan is included as part of her ICP.

HIGH RISK PRENATAL CARE. With her age, SCD, and history with opioids, Carmen's pregnancy is high risk and requires access to high risk prenatal and postnatal OB/GYN care. The ICM will be in contact with MSIC (her chosen medical home)

and OB/GYN provider to support comprehensive care coordination to ensure all aspects of Carmen's pregnancy needs are effectively addressed and her providers have the supports they need to manage her depression and risk for opioid use. To support these needs, the ICM explains the importance of timely prenatal care and availability of our Start Smart maternity care management program that offers timely outreach on pregnancy, newborn care, and breastfeeding. The ICM recommends an appointment with Carmen's chosen OB/GYN within three days of release, who will then determine the frequency of future prenatal and high risk OB visits based on Carmen's risks and needs which can be programmed into our Start Smart mobile app and texting program (subject to AHCCCS approval) for reminders, in addition to weekly texts and tips for a healthy delivery.

CULTURALLY RESPONSIVE SUPPORT. All AZCH ICM are trained to support members in a culturally responsive manner and consider any cultural preferences or barriers when working with members and their chosen circle of support. This could include identifying a PSS who shares Carmen's ethnic background and understanding cultural influences that could impact care and treatment, family support, level of engagement, and availability of additional resources.

OTHER CONSIDERATIONS. Given Carmen's current circumstances there is a likelihood of trauma. We will offer trauma informed training to her providers and informal supports as indicated. Given her age, Carmen is likely to respond best to information and communication through a smartphone. If Carmen does not have a smartphone, we will arrange one through SafeLink or provide a disposable phone at no cost, giving her access to our mobile resources and texting options, as well as consistent communication with her ICM and ICT.

MANAGING MEMBER CARE AND SERVICES

As mentioned above Carmen elects to return to her previous MSIC, the Children's Clinic. The MSIC will serve as Carmen's medical home, managing her current SCD, pain management needs, and depression, and coordinating with Carmen's chosen high-risk OB provider for her prenatal and postpartum care. Should Carmen's BH needs intensify, MSIC will coordinate with CODAC, a designated AZCH Center of Excellence that offers a full spectrum of BH services and a pregnant women's specific MAT Treatment program. Our ICM coordinates with both JHS and the MSIC in advance of Carmen's first appointment to confirm comprehensive understanding of Carmen's health risks and needs. In advance of Carmen's known release date, the ICM schedules an appointment at the MSIC on a day and time of Carmen's preference, preferably the day Carmen is released. To support effective continuity of care by providing a complete picture of Carmen's status and needs, and, adhering to a trauma-informed approach by reducing the amount of information Carmen will have to share again with her treatment team at the MSIC, the ICM has updated Carmen's record in MyHealthDirect, which includes our initial assessment and information on her SCD, opioid use, depression, pregnancy, need for transportation and housing, and assistance with completing high school. The MSIC will request and review Carmen's medical record from the Detention Center. The ICM will reach out to Carmen's CRS advocate to provide an update and status, and schedule an appointment and coordinate with the high-risk OB provider.

MEMBER-DRIVEN INTEGRATED CARE PLAN (ICP). The following ICP, created with and approved by Carmen, is available to Carmen and authorized ICT participants through our secure Web Portals; it is developed to address short term and long term care and service needs, capturing and directly responding to Carmen's self-determined goals.

Carmen's Goal	Short Term Planning	Longer Term Planning
I want to stay out of jail	• Connect with PSS to support a smooth transition back home. • Offer an Adult Family Support Partner to provide support to the household and engage mom, siblings, and baby's father, as directed by Carmen, educating on high risk behaviors and triggers and how to respond and support. • Develop a safety plan that recognizes and responds to Carmen's substance use, helping her develop coping strategies for her identified triggers and avoiding inappropriate opioid use and re-involvement with CJ system, further described below.	• Should Carmen want to transition to independent living, we provide housing placement assistance, coordinating with our housing specialist and the Homeless Management Information System (HMIS), linking to housing options like CODAC's Las Amigas program, a supportive residential community with a comprehensive treatment approach to meet the social, psychological, and physical needs of women age 18 or older.
I want to be pain free	• Reconnect with MSIC, scheduling appointments and arranging transportation as needed. • Engage in chronic pain disease management (DM) program.	• Upon any signs of inappropriate opioid use, coordinate with CODAC for assistance with SUD assessment and interventions.

	• Our parent company's award-winning Living Well program incorporates SCD expertise and a culturally focused assessment, along with a toolkit to support members in monitoring for and responding appropriately to SCD crises. Carmen is supported in her ability to manage her SCD with this program. We provide on-site education to the clinical team at the MSIC, and the staff and informal supports associated with her housing and educational services to support them in recognizing and responding effectively to mitigate crises. • Documenting these and other tailored strategies in a safety plan for SCD pain crisis, supporting clinically appropriate use of narcotics that provide Carmen with relief needed and avoiding inappropriate use.	• SCD is noted for creating challenges with managing chronic pain and affected individuals having difficulty with vocational or educational activities, or SCD crises. By helping Carmen develop her health literacy for knowing the signs and symptoms of a developing SCD crisis we can help her be more comfortable and have a more stable life, while avoiding preventable ED utilization and inpatient stays.
I want to have a healthy baby	• Connect with high risk OB provider. • Engage in Start Smart to push valuable education and prenatal/ postpartum care information, including reminders. • Educate and engage using Start Smart Mobile App and Texting. • Connect with Nurse Family Partnership, providing home visits by a RN throughout pregnancy until baby is 2 years old. Provide education, home safety assessment, referrals for healthcare, childcare, job training, and other support services. • Arrange transportation to appointments as needed. • Educate on availability of CentAccount rewards earned by completing prenatal and postpartum care visits and used to purchase healthy foods, diapers and other health-related items.	• Educate on importance of postpartum care and EPSDT including well child visits and developmental screenings. • Educate on CentAccount for EPSDT. • Refer to WIC, the Diaper Bank of Southern AZ and other wraparound postpartum services.
I want to be happy	• Completion of the Edinburgh depression screening at regular intervals during pregnancy and postpartum. • Ensure MSIC is equipped to address depression, providing needed support to MSIC and Carmen, including self-management and referral to CODAC for more intense needs. • Refer to 7 Cups, online tool with access to trained, diverse, and compassionate peer listeners, providing support on issues such as depression, anxiety, financial hardship, and substance use.	• Refer to Women's Counseling Network for access to a network of therapists who provide individual counseling for women free of charge.
I want to finish high school, get a job, and live like an adult	• Refer to the Teenage Parent Program (TAPP). TAPP serves any pregnant or parenting teen, regardless of residential location, and addresses the multiple challenges to educational success faced by teenage parents. In addition to educational curricula and support, TAPP offers childcare and classes for students on pregnancy, birth and parenting. • Since Carmen has a qualifying diagnosis under IDEA and the Rehab Act, and her SCD is causing issues in school, we would support her in requesting an update to her IEP/504 plan to ensure access to reasonable accommodations, e.g. tutoring and home/facility based instruction.	• Connect Carmen with supportive employment resources to secure employment when she is ready to take that next step. • Assist with Carmen's needs for services such as obtaining a State ID, social security card, food stamps, WIC, a free phone, and other benefits for which she is eligible.

COORDINATING SERVICES. The ICM will coordinate with the MSIC to proactively link with specialists and ancillary service providers to meet the full spectrum of Carmen's complex medical needs, in accordance with her ICP. The ICM and AZCH's provider support resources will support the MSIC in deploying current best practices for use of physical therapy and other non-medical interventions in lieu of opioids for pain management. For example, the MSIC has a chronic pain management program, Integrated Touch, which includes a consulting neurologist. If treatment strategies by the MSIC are unsuccessful, a pain management specialist may be consulted. With the SCD comorbidity, Carmen's pregnancy has a risk of fetal complications or early delivery so an OB/GYN specializing in high-risk pregnancies provides oversight and coordination of Carmen's medical care in the context of the ICT. Depending on clinical need, a

perinatologist consult may be indicated, and, after Carmen gives birth, a neonatologist may then be involved. The ICM coordinates with MSIC and all of Carmen's providers to ensure that her depression is effectively addressed. Carmen will be counseled by her OB/GYN on the availability of options for Long Acting Reversible Contraception (LARC) after she delivers her baby. The ICM will provide the centralized coordination of Carmen's providers and ensure all care is provided on a timely basis and attaining ICP goals, promoting a whole person approach, and mobilizing all needed resources. The ICM engages all of Carmen's treating providers in the care planning process.

SELF-SERVICE SUPPORT FOR CARMEN'S PREGNANCY AND PARENTING. Our ICM will ensure Carmen has access to our Start Smart Pregnancy Management Program with comprehensive information to inform healthy pregnancies and delivery, in addition to Nurse Family Partnership. With approval for implementation in Arizona, Carmen will have access to Start Smart Mobile, an interactive and personalized mobile application for new and expecting mothers that includes the expecting mother's due date and helps parents stay on track with key prevention milestones, set personalized reminders, proactively identify health issues, and set self-service functions and alerts, in addition to Start Smart Texting with weekly texts to promote a healthy pregnancy and healthy delivery.

REASSESSMENT, MONITORING AND FOLLOW UP

Reassessment, monitoring, and follow up are key components of our ICMCC program. Based on Carmen's needs and ICP, the ICM will meet with Carmen via phone or in person as often as needed, typically weekly based on Carmen's current circumstances, moving to monthly as she stabilizes and gets established in care. The ICM will continuously review medical records and systematic reporting to identify and respond to any additional risk factors for Carmen and her baby and update her ICP as needed. Once Carmen is engaged and stabilized in care at the MSIC, our real time PHM solution, leveraging our Centelligence® data analytics and monitoring platform, is used by our ICM to systematically monitor for gaps in Carmen's care, receiving daily notifications or alerts based on trigger events, such as a contraindicated medication or treatment, ED visit, or upcoming prenatal, postpartum, or well child visit. Carmen will have access to the ICM or other members of the ICT, and the 24/7 crisis line, so that she knows she has someone she can count on for support at all times. Her family and supports may also contact the ICM or our nurse assist line after hours, for assistance in supporting Carmen.

ALTERNATIVE APPROACH: RURAL SETTING

If Carmen lived in a rural area of the state, resources described above may not have been as readily available. AZCH is equally equipped and experienced in managing complex members in rural settings, we recognize that for complex members in rural areas our ability to provide virtual integration and care coordination is even more critical to help keep Carmen engaged in her ICP and accessing appropriate services. To start, MSICs are only available in Tucson, Phoenix, Flagstaff, or Yuma. Consistent with local patterns of care for CRS members, we would transport Carmen to the closest MSIC. The ICM would coordinate with the MSIC and other specialty care providers to provide all needed services in one day on those days she is scheduled to be at MSIC. There is limited access to high risk OB/GYN care in rural areas, with OB/GYN services sometimes provided in family medicine practices and through mid-wives. As a high risk pregnancy, a mid-wife is not appropriate for Carmen. We will work with Carmen and the community OB/GYN to identify, have access to and consult with an appropriate high-risk provider in the metro area. During her pregnancy, we would provide transportation for Carmen to see a high risk OB/GYN twice a month, or more frequently as needed. Carmen can attend SCD clinics that are offered through the MSIC six times per year. We can connect her local provider with telemedicine resources, providing some high risk OB visits remotely, such as coordination with local OB/GYN on what is safe and not safe for opioid treatment. If there is not a local pain management provider, we can support her local provider through our hub and spoke model, providing support and services to PCPs managing pain through our pain management Center of Excellence, using telemedicine and Project ECHO (physician to physician consultation and education). We would connect all of her providers to our Provider Portal for access to her ICP as well as her safety plan. We would plan for Carmen to deliver at a high risk OB/GYN center, providing her housing through Ronald McDonald house at 37 weeks or before as indicated, in anticipation of her delivery date. If she has a crisis and needs opioids for pain management, she will be admitted to a high risk OB/GYN center. If she had no housing option, we would coordinate with the RBHA to identify supportive housing in her community upon release. We would identify other community resources to assist with her educational and employment goals and child care, arranging for her to take her GED if necessary.

NARRATIVE SUBMISSION
RESPONSE #7

NARRATIVE SUBMISSION RESPONSE

7. Describe how the Offeror will improve member engagement, develop and implement best practices, and track and…

ALIGNING ENGAGEMENT STRATEGY TO MEMBER NEED

Arizona Complete Health-Complete Care Plan (AZCH) takes a person-centered approach to engagement and understanding the needs of members in special populations while honoring their voice and choice throughout their healthcare journey. The populations included in this question present unique issues and represent greater complexity in multi-system coordination and challenges around member engagement. Through our experience, we have been successful in establishing collaborative relationships with community providers and system partners that has led to innovation and effective engagement of "difficult to engage" members. We know that proactive identification, targeted outreach and member-directed communication to identify and prioritize actions is the key to improving outcomes for these populations. We will replicate and build on this approach as we expand as a Complete Care plan in awarded GSAs through innovations like our program specialists, each with work or lived experience, who work directly with these members, their support systems and system partners. Prior to October 1, 2018 we will create a Special Populations subcommittee that reports to the Quality Management Performance Improvement (QMPI) committee to monitor utilization trends, including readmissions, crisis events, pharmacy utilization, Emergency Department (ED) visits, outpatient service utilization, and other population specific outcomes described below to determine efficacy of interventions and drive overall engagement for these special population groups.

AZCH funds an Engagement Specialist at Catholic Social Services for direct outreach to members experiencing homelessness, connecting them with employment opportunities, housing, and health screening through the Tucson Homeless Work Program.
Of 290 participants to date, 40% entered permanent housing and 14% gained long term employment.

JUSTICE INVOLVED (INCLUDING PROBATION, PAROLE, REACH-IN).

Engagement. AZCH has been successful with justice involved members because of our strong relationships with system partners, including courts, detention centers, probation officers and law enforcement. Our engagement strategy for justice leverages in-person, high touch member outreach within and outside of detention and correctional institutions. AZCH identifies justice involved members through daily booking/release feeds from five County Detention Centers. Daily information is matched against our membership and distributed to our Jail Liaisons and providers to alert them when a member has been incarcerated; this generates coordination and release planning in collaboration with the Detention Health Care Provider (DHCP). ***AZCH is the only health plan that contracts with and funds Jail Liaisons co-located in five Co. Detention Centers.*** The Jail Liaisons engage members/potential members into services, assist with completing AHCCCS applications/re-applications, and collaborate with Justice System Partners for coordination of member physical health (PH), behavioral health (BH) and social determinants of health (SDOH) as part of our ***Reach-in Program***. In CY17, 1,337 or 67% of members identified for Reach-In opted to participate in the program, which then increased to 80% in the following quarter. Participating members in our Reach-In Program had 6.6 **fewer ED visits per 100 members post-release, 10.3 fewer crisis events, and 3.6 fewer arrests, saving an average of $1500 per member or $954,000 annually compared to non-participants**, due in part to over 50% of participants receiving at least one BH service. Jail liaisons also completed 218 AHCCCS applications. Our AZCH's ***Community Re-entry Program*** requires integrated health homes (IHHs) to engage with their members while in detention, this program has **resulted in 40% fewer incarcerations in the 180-day period after participants entered the program.** In partnership with the Arizona Department of Corrections (ADC), we are the first to implement a ***Criminal Justice Community Connection Program***. Located at the Wilmot Prison Employment Unit, our funded Prison Liaison engages with inmates about the benefits of services such as housing/employment support and schedules an intake appointment to occur within seven days of release. In Pima Co., we contract with ***HOPE, Inc.***, a Peer and Family Run Organization (PFRO) to engage detainees prior to or following initial video court appearance, offer peer support services and alert the Judge when a member is eligible for Mental Health Court. AZCH partnered with the Pinal Co. Detention Center to create the ***Housing Unit for Military Veterans program*** that identifies Veterans and houses them in a Veteran-only pod. AZCH contracts with provider organizations to engage, mentor and educate Veterans.

Best Practices. Justice involved members have complex needs and require positive supports such as peer relations, cognitive reframing, and assertive communications skills, while focusing on trauma-informed care (TIC). We continually seek out and apply evidence-based practices (EBPs) proven to be successful for justice-involved members. We refer eligible members to Assertive Community Treatment (ACT) and we will work with the RBHA and other Complete Care plans in our awarded GSAs to develop a Forensic ACT Team for GMHSA members in CY20 in urban areas. AZCH offers staff, providers, agencies and officers training in Motivational Interviewing (MI), TIC, Multi-systemic Therapy, Functional Family Therapy, Moral Recognition Therapy, FACT teams, EBPs specific to Community Supervision, and addressing Criminogenic Needs through the Risk, Needs and Responsivity Principles. We participate in the Juvenile Detention Alternative Initiative and the Crossover Youth Practice Model. ***We are collaborating with Pima Co. Administration and Sheriff's Department on design of a Re-entry and Gap Housing Facility for justice involved individuals to be operated by AZCH with an estimated completion date of 2021.***

Engagement and Best Practices Innovations.

- We are implementing *INSIDE*, a peer support certificate program provided by AZCH in collaboration with ADC, for inmates while incarcerated. Inmates are provided opportunities to practice their learned peer support skills in groups, education workshops, and daily encounters with other inmates. Trainings start early April 2018.
- We are expanding our Reach-In program beginning February 2018, to include a screening for Traumatic Brain Injury (TBI), incorporating results in the development of the treatment plan with providers. A national analysis of inmate records indicates 60% of those in criminal justice system have a TBI compared to 9.5% of the general population.
- We will coordinate with the RBHA to identify targeted Investment (TI) opportunities. In Yuma and Pima, we have invested in an extension of the Re-entry Program to include co-location of an integrated clinic with Probation. Members could receive Peer Support, Medication Assisted Treatment (MAT), and gap housing. Yuma clinic is targeted to open in May 2018 and Pima recently identified a location. As part of these integrated clinics, we will partner with Community Health Associates to facilitate scheduling and improved communication.
- AZCH has implemented a data sharing process with Yuma Co. Adult Probation and will be establishing a process in Pima Co by Q4 2018.
- We partner on the Justice Health Information Data Exchange with Pima Co. BH Administration that provides the DHCP with real time information that identifies if a detainee is connected to services, the member's PCP/IHH to facilitate coordination of care.
- We are developing a community re-entry program in two Tribal Detention Centers (Tohono O'odham Nation and San Carlos), expected to go-live by March 2018.
- We are implementing MAT services while members are incarcerated in the Pima Co. Adult Detention Complex and the Graham Co. Detention Center expected to start in April 2018. We will expand services to other counties and monitor outcomes such as inmate transition to community services, employment, and housing.
- We will load preventative health information to inmate tablets provided by the Pima Co. Sheriff's Department by 10/1/2018.

Goals. Our goals for our Justice Involved members under Complete Care are*: 1) Increase percentage of detainees engaged in BH services by 15% in Year 2 and 20% in Year 3 from Year 1 baseline. 2) Decrease percentage of members in detention by 10% in Year 2 and 20% in Year 3. 3) Increasing number of AHCCCS applications completed by 20% by Year 2 of the contract*.

Continuous Monitoring. Beyond the goals and metrics stated above, our QMPI committee tracks percentage of engaged justice involved members with at least one BH service, arrest rates/recidivism statistics monthly to monitor effectiveness and identify members who require targeted outreach by the Integrated Care Team (ICT) or Jail Liaison. For example, Reach-in and Re-entry program metrics include completed follow-up appointments, reduction in arrests/booking, reduction in total cost of care, increased participation in employment, peer and housing services and number of AHCCCS applications completed. These metrics will fall under the Special Populations subcommittee of QMPI.

COURT ORDERED EVALUATION (COE)/COURT ORDERED TREATMENT (COT). AZCH has extensive experience with this population serving 857 COE/COT members over the past year with strong relationships with counties and other system partners.

Engagement. We recognize that these members may be resistant to evaluation/treatment so our engagement strategy centers on supporting providers with easy and automated tools, actionable data and collaborative relationships that

increase member engagement and assist in identifying non-adherent members quickly. ***AZCH developed a custom COE/COT module within our Provider Portal*** allowing providers easy access to specific data for members in COE/COT, including bi-directional functionality to capture data, track members through the COE/COT process, deliver care gap notifications and monitor outcomes for members on COT. Our Title 36 liaisons work closely with each Co. and COE/COT stakeholders to engage members in evaluation/treatment according to that Co.'s interpretation of Title 36 rules, resources and expectations. We have experience working with tribal courts and have collaborated with the ***San Carlos Apache tribe*** to develop a process for addressing tribal involuntary commitments and working with tribal providers to provide care upon discharge. Through our partnership with the ***Banner Crisis Response Center (CRC)***, AZCH became aware of a growing volume of revocations in mid-2017. In response we provided training to IHHs to foster a better understanding of the involuntary process. As a result, **CRC revocations decreased from 70 to 47 from July to October 2017.** We share tracking mechanisms with providers to help them comply with Title 36 statutes and complete monthly BHMP appointments to ensure regular contact with members. We implemented a real-time referral process for members who have been non-adherent so our Integrated Care Managers (ICMs) can follow up with providers to discuss opportunities to improve engagement.

Best Practices. We implement best practices that go beyond the Title 36 statute to ensure optimal engagement leading to improved health outcomes for COE/COT members. Previously, if a member was identified as ineligible, an SMI evaluation was not always pursued. To close this gap we have worked with providers to ensure that all GMHSA members are completing SMI evaluations in the COE process so they can receive services for their COT. **In 2017, 75% of GMHSA individuals on COT became SMI eligible and 67% of Dual Eligible individuals became SMI eligible.** Additionally, we require face-to-face annual reviews for all members on COT. We will continue to conduct monthly audits to ensure post-hospitalization outpatient appointments are being completed per requirements and audit for revocations of the treatment plans for members who are non-adherent. Judicial reviews are audited quarterly to ensure compliance by the provider. Should the provider not comply, corrective actions are issued. Providers are required to report when a member's COT has been tolled, which is monitored by the Title 36 Liaison. We attend monthly Title 36 cross system meetings to ensure our process is optimized and develop work plans to address any barriers identified.

Engagement and Best Practices Innovations. We quickly identify individuals who are at risk for non-adherence and work with providers and each County to develop local solutions to expedite access to services, including:

- In 2018 COT rosters will be automatically compared to our daily hospital census and booking feeds so we can alert the assigned provider to re-engage members who have entered the hospital or jail.
- We will collaborate with providers/hospitals to engage members in awarded counties, particularly when they submit urgent engagement requests for individuals petitioned for COE/COT when there is no agency assignment.
- We are working with Pima Co. to develop a comprehensive data set to monitor members who are COE/COT and track members with repeat petitions to be completed by CY19.
- Agencies retain member assignment from an urgent engagement until member accepts services or has COT.

Goals. Our goal for our ***members identified for COE/COT is to increase engagement as evidenced by a reduction in revocations by at least 10% in Year 2 and 25% in Year 3.***

Continuous Monitoring. In addition to the standard population metrics, the QMPI Special Populations subcommittee will monitor, provider participation in the HIE and our Provider Portal, monthly BHMP appointments for members identified COE/COT, annual reviews, amendments, incarcerations, non-adherence, re-hospitalizations and transfers.

MEMBERS WITH HIGH NEEDS AND HIGH COSTS.

Engagement. The High Needs/High Cost (HNHC) members often have complex co-occurring BH and PH issues for which AZCH will leverage our considerable experience with integrated care management and IHHs. Since data-driven identification is a key precursor to engagement, AZCH leverages our real time integrated Population Health Management (PHM) Solution to identify current HNHC members as well as those at risk to become HNHC. Our PHM Solution is supported by Centelligence® our comprehensive family of integrated tools that collect, analyze, and stratify full data sets, such as BH, PH and pharmacy claims/authorizations; AHCCCS Blind Spot data; PRAPARE (for SDOH) and other assessment results; real time ED, admission, discharge, and transfer data; HIE and jail feeds; we can thus accelerate identification and engage members at the right time. On a daily basis, our PHM Solution pushes clinical, financial, and insights to action to our ICMs, allowing them to intervene quickly at the member or population level, and continuously monitor outcomes and document clinical information. To help HNHC members meet individual goals and improve their quality of life, our ICM immediately reaches out to members to engage them in an assessment process to

address potential gaps in care and SDOH needs. For members who are difficult to reach, the ICM uses our local, Engagement Specialists (e.g. Community Health Workers, Peer Support Specialists, and Promotoras) to meet members where they are. Our assigned ICM then orchestrates a tailored plan for engagement and coordinates across an ICT to identify and honor member goals and preferences.

Best Practices. Our ICMs facilitate regular member outreach and provider/community collaboration to provide targeted information designed to engage members in their health. This includes EBPs such as ACT teams, peer and family support, and condition-specific programs that offer effective tools to improve wellness. To help enroll members in programs, our Engagement Specialists and ICMs are trained in engagement skills such as TIC and MI to effectively communicate with members who have cultural preferences, clinical challenges and SDOH. AZCH launched an ***Anxiety Disease Management Program*** in 2018 when we identified that a high percentage of members with an Anxiety Diagnosis contributed to high ED utilization for PH/BH causes. We identified 131 members with more than four ED visits and/or BH hospital admissions within a six month period. We engaged these members to understand their barriers and jointly design interventions that will prevent ED utilization and support them in more appropriate care settings. We track utilization daily to facilitate immediate outreach to these members and engagement upon a new ED or inpatient event.

Engagement and Best Practices Innovations.

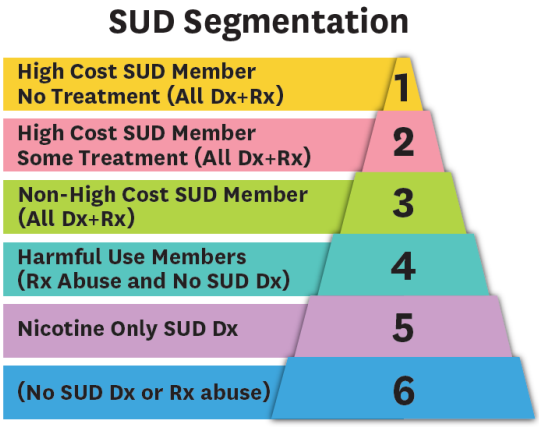
- We use our Hospital Engagement and Linkage Peer Program (HELPP) to increase engagement in the hospital for difficult-to-engage members, using peers to support members in expressing their goals and preferences and connecting them to services. We are starting a similar peer program with the EDs in the first quarter of 2018.
- In Q1 2019, we will deploy our rapid response ICMs in urban areas to conduct onsite assessment in the ED seven days/week for "hard to place" members when they are identified through Health Current as being at an ED or when we are notified of placement challenges.
- We will be giving hard to reach HNHC members a cellphone loaded with the appropriate apps and phone numbers when they are in the ED, primary care setting, or HH to keep them connected.
- We are connecting HNHC members with social services to improve engagement and directly reduce costs. **After connecting 65 members with housing between April and September 2016, we saw a 57% decrease in their ED visits and 5.5% decrease in inpatient stays**.
- We will host group ICTs via virtual visits in Q3 2018 with the member and provider/community agencies to facilitate face-to-face coordination incorporating member voice and choice.
- We have deployed our Medication Therapy Management program, in which a clinical pharmacist reviews medications and makes recommendations to optimize medication therapy, reviewing outcomes with members and providers.
- In June 2018 we will implement Project ECHO for rural and urban providers to participate in integrated health education and clinical case studies, sharing best practices of complex cases including engagement.

Goals. Our goal is to ***reduce the percentage of avoidable ED and inpatient utilization for our members identified as High Need High Cost (HNHC) by at least 10% in Year 2 and 20% in Year 3.***

Continuous Monitoring. For members with HNHC, QMPI committee tracks the primary cost drivers for HNHC members are preventable ED and hospital admissions, NICU utilization, out of home placements, and lack of medication adherence. AZCH tracks ED and hospital utilization, prenatal/postnatal care, high risk children, and produces pharmacy reports to highlight BH/PH prescribing patterns and outliers. During our monthly clinical care rounds we review care gaps and make recommendations for clinical interventions.

MEMBERS WITH SUBSTANCE USE DISORDER.

Engagement. Almost 70% of our members with a BH diagnosis and 30% of members without are affected by a substance use disorder (SUD), including abuse of nicotine, alcohol, cannabis, and opioids. Our experience as a RBHA has gifted us with a deep bench of SUD experts which gives us a clear edge in engaging members with a SUD. These members, including those at risk, are first identified using our SUD Segmentation Model. The Opioid Risk Classification Algorithm identifies the best level of care based on the severity of an individual's SUD. It specializes in early identification and prevention



before a high-risk individual's SUD worsens. For example, 42% of our current GMHSA pregnant members have a SUD, which immediately places them in a high need segment. We tailor engagement strategies to the segmentation level. High need members are assigned to an ICM who outreaches the member, develops a member-directed Integrated Care Plan (ICP) that addresses the member's PH, BH and SDOH needs. The ICM monitors the member's progress in coordination with active providers and community entities. Through ICM, we have **decreased the percentage of our members with a SUD diagnosis that had no services from 24% in January 2016 to less than 1% as of June 2017.**

Best Practices. ***AZCH contractually requires that all SUD providers base their treatment on EBPs.*** We audit our largest providers to verify fidelity to their chosen EBP. We promote the use of EBPs including Matrix Model, Seeking Safety, Seven Challenges, Peer and Family Support, the Adolescent Community Reinforcement Approach, and Nurturing Treatment for Families. We empower members to address their SUDs with the support of peers, online peer support, and families of origin or choice. ***We have nearly 600 Peer Support Specialists in our network.*** We contract with Engagement Specialists in the community focused on opioid treatment, targeting locations frequented by members with SUDs such as needle exchange programs, EDs, and homeless shelters. We have focused programs for during and after pregnancy for women who are using opioids or other substances. We have a women's specific MAT program that offers OB/GYN care at the facility and a women's specific SUD BHRF/OP facility with an NP licensed for Suboxone.

Engagement and Best Practices Innovations.

- We are expanding the availability of MAT to high need members, such as inside the jail as part of a grant in Pima Co. We are using telemedicine as a tool to provide MAT where it is not available. Through this work we have already ***increased MAT capacity by 16% from Oct 2015-2017*** and will continue to expand as demand dictates.
- We will develop a Pain Management Center of Excellence in CY20.
- We facilitated a program with Tucson Medical Center and expanding to other hospitals identified as hot spots to address neo-natal drug use. Providers are now on-site at the hospital getting members engaged in treatment with 55 women engaged so far. We work with providers to offer direct services to the affected child and expand this program to all awarded GSAs in 2019.
- In CY20, we will implement a P4P program to reduce babies born with neonatal abstinence syndrome (NAS), incentivizing providers with referrals to SUD treatment as well as postpartum care.
- We collaborate with RBHAs to access Substance Use Block Grant dollars for members who lose Medicaid coverage.
- We partnered with Sonoran Prevention Works (SPW) to ensure communities and providers are trained on Naloxone and Narcan use and access. We are working with SPW, hospitals, jails, providers, and health departments to ensure increased availability of Naloxone/Narcan in high risk areas. ***With AZCH's assistance, SPW distributed 28,476 Naloxone kits in 2017 and there were 2,450 overdose referrals.***
- We hold opioid round table discussions with our SUD providers, law enforcement, hospitals, health departments, and coalitions from each County. These discussions provide a venue for collaboration and partnerships.
- We are partnering in the Drug Treatment Alternative to Prison (DTAP) program where individuals with substance-related offenses can engage in treatment instead of being sentenced to prison, which has resulted in $4 million savings to taxpayers over the last six years. We will expand this program in other counties.
- We are collaborating with FQHCs to identify and certify more family practice physicians to prescribe Suboxone and Vivitrol, increasing the number of prescribers in rural communities.
- We have contracted with three providers to visit needle exchange programs which are hot spots for engaging opioid dependent members into treatment. Each provider has designated "hot spot times" to visit the clinics.
- We proactively address stigma related to SUDs by educating BH and PH providers and family members about the disease of SUD and the use of welcoming and respectful language in engaging members into care.
- We implemented programing to address trauma and increase job opportunities, reduce homelessness/jail recidivism as these factors negatively affect recovery outcomes.
- Our prevention strategies include educating and improving health literacy related to SUD, pain management, trauma and addiction. We use health promotion and peer support services to assist members in controlling substance use.
- We encourage the use of MAT treatment and harm reduction strategies to reduce the negative impact of substance abuse and prevent the escalation of substance abuse.

Goals. Our goal is to ***reduce the mortality rate for our members due to opioid overdose by at least 20% in Year 2, 30% in Year 3, and 40% in Year 5.***

Continuous Monitoring. QMPI committee will monitor outcomes for SUD including detox treatment recidivism, using this data to inform effectiveness of detox and management programs. This includes tracking MAT members, the number of members served by which drug to determine if there is any gap in provider capacity. We track outcomes by provider, comparing treatment success to locate providers that may be more effective at engaging members.

CHILDREN AT RISK OF REMOVAL BY DEPARTMENT OF CHILD SAFETY (DCS).

Engagement. To build on our experience with children at risk of removal, AZCH is increasing our infrastructure to support these children in support of DCS' SAFE AZ Model. While foster care enrollment has decreased over 2017, there are still over 14,000 children who are in custody, with neglect being the primary reason for removal. To avoid the need for DCS involvement, we identify early risk factors through our PHM Solution, using SDOH data such as poverty, generational trauma, and addiction, which all contribute to the family's risk for abuse and neglect. Our children's ICMs provide targeted care management to engage children and families to ensure services are coordinated and provided within the required timelines, such as following up with the provider to ensure expeditious contact with the parent/guardian/custodian, but no later than 72 hours of receipt of referral. We contract with Family Preservation service providers to engage families to have access to tailored services such as SUD treatment, anger management, and parenting skills; connect families with peer and family support specialists, and assist with transportation. We conduct assessments and coordinate covered services and supports with in-home services being provided by DCS.

Best Practices. We will build provider capacity in support of the SAFE AZ Model to improve permanency outcomes and align with DCS' goals. We will continue to support providers and AZCH staff in expanding and maintaining fidelity to family centered EBPs such as MI, High Fidelity Wraparound, family preservation, evidence-based parenting curricula, peer and family support, and trauma-focused cognitive behavioral therapy. We educate and reimburse providers to conduct the Adverse Childhood Experience (ACE) questionnaire in primary care offices, to assess risk and identify families who may need additional education, skill-building, or resources to address potential PH and BH conditions. We have been active participants in the Crossover Youth Practice Model (CYPM) in Southern AZ counties, which uses a research-based approach to assist child welfare, juvenile justice and related agencies to adopt best practices. We will work with the DCS Office of Prevention to align our engagement strategies and evaluate their success.

Engagement and Best Practices Innovations.

- We are partnering with in-home and community-based services and respite providers, such as Arizona Families F.I.R.S.T., Healthy Families AZ, and MIKID.
- We are funding the co-location of an Engagement Specialist with DCS staff to facilitate communication and coordination with the family and DCS based on feedback from our Foster Kinship/Advisory Council.
- We will tailor our CentAccount member incentives for this population to include rewards that are tied to outcomes relevant for families successfully completing treatment goals to implement in CY20.
- We use peer and family support services and are expanding the use of PFRO organizations to assist substance-using parents in accessing SUD services; offer family preservations services; and support families in the recovery process.
- We conduct focus groups with families to identify barriers and successful engagement activities and incentives.
- Our VBP initiatives will incentivize providers to make available childcare services while parents receive treatment.
- In CY20, we will provide financial incentives for contracted providers if their assigned child remains with the family and is stable for six months or is no longer identified by DCS as an at-risk family.

Goals. Approximately 8.5% of children statewide are re-removed from their homes within one year of reunification; ***our goal is to decrease this for our members re-removed by 30% in Year 2 and 45% in Year 3.***

Continuous Monitoring. Through our QMPI committee, we monitor ACES scores and referrals to BH/PH prevention and treatment services. Beyond required AHCCCS measures**,** we monitor service delivery, engagement, and outcomes. We track rates of removal of children from their home after reunification. We use our automated PHM Solution to monitor adherence to treatment in real time, including medication adherence.

CHILDREN TRANSITIONING FROM THE CMDP TO ARIZONA COMPLETE HEALTH.

Engagement. Children transitioning out of CMDP represent two groups: members transitioning from CMDP to AZCH due to reunification and members who are transition age youth (TAY) aging out of the system. AZCH is uniquely positioned to provide a seamless transition from CMDP to adult Title 19 services given our experience as a RBHA for children and families involved in the foster care system. AZCH utilizes enrollment data and system partnerships to identify children who are transitioning to AZCH. Our ICMs support Child and Family Teams (CFTs), facilitating coordination of care and

monitoring treatment and outcomes utilizing our real time PHM Solution. Engagement is driven by the needs of the member and type of transition. For children returning home or into adoption, our goal is to maintain continuity of services and prevent children from being re-removed. All CMDP members are served through CFTs and high needs members are assigned to Health Care Coordinators (HCCs) at provider offices with reduced caseloads (typically 1 to 15). Our ICMs track and monitor children transitioning from DCS/CMDP to maintain their enrollment and engage members to link them to services. Historically, 84% of our members aging out shift to Medicaid enrollment while 6% stay with CMDP. We recognize that approximately 10% of TAY fail to engage in the DCS or Medicaid system, resulting in lack of access to services. We will collaborate with DCS to reduce the percentage of children who do not engage into the system, leveraging peer support, targeted engagement, housing, continuing education, and employment programs.

Best Practices. CFTs and dedicated ICMs who work with CMDP children are trained in High Fidelity Wraparound and Family Preservation interventions, which have proven effective with children who transition back home. AZCH funded training and provided technical support to seven certified High Fidelity Wraparound coaches in the South. We support the use of formal/informal peer supports and partnered with providers, system partners, and AHCCCS on the development of a Young Adult Peer Support Training Program focused on TAY. We collaborated with Intermountain to expand an Independent Living program to assist TAY to obtain the skills to live independently as an adult and will expand these programs system wide. For TAY aging out of the system, we start planning for the transition to adulthood at age 14 linking teens with the necessary life skills, housing, and employment opportunities to meet their goals and support independence**.** For youth who do not receive TAY supports through their provider, our ICMs will help obtain the training and skill development though accelerated training programs and peer mentoring. Staff that work with TAY take our TAY training curriculum, which incorporates the Transition to Independence model. ***We assembled TAY teams with health home HCCs and support staff, resulting in increased employment rates from 7 to 16% and 96% maintaining stable housing.*** AZCH staff is trained in TIC and MI and we will support the continuation of TIC and MI in our network.

Engagement and Best Practices Innovations.

- We will develop a peer run post-reunification program in CY19 for children returning home and provide treatment opportunities for parents including SUD treatment, anger management, and stress management to prevent removal.
- We have included a young adult that has transitioned out of foster care in our Young Adult Council to help understand and engage this population as a result of a series of TAY focus groups conducted in 2016 and 2017.
- We have worked with AzCA to expand their Young Adult Councils to engage young adult members and assist them in learning communication skills and developing leadership skills.
- We established a pilot with Chicanos por la Causa to tap into housing subsidies and link TAY members to resources.
- We fund Engagement Specialists to engage TAY in schools, shelters, Good Will Metro, and in the community.
- We conduct regular focus groups with parents and TAY to identify barriers, engagement activities and incentives.
- We created a web-based resource directory specific to TAY to assist them in obtaining community services.
- We will offer member incentives through our CentAccount program beginning July 2018 for successfully completing EPSDT screening and preventative care services*, and we offer aligned provider incentives for EPSDT goals.*

GOALS. We will establish a ***goal of engagement to improve employment, increase education and reduce homelessness in this population based on year 1 baseline data.***

Continuous Monitoring. For this population, we track the rate of removal of children from their home after reunification. AZCH monitors service delivery, engagement and outcomes and tracks employment rates, housing stability, and school attendance after transition. We document and monitor service delivery in real time though our PHM Solution. AZCH monitors provider fidelity to EBPs and engagement best practices. We monitor levels of parental and child engagement into services including peer support services and preventative care.

NARRATIVE SUBMISSION
RESPONSE #8

NARRATIVE SUBMISSION
RESPONSE #8

NARRATIVE SUBMISSION RESPONSE

8. AHCCCS is responsible for payment of more than fifty percent of all births in Arizona. Not including the …

OUR STRATEGIES TO IMPROVE BIRTH OUTCOMES, ADD VALUE, AND IMPROVE MEMBER EXPERIENCE

During the last year, Arizona Complete Health-Complete Care Plan (AZCH) has responded to perinatal trends by increasing the reach of our Maternal Child Health (MCH) Program—with engagement now exceeding 85% of all deliveries. This engagement increases accurate and customized information sharing about programs, services and other benefits available to members. Our MCH program is an excellent example of how AZCH is carrying out our vision of "transforming the health of the community one person at a time" – mother and child. Our focus extends beyond pregnancy through coordinated, measured efforts to promote family planning, advance early childhood health, and exceptional member experience. Improvement toward this goal and other key outcome measures (e.g., C-section, pre-term delivery, well-baby checks, and postpartum visits) is possible by pairing evidence-based strategies, such as Centene Corporation's (Centene) Start Smart For Your Baby® (Start Smart) program, with Arizona-based experience to identify and respond to the local needs of pregnant women, infants and families. We assist local communities in reducing health disparities and addressing social determinants of health (SDOH). Through our interactions and communications, we demonstrate our respect for mothers and our appreciation for the obstetrical and child health specialists who care for them. To date, our MCH program has yielded 11% better-than-national-benchmark results for singleton high-risk pregnancies with a low birth weight (LBW). ***We will organize our efforts and collaborations to exceed the March of Dimes LBW goal of 8.1% for the AZCH population as it expands under AHCCCS Complete Care.***

POTENTIAL BARRIERS IDENTIFIED

Through our efforts to support pregnant women and their families across Arizona, we have identified multiple barriers that can impede progress toward important health improvement goals. AZCH recognizes that healthy babies start with healthy mothers. AZCH will target education and awareness campaigns based on Community Health Needs Assessments (CHNA) and data analytics "hot spotting." For example, Yuma's 2016 CHNA reports a high incidence of TB, Dengue fever and diabetes; all conditions that could pose significant issues during pregnancy. AZCH will work with the local public health department and other community organizations to support awareness/educational campaigns on prevention and early identification. Through our hot spot data analysis, we have identified that Pinal County has a high incidence of smoking and diabetes and we will tailor our education campaigns to focus on the dangers of smoking on mother and baby's health, and prevention of diabetes. Similar awareness campaigns working with our providers and promoting AHCCCS policies such as in-hospital administration of Long-Acting, Reversible Contraceptives (LARC) or member choice for postpartum doulas and midwives have proven effective for increasing member utilization and choice. Other identified barriers impacting effective health care for pregnant women and their families include, but are not limited to:

- Inaccurate contact information for members
- Resistance by some members to engage in services
- Obtaining Notification of Pregnancy (NOP) forms from providers
- Identification/treatment of substance use disorders during pregnancy, including tobacco
- Inconsistent referrals to medication assisted treatment (MAT) services by obstetrical groups
- Lack of OB/GYN providers, and particularly high risk OB/GYNs, and lack of access to care in rural areas.
- Domestic violence risk and other family stressors or lack of natural supports
- Underlying mental illness of members
- Inconsistent post-delivery care for interconception family planning and depression screening
- Member/family or cultural preferences for formula-feeding of infants
- Health disparities and SDOH that exist in some regions, including significant TB and air quality issues, as well as high diabetes rates

SUCCESSFUL STRATEGIES TO OVERCOME BARRIERS

START SMART PROGRAM: PREGNANCY THROUGH CHILD'S FIRST BIRTHDAY

Our Start Smart For Your Baby® program has received national recognition by the Utilization Review Accreditation Commission (URAC) Quality Summit, and in 2014 was awarded the Children's Health Award by the Medicaid Health Plans of America. AZCH began introducing the scalable, comprehensive Start Smart program to a high-risk population in fall 2016. We will expand program operations in early 2018 to all expecting mothers in our Arizona communities. To meet the needs of our membership, we worked with AHCCCS leadership to tailor the Start Smart program by including state-specific resources, adding content on sun protection for mom and baby, and expanding information about 'kick counts'

during 38 to 40 weeks. Centene's Start Smart program has demonstrated statistically significant improvements in health outcomes, namely lower incidence of LBW (<2500 g: 8% less; < 1500 g: 20% less; < 1000 g: 31% less). Other components include well-woman care, prenatal services, support for families while the baby is in the NICU, and follow-up to ensure quality care after the baby goes home. Infants can remain enrolled in the program up to the age of two years if needed.

Text Messaging and Interactive Mobile Phone Apps. ***Start Smart Text*** is an opt-in texting program offering short educational messages to members before and after delivery at no-cost to participants. Text messages promote healthy behaviors, such as weight management and breastfeeding, and timely visits for prenatal, postpartum and well-child care including safe sleeping information. A national review of all Start Smart Text data demonstrated significant gains for HEDIS measures -- prenatal (up 6.6%) and postnatal (up 6.8%). Start Smart Text messages are also available to the father of the baby. ***Start Smart Mobile*** is our smartphone app, fully integrated with other member-engaging technology that provides an interactive experience personalized around the member's due date. It helps members track prevention milestones, set reminders, proactively identify health issues and take action, and access other programs, such as telephonic care management and 24x7 nurse assist line. Start Smart Mobile users can access a range of interactive tracking tools, alerts, educational videos, breastfeeding podcasts and more. Members may also be eligible to receive a cell phone that includes preloaded apps and plan phone numbers. ***Start Smart Mobile Live Support.*** During their third trimester, members may access this new breastfeeding and lactation consulting service. This smartphone app connects new parents with unlimited 24x7 access to live, one-on-one video consultation with lactation consultants, pediatric nutritionists, and mother-baby nurses.

MEMBER INCENTIVES. By July 2018, per AHCCCS guidelines and approval, AZCH will launch its member incentive program, CentAccount, to encourage members to receive important preventive services, especially those associated with healthy birth outcomes such as regular prenatal care visits. Rewards are loaded onto the member's CentAccount and can be used at local retail stores for many items, such as baby care supplies, groceries, and personal care products. After delivery, members receive an additional incentive upon completion of their postpartum visit. We will evaluate the performance of the incentives, communicating results, and making adjustments to continually improve member engagement. We incentivize providers for Value Based Purchasing along the same milestones as members to encourage a partnership approach between providers and members to participation in prenatal preventative health and wellness.

EARLY NOP. A driver of Start Smart results is early identification of pregnancy via NOP. The NOP form transmits information such as due date, pregnancy risk factors, and current contact information. Centene analyzed over 200,000 deliveries (from 2010 to 2016) to assess the cost and quality impact of Start Smart's NOP tool. Propensity-matched members with early NOP saved $507 per delivery (total direct cost of delivery and neonatal care). When scaling these savings to AZCH-sized populations, annual cost savings is anticipated to exceed one million dollars. Currently, AZCH is only notified of 35% of member pregnancies via NOP, therefore AZCH has expanded our data streams to include pharmacy, lab results, medical and BH claim to create a comprehensive systematic approach for mining data and pushing real-time triggers to providers and our MCH Integrated Care Managers (ICM) to connect appropriately with members about possible pregnancy. ***Our goal is to increase NOP rates to 70% of all deliveries in CY20.***

MATERNAL CHILD HEALTH: IDENTIFICATION, STRATIFICATION, OUTREACH AND PREGNANCY MANAGEMENT

Identification. As mentioned above, AZCH will identify pregnant women through the NOP form, lab and ultrasound data, claims data including CPT and ICD 10 codes, state eligibility files and other data systems, such as our population health management tool that receives daily, real time data links with our HIE to receive Emergency Department (ED), hospitalization, jail feed and SDOH. Members, providers, community care managers, our ICMs, care coordinators, or community health workers can submit NOP forms. We incentivize providers for rapid notification of pregnancy.

Stratification. Our Population Health Management (PHM) Solution produces a *member engagement score* to equip the MCH team (a specialized sub-group of the Integrated Care Management Team) with essential real-time information that helps prioritize engagement of members based on individual factors. PHM Solution is enhanced by our comprehensive assessment tool that hones in on risk for premature birth and LBW by collecting member and provider-reported information across several domains: age, psychological, race/ethnicity, tribal affiliation, SDOH, domestic violence, nutritional, dental, medical, BH, substance use and educational needs. Our extensive experience linking physical and behavioral health data for risk stratification is an advantage for supporting needs of mothers. We stratify our pregnant

members into high, moderate and low risk and outreach accordingly. We quickly update our risk strata as we identify new information. The current distribution of members by risk group is high (26%), moderate (21%) and low (53%). Before and after the birth event, the MCH team attempts to assess maternal depression risk (e.g., Edinburgh Depression Screening) for all members by phone or in person; results feed AZCH's risk stratification model.

Outreach. Our MCH team contacts by phone all members newly-identified as pregnant within five days of pregnancy notification to inform them of the maternal-child care services available during and after their pregnancy. These initial discussions and information from our data systems serve as a foundation for a personalized *Integrated Pregnancy Care Plan (IPCP)*, described on the next page. As needed, we assist with selecting a health care provider that can meet their unique physical, behavioral and cultural needs and preferences throughout pregnancy, including choice of a licensed or certified midwife. Listening and supporting members during this decision-making process is a top priority for the MCH team. Working through a network of community partnerships, we engage members where they live and help them access other services to address critical SDOH, such as housing, employment and food security. Our health home, PCP and OB/GYN providers assist in outreach to and management of high-risk members. Throughout the process of member outreach, we encourage our members and providers to discuss plans for breastfeeding, birth spacing, use of LARC, referrals to specialists, development delays, and well-child visits.

Engagement Specialists: Community Health Workers (CHW)/Promotoras. Our goal is to find even the hard to reach pregnant members, connect them with a MCH ICM, engage them in our Start Smart program for pregnancy and postpartum, provide the support options and respect her choices without stigma. Currently, AZCH is successfully reaching 85% of pregnant members. Our goal is to increase successful outreach to 90% of pregnant members by their 2nd trimester in 2019. To do this, we are expanding use of Engagement Specialists, CHWs and Promotoras and tactics determined to be most effective based on systematic program evaluation. This team will also enhance our results in making and managing referrals to MAT providers for members in need of this service. In rural areas we have successfully employed CHWs and Promotoras through our FQHCs to engage members across the prenatal and postpartum continuum. AZCH has a pilot in Yuma where we have supported increased use of CHW/Promotoras and will partner with additional network providers to achieve specific health improvement goals or address identified barriers, such as domestic violence risk identification, breastfeeding and well-child visit schedule adherence.

Integrated Care Plan During Pregnancy. We develop the personalized integrated *Pregnancy Care Plan* in collaboration with the member to address barriers, needs and health goals identified through assessments. If the member has a complex pregnancy and/or multiple chronic conditions (e.g., BH conditions, substance use disorder (SUD)), the MCH team gathers input from an interdisciplinary integrated care team (ICT) comprised of pharmacists, social workers, nurses, utilization managers, medical directors, and CHW/Promotoras. The *IPCP* addresses continuity and coordination of care, frequency of care, communication and decision making, behavioral support, nutritional counseling, community-based supports, SDOH, and spiritual support. High-risk members can receive home-based services (e.g. medication administration, IV hydration) by OB/GYN nurses to reduce hospitalization risk. When the MCH team or providers identify a high-risk pregnancy, the MCH ICM submits a referral to a contracted provider that provides:

- Preterm Labor/Premature Rupture of Membrane Management
- MAT services
- 17P Administration and Care Management
- Gestational Hypertension and Preeclampsia Management
- Diabetes and Gestational Diabetes Management
- Continuous Anticoagulation Infusion Therapy
- Continuous Ondansterom Infusion Therapy for persistent nausea or hyperemesis gravid arum
- Fetal Surveillance including use of in home fetal heart rate/non-stress test monitor, and telephonic assessment of fetal heart rate
- Antenatal Corticosteroid Therapy

FOCUS ON HIGH RISK POPULATIONS.

Pregnancy and SUD. AZCH provides specialized programs during and after pregnancy for women using or with a history of using opioids or other substances. When a member is identified with SUD, the assigned MCH ICM will work with the member and their provider to identify options for treatment, including MAT or other appropriate outpatient or residential care for the mother and baby. Our MAT clinic/programs serve pregnant women immediately with no waitlist for this population at any time. According to the Arizona Neonatal Abstinence Syndrome Work Group, 70% of Arizona

babies suffering NAS are covered by AHCCCS at an annual cost of $60 million. Through our RBHA's leadership on the Pregnancy and Newborn Task Force, we joined a partnership with Tucson Medical Center and community-based providers (both medical and BH) to offer NAS assessment, therapy, and resource referral services inside the hospital. As of today, AZCH has coordinated care for 55 families through the program. We are expanding the program to Banner Hospital and St. Joseph's Hospital in Tucson, and by Q1 2019, and will expand these In-hospital services to both urban and rural areas in our GSAs. We will collaborate with NAS experts to open a NAS residential facility in AZ modeled after Lily's Place an EBP in West Virginia that provides a specialized environment for infants and coordinates support for mothers. We will work with the RBHA to use SABG funds for pregnant and parenting women. Through our existing network we offer the following specialized SUD services that support pregnant women and their children:

- women's specific MAT Treatment program that offers OB/GYN care at the facility as well
- women's specific SUD BHRF/OUTPT facility with an NP that is licensed for Suboxone
- women's specific SUD BHRFs that house both the women and their children/babies
- MAT clinics that offer Methadone for pregnant women, if this is the identified need, or MAT clinics/doctors that will offer Subutex/Suboxone, if this is the identified need

We coordinate closely with hospitals, MAT clinics and jails to ensure that our pregnant members with SUD are receiving initial and/or continued treatment, and discharge wraparound services. Treatment is crucial to improving outcomes, but prevention is central in addressing the issue. We recently adopted a predictive modeling platform to identify members with scores indicative of escalation and those mostly likely to respond to intervention. These members are outreached with individualize prevention plans designed to abate migration toward more perilous substance use. Our prevention strategies include improving health care literacy related to substance use, pain management, trauma and addiction. We utilize health promotion and peer support services to assist members in controlling their substance use.

Pregnancy and HIV/AIDS. Members who are pregnant and diagnosed with HIV/AIDS would be in our Special Needs HIV program and a MCH ICM would follow the mom through pregnancy and coordinate treatment between the OB/GYN and Infectious Disease specialist, ensuring the mom was on antiretrovirals to reduce risk of a HIV-infected. The baby would be tested at birth and if determined to be HIV positive, we would help mom and baby with care.

Recent Deliveries and Unintended Pregnancies. Evidence shows a strong correlation between pregnancy spacing (time from delivery to subsequent conception) and birth outcomes. Centene recently analyzed contraceptive use and pregnancy spacing for 466,680 deliveries (from 2012 and 2016). Of the deliveries analyzed, women utilizing LARC had an additional eight months of pregnancy spacing on average and were 3.5 times more likely to experience >18 months until their next child. In Q2 2018, AZCH is initiating an education campaign for our members and providers on the benefits of LARC as an effective option. Currently, AZCH reimburses our providers for providing a LARC in an outpatient setting. We encourage our maternity providers to have a discussion related to contraceptive use and pregnancy spacing with a pregnant woman as part of the prenatal/postpartum visits, including the option to have a LARC while still in the hospital. We are monitoring teen pregnancy rates (currently 6% of all deliveries), conception within six months of delivery, and rates of LARC utilization in 2018, to determine the effectiveness of our member and provider education related to reducing rates of unintended pregnancy, birth spacing, and reproductive life planning.

ADDRESSING BARRIERS THROUGH ADDITIONAL SPECIALIZED PROGRAMS AND SERVICES

Referral to Nurse Family Partnership as appropriate for members having their first baby. This free program provides weekly or bi-weekly visits by a registered nurse in member's home throughout pregnancy and continues until baby is two years old. It provides education, home safety assessment; referrals for healthcare, childcare, job training, and other support services within the community. It encourages fathers, family members, and friends to participate.

Enhanced Postpartum Care with Doulas. The use of doulas during the prenatal and postpartum periods is well-established by many providers and supported by AZCH. Centene has demonstrated a 12.8% higher rate of breastfeeding in women who received a postpartum doula services**.** Expansion of the postpartum doula program helps us address barriers such as: formula-feeding, inter-conception family planning, and depression screening. A postpartum pilot that includes family support, education on newborn care, breastfeeding, postpartum depression and family planning is

currently underway with expansion in Q3 2018. We will expand access to doula services at FQHCs and community partner agencies by supporting a postpartum doula training program and facilitate placements with our members.

Health Disparities, SDOH and Cultural Competency. AZCH uses a culturally aware approach when working with pregnant members. Pregnancy and women's reproductive health requires understanding of cultural significance for our members which may require sensitivity, understanding and competency from providers when delivering services during and post-pregnancy. We offer on-line cultural competency training for providers with specialized training available for OB/GYN providers. AZCH Staff are trained to work with diverse populations to address health disparities and SDOH and ensure members receive culturally sensitive services based upon their preferences. We will work collaboratively with local communities and Tribes (including Tribal service providers such as: Indian Health Service, Tribal 638 facilities, Urban Indian Organizations) and other organizations to continuously learn unique cultural aspects. We work to coordinate any requests for traditional healing services during this time and provide translation services as needed.

Domestic Violence Expedited Referrals. Whether domestic abuse is physical, sexual, verbal or emotional, it may lead to health consequences for both the mother and the fetus. Our MCH Team completes the Start Smart OB/GYN screening upon initiation of care management which includes assessment of feeling safe in their home and/or presence of domestic violence. Should a risk be identified the MCH ICM will provide support and necessary resources/referrals. We expedite referrals to agencies such as Emerge or Catholic Community Services to assist members with finding shelter and resources to support them during their pregnancy. We conduct timely follow-up to ensure that the member has connected with an agency and is receiving assistance. Members' IPCP include service needs and referral details and are updated throughout the course of members' involvement with the MCH team.

Smoking Cessation. AZCH connects any interested member to the Arizona Smokers' Helpline (ASHLine) for assistance and support with smoking cessation. AZCH will implement a specialized quit program for pregnant members called Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT®) in Q4 2018. SCRIPT® is an evidence-based program designed for prenatal providers to offer in their practices which is endorsed by the Agency for Healthcare Research and Quality Smoking Cessation Clinical Practice Guidelines. SCRIPT® addresses a critical need of bridging cessation support during and after pregnancy, a time when relapse risk is elevated.

Innovations in Provider Contracting. To reduce the number of high risk pregnancies, babies with NAS and to promote proper care after delivery, providers are incentivized with each successful initial referral to substance use/opioid treatment and postpartum care. This program is also designed to increase the rate of NOP from OB/GYN providers, which allows us to identify members at risk for high-risk pregnancies or may have a history of preterm delivery and/or other BH/medical conditions that may cause complications during pregnancy. AZCH will identify an OB/GYN Center of Excellence (COE) by Q4 2019. We will leverage the COE to provide hub and spoke services to non-urban communities that include telemedicine, provider consultations and training through Project Echo, a tele-training program.

RESULTS THAT DEMONSTRATE ABILITY TO SUPPORT HIGH RISK MEMBERS

AZCH has demonstrated its ability to achieve improved perinatal outcomes for a challenging, high-risk population. In 2016, our RBHA plan implemented the Start Smart program as a primary strategy to improve pregnancy outcomes for members with serious mental illness. Our analysis of 214 singleton cases revealed promising results:

- ICMs were able to engage with 84% of members using Start Smart methods and tools,
- Over the past twelve months, the LBW rate was 8.3% (below risk-adjusted benchmark 9.4%),
- Preterm deliveries have trended downward since Start Smart implementation, hitting 9.1% in the most recent quarter (below risk-adjusted benchmark 11.6%).

AZCH has demonstrated an ability to expand care coordination for pregnant women, increasing reach from 20% (October 2016) to 88% (September 2017) of all deliveries. As the MCH team continued to develop programs specific for health pregnancy, LBW rates for singletons fell from a peak of 12.0% (March/April 2017) to 7.5% (August/September 2017). The AZCH MCH team is employing best practices to reduce preterm delivery (which was 10.3% in past year), including expansion of Start Smart, to exceed the national average benchmark of 9.6%. By employing this program, we have achieved better than benchmark performance in three of the four most recent months.

NARRATIVE SUBMISSION RESPONSE #9

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NARRATIVE SUBMISSION RESPONSE

9. Describe how the Offeror will address the developmental needs of young children including early identification …

Arizona Complete Health-Complete Care Plan (AZCH) shares AHCCCS' goal of improving health outcomes for children with specialized needs through early screening, identification, and intervention. Our vision is to use our experience to enhance our streamlined, team-based system of care that facilitates early identification of delay, creates a smooth pathway for referral to specialized services, improves access to care, alleviates the burdens of service coordination on families and builds a transition into an adulthood that maximizes independence. Under the AHCCCS Complete Care model, we will make necessary investments to transform the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to enhance use of data analytics, mobile applications, social media, member and provider incentives and other tools to empower families. AZCH is well positioned to address this population due to our extensive experience serving children with specialized and complex needs. AZCH recognizes the vital importance of family involvement in the development and health of a child including addressing the social determinants of health (SDOH). Our early intervention programs take a family-centered approach, ensuring that members have access to high quality preventative health services and developmental screenings for EPSDT services in line with AMPM 430 and the AHCCCS periodicity schedule. Early identification begins with our ***EPSDT Program***, which is supported by our local EPSDT Team of Nurses and EPSDT Coordinators who conduct targeted outreach and education to families and providers on EPSDT programs/processes. This team is led by a Director and Manager each having over 10 years' experience in Acute and RBHA programs. The EPSDT Team works closely with the AZCH Children's Integrated Care Management team (Children's ICM), a specialized team in our Integrated Care Management and Care Coordination Program, to provide ongoing care coordination and monitoring of EPSDT members with developmental delays and other specialized needs. AZCH supports the Collaborative Care Model, an evidence-based practice for integrated care which focuses on placing the member's primary care provider (PCP) at the center of coordination, and the use of Child and Family Teams (CFT) for those that require it. The member's PCP will be supported by our multi-disciplinary Children's ICM staff who are trained to use a consultative collaboration approach with providers. Our adoption of this approach allows us to ensure coordination of care based on early identification and assessment of physical health (PH) and behavioral health (BH) risk factors or special health care needs (SHCN), including identification for Children's Rehabilitative Services (CRS) enrollment and autism. This approach offers the support tools and streamlined referral process PCPs need to conduct screenings for delays and take action once a delay is identified. EPSDT services and the early intensive behavioral intervention benefit to members is coordinated by our Children's ICM team which can include multi-disciplinary team including: EPSDT and MCH Coordinators, Integrated Care Managers (ICM), CFT Coaches, the Children's Advocate, Board Certified Behavior Analysts (BCBA), and Resource Specialists. The Children's ICM team receives clinical leadership from the Chief Medical Officer, Children's Medical Director, Children's Healthcare Administrator, and our Children's Clinical Practice Manager.

EARLY IDENTIFICATION OF DEVELOPMENTAL DELAY

Identifying, diagnosing, and caring for children with developmental delays requires collaboration between providers; teachers; parents and caregivers; and family and community support systems in order to identify, treat, and stabilize their developmental, physical and/or behavioral conditions, and to provide members with support and resources that address SDOH. The importance of the parental role cannot be overstated as parents/caregivers are often the first individuals to notice signs of developmental delay. Our goal is to ensure that 98% of EPSDT Tracking Forms will indicate completion of developmental surveillance in line with AHCCCS requirements.

In CYE 2017, zero EPSDT members were waitlisted for AzEIP services

DEVELOPMENTAL SCREENING PROCESS. AZCH conducts extensive monitoring to ensure members receive a developmental screening during the 9, 18 and 24 month EPSDT appointments. AZCH conducts comprehensive reviews to ensure providers have evidence of required training completion, that an AHCCCS approved tool has been utilized, and that screenings have been administered. Our developmental screening monitoring process includes:

- 100% of EPSDT tracking forms are reviewed to identify potential developmental delays or need for a referral
- Children eligible for the Arizona Early Intervention Program (AzEIP) are immediately referred to our AzEIP Coordinator who will work to urgently connect the family with a qualified provider to meet the speech therapy, physical therapy or occupational therapy need

- When the EPSDT tracking form indicates the need for other specialized referrals and services, such as ophthalmology or audiology, the EPSDT Coordinator refers the member to the Children's ICM team who will outreach the family to assist with education, support, and coordination of timely services
- Whether a child is referred to the AzEIP Program or another specialty provider, AZCH maintains high touch though confirmation of service initiation. AZCH staff work to break down barriers, re-engage when needed, and provide a single point of contact for the family to ensure the provision of quality and timely services
- Based on assessment of need and family choice, the Children's ICM continues to support children and families on an ongoing basis to provide education, resource linkage, and care coordination
- EPSDT referrals are tracked and monitored from referral point through service initiation via the Quality Management Committee structure to ensure that system complexities do not delay or prevent service initiation

EPSDT MEMBER ENGAGEMENT. Our EPSDT Team provides targeted outreach and education to members/families. Members/families are first introduced to the EPSDT program through a letter in their new member packet educating them on the importance of EPSDT screenings and the required intervals. All members/families receive EPSDT education through a member EPSDT quarterly newsletter, educational materials, calls and/or individualized letters, which cover topics such as but not limited to required health screenings and information about EPSDT well visits, immunizations, and community resources (such as but not limited to Women, Infants, and Children (WIC), AzEIP, lead testing, CRS, and/or Head Start). During CYE 2017:

- 652 members were tracked as a no show to an EPSDT appointment; 100% of these members were outreached by the EPSDT Team for education and assistance with rescheduling
- 14 members were identified as having an elevated blood lead level; the EPSDT Team coordinated between the provider and member's family to ensure re-testing or appropriate intervention(s) occurred at required intervals
- 429 members were identified for WIC referrals; 100% of these members received education; 100% received assistance with locating and initiating WIC services

Building on positive experience of our Texas and Mississippi affiliates, we go beyond contractually required outreach to improve EPSDT engagement and outcomes, our Mississippi affiliate **increased the percentage of children <1 year who received the recommended screenings 64% in 2012 to 99% in 2016, while rates for children between 1-2 years increased from 94% to 100%** during that same time period. This increase was due to a multipronged approach to member engagement and incentives similar to what we are enhancing for AZCH. AZCH will implement proactive outreach management strategies in Q1 2018 including calling members/care givers during evening and weekend hours. We will use automated outbound calls to support telephonic and electronic member engagement through their integrated health engagement management tool. These outreach and engagement strategies are supplemented by our customized postcard that beginning in March 2018 and will go out to members at 8, 17, and 23 months of age. The goal is to educate the family on the importance of the screening and empower them to engage in a conversation with the provider about the screening and results, and incorporating the impact of SDOH. With AHCCCS approval we will implement our ***member incentive program CentAccount*** in July 2018 and align rewards with EPSDT milestones. AZCH will use the Plan-Do-Study-Act cycle to track/monitor for increases in screening completion post implementation and report results through the EPSDT Committee. In addition, through our **Start Smart Text program** to be implemented by Q4 2018, we will proactively engage members using EPSDT educational and reminder texts (for members who opt-in).

EPSDT PROVIDER ENGAGEMENT. AZCH staff target EPSDT providers and deliver in-person site visits, initial/ongoing trainings, technical assistance, and training on our Provider Manual and Portal. The Provider Portal hosts an EPSDT periodicity schedule, as well as EPSDT Care Gap alerts for members on the provider's panel. We provide education using Bright Futures literature, mail, calls and/or site visits. Our Provider Engagement Specialists (PES) host biannual *Provider Forums*, monthly BH and PH Provider calls, and starting in 2018, quarterly BH specific provider forums, in which our EPSDT Coordinator provides training on the EPSDT program and requirements for completing related forms. Forum attendance in November 2017 included 116 unique providers and 68 unique provider groups where we shared best practices. In addition, our PES in conjunction with EPSDT staff conduct site visits for providers who need more information about the importance of screening. In fact, we conducted 1598 provider office visits that impacted 2528 individual providers in 2017. The provider forums and meetings include specific training opportunities, in which our PES educate providers on how to: access approved screening tools and training requirements; complete a referral for services if a concern is identified; and submit claims. AZCH will launch a ***Click to Chat*** feature through the Provider Portal

in April 2019, where technical assistance in completing EPSDT forms can be obtained in real time. AZCH contractually requires PCPs to adhere to State EPSDT provisions, including follow up on EPSDT screening results. We have contracted with a **Developmental Pediatrician and a child psychologist to host biannual trainings for providers** on the use of EPSDT screening tools, after learning through a survey that many providers were uncomfortable using the tools.

EPSDT PROGRAM MONITORING PROCESS AND OUTCOMES. AZCH understands that reaching all members for needed developmental screenings involves going beyond the expectation and delivery of EPSDT tracking forms. To enhance monitoring and outreach efforts, we track compliance with recommended preventive and follow-up services through our Centelligence® enterprise platform. Centelligence produces HEDIS, non-HEDIS, clinical, and non-clinical measures and operational dashboards, giving all member-facing staff actionable clinical information at the point of interaction. Specifically, tracking, monitoring and reporting compliance with EPSDT service provision requirements is available through the platform. Utilizing this data, AZCH implemented multiple member and provider education activities to drive and increase screenings, which resulted in the following outcomes from Q1 2017 to Q4 2017: 10% increase-children birth to 15 months receiving at least six EPSDT visits; 4% increase-children ages three to six years receiving an annual EPSDT visit; 7.7% increase-children receiving a preventative dental service; 15% increase-children receiving verbal lead screening; 3% increase-developmental screening tools identified; 5% increase-total number of EPSDT tracking forms received

AUTISM SPECTRUM DISORDER (ASD) SCREENING. We understand access to providers who diagnose and treat ASD is a challenge and that it is vital for ASD to be identified by 18 months of age. Arizona lags one year behind the national average age of ASD diagnosis of three years, 10 months. ***Our goal is to lower the age of diagnosis of our members by three months each year of the contract.*** As active members of the AHCCCS ASD Advisory Committee, we embrace the recommendations put forward in the final report, which focuses on solutions that will: (1) achieve earlier diagnosis; (2) increase access to treatment services; (3) streamline the system of care; and (4) provide family supports and care coordination. To achieve this, we include all members diagnosed with ASD or at-risk of ASD to be part of the Children's ICM team, giving family's access to an ICM (who serves as the point of contact), CFT Coach, Resource Specialist, and/or other staff. We have partnered with The University of Arizona College of Nursing (UA CON) and CRS-Children's Clinics to fund a ***Developmental Pediatric Nurse Practitioner (NP) Certificate Program*** to increase provider capacity to conduct screenings and identify delays sooner resulting in earlier diagnosis. The UA CON and Children's Clinics will develop curriculum for this certificate program. The program will be offered to practicing NPs who are specialized in Pediatrics and Family Practice and will be incorporated as part of the UA CON current developmental nurse practitioner program to certify future NPs beginning fall of 2019. AZCH is committing investment funding to our partnership with Southwest Autism Research and Resource Center (SARRC), enabling expansion of the Naturalistic Observation Diagnostic Assessment (NODA), which is a telehealth diagnostic system that guides parents to collect short videos of child behavior, remotely share them with a provider who conducts a diagnostic assessment, and reduce the time between the parent's initial concern and diagnosis of ASD. AZCH will begin operationalizing the use of NODA throughout our service area with the goal of availability for members in all regions by January 2019. AZCH is funding a collaboration with SARRC in the Central region to leverage best practices in the early identification and assessment of ASD. AZCH will expand upon SARRC's grant with the National Institute of Health where 107 pediatricians in Maricopa County were engaged in providing ASD screenings at the 12, 18 and 24 month well visits as a best practice. Offering PCPs supports they need to serve as a health home for members with ASD, including a direct path for referrals to treatment specialists, builds the comfort level for PCPs to conduct screenings, which is key to lowering the age of ASD diagnosis. We understand that supporting new entry points for conducting screenings is essential in order to achieve our goal of lowering the age of diagnosis. We are investing in Chicanos Por La Causa (CPLC), to support and fund screenings for delay at the CPLC Early Head Start (serving children ages zero to three with focus on pregnant and parenting teens) and Migrant and Seasonal Health Start (children zero to five) programs beginning in April 2019. We will support screenings at the CPLC Maryvale Community Center, home to WIC and other social service offices, beginning April 2019.

CHILDREN'S INTEGRATED CARE MANAGEMENT TEAM: ENSURING PROVISION AND MANAGEMENT OF SERVICES

Our person-centered, Children's ICM Team is designed to provide proactive identification and specialized care management/coordination for members identified as having a developmental delay or SHCN. AZCH's high-touch approach prevents children and youth from "falling through the cracks" through verification of provision of services for children identified with developmental delays or SHCN. Our Children's ICM staff work directly with the child/caregiver, to manage services and supports, including SDOH or health disparities that may be impacting screening or access to

services. We verify service provision through real-time QM monitoring from referral through service completion. Our Population Health Management (PHM) solution automates the identification of care gaps for EPSDT members, informing ICM staff in real time of opportunities for improved coordination of care.

IDENTIFICATION AND STRATIFICATION. All children are eligible for care coordination and access to a Resource Specialist to help link the family with specialized supports as needed. Members with a high acuity in need of a higher level of care receive a dedicated ICM and are enrolled in the Children's ICM program. Members are identified for the Children's ICM by referral, proactive children's risk stratification and ranking, or through our PHM solution that identifies care gaps through reporting on authorizations, claims, pharmacy data, Emergency Department reports, crisis system encounters and hospitalizations.

COORDINATED SERVICE DELIVERY. An ICM serves as the single point of contact and leverages other resources in the Children's ICM program to connect members to services. The ICM engages members, family/caregivers, PCP/health homes, specialty providers, and community agencies, and supports care through Integrated Care Team meetings (including CFT teams if applicable), a shared Integrated Care Plan (ICP), weekly case rounds, and sharing actionable data. Our ICMs outreach to parents/guardians on a monthly basis. If members need additional care due to a crisis event, our CFT Coach will support our ICM, and contact members/families on a daily or weekly basis. Our CFT Coach will continue to support the member until the crisis event is resolved and remains available as needed. The ICM facilitates coordination through logistical efforts such as obtaining/maintaining member releases of information and sharing ICPs, assessments/screenings, and other care planning information to support the collaborative care approach within the Children's ICM team. The following are services that members are able to receive once they are identified:

SPECIALIZED MEMBER SUPPORT. AZCH has a dedicated Dental Liaison who works with our ICM to identify pediatric dentists that specialize in services for members with SHCN. This role collaborates directly with dentists to secure appropriate services. AZCH presently has five pediatric dentists in Pima County and seven in Maricopa who serve members with SHCN. AZCH staff use our Appointment Wizard ™ Tool powered by ***MyHealthDirect***, which is our secure real-time appointment scheduling tool to allow staff to schedule appointments and issue text/email reminders for members with participating providers. All AZCH staff have access to this scheduling tool to set-up appointments while on the phone or while meeting with members and/or their families, eliminating the need for multiple calls to-and-from provider offices. We will implement a ***Caregiver Portal*** that will give authorized member caregivers access to a secure portal with member information, updates/communication, and interactive assists. Authorized caregivers can view a member's health and medication history, and ICP if applicable. This portal will go live in October 2018.

PEER AND FAMILY SUPPORT. AZCH has a strong history of using Family Support Services (delivered by Family Support Specialists) for children, including DCS-involved children as well as ALTCS enrolled. Family Support Services are available in all AZCH service areas and utilization is tracked through claims data. We have taken steps to strengthen the role of Family Run Organizations, such as MIKID, and have engaged Family Involvement Center (FIC) to provide supports for DCS at-risk families in Maricopa County working through the DCS Office of Prevention. Family Support Specialists offer navigation support, community resource linkage, and guidance for families through the educational system, DCS, juvenile justice, DDD, AzEIP, and the court system. In partnership with MIKID, AZCH developed a state-approved Family Support Training curriculum allowing geographic and population targeted workforce development in regard to family support and regional needs. We will expand these activities beginning in October 2018 to provide the same level of support and parent-to-parent mentoring for members with a CRS qualifying condition and ASD, through partnerships with Raising Special Kids and FIC. We will provide family supports for the DCS at-risk population. AZCH will meet all requirements as indicated in the Contract for children with SHCN.

MANAGEMENT OF EARLY INTENSIVE BEHAVIORAL INTERVENTION BENEFIT

AZCH has extensive history through our RBHA experience in managing an early intensive behavioral intervention benefit (EIBI), including supporting the needs of children with SMB, SED, ASD, children enrolled in ALTCS, and children enrolled in Comprehensive Medical and Dental Program (CMDP). We understand that the management of the EIBI is critical and designed to support school readiness, family empowerment, and a successful transition into adulthood to support independence to the greatest extent. ***The care for children identified as requiring EIBI is managed by the member's ICM as described above. For members with ASD or at-risk of ASD, we align our processes with AHCCCS ASD Advisory Committee Recommendations.*** Our ICM provides one-on-one focused care coordination services for members to ensure access to all medically necessary services and reduce stress/burden on the family. Care coordination includes communications with providers and other entities serving the member including schools and community agencies, and

linking members to providers of EIBI services. We will implement a specialized assessment in October 2018. This assessment will be developed specifically to capture the unique needs of members with SHCN and will be administered by our ICM. In addition, our ICM will work directly with our Utilization Managers (UM), as well as, other departments, when applicable, to ensure the member encounters no barriers to care. An example of this would be confirming with the UM that prior authorizations for services are timely so treatment can commence. Our ***Resource Specialist*** works closely with the ICM to ensure the family understands the steps involved in the EIBI, has family supports in place, provides resources linkage and serves as the member's community advocate. This is to aid their family support specialist as they assist families to interface with the educational system to ensure appropriate Individualized Education Programs and successful parent/teacher relationships. AZCH is supporting SARRC in its online launch of its JumpStart program to help prepare family members for navigating ASD services. Partners like Raising Special Kids and FIC guide families to ensure a level of understanding and readiness to support a successful outcome through EIBI. This level of support from AZCH and the Family Support Specialist is key to achieving optimal outcomes, for the child member and entire family, as this level of engagement supports the health care needs and social determinants of parents, caregivers and siblings.

A STRONG PROVIDER NETWORK. AZCH understands in order to provide the EIBI benefit we must maintain a strong network of providers with expertise in managing this level of intervention. For children with a qualifying CRS diagnosis, Tucson Children's Clinics (Children's Clinics), as a Multi-Specialty Interdisciplinary Clinic (MSIC) serving the CRS population, provides a full array of pediatric medical services in a multi-disciplinary team setting. Children's Clinics offers services such as but not limited to therapies (including speech, occupational, and physical therapies) as well as applied behavioral analysis (ABA), psychology, and psychiatry services. AZCH is currently working with the Children's Clinics to transform their practice into a Center of Excellence (COE) for ASD, leveraging this unique provider's ability to expand from its current CRS focus to include ASD while also being able to address co-morbidities that are common for members with ASD. In fall 2019, COEs will support all awarded GSA's through our hub and spoke model, extending ASD COE expertise to non-urban communities through telemedicine and provider consults. We are contracted with District Medical Group (DMG), Yuma Regional Medical Center and Flagstaff Medical Center for Children's Rehabilitative Services, the designated MSIC's in Arizona. Another AZCH partner, Touchstone Health Services (Touchstone), serves the zero to five age group for both behavioral and ASD needs and is already an ASD COE. To expand services for members, Touchstone enhanced its practice to incorporate primary care. Through AZCH's partnership with SARRC, we are able to extend the right level of care to members and families, and offer top-level research, innovations, and trainings to other providers. Additionally, Southwest Human Development, also a zero to five provider, is part of the AZCH network. AZCH's provider network is trained to offer the right level of therapies, including ABA, Pivotal Response Training®, which is an intervention model derived from ABA approaches that targets individual behaviors one at a time and Floor Time, which encourages parents to engage children literally at their level by getting on the floor to play building on the child's existing strengths as well as other evidence-based strategies. Also contributing to our network is Intermountain Centers for Human Development, who provides ABA training to staff at Sun Life Family Health Center in Pinal County, as well as BCBA in-home assessment in rural areas of both the Central and Northern regions. We are currently developing specialty provider resources in rural areas through expansion of existing network providers (e.g. Arizona Children's Association, Easter Seals Blake Foundation) in those areas that will be in place by mid-2018. AZCH has recognized that the DES/DDD system of care has developed a statewide network of specialized intellectual/DD (I/DD) ALTCS providers. Through our experience with dually enrolled members, we have identified potential providers for recruitment. AZCH has begun discussions with providers to share our vision of integrated healthcare for members and have responded to concerns about the costs and benefits of expanding their capacity to serve people with I/DD. In addition, we have focused on identifying and developing specialty providers to serve members with complex behavioral and acute care needs, such as co-developing a specialized unit for the assessment and treatment of members (ages 12-17 years old) with I/DD-ASD and complex behavioral concerns with Sonora Behavioral Health Hospital by July 2019 to increase re-integration opportunities into their communities. In addition, during CY19 we will develop family support specialists in rural areas that have training in functional behavioral assessment that can support the family in implementing the behavioral analyst plan. AZCH believes that a commitment to member voice and choice, as well as to cost-effective outcomes, can be best served by expanding the variety and capacities of specialty providers, large and small, throughout the State.

NARRATIVE SUBMISSION
RESPONSE #10

NARRATIVE SUBMISSION
RESPONSE #10

NARRATIVE SUBMISSION RESPONSE

10. Describe how the Offeror will minimize Emergency Department holds for behavioral health conditions, reduce…

Arizona Complete Health-Complete Care Plan (AZCH) minimizes Emergency Department (ED) holds/wait times, which dually refers to an adult/child waiting in an ED for a behavioral health (BH) placement and ED use, and reduces psychiatric hospital admissions and days, including out-of-state (OOS). We have found, as discussed in this response, that members difficult to place include involuntary with special needs; members with cognitive and developmental disabilities; and children with autism spectrum disorder (ASD), sexually maladaptive behaviors (SMB), or seriously emotionally disturbed (SED). ***We will establish a goal of reducing the average ED hold time in year one of the contract and reduce the number of psychiatric hospital admissions by 10% by Year 2 over Year 1 baseline.*** Our Integrated Care Managers (ICM) with the support of our Integrated Care Teams (ICT) coordinate care and monitor services for members and are accountable for meeting these goals.

SOLUTIONS SPECIFIC TO REGIONAL NEEDS

As the RBHA in southern Arizona since 2005, we understand the complex, multi-systemic issues driving ED holds and recognize that each region has nuances that impact how member care is provided. Maricopa County has a unique system for providing Court-Ordered Evaluations (COE) and Court-Ordered Treatment (COT). We know members in Maricopa County who visit the ED and are petitioned for COE may be held for over 24 hours while awaiting COE at the county designated facility, Desert Vista. As Desert Vista is the sole provider for COE/COT services in Maricopa County with limited capacity, we understand the impact on members and ED hold times. We are committed to participating in the development of solutions that are specific to each county and/or region including Maricopa County. We will implement similar strategies, as we have in the South, in new regions to co-develop solutions that are based on local resources and geared toward expediting and facilitating access to appropriate services. In Pima County, we spearheaded monthly meetings with local hospitals to develop ED diversion strategies. These meetings are outcome-driven and allow us to have open dialogue with EDs and learn their specific challenges. AZCH will collaborate with all system partners, regional crisis providers, and health plans to hold similar meetings in all regions. We will share our experiences that have produced positive outcomes for members while decreasing ED holds, reducing admissions, and increasing access to alternative community-based services.

We saw a decrease in ED use from 130.38 to 121.36/per 1,000 member months over the past 12 months.

MINIMIZING ED HOLDS FOR BH CONDITIONS. Our ***Rapid Response ED Hold Reduction Program*** minimizes ED holds and reduces inappropriate ED use. Our ICMs leverage real time alerts and employ timely strategies to monitor and decrease hold times. Beginning 10/1/2018, ICMs will ***serve members seven days a week and will be dispatched rapidly to EDs to meet with members to complete assessments, coordinate care, and expedite placements.*** Once ED holds are identified, members will be immediately engaged by the ICT for assessment and resource linkage. Our ICTs include multi-disciplinary BH and PH professionals; including, housing, employment and peer support staff.

Real Time Monitoring. Our Reduction Program identifies and tracks length of time members spend in the ED awaiting placement. We monitor ED utilization in real time seven days a week through our Population Health Management (PHM) solution, pulling in real time data from Health Current. We work with EDs to encourage timely submission of ED admissions to Health Current by meeting with them regularly to educate on the value of timely notification. For EDs not connected to Health Current, we train them to call our nurse assist line. ICMs are typically aware of member ED visits within two hours of the visit, which triggers planning for coordination and resource linkage. We also monitor ED trends through our Integrated High-Risk ED Outreach Report and high utilizer report which identifies members with two ED visits in the past 90 days. ICMs review reports weekly for additional member outreach. While in the ED, ICMs reassess members twice daily until placement arrangements are completed. We reassess more frequently if requested by the ED or the members require crisis intervention, dispatching the ICM to the ED as needed when a member is in an ED over 20 hours and no placement arrangements have been made. We work with the ED to determine if a higher level of care is needed and identify an alternative plan if the members can safely reside within the community. We review internal/external shared electronic medical reports to identify member utilization trends, co-occurring BH/PH conditions, and member discharge plans.

Average ED hold times for adults decreased 77% and for children 60% in 2017

Minimizing ED Utilization for BH Reasons. AZCH encourages direct admits (with no stop in the ED by partnering with inpatient psychiatric facilities to complete their own basic medical clearance examinations. AZCH provides training to local law enforcement, Emergency Medical Services providers, and Skilled Nursing Facilities about alternatives to EDs for BH reasons and through 911 diversions. AZCH collaborates with RBHAs, regional crisis providers, and other health plans to facilitate regional ED workgroups to establish joint processes to reduce over-utilization of EDs.

ED Diversion Partnerships. We collaborated with ConnectionsAZ to develop and implement the ***Crisis High Utilizer Program*** to improve care for adults/children who have high use of EDs and crisis services for BH reasons. ConnectionsAZ generates monthly trending reports and daily data feeds to AZCH, providing real-time and actionable analysis. AZCH staff analyze the data on a monthly call with Crisis Response Center (CRC) leaders and AZCH leadership to discuss member needs and develop alternative treatment plans with all involved providers. Our collaboration includes a set time for rounds to participate in discharge planning; collaborating with the CRC to create slotted times for treatment team meetings for easier scheduling; working with providers to more easily access crisis after care services to facilitate quicker placement***. Results from our High Utilizer Program show a significant decrease in repeat utilization upon discharge: for children (down from 1.6% to 1.1%), adults (down from 3.3% to 2.2%), and adult 30 day repeat utilization (down from 5.5% to 2.8%).*** We work with fire departments for approval to provide Treat and Refer services that allows reimbursement for transports to sites other than the ED. We worked with Golder Ranch Fire District to be the first Treat and Refer provider in Arizona and are now contracted with Golder Mountain and City of Surprise Fire Departments.

REDUCING PSYCHIATRIC HOSPITAL ADMISSIONS. AZCH strategies to reduce admissions focus on both new admissions and readmissions. We reduce the number of psychiatric hospital admissions overall ***by identifying triggers, social determinants of health (SDOH), and at risk populations and by connecting members to services in the community, monitoring compliance and addressing barriers***. We train crisis providers on alternatives to inpatient care available to AZCH members and educate on the availability of our 24/7 review for all admissions. In preventing readmissions, discharge planning begins from the point of admission, with the goal of placing members in the least restrictive environment.

Psychiatric Admission Identification. We identify psychiatric admissions through hospital notifications via our PHM Solution. Upon notification of an admission, AZCH's referral specialists notify the member's health home and/or primary care provider (PCP) of the admission to assist the facility in coordinating effective discharge planning. We are expanding the use of Health Current data to improve admission identification. Through this expansion, we receive a daily analytics and feeds producing risk score that enables ICMs to identify members with an increased risk for admission/readmission. These insights to action are pushed to our ICMs daily to outreach to members and providers and intervene before ED use or admissions occur. We are working with BH facilities to feed data to Health Current.

Psychiatric Admission Assessment and Intervention. Our Utilization Management (UM) Reviewer (or ICM for members in care management) ensures members are being treated in the most appropriate care level and as medically-necessary for their condition. The UM reviewer collaborates upon admission with the hospital discharge planner, AZCH ICM, and as appropriate PCP and/or health home to evaluate appropriateness of the admission and initiate a discharge plan. If the member's visit is a readmission, UM/ICM reviews the previous discharge plan to address any barriers or gaps that caused the readmission. This information is documented in our member clinical record and utilized by the member's ICM to maximize follow up.

Psychiatric Readmission Monitoring. We monitor and prevent readmissions by identifying members at risk of readmission through our Readmission Score Model. Our ***Readmission Risk Score Model*** analyzes 450 variables that impact member readmission risk. If an elevated readmission risk score is present, we refer to ICM for follow-up. Post discharge, members are followed closely to prevent avoidable ED use and re-admissions. Our ICM supports the discharge plan; collaborates with the AZCH pharmacist as needed; educates members/caregivers on risk mitigation; coordinates with PH and BH providers; arranges for follow-up care; and addresses needs such as transportation, SDOHs, peer and family supports, and works to remove any identified barriers. Following the discharge, a reassessment is completed and updates are made to the integrated care plan (ICP) with the member's input as appropriate.

We have seen a 14% reduction in BH inpatient admissions and a 9% reduction in BH readmissions in the past year.

Specialized Programs Targeting Readmission. We are piloting the Hospital Engagement and Linkage Peer Program (HELPP) program with Sonora Behavioral Health Hospital that targets reducing readmissions. HELPP focuses on difficult to engage members by improving coordination between the member, hospital staff, PCP, health home, and AZCH.

HELPP employs Peer Support Specialist (PSS) who meet with members prior to discharge to assist members in understanding their treatment and resource needs. The PSS then will visit with the member in their home to review their post discharge instructions, the member's ICP and when to contact their provider and ICM. The PSS is available to attend a follow up visit with the member and provider. AZCH is working with Pathways and Sonora BH Hospital to develop a specialized children's program that includes training Home Care Training to Home Care Clients (HCTC) and a specialized inpatient unit to assist children with complex behaviors to live successfully in the community. Pathways uses a temporary hospitalization for "extinction bursts" that require special treatment procedures such as medication, seclusion, or restraint due to dangerous behaviors. During the hospitalization, Pathways will keep the HCTC bed available for the child and work with the hospital to co-develop one shared care plan. The goal is reduce hospitalizations and OOS placements and deliver services that focus on creating a consistent environment for members, eliminating the chance for multiple bed transitions/placements.

Identifying Triggers and Special Populations. Our PHM Solution, leveraging our proprietary Centelligence® Health Informatics Platform, allows us to analyze claims data, including inpatient utilization, and identification of Potentially Preventable Events such as ED visits and admissions/readmissions. To increase identification of triggers, AZCH is implementing a Quality-Based Pay for Performance Program that rewards PCPs and health homes with a bonus payment when they achieve target quality results in reducing ED use, acute hospital admissions/readmissions, and length of stay. We also recognize the value of preventive care in reducing higher costs of care. For example, in our SMI population, members assigned to a PCP with at least one well check visit showed a ***6.4% decrease in overall PMPM costs from Q4 2016 to Q4 2017***. Our disease management and other clinical programs are designed to reduce higher levels of care through health education, self-management, and health literacy. We most recently implemented our ***Anxiety Disease Management Program*** to reduce ED/inpatient utilization for members with anxiety as we identified that 65% of our members presenting to the ED with PH conditions and 77% of members with BH conditions had symptoms of anxiety. We are outreaching to these members to better understand their challenges and jointly design engagement and intervention strategies among this group and then tracking utilization daily to facilitate immediate outreach upon an ED or inpatient event. Examples of other populations we target for specialized intervention include children (see below) and justice-involved members. For example, our Provider Portal offers providers, justice system partners, and crisis services providers access to COT information, including county of COT, and COT standards to enhance care coordination.

Child ED Holds and Psychiatric Hospitalizations. Children are systematically identified for ICM through our PHM Solution in real time, referred by an algorithm that measures risk, care gaps, and conditions warranting care management, such as children with developmental delay disorder (DDD), ASD and/or SMB. We identify children for ICM through real time ED notification, hospital discharge referrals from UM, information received from regional crisis providers, and system partners. Children with complex needs are assigned a Children Family Team (CFT) Coach as needed to engage the member's guardian, PCP and/or health home, to explain plan benefits, coordinate services and provide technical assistance. CFT Coaches complete Health Risk Assessments with the member's guardian to identify care gaps and/or referral needs. Our CFT Coaches provide technical assistance to CFTs for members with complex needs. For members with SMB, OOS placements average 12-15 months while in-state placements have an average of 10-12 months with no significant differences in health outcomes. AZCH will lead a collaborative of successful AHCCCS Complete Care contractors to identify and develop ***two more community based programs in Year 2 of the contract***.

Linking Members with Community and Social Services to Avoid Admissions. Social determinants have a direct impact on keeping members in the community. After connecting 65 members with housing between April and September 2016, we saw a ***57% decrease in their ED visits and 5.5% decrease in inpatient stays***. As part of our post hospital outreach, our ICMs connect members with necessary social services such as housing, food, utilities, and employment.

Reducing Out of State (OOS) Psychiatric Hospital Admissions. OOS placements are often the result of no in state alternative. Our first step is to understand the gaps. These are members with complex PH and BH conditions that make them difficult to place. Through our network development process, we have a formal process for systematic review and development of programs that will keep members in state. At the individual level, our ICMs explore all available alternatives and understand and address the unique barriers to in-state placement. If a member must go OOS, we monitor closely throughout their stay. We recognize the importance of planning early for where they will return. A CFT Coach is assigned to child members placed OOS and attends CFT integrated rounds to facilitate and ensure coordination of care and discharge planning. At minimum, CFT rounds are held monthly. When children return from OOS placement, the CFT Coach continues to follow the child to ensure services are in place and the child is receiving needed support. In

October 2015, AZCH received 12 youth in OOS placements from the previous RBHA. AZCH was able to quickly work with guardians and providers to identify alternative placements in Arizona and arranged to bring back seven youth to the State within three months. Over the past two years, we have had as few as two children in OOS placements at one time. ***We commit to a 25% reduction for OOS placements in Year 2 and a 50% total reduction in Year 3, from Year 1 baseline.*** To support these goals, we are developing the following programs:

- Working with Sonora BH Hospital to create a specialized inpatient unit for children with ASD/DDD and SMB in CY20, in which members spend a minimum of 30 days for evaluation, Functional Behavioral Assessment (FBA), treatment plan, and family participation to assist members to return to their community.
- Developing community-based training programs for members with ASD/DDD/SMB in CY19. This includes training for HCTCs and BH residential facilities to ensure that staff are appropriately trained to work with these members.
- Working with Touchstone Health Services (Touchstone) and SW Autism Research and Resource Center to develop community-based wrap services and increased community evaluation, and FBAs without the need to hospitalize in CY19.
- Collaborating with providers in CY21 to develop an ACO-type arrangement to serve children with complex needs. The arrangement includes a children's inpatient psychiatric provider, a family support provider, a community-based wrap around provider and an outpatient treatment center. The ACO will be paid an episode of care rate that encourages collaboration between the organizations to effectively coordinate care and help children live successfully in the community and reduce the need for OOS placements.
- Expanding the partnership with Touchstone and Child and Family Support Services in Pima County to implement an intensive In-Home Children's Program (IHCP) focused on children in the justice center (or Cross-Over Youth) at-risk for OOS placement. The IHCP, expanding in CY19, coordinates directly with providers, to deliver intensive WRAP services for children using evidence-based practices such as Adolescent Community Reinforcement Approach.

ENSURING FOLLOW UP CARE IS PROVIDED

FOLLOW UP CARE POST ED VISIT. Our ICMs complete a minimum of three outreach calls to engage members post ED visit, calling on different times and days. Our ICMs outreach to providers to ensure follow-up appointments are scheduled and services are rendered as planned. ICMs use our secure real-time appointment scheduling tool to immediately schedule appointments at PCP and health home offices and issue text or email reminders for members with participating providers. All AZCH staff have access to the ***MyHealthDirect*** scheduling tool to set-up appointments while on the phone or meeting with members and/or their families, eliminating the need for multiple calls to-and-from provider offices. If members do not have access to a phone, the ICM will coordinate with the member to obtain a Safelink phone, at no charge to the member. The ICM will download appropriate apps, including the AZCH Member Mobile App. Additionally, ICMs mail ED Letters to members that include a listing of alternative community-based services. Our ICMs continue to monitor ED use and other services with the member and their ICT as needed.

FOLLOW-UP CARE POST HOSPITALIZATION/OOS HOSPITALIZATION. ICMs outreach to members within 72 hours post discharge to complete a Post Discharge Assessment and identify resource needs. This may include addressing barriers and SDOHs; medication reconciliation; DME and home health follow-up; and general assessment of the member's condition since discharge. Our ICM coordinates with the members PCP, health home, and/or other providers to prevent future gaps in care, which may include assisting the member in making follow-up appointments and/or securing transportation. Per AHCCCS standards, we provide discharge planning assistance and follow-up when needed for members who have Medicare or other third party payers that are primary.

INCREASING ALTERNATIVE COMMUNITY-BASED SERVICES

Proactive, Long-Term Capacity Building. It is our experience that increasing alternative community-based services decreases ED holds and inpatient admissions admits. AZCH continually assesses and monitors network adequacy related too hard to place members, such as members with co-occurring PH and BH conditions, SMBs, ASD or individuals with intellectual or developmental disabilities. We contract with providers specializing in serving hard to place members, creating funding mechanisms that are focused on a "no wrong door" approach. AZCH will create incentives and case rate payment strategies to effectively compensate providers for serving these members, and facilitate the development of provider partnerships to establish continuums of care to better serve members and expand network capacity. As an example, AZCH has developed Brief Intervention Programs (BIP) housed in BHRFs to provide specialized, 24/7 supervised facility-based alternatives to psychiatric inpatient care. We will collaborate with other Complete Care plans to develop new programs and expand the network capacity to serve hard to place and treat members across the system.

Following are examples of initiatives and efforts to continuously build capacity in the community.

Community-Based Alternative Settings

Increasing Utilization of Peer and Family Supports. AZCH has a long-standing history contracting with Peer/Family Run Organizations (PRFO) and has over 600 Peer and Family Support Staff within our network, which have been proven to be an effective tool in decreasing use of the ED and increasing alternative services. AZCH is developing a case rate pilot with HOPE Inc. (a PFRO) to improve outcomes for members with dual criminal system involvement and substance use targeting Q3 2018 for implementation. The pilot provides HOPE Inc. with a flexible framework to individualize treatment while providing a stable financial structure with a pay for performance layer if the pilot shows expected outcomes, such as no jail recidivism, employment, adherence to probation/court mandates, abstinence from substances, and consistent engagement. AZCH members also have access to our online peer support, 7 Cups is an online tool that anonymously and securely connects members to trained, diverse, and compassionate peer listeners, providing support in 140 languages on issues such as depression, anxiety, financial hardship, and substance abuse available by 1/1/2019. We use family support to help families navigate the return of members to home and will expand family support providers to all areas awarded by 7/1/2019.

"Second Responder" Services. Following a crisis episode or to prevent a crisis episode, we offer a 24/7 in-home community providers that go to our members and continues care with the member for up to six weeks. Second Responder services are designed to help members live successfully in the community and avoid the need for a higher level of care. AZCH has four second responder service programs; including, Peer Crisis Aftercare, Foster Care Stabilization, IDD and Behavior Management, and Housing Support. We will implement a fifth second responder service specializing in ASD in awarded regions by 11/1/2019.

Assertive Community Treatment (ACT) Teams, including Medical and Forensic ACT Teams. AZCH contracts with ACT teams to provide community-based care to empower members to live independently within their community. We support the use and expansion of these teams to serve GMH/SA members with complex needs.

Facility-Based Alternative Settings

Care Connections Program. Outpatient facility, provided through ConnectionsAZ, where members can receive post-crisis stabilization services in a primary care setting. Provides a transitional care plan and weekly review with ICM.

BIP. BIP is a BH residential facility that provides brief BH stabilization services following a crisis episode. AZCH has provided extensive education to system partners and providers regarding identification of members who would be better served in a BIP setting rather than an ED. ***In October 2017, BIPs served 158 members and of those, 113 members were returned to the community***.

Assessment Intervention Centers (AIC). AICs are specialized residential-based programs designed to develop comprehensive multidisciplinary (Behavioral Analysis, Psychiatric, Psychological and Family Therapy) assessments to determine what needs to be in place for a child to live successfully in the community. AZCH helped develop and contracts with three AICs.

Short-Term Crisis Aftercare Residential (Transition Point). Transition Point provides stabilization care for adult members who can benefit from brief residential services for up to 14 days. AZCH has collaborated with Community Bridges, Inc. to open a facility in Tucson in early 2018.

Healthy Together. By 10/1/18, this program will provide personalized in-home primary care for adult members who are home bound from chronic or BH conditions.

Increasing Access to Sub-Acute Facilities. In collaboration with AZCH, Community Bridges, Inc. is opening non-Institute for Mental Disease sub-acute facilities in Casa Grande and Benson, and Horizon Human Services is opening a sub-acute in Florence in Q3 2018. These facilities allow members to remain close to their support system and providers while receiving appropriate treatment. Both units can serve individuals receiving COT.

NARRATIVE SUBMISSION
RESPONSE #11

NARRATIVE SUBMISSION
RESPONSE #11

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

11. Describe the strategies the Offeror will utilize to ensure development of a comprehensive provider network…

NETWORK DEVELOPMENT OVERVIEW

Arizona Complete Health-Complete Care Plan (AZCH) believes that delivering high quality, accessible specialty and behavioral health (BH) services to our members requires a comprehensive network of committed, informed, and performance-minded providers and community agencies who share in our mission of improving the health of our communities, one person at a time. The current AZCH network, which includes specialty and BH providers, has served AZ Medicaid members since 2005, including the integrated needs of our ALTCS members since 2008, RBHA members since 2015 and GMHSA Dual members since 2016. We will leverage this experience and our existing AZ contracts across all product lines to ensure a comprehensive network in any GSAs we are awarded, in accordance with Program Requirements, including Section D.26 Network Development (ND) and Medicare standards. With a fully contracted and credentialed statewide network of more than 20,000 specialty and BH providers, we will be fully prepared to serve all AHCCCS Complete Care and DSNP GSAs before 10/1/18. This includes the AzSH, Peer-Run and Family-Run Organizations, Multi-Specialty Interdisciplinary Clinics (MSIC), six Centers of Excellence (COE), Targeted Investment Providers, and other specialists serving complex populations. We do not subcontract or delegate to any other entity for the delivery of BH services.

AZCH Network Snapshot
Integrated Health Homes: 17
PCPs: 5,248
Hospitals: 162
Sub-Acute Facilities: 32
Specialty Providers: 20,077
Psychiatrists: 328
Licensed BH Providers: 718
Peer Support: 599
Ancillary Providers: 912

Our local experience, network and resources are backed by the largest national Medicaid managed care plan, including our national BH COE, bringing technology, tools, and best practices that support our providers in delivery system transformation to achieve AHCCCS' integrated care vision, guidelines, and goals. Our guiding principle is a person-centered, proactive approach that begins with understanding the needs of our members, continuously monitoring and addressing network capacity, identifying high-value providers, and driving members to these providers.

STRATEGIES ENSURING THE DEVELOPMENT OF A COMPREHENSIVE NETWORK

Critical elements of our ND approach include 1) Identification of Member Need; 2) Assessment of Current and Future Capacity; 3) Contracting and Retention; 4) Governance and Monitoring. We have a robust ND team empowered to build and maintain our specialty and BH network. It includes Contracting, Provider Engagement, Provider Data Management and Credentialing. A total of 55 staff work to meet the network needs of the AHCCCS members we serve. The Network Performance Oversight Committee (NPOC) and Quality Management Performance Improvement Committee (QMPI) complement each other in providing oversight.

1) IDENTIFICATION OF MEMBER NEED. The central component of ensuring a comprehensive network is understanding our members' needs and developing a tailored network to meet those needs. To accomplish this, we use a multi-faceted approach that includes member risk stratification, member and stakeholder feedback and provider communication. We obtain ***member and stakeholder feedback*** through member forums, social media and interactions with internal departments including; Customer Service (CS), Medical Management (MM) including Care Management (CM) and Utilization Management (UM), Quality Management (QM), Office of Individual and Family Affairs/Member Advocacy (OIFA/MA) and Grievance and Appeals (G&A). Our ongoing activities include regular provider forums that consist of a cross-section of specialty and BH providers and meetings with community stakeholders, such as government and justice partners, to solicit feedback on barriers to care. We address ***membership trends, utilization trends and cultural needs*** of our members by using Centelligence®, our proprietary technology, that enables us to combine and analyze several sources of data including claims, Blind Spot, social determinants of health (SDOH) through diagnosis codes, over and under-utilization, jail and housing data, as well as out-of-state (OOS) placements and out-of-network utilization. We identify trends by region and compare them to estimated number of enrollees; projection of future members meeting AHCCCS eligibility; anticipated numbers of persons with BH and substance use needs; anticipated number of adults and

children with co-morbid conditions; and special populations, e.g. individuals with special health care needs. We are especially cognizant of the ***cultural needs*** of our members and ensure we are compliant with ACOM policy 405. We recognize race and cultural backgrounds, limited English proficiency, disabilities, gender, sexual orientation, gender identity and other cultural factors may affect approaches to identifying PH and BH needs, preferences and treatment. We train staff and providers on cultural competency and recruit providers who have demonstrated ability in specific cultural aspects (e.g. Living Out Loud for LGBTQ members and the Banner University refugee clinic). We currently contract with providers who speak 90 different languages and contract with a language vendor who provides 24/7 coverage in over 200 languages.

2) ASSESSMENT OF CAPACITY. With an established network in AZ, capacity assessment becomes a key element of our Complete Care ND plan. Through network analytics, AZCH applies member need intelligence to employ a multi-tiered approach to assess and build network capacity and immediately address gaps. AZCH contracting staff utilizes ***geo-mapping*** and ***Medicare time and distance*** software to generate reports that plot member and provider locations and travel distances for the various provider types for each GSA. We use the membership trend data to identify member ratios, stratified by adults and children, ensuring there are sufficient specialty and BH providers to cover areas of high-density as well as lower-density areas such as frontier, rural, tribal, and border communities. AZCH combines utilization and geographic information to identify ***hot spots*** within a specific geography and build networks that address identified health disparities and disease prevalence. Our acute care plan identified that in Maricopa County, 20.6% of our 5,149 members with an asthma diagnosis lived in eight adjacent zip codes. AZCH developed a comprehensive network of 21 allergist and pulmonologists within a 3-mile radius and 67 within a 10-mile radius of this hot spot. Other network capacity assessment tools are ***appointment availability, wait times and panel size***. Quarterly, AZCH conducts "secret shopper" calls to provider offices to ensure appropriate appointment availability for members and compliance with AHCCCS standards. Provider Engagement Specialists (PES) conduct onsite validation of the results, and monitor clinic wait times. AZCH compares this to panel size to further determine network adequacy and ensures that each provider has the capacity to serve members. This is our current approach that we will use to assess, build and maintain a comprehensive network in the Central and Southern GSAs, and the approach we would use to augment and further build our current network in the Northern GSA if awarded.

3) CONTRACTING, RETENTION AND NETWORK ENHANCEMENT STRATEGIES. The identification of member needs and assessment of the network informs strategies to contract with and build capacity for specialty and BH providers.

Provider Outreach Implementation Plan to Support Network Build. By 10/1/18, we will fulfill network adequacy requirements across all awarded GSAs for both the Complete Care and DSNP programs through signed provider contracts and completion of credentialing. Activities to fully develop an integrated network have already begun and include education of existing providers on integrated care and broad provider outreach to non-contracted providers via direct mail; telephonic outreach; and a veteran team of ND professionals who conduct face-to-face visits. We prioritize our outreach efforts based on our previously conducted assessment of need and capacity, and employ a high touch, boots on the ground approach. This ensures we contract with a network of providers that is sufficient in number, mix, and geographic distribution that meet the needs of the anticipated number of members for the provision of all covered services, offering members choice and access at least equal to community norms. We will leverage all existing contracts and credentialing through our product lines to fast track the contracting, credentialing, and onboarding process. We will ensure provision credentialing when indicated and consistent with AMPM.

Retention. While not considered a traditional contracting strategy, **provider relationships** are a key principle to provider retention and a high-value network, as demonstrated by the contracting challenges described on the next page. AZCH **customizes payment strategies**. First, AZCH ensures that the base funding for fee-for-service (FFS) is appropriate. At least annually, we analyze the FFS fee schedule and create a **payment differential** when necessary for contracting with specialty, BH or non-urban providers. AZCH leverages all of our AZ products to streamline contracting and enhance our Medicaid network and have been able to offer providers volume and diversification of products. Value-based payment (**VBP)** is one of the most critical payment strategies to our success. AZCH has developed a comprehensive VBP strategy that relies on a partnership approach to identify providers' readiness for VBP, equips them with tools and resources to move across the VBP continuum towards shared risk, and incentivizes quality and member experience outcomes. VBP

payment mechanisms include pay for performance, bundled payments, case rates, shared savings and shared risk. **Our goal is to have 80% of AZCH spend made to high value, integrated providers under VBP by 2020.**

Network Enhancement. While it is important to have a sufficient network of specialty and BH providers, it is equally important to have a high-value network aligned with improving member experience and outcomes as well as cost. The identification of high-value providers, COE's and accountable care organizations/communities (ACO/C) are a key component to continuous improvement and practice transformation toward integration. We have six COEs in the areas of adult and child integrated health homes, sleep apnea, CHF and autism. If awarded Maricopa County, we will contract with the recognized autism COE in Phoenix by 10/1/18. By the end of 2019, AZCH commits to identifying COEs in Pain Management, as defined in the Complete Care RFP, Peer Support Services, OB/GYN and opioid treatment. To build capacity in our non-urban areas, we will leverage our COEs through our ***hub and spoke model*** to both utilize services at the COE location (hub) and virtually through telehealth and provider consultations (spoke). They will conduct provider education forums (either onsite or through Project ECHO, a telemedicine training solution). AZCH recognizes other high-value providers based on use of EBP, quality and cost outcomes, and member experience that may not meet all of the requirements of a COE. AZCH has high-value providers in the areas of complex adolescent and children's care, as well as justice involved populations. By 10/1/19, for qualified high-value providers and COEs, AZCH will implement the Centene ***Gold Card Program***, a non-financial incentive in which providers who demonstrate appropriate utilization based on EBP are waived from certain prior authorization requirements. We recognize the continued emergence of ACO/C like Banner Health, Equality Health and forming ACOs like the BH Coalition or the IPA forming with Healthy Arizona Network, consisting of many FQHCs. We have contracted with Equality who has created accountable communities (specific areas in a larger urban area) that address the integrated needs of members, focusing on Latino cultures. We are moving to shared risk with Equality by 10/1/19. AZCH recognizes Banner's accountable neighborhoods and will leverage our current relationship to enter into a shared risk contract for our Medicaid line of business by 10/1/19. We are contracting with an outside consultant experienced in practice transformation to assist at least two practices in Year 1 with integrated practice transformation.

4) GOVERNANCE AND MONITORING. Our network governance lies with the NPOC, a monthly cross-departmental team charged with ensuring execution, oversight and monitoring of our network. The NPOC monitors the network against our ***Network Development and Management Plan***, which is developed and maintained to demonstrate an adequate network, including all requirements as outlined in ACOM Policy 415. The NPOC is led by the VP of ND and consists of members from Executive Management, MM, CS, Member Retention (MR), QM, G&A, OIFA/MA, Justice, Finance and other departments such as Pharmacy on an ad hoc basis. The NPOC reviews network adequacy, appointment availability, G&A, and over/under-utilization, combined with quality elements such as quality of care concerns, member satisfaction results, and achievement of AHCCCS performance measures (e.g. EPSDT, access to care, preventive services). ND staff present recommendations to NPOC, who provides direction on immediate and long-term strategies to address trends, identified gaps, and member needs. The NPOC reports applicable access to care information to QMPI.

ADDRESSING SPECIALTY AND BH NETWORK CHALLENGES

AZCH has used the approach described above to build a high functioning network for specialty and BH providers in the Central and Southern GSAs. From this local experience, there are challenges and gaps to developing a statewide network to deliver integrated care. Below are specific examples of population and geographic driven challenges and strategies.

POPULATION DRIVEN CHALLENGES. ***Challenge.*** Through UM and QM data, AZCH identified access to Integrated Health Homes (IHH) to serve the whole health of our members as a gap in 2014. ***Innovations.*** AZCH worked with providers to develop 17 IHHs for children and adults in urban and non-urban communities in Southern AZ. These IHHs consist of both traditional BH providers (Casa De los Ninos) and PH providers (El Rio) who now provide integrated services. We utilized VBP methodologies to promote integrated health care and have designated three as COE's. AZCH is implementing a VBP contract with Banner University Healthy Together Care Partnership (HTCP) no later than 10/1/18 to provide multi-disciplinary IC services to members who have high needs/high cost and are homebound. Based on HTCP data, we **anticipate a 15% reduction in Emergency Department (ED) utilization.** HTCP will serve members in Pima and Cochise counties, with anticipated expansion to Maricopa and Pinal counties in 2020.

Challenge. There is the lack of providers available to diagnose and treat children with developmental delays, as evidenced by a 6-month wait for an appointment with a developmental pediatrician. Additionally, the average age to diagnose autism in AZ is 4yrs 10mos compared to the national average of 3yrs 10mos***. Innovations.*** AZCH has brought together the UA College of Nursing (UA CON) and Children's Clinics to develop a certificate program for Pediatric NP's in developmental pediatrics to expand capacity for early identification of delay or autism. AZCH will fund the program and facilitate partnership discussions while the UA CON and Children's Clinics will work together to develop curriculum for both new and existing NP's. Program curriculum will be imbedded in NP training so all Pediatric NP's receive education, and have the option of obtaining a certificate. Children's Clinics will be the clinical site for the program and will be offered to students at UA Phoenix and Tucson campuses with a launch date of fall 2019. We have contracted with Sydney Rice, MD, and Dave Harvey, PhD, experts in early childhood development, to provide bi-annual training on detection of developmental delays to pediatricians and other practitioners. Additionally, AZCH has contracted with Southwest Autism Resource and Research Center (SARRC) to support expanded use of an online and mobile tool, Naturalistic Observational Diagnostic Assessment (NODA), for assessing early childhood development and will launch by January 2019. **AZCH's goal is to reduce the Diagnosis age of our members with autism by three months every year.**

Challenge. In the United States, one fourth of the national funding for children's mental health is spent on residential treatment and our analysis shows that children placed OOS for sexually maladaptive behavior (SMB) have an average placement of 12-15 months, while children placed in-state have an average placement of 10-12 months with no significant difference in health outcomes. The *AZ vision-12 Principles for Children BH Service Delivery* as outlined in AMPM Policy 430 advocate for children to receive services in their community. ***Innovations.*** AZCH will lead a collaborative of Complete Care contractors to develop at least two additional community based programs in the second year of the contract. These options will include SMB treatment for children with intellectual disabilities. The community based programs will include a Home Care Training to Home Care Clients home and a BHRF home. We are partnering with Sonora Behavioral Health Hospital to develop a 30-90 day program to address the need for short term intensive interventions. **Increased community based programming will lead to quicker reunification with the family of 4-6 months by 2020 and cost avoidance of $60,000 per child per year.**

Challenge. AZCH recognizes the growing issue of sex trafficking and the paucity of treating providers. ***Innovations.*** AZCH is an active participant with Southern AZ Anti-Trafficking Unified Response Network (SAATURN), a coalition of behavioral health providers, courts, law enforcement, educational institutions and faith based organizations working together to combat human trafficking in Pima, Cochise and Santa Cruz Counties. AZCH currently contracts with providers with expertise treating adolescent victims including Mingus Mountain Academy and Devereux Arizona. AZCH will engage and support similar coalitions across the state and provide leadership in building capacity in the continuum of care available to meet the needs of this population. The outcome will be to support the development of a state-wide infrastructure to engage, support and treat victims of human trafficking within two years of contract award. By Q2 2018, we will partner with the Crisis Response Center (CRC) to develop a comprehensive protocol that will identify and support the needs of children who present in crisis following an event believed to be related to sex trafficking.

Challenge. Members who are homeless are more difficult to engage in BH and specialty services as demonstrated by ED and inpatient (IP) utilization and performance measures. ***Innovations.*** We collaborated with Circle the City to develop a VBP model to support a related organization, Engage Health. Engage will locate members who are homeless and high risk, to engage them in PH, specialty and BH services. Upon award, AZCH and Engage will implement the program by July 2018 in Maricopa County. **We expect a 20% cost reduction for these members from ED and IP utilization.**

Challenge. Individuals who are justice involved require a higher level of coordination between provider and system partners. Justice Reach-In has shown a reduction of 6.6 fewer ED visits per 100 members post-release, 10.3 fewer crisis events, and 3.6 fewer arrests, saving an average of $1500 per member or $954,000 annually. ***Innovations.*** AZCH is partnering with Pima County, Pretrial Services, and the jail to develop a re-entry center designed to provide a community transition facility to assess, house and engage people into services; provide short term transitional housing; and serve as a pre-booking center in lieu of jail. We have committed to providing oversight of the re-entry and housing operations upon completion. **We are projecting completion in 2021 and expecting an additional 5% reduction in recidivism**. AZCH and Pinal County Detention Center created the Housing Unit for Military Veterans that houses them in

veteran-only pods and began on 11/28/17. AZCH contracts with providers who are allowed to enter the pod to mentor, counsel, and educate veterans. **We expect a 20% decrease in recidivism for veterans in this program.**
Challenge. UM data shows that members who experience a crisis event have higher cost and ED utilization post crisis often due to lack of available post-crisis stabilization services. ***Innovations.*** AZCH has addressed post-crisis stabilization with our Second Responder program, offering 24/7 in-home and community services for up to 6 weeks. We helped develop and contract for a Brief Intervention Program, a sub-acute short stay non-inpatient solution. Additionally, AZCH will contract with Connections AZ who is creating a 24/7 outpatient crisis transition center expected to be operationalized in 2019. **The regional community stabilization rate after a member has experienced a crisis event is 79% and Pima County is 83%, this represents a 128% increase since 10/1/15 (rate was 39%).**
Challenge. As evidenced by longer ED and IP holds due to lack of placement options, there is a lack of Skilled Nursing Facilities (SNF) and Behavioral Health Residential Facilities (BHRF) to address members with complex comorbid PH and BH needs. **Innovation.** Within the first year of the contract, AZCH will partner with at least one SNF and BHRF in Maricopa and Pima to develop capacity for members with comorbid PH and BH needs.
GEOGRAPHIC DRIVEN CHALLENGES. ***Challenge.*** A significant issue identified through geo-mapping and hot spots is the lack of specialty services in non-urban communities. ***Innovations.*** We will leverage our ASD, CHF, Pain Management and OB/GYN COEs to act as a **hub and spoke model** with telemedicine, provider consultation and training through Project Echo to non-urban communities. Our VBP strategy addresses issues around payment barriers for services for telemedicine. For autism, we have identified Children's Clinics, the MSIC for Southern Arizona, as a COE. This will facilitate our contracting needs for the CRS population. We will leverage our current CHF COE to provide hub and spoke services to non-urban providers by 10/1/19. AZCH will ensure sufficient transportation services for members who need to visit urban centers for care. AZCH contracts with VEYO, as well as having transportation services available through our BH providers.
Challenge. Opioid addiction is a statewide issue exacerbated by lack of treatment services available in non-urban communities. ***Innovations.*** In the development of our Pain Mgmt. and Opioid COEs, through a hub and spoke approach, our urban COEs will increase access to services and education for non-urban clinics. Additionally, AZCH worked with Community Medical Services (CMS) to open a medication unit in Safford on 3/1/18 and in Sierra Vista within the next eight months. We are working with CMS on opioid case rates by 4/1/19. Through provider feedback we learned that physicians in Cochise and Santa Cruz counties were experiencing a high volume of patients requesting opioid prescriptions and that these communities had limited resources. We contracted with Community Health Associates (CHA) to ensure members needing MAT services are referred to CHA for intake and transport to Tucson for a one time face-to-face appointment to start buprenorphine services. CHA provides ongoing telemedicine services for our members. We have engaged 13 members into treatment in these communities with 12 remaining clean and sober. **We will employ similar strategies in hot spots in the first year of the contract.**
Challenge. Geo-mapping identified oral health as a deficiency in several of our non-urban communities. ***Innovations.*** We established a payment differential for mobile dentistry with Mobile Dentistry of Arizona, Sunset Community Health Center and Community Dental Foundation. They provide services to members living in Yuma and Cochise Counties with the goal to expand to any GSA we are awarded in 2019. **AZCH will use Blind Spot data, as well as data from relinquishing plans, to immediately affect the use of oral health in non-urban counties.**
Challenge. Through member community forums, AZCH identified a need for Peer and Family run agencies in non-urban communities. ***Innovations.*** AZCH created a payment differential and increased the number of Peer and Family run agencies from three to eight non-urban communities and partnered to develop mobile units serving other smaller communities.

Addressing Tribal Needs ….
Based on our work with the Tohono O'Odham Nation, AZCH identified a lack of services available in tribal communities. In response, AZCH established a memorandum of understanding with the Nation and contracted with Intermountain through a payment differential to provide services on the reservation and has **led to 13% increase for members being treated for SUD.**

NARRATIVE SUBMISSION
RESPONSE #12

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

12. Describe the Offeror's specific processes to effectively manage provider relations and communications…

PROVIDER RELATIONS OVERVIEW

Arizona Complete Health-Complete Care Plan (AZCH) is convinced that successful provider collaboration built on trust is the most critical factor to the success of the Complete Care program. . Accordingly, we are dramatically increasing our focus and mobilizing resources to become the "health plan of choice" for our provider partners. Key deliverables to providers include: offering reliable, responsive, timely, and streamlined resolutions; delivering meaningful, relevant, proactive, and transparent communications; and minimizing administrative burden, including timely and accurate claims payment. Supporting our vision and goals is our provider engagement model (PEM), designed to be proactive and build provider partnerships that streamline communication and minimize administrative burden. Our PEM includes automated functional processes that aim to improve timeliness and accuracy for traditional functions, such as claims payment and authorizations. Further, the PEM facilitates one call resolution, targeted education, and hands-on support to ensure providers can meet administrative requirements and leverage technological resources available to them to reduce manual work. AZCH continually refines these processes through a formal Plan-Do-Study-Act (PDSA) model, seeking opportunities for process improvement by identifying areas of concern, developing a strategy to mitigate the concern, implementing the strategy, studying the results, and then making refinements to the solution. We use Lean Six Sigma methodologies to optimize plan efficiency and improve provider satisfaction through streamlined processes and reduced turnaround times impacting providers. AZCH currently has 1 black belt, 8 green belts, and 12 green/yellow belts in progress.

> *Once PESs were empowered to handle issues directly,* ***overall claims denials dropped 27%*** *(from August 2016 to July 2017).*

In 2016, providers who completed our annual survey reported they did not consistently understand who could help resolve specific issues within AZCH. AZCH responded by reorganizing the Provider Relations team structure, empowering our Provider Engagement Specialists (PES) to resolve issues stemming from disparate departments and serve as the provider's single point of contact. ***Our goal is to improve provider satisfaction survey results in the overall plan rating and provider loyalty categories by 5% at the end of Year 1.*** We track and measure this through analysis of provider satisfaction through surveys and direct feedback, state fair hearing requests, administrative appeals, disputes, and provider performance, and have set metrics to benchmark and improve our performance in these areas annually.

PROACTIVE PROVIDER EDUCATION AND COMMUNICATION

Our processes are designed to dramatically open up provider communication channels and create an environment where providers feel engaged and informed. For day to day operational issues, every provider is assigned a PES who they can call directly for one call resolution, pulling in claims or other experts, as needed, but the PES is accountable for resolving the issue. For strategic and higher level concerns, all providers have access to the AZCH leadership team, endorsing an open door policy and active engagement at all levels. The goal is to create a comprehensive, integrated care system that partners with providers to offer a variety of resources, information, and tools to build strong working relationships, resolve operational issues, share best practices, promote mutual values and goals, improve health care delivery, and understand unique health care communities.

PROVIDER ORIENTATION. Provider orientation begins at contract execution. Once contracted, providers are immediately assigned to a PES who schedules their first orientation session. They are then presented with the New Provider Orientation manual, providing key resources, such as a review of the Provider Manual, AZCH and AHCCCS Provider Portal link, forms, PaySpan, an electronic data interchange (EDI), registration, and AHCCCS Rules and Regulation Manuals. After 90 days, the assigned PES will again meet with the provider face-to-face to conduct a 90-day Readiness Review, and follow up with any needed education, training, and support, such as hands-on staff tutorials of our Provider Portal.

ONGOING AND TARGETED EDUCATION. Ongoing provider education is delivered in person by the PES and through regional forums, webinars, newsletters, emails, and conference calls. This education is specified in written policies and procedures. Topics selected are relevant to the provider and include provider responsibilities for covered and non-

covered services; targeted technical assistance (including tips for successful claims submission, Prior Authorization (PA) rules, and leveraging website tools); continuity of care; cultural, disability, and poverty sensitivity and competency; referrals and resources for members with special health care needs; and integrated care. Our model includes field-based PESs in rural communities to ensure their issues and concerns are well represented, for example, lack of referral sources and IT infrastructure. When appropriate, the PES will enlist the support of functional leadership within AZCH to complement required training, and ad hoc, targeted trainings will be conducted for specific providers/clinics/groups based on demonstrated need. For example, in November 2017, we presented to the Arizona Council of Human Services Providers after rigorous analysis of provider claims experiences for GMHSA dual eligible members. The overview included: metrics around dual member claims experiences; data on claim approvals and denials; top five denial reasons for provider claims; provider tips to address specific denial reason codes; and proactive steps taken by the plan to systemically resolve common denials.

PROVIDER FORUMS. AZCH hosted more than 20 provider meetings and a held a two-day CEO retreat in 2017. A key goal of these meetings was to prepare the behavioral health (BH) network in Arizona for the next phase of integrated care, and transitioning from coordinating with one RBHA to working with multiple AHCCCS Complete Care contractors. We included national speakers and local experts with sessions on integrated service delivery, person centeredness, member choice, the opioid crisis, coordination of care, social determinants of health (SDOH), justice, workforce development, housing, medical appropriateness/necessity, appointment availability, PA, outcome measurements, Centers of Excellence, Fee-For-Service Claims submission, shared risk, and value-based purchasing payment models. These trainings emphasized AHCCCS' vision, system values, and guiding principles, and our common commitment to integrated care, improved outcomes, and bending the cost curve. Through these and future forums, providers have in-person communication with AZCH provider engagement and plan leadership to address any topic. To support a successful transformation of the delivery system, we are ***committed to holding monthly provider forums in each awarded urban and rural county for 60 days pre go-live to 3 months post implementation***. These meetings will be structured to hear concerns, brainstorm solutions, and introduce our PES and leadership team. On an ongoing basis, AZCH will hold open provider forums no less than semi-annually, chaired by the CEO or designated executive and attended by plan leadership. Our Provider Forum series will be augmented with quarterly BH informational meetings open to BH providers, to identify issues, solicit feedback, and support the transition and ongoing needs of BH providers.

PROVIDER PARTICIPATION ON COMMITTEES. Currently, we obtain provider feedback on performance, evidence-based practices and program design by including providers on our quality, pharmacy and advisory committees. These include representation from across our network and across disciplines, including PH, BH, pharmacy, and dental providers. ***To further enhance this feedback and engagement, AZCH is restructuring our governing Board of Directors to include at least one PH provider and one BH provider.*** One example of specialized provider advisory feedback is our Children's System of Care meetings that began in 2016 and held quarterly. Our goal is to identify system strengths and weaknesses and bolster the system to ensure that children and families' needs are being met. These meetings are held in the community: Pima, Pinal, Yuma, Graham, and Cochise Counties. Information obtained through all provider channels will be shared across the organization, as applicable, and issues and concerns addressed through our established quality infrastructure, including our Communication, Access, Respect, and Education (CARE) Task Force.

PROVIDER LEARNING COLLABORATIVES. We will build on our successful approach to provider communication through our annual provider CEO Retreat by developing annual provider Learning Collaboratives on focused topic areas. We will host the Learning Collaboratives, identifying a relevant topic based on provider feedback and inviting local and national speakers to discuss evidence-based and national best practices. Based on feedback from our recent CEO Retreat, our initial Learning Collaborative to occur mid-2018 will focus on Planning for Integration Transformation. We will hold a follow-up Learning Collaborative in 2019 to discuss progress and lessons learned. We anticipate a future Learning Collaboratives focused on Special Populations such as Children's Health Care and SDOH. .

PROVIDER TOOLS. A key process AZCH has developed to support providers has been the availability of specific, targeted data and information to providers through the Provider Portal, including access to provider analytics dashboards. We synthesize key data elements for providers, reducing their need to spend valuable time tracking metrics, and increasing their knowledge of key practice indicators, such as billed versus paid charges, percentage of claims paid upon first

submission, and PA approvals. In addition, our provider tools identify practice and provider performance, cost and utilization trending including total medical expense against targets, quality measure performance, active and non-active member pattern analysis, disease state prevalence, readmission analysis, Emergency Department utilization, and population health trends.

SUPPORTING PROVIDERS AND IMPROVING PROVIDER EXPERIENCE

AZCH has standardized, automated processes designed to support the administrative needs of providers; minimize issues, concerns, and complaints; and ensure members have access to timely, appropriate, and quality services. There is a natural hierarchy with providers, and until issues of claims payment, PA, contracting turnaround times and credentialing are resolved, achieving higher level issues of system transformation are not possible.

TIMELY CLAIMS PROCESSING AND PAYMENT. Our claims process supports accurate, complete, and timely encounter capture and payment through diligent system configuration, monitoring, trend analysis, and audits.

System Configuration. Our Network teams work closely with System Configuration to ensure the timely and accurate loading and testing of provider contracts. To improve clean claim submission, our health information system utilizes automated pre-adjudication logic for all claims (electronic, paper-based, and web-submitted). If a claim fails pre-adjudication, we notify the provider explaining what we need to adjudicate the claim. AZCH's claims adjudication software captures the date of payment to determine claims timeliness, and automatically assesses applicable penalties and interest payments in accordance with AHCCCS rules. AZCH directs providers to submit claims through EDI to increase accuracy of first claim submissions and reduce claims adjudication turnaround time, and has made EDI claims submission available through the Provider Portal. Our current auto-adjudication rate is 87.7%.

New Provider Claims Monitoring. Prior to auto-adjudication, AZCH monitors claims submissions from new providers for at least 60 days. During that period, the PES, in conjunction with the claims educator, identifies provider billing issues and provides technical assistance to ensure accurate billing and payment.

Provider Appeal Trends. AZCH Grievance and Appeals (G&A) department tracks and trends provider appeals monthly, including claims disputes. G&A identifies trends in provider grievances and works with the PES, claims educator and other departments as necessary to address issues causing provider grievances.

Check Run Audits. . Working directly the PES team, the claims liaison reviews adjudicated claims for denial patterns, such as by procedure, denial codes and/or individual provider. The claims liaison generates a summary report of their findings, and the report is shared with a standing multidisciplinary review team comprised of PESs and leadership from Claims, Medical Management and members of the Executive Team. Weekly, the team collaboratively reviews the report, seeking to identify systematic trends and potential root causes for denials, and formulates appropriate solutions, including provider education, individualized technical assistance, and system configuration enhancements. AZCH proactively identifies possible payment errors during our quarterly audit of providers with 25 or more denied claims and deploys a standard process to educate the provider and efficiently rectify any claims that are processed inaccurately.

Check Run Audit Process Improvement in Action
Issue: In July 2017, our Check Run Audit identified a pattern of denied claims for Banner Health totaling 75 claim lines ($193,671.63 amount charged) denying for Invalid or Missing Discharge Status, affecting three separate facilities.
Process Improvement Strategy: Root cause analysis indicated a billing education issue, so AZCH's PES assigned to Banner provided technical assistance to remediate the billing issue.
Results: As of December 2017, Banner claims denials for the above reasons were **zero ($0).**
Claims Processing Improvement in Action
Issue: Though we average over 95% in claims accuracy, the 2016 provider survey indicated that only 35% and 39% of the respondents responded positively to the accuracy and turnaround times of claims processing, respectively.
Process Improvement Strategy: Non-clean and late claims submissions were the primary factors that led to claims issues. To mitigate, we implemented a strategy focused on system configuration enhancements (Provider Portal), improved communication (improved warm transfer process between claims educator and provider engagement specialist), and provider education (minimum standards for clean claim submission and timeliness standards).

Results: We have improved auto adjudication rates across the board**.**

- Cenpatico Integrated Care (CIC): November 2016 = 65.8% → October 2017 = 88.9%
- Health Net Access (HNA): November 2016 = 64.2% → October 2017 = 81.7%
- 12-month average of claims processed within 30 days for CIC is 99.1% and for HNA 98.5%

PA AND UTILIZATION MANAGEMENT (UM) SIMPLIFICATION. .

Technology. AZCH leverages technology to simplify the UM process for providers and ensure a seamless system of care. We have configured our website so both contracted and non-contracted providers can determine if a PA is required for a specific service or treatment. Contracted providers can request a PA 24/7 through our secure web-based Provider Portal. Providers can also attach medical necessity documentation to a PA request directly through the Portal to ensure timely and accurate completion of the request. AZCH's web-based PA system allows for real-time medical determinations, including the scheduled implementation of an auto-determination rules engine scheduled for Q3 2018 to quickly approve PAs and provide a timely response to providers via our secure Provider Portal.

PA Requirement Review. Our PA rules are proactively reviewed annually by our Medical Director and Quality Management and Process Improvement (QMPI) Committee to validate that PA requirements have value. When PA requirements are no longer indicated, we remove requirements, communicate the change to providers, and configure our systems to ensure claims edits and adjudication rules are set to pay claims based on the new rules.

Multidisciplinary Oversight Structure. We include members of the Medical Management Team on provider Joint Operations Committees to obtain direct feedback on the current successes and improvement needs of the PA process. This has created better communication, visibility, and accountability between UM staff and the providers.

Consistent Application of Review Criteria. 1) Audits - We conduct audits to ensure appropriate documentation and timeliness requirements are consistent with all AZCH and AHCCCS standards; 2) Inter-rater Reliability (IRR) **–** AZCH conducts internal IRR testing to monitor the consistency of criteria application for all health plan personnel who participate in the medical necessity review of services; 3) Corporate Physician Peer Review – Local Medical Directors are evaluated for IRR annually through a peer review process by Centene's Medical Management Audit Department.

PA Process Improvement in Action
Issue: Based on feedback from recent Provider Forums, we sought to improve our PA accuracy and timeliness
Process Improvement Strategy: We utilized a system configuration strategy to meet the provider request by enhancing the functionality of our web-based PA system. The goal was to improve real-time medical appropriateness review and determination for select procedures. Additionally, we have designed an interactive auto-determination engine to quickly approve PAs and provide a timely information to providers via an interactive lookup tool on our secure Portal. Implementation for this process and. improvement is scheduled for Q3 2018
Results: PA turnaround times for our RBHA line of business for routine services was reduced by 44% from 11/16 to 12/17, and expedited services turnaround times was reduced by 48% from 10/16 to 10/17. We are continuing to trend downward in these metrics and are currently merging best practices into all AZCH lines of business.

CONTRACTING TURNAROUND TIMES. Wherever feasible, we have automated our processes for contracting, and our goal is to ensure an appropriate balance of vetting qualifications of providers with expediting the ability to begin offering services. Our standard practices include clearly documenting contracting processes, such as our commitment to exceed the requirements and acknowledge within two days, and contract within 30 days, identifying cross-departmental interfaces to anticipate barriers, and collaborate on process improvements that prioritize added value to the provider. Results, feedback, and performance to standards, are discussed in monthly cross-departmental contracting and credentialing meetings and reported up to the QMPI Committee. System configuration for newly contracted providers follows a highly managed, standardized process, utilizing system tools to manage along the course of implementation. Contract configuration is scoped by our AZ Contract Implementation Analyst (CIA), with support from the applicable contractor responsible for the contract. Following system configuration, the work must be approved via User Acceptance Testing by the requesting CIA, ensuring accurate and timely load of provider data.

Provider Contracting Process Improvement in Action
Issue: As we build our integrated network, we have proactively sought to improve our contracting process, reduce unnecessary requirements, and ensure providers can begin offering care to members as quickly as possible

Process Improvement Strategy: Starting 2018, AZCH will use a combined Provider Participation Agreement that incorporates all lines of business. We reduced the turnaround time for responding to contracting requests by introducing a new team metric and performance goal of responding within two days. We leveraged our SharePoint site to identify and resolve contract load issues that resulted from miscommunication or lack of transparency. Documentation of the contracting status via SharePoint created visibility and accountability, leading to improved internal resolution and task completion.
Results: Our proactive efforts have already shown anecdotal evidence of improvement, and we are confident that our 2018 data will identify demonstrated results.

CREDENTIALING PROCESSES. The traditional process of credentialing can be frustrating to providers interested in joining a managed care network. Plans must balance the due diligence required to ensure providers are qualified with quick turnaround times that supports an expedient ability for providers to see members. AZCH has made proactive efforts to enhance automation, structure and process within the credentialing function to ensure quick turnaround times without sacrificing credentialing quality. We are also able to leverage our fully credentialed, statewide network, eliminating duplication of credentialing and allowing providers to start seeing members quicker.

Credentialing Team Structure. Our team is structured to ensure a subject matter expert for each type of credentialing, including separate SMEs responsible for: Triaging all credentialing inquiries and requests; Initial credentialing, provisional credentialing and existing "add TIN" affiliations; Organizational credentialing; Re-credentialing; Community Service Agencies; Delegated entities: Provider status notifications, weekly reports, and post credentialing committee updates.

Credentialing Authorization. Though all credentialing applications are formally approved through a monthly credentialing committee, consistent with the AMPM section 950, AZCH's Medical Director reviews and provisionally approves compliant credentialing files weekly, allowing providers to be credentialed and begin treating members.

Credentialing File Audits. AZCH proactively audits credentialing files for accuracy and timeliness to eliminate potential barriers to care caused by administrative errors. Quarterly, the credentialing manager reviews key provider information, such as NPI, TIN, specialty, primary source verification of license, and exclusion databases to ensure accurate information is loaded for each provider. If any information is missing or inaccurate, we outreach to the provider to verify and complete information and relay potential billing and credentialing concerns.

Weekly Interdepartmental Meetings. The credentialing team facilitates weekly meetings with interdependent departments to improve communication and address concerns quickly, such as: Contracts, Network Development and Provider Data Management. Issues discussed include, but are not limited to: credentialing inventory, pending contracts for practitioners that have been credentialed or in inventory, providers due for re-credentialing, providers pending termination and those that have been terminated.

Provider Credentialing Process Improvement in Action
Issue: In the most recent RBHA claims survey, we received feedback from providers identifying a barrier in the length of time to complete the credentialing process
Process Improvement Strategy: Using the PDSA improvement test of change cycle, we tested and implemented several improvements to the credentialing process including: 1) Implementation of an efficient, non-duplicative process to add providers already credentialed who work for multiple practice locations or groups; 2) Process to reduce sending duplicative files to the Credentials Verification Organization (CVO); 3) Maximizing the services provided by the Council for Affordable Quality Healthcare (CAQH); and 4) Revisions to credentialing forms to include only the minimum necessary information.
Results: Through this improvement initiative, the average number of days to complete the credentialing process decreased from **46 days** in CY16 to **32.25 days** in CY17; an **improvement of nearly 30%.**

ONGOING SATISFACTION AND EXPERIENCE

Through provider interviews and Provider Journey Mapping, we will focus on the provider experience at each point of plan-provider interaction to identify and address provider pain points, engaging providers and soliciting direct input into both the problem definition and problem solution, and evaluating impact through our QMPI program.

NARRATIVE SUBMISSION
RESPONSE #13

NARRATIVE SUBMISSION
RESPONSE #13

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

13. How will the Offeror effectively obtain and utilize member and provider feedback? Describe the Offeror's…

LISTENING TO OUR MEMBERS AND PROVIDERS

Arizona Complete Health-Complete Care Plan (AZCH) is committed to transforming the health of the communities we serve and being a trusted partner for members, providers and community stakeholders. We fully recognize when a transformational change like the Complete Care program occurs, it is imperative that we monitor and respond to provider and member feedback to foster success. We will continue to consistently engage ***all*** stakeholders by being transparent, offering multiple channels for communication with ***no wrong door***, closing the feedback loop, and regularly soliciting input on our operations and program design. From our experience in AZ, we know these efforts will enable more effective delivery of integrated care that addresses the whole health and social determinants of health (SDOH) needs of our members and improves their healthcare experience and quality of life. We use every member or provider interaction as an opportunity to solicit feedback and suggestions for improvement. AZCH utilizes distinct systematic processes to obtain feedback as well as personalized methods to address individual member or provider concerns. We proactively collect member and provider feedback over the phone, face to face at community events, through surveys, committees, provider forums, focus groups, and via email or other written communications. Moving forward, AZCH is developing strategies to use web-based engagement venues such as virtual provider summits, in addition to face-to-face meetings, to promote greater statewide engagement. Through our enterprise-wide inquiry, tracking, workflow, and data management platform, we route member and provider feedback to the appropriate functional team for a timely response and follow up within the AHCCCS regulatory timelines. We also utilize the information gathered to identify trends and opportunities to take action to improve the member and provider experience.

> **Committed to Transformation…**
>
> *"Change is hard in health care, but Cenpatico Integrated Care (CIC) has been willing to take the bold steps to transforming the system toward value-based outcomes. CMS appreciates CIC's collaborative approach and willingness to make adjustments based on provider feedback." – Nick Stavros, CEO, Community Medical Services*

USING FEEDBACK TO DRIVE IMPROVEMENT

AZCH has adopted Continuous Quality Improvement as a core business strategy focused on achieving the **Triple Aim**: simultaneously improving the health of our members (including all demographic groups and those with special needs), enhancing each member's experience of care, and lowering the per capita cost of their healthcare. We are also committed to the fourth component of the **Quadruple Aim:** improving the work life of our network providers and their staff, as well as their experience and satisfaction. Using proven Quality Improvement (QI) tools and methodologies, our QI team reviews the member and provider feedback data and conducts quantitative and root-cause analyses to develop corrective action plans and focused performance improvement projects to address areas needing remediation. We use the Plan-Do-Study-Act (PDSA) cycle to test changes, initially on a small scale, and modify them, as needed, before full implementation. AZCH reports all improvement actions through our Quality Management and Performance Improvement (QMPI) Committee.

EFFECTIVELY OBTAINING AND UTILIZING MEMBER AND PROVIDER FEEDBACK

ENTERPRISE-WIDE ENGAGEMENT STRATEGY

In October 2017, AZCH launched the **Communication, Access, Respect, and Education** Task Force (CARE Task Force) as an enterprise-wide solution to identify and improve critical elements of the member and provider experience. To monitor the effectiveness of our CARE strategy, we have developed a member/provider experience dashboard that includes key performance indicators (KPI) such as provider complaints and grievance rates and member technology engagement. The cross-functional CARE Task Force reports initiatives and data trends quarterly to QMPI Committee. As part of the monthly CARE Task Force, AZCH will leverage Centene's national experience in Journey Mapping and identify the AZCH member and provider journey in Q1 2018 to better understand our members' and providers' perspective and

healthcare experience. Our goal is to make our members' journey as pleasant, easy to navigate, and as affirming as possible—enhancing those interactions we do control and providing education and empathy for those we don't. We will map pathways that our members and provider typically engage with and then develop short and long-term interventions to sustain ease of access to services, improve overall health outcomes and meet the needs of all customers. AZCH will focus on the following critical elements that are inter-related and directly impact experience:

- Improved Quality of Life
- Provider and Plan Coordination
- Accessible Information
- Knowledgeable and Accessible Plan Personnel
- Retention of High-Quality Providers

We know that transportation is a primary service impacting member experience for all AHCCCS Plans and can result in quality of care concerns. Through our PDSA cycle we have initiated interventions, including changing transportation vendors, to address the issue. As a learning organization and consistent with a PDSA process, we continue to evaluate and enhance interventions to meet desired outcomes. Since we have not seen satisfactory improvements we are implementing a new intervention in 2018. We will gather more real-time member feedback through a brief screening related to transportation via customer service calls. Additionally, we will educate members that frequently access their transportation benefit about the use of this benefit and how to report issues. We will continue to address all service issues with our transportation provider until resolved. **Our goal is to reduce transportation related G&A by 10% in 2018 with these interventions.**

COMPLETE CARE TRANSITION AND IMPLEMENTATION FEEDBACK MECHANISMS

AZCH has benefited from the lessons in serving AZ Medicaid members since 2005, including the integrated needs of our ALTCS members since 2008, RBHA members since 2015 and GMHSA Dual members since 2016, and we are well prepared to successfully implement a fully integrated system of care for all our members and providers. We understand and are prepared to address the unique member and provider issues that may arise during this transition. AZCH will utilize member information gathered from the relinquishing contractors and the RBHAs to ensure no member slips through the cracks and every member receives needed services appropriately and timely. Additionally, we have designed and tested a member and provider feedback mechanism that we will utilize during the first 90 days of the transition and implementation of the Complete Care contract. Through our integrated cross-functional Rapid Response Team (RRT), led by our AZCH Complete Care CEO and Transition Coordinator and part of our Quality Management (QM) structure, we will triage and respond to the immediate needs of members and providers as identified. We will monitor the call center throughout the day, and will immediately refer urgent concerns to the RRT as appropriate. The RRT will track the issue to completion and follow-up with the member or provider to ensure the issue has been resolved and take further action if needed. In the fall of 2017, AZCH began facilitating pre-implementation state-wide provider and member focus groups. We will also conduct **provider implementation forums in every county awarded 60-days pre go-live through three months post implementation** to receive feedback and engage strategies to address their concerns. As an example, through a recent member focus group, we learned that many members fear receiving bad news or feel shame and embarrassment over their current health status which hinders them from accessing needed care. To address this barrier to care, we are implementing a *"Progress not Perfection"* education campaign and support members while on their journey to better health. The campaign will be delivered through focus groups, social media, and other traditional outreach efforts and is scheduled to begin Q3 CY18. We are also working closely with local community agencies to further understand and develop strategies to address SDOH such as homelessness, food and nutrition, economic stability and education within each community.

OBTAINING MEMBER EXPERIENCE THROUGH SURVEY RESULTS

AZCH participates in and conducts member satisfaction/experience surveys and utilizes both internal and the AHCCCS CAHPS survey to identify strategies that positively impact member experience. The results of a recent survey indicated an opportunity to improve our members' experience in the area of PH and BH Coordination of Care (COC). In response, we implemented a COC Performance Improvement Project (PIP) that is multi-departmental, physician-led and incorporates data analytics and technology to achieve improvement with the goal of increasing coordination of care specifically between BH and PH providers. KPIs include the reduction of potentially preventable events (PPE) and

improvement in member satisfaction. We also conduct monthly member surveys that measure the members' experience in areas such as, cleanliness of the agency, feeling supported and encouraged, and getting services and treatments that are helping the member improve their overall health. The results have consistently scored between 4-5 out of 5 demonstrating a positive member experience. ***As a Complete Care plan our goal is to achieve a 4-Star Rating on the child CAHPS member satisfaction survey in Year 1 and adult survey in Year 2.***

OBTAINING PROVIDER EXPERIENCE THROUGH SURVEY RESULTS

We participate in annual provider surveys administered by AHCCCS as well as AHCCCS approved, internally generated surveys. For example, we conduct an annual provider survey to gain additional feedback in areas such as claims, collaboration, accessibility of training, transparency and availability of technical assistance. In the most recent RBHA claims survey, we identified several areas where we have used feedback to improve our processes or programmatic approach; we have highlighted one such example. ***Issue:*** Negative feedback from providers regarding the length of time to complete the credentialing process. ***Improvement goal:*** Streamline and simplify the credentialing team processes to improve timeliness, accuracy, and provider experience. ***Improvement Process:*** By using the PDSA improvement test of change cycle, we tested and implemented several improvements to the credentialing process including:

- Implementation of an efficient process to move providers already credentialed but who work for multiple agencies ("Existing Add" process)
- Creating a process to reduce sending duplicative files to the Credentials Verification Organization and the National Practitioner Data Bank
- Maximizing the services provided by the Council for Affordable Quality Healthcare; and
- Revisions to credentialing forms to include only the minimum necessary information

Results: Through this improvement initiative, the average number of days to complete the credentialing process decreased from 46 days in CY 2016 to 32.25 days in CY 2017; an **improvement of nearly 30%.**

Feedback Through Provider Engagement. As part of our provider engagement model, we assign a dedicated Provider Engagement Specialist (PES) to each provider with access to a team of claims, operational and clinical representatives for questions and assistance on authorizations and claims submission, processes or payment. We meet with any provider upon request and host claim review meetings as needed. AZCH engages in regular provider and stakeholder meetings and forums throughout the year. We will continue our practice of holding quarterly provider forums where we discuss provider focused topics such as coordination of care, EPSDT, claims and prior authorization issues. The forums are utilized to connect providers to their assigned PES to address outstanding provider concerns and answer any questions. To ensure we pay providers timely and accurately, our Claims Educator addresses provider questions and proactively reviews claims trends to assist and educate contracted and non-contracted providers to help them be successful in claims submission. We also offer providers resources such as our provider manual, portal, website, fee schedules and face-to-face meetings as needed. Throughout implementation, AZCH will increase the frequency of provider meetings to monthly for our largest providers to identify issues, solicit feedback and support their transition.

COMMITTEE AND ADVOCACY COUNCIL PARTICIPATION

AZCH is committed to listening and utilizing the feedback offered by our members, their families, peers, and providers. AZCH will comply with the requirements outlined in the contract related to peer and family member participation on each of our formal committees including our Governance Committee. Additionally, we will continue the practice of facilitating a **Member Advocacy Council (MAC)** that will consist of adult members, including those receiving both BH and PH services, a parent/guardian of a child with special health care needs, a member from our Executive Management Team and representation from professional and advocacy groups as needed. Currently, we utilize a robust graduated council structure to ensure member and family voice is embedded at all levels of the system and are well prepared to modify our current system to meet the new contract requirements. Our Councils offer opportunities for members and families to provide input and feedback on policy and programs and address barriers before they become larger system issues. Each council level interconnects to the next to ensure that each council level receives feedback. Currently, our RBHA operates and manages advisory councils and forums such as Member Advisory and Family Advisory Councils, Foster/Kinship/Adoption Forums and a Member and Family Governance Board. AZCH is piloting Young Adult Councils to help understand and engage our young adult and transition age youth members around issues of health and wellness.

As a part of this process, the Young Adult Members are taking on co-leadership roles on the councils to help them develop leadership skills, learn effective communication skills and to help empower them to be more active in the management of their particular health conditions. The impact of the current **Member and Family Advisory Councils,** which we will continue as a Complete Care Plan, is demonstrated by two-way dialogue with our members that has been part of our strategy for more than 10 years. This Council has been instrumental in providing direct feedback to our QM program and our Marketing and Communications team. Through our **Member and Family Advisory Councils and our Foster Kinship/Adoptive Councils,** we have hosted meetings across the State to meet members and their advocates where they are. Over the last year, more than 1,400 members and their families participated in 228 Council meetings across all counties. These Councils have been a valuable method to gain meaningful insight and input from our members and their families. Through this member feedback, we have implemented several system changes, including changing our transportation provider, creating a text messaging pilot to provide reminders for council meetings, and improving the content of the public website**.** In response to member feedback expressed through our advisory councils, our Peer and Family Run organizations (PFRO) have all agreed to support the needs of our members by offering extended hours. Additionally, AZCH will engage with individual members at every opportunity to ensure we hear the voice of the member throughout the organization and by our network of providers. AZCH will advocate for the needs of our members through highly skilled and experienced Member Advocacy, Office of Individual and Family Affairs, Grievance and Appeals (G&A), Customer Service, Medical Management (MM) and other member-facing staff. The advocacy teams will focus on meeting the needs of our CRS, adult BH, child BH and veteran members and will work to identify concerns, remove barriers that affect service delivery and the member experience.

GRIEVANCES, APPEALS AND CLAIMS DISPUTES

The G&A staff log, track and trend all member grievances through our systems platform. Tracking categories include availability and accessibility of services and providers, assessment/service plan content, continuity of care, and mistreatment. When they identify a negative trend or any critical issues, they immediately identify root cause and implement appropriate temporary and permanent solutions. The AZCH Medical Director reviews all grievances weekly for potential quality of care concerns. The G&A team reports trended data to our QMPI Committee monthly where we identify opportunities for improvement and potential actions for improvement. We integrate approved activities and initiatives into our annual QI work plan. The G&A staff also track and trend provider claim dispute data and work with AZCH MM, Claims, and assigned PES to correct identified issues and provide technical assistance to providers.

AZCH Listens to Members and Families…

"This is the first time that I have really been able to feel like I am part of the system for change rather than being on the outside just accepting what is offered for my son."

IMPROVING THE MEMBER EXPERIENCE - EXAMPLE

IMPROVING MEMBER EXPERIENCE THROUGH VOICE AND CHOICE

We understand the importance of listening to our members' Voices collectively through examining data and trends. We use this feedback to improve the system of care and improve our members' experience. Below, we highlight an example of how we improved member experience through a collaborative approach with both members and providers. ***Issue*:** In August 2017, the G&A Department identified a 50% increase in member grievances related to referrals to specialty agency providers when compared to the previous 12-month average. Examination the grievances showed an emerging trend of members alleging that health home (HH) providers were not consistently honoring the members Choice concerning specialty services. ***Improvement goal*:** Eliminate grievances related to **Member Choice** of specialty provider by improving the referral process for members receiving care through a HH provider. ***Improvement process and interventions:*** Through our PDSA process, we tested and implemented several improvements to the specialty referral process including:

- Through our PES team, we implemented a provider engagement strategy to educate providers about the contractual requirements related to the specialty referral process.
- Developed and implemented to all staff and providers our "Member Voice/Member Choice" campaign which emphasizes our commitment to encouraging members to be active participants in their healthcare.

- With the support of the HH providers and our Individual and Family Affairs Department, we created and implemented an innovative member self-referral process.
- We revised our payment strategies effective October 1, 2017 to align with member feedback and incentivize Member Choice.

***Results**:* As a result of these interventions, over the past four months we have seen a steady downward trend in the number of grievances related to specialty referrals, including a 33% decrease in October 2017, and an 89% decrease in November 2017, when compared to the number received in August 2017. A quarterly comparison demonstrates that we received 45% fewer grievances in Q1 CY18 when compared to the previous quarter, and 33% fewer when compared to the prior three quarters.

IMPROVING THE PROVIDER EXPERIENCE - EXAMPLE

PROVIDER FEEDBACK DRIVING SOCIAL DETERMINANT INFORMED RISK STRATIFICATION

We understand the complexities in managing a population that has both PH and BH needs, and we consistently look for new opportunities to collaborate with our providers to improve our analytics and systems of care to support our providers and improve the care delivered to our members. Below we highlight a recent initiative undertaken in collaboration with our HH providers to enhance and improve the actionable data available to them to support the services, treatments, and programs they offer. ***Issue*:** Our risk stratification method offered providers a partial understanding of the unique needs of our members requiring integrated care. Historically we risk stratified members based on physical and behavioral health utilization and diagnosis components offering providers a partial understanding of the unique needs of this segment of our members. ***Improvement goal*:** Improve our risk stratification process and reports to include SDOH, giving the providers a complete picture of the member's needs. ***Improvement process and interventions:*** Based on the provider feedback and using established QI methods, we tested and implemented several interventions to improve our risk stratification process. In collaboration with our providers, we identified and prioritized social determinants of health conditions such as homelessness, employment and involvement in the justice system to include in our risk stratification process. A significant component of this initiative was to equip providers with actionable information and data, pulled from demographics, our predictive modeling platform and blind spot data provided by AHCCCS. In February 2016, AZCH implemented the **Social Determinant Informed Risk Stratification** pilot for our members receiving care through our HH providers. We send a monthly risk stratification report to each HH providers via their secure FTP site. The report includes updated risk scores for all their assigned members on a rolling 6-month basis. AZCH generates our risk reports through our comprehensive Population Health Management solution which includes a combination of proprietary algorithms, risk stratification, and advanced predictive analytics. ***Results:*** Utilizing social determinants to risk stratify our membership has allowed our providers to **prioritize housing** and **competitive employment** for members at higher risk. Between October 2016 and September 2017, we achieved **a 20% decrease** in the number of homeless members and a **5% decrease** in the rate of homelessness. The rate of members **competitively employed** has increased over **19%** in the past 24 months and, as of October 2017, **25.2%** of all adult members (SMI, GMH, SUD combined) are competitively employed, exceeding the statewide average of 24%. Additionally, between October 2016 and September 2017, **Emergency Department utilization has decreased by 6.3%** for all our HH providers.

AZCH Partners with Providers…

"The self-referral process is helpful in assisting members receive quality services within their window of opportunity. Members receive services same day or within 24 hours. This has been helpful so that we don't lose members to their addiction, the streets, or mental destabilization." – AZCH Peer & Family Run Organization

NARRATIVE SUBMISSION
RESPONSE #14

NARRATIVE SUBMISSION
RESPONSE #14

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

14. AHCCCS began its integration efforts almost 10 years ago, and through this RFP is making major advances to …

PRINCIPLES UNDERLYING VALUE-BASED INTEGRATION STRATEGIES

The lynchpin of the implementation of integrated service delivery is value-based payment (VBP), supporting AHCCCS' guiding principles of *improved health outcomes and cost containment and/or reduction of health care costs without compromising quality*. We aspire to be the health plan of choice for members and providers and to be the premier health plan in developing VBP strategies that align incentives with goals for integration and continuous quality improvement. **Our goal is to have 80% of Arizona Complete Health-Complete Care Plan (AZCH) spend made to high value, integrated providers under VBP by 2020.** Our approach for increasing VBP is rooted in the person-centered guidelines set by the Health Care Payment Learning and Action Network (LAN) to create an approach that gradually increases in size and scope to best meet the current capabilities and financial viability for all provider types. **Our goal is to move providers currently below a LAN Level 3 (associated with 10% of AZCH spend), up at least one LAN level each of the first three years of the Complete Care program.**

Broadly, our VBP program works to *move providers along the VBP continuum* by:

- Building alignment between AZCH and provider utilizing financial incentives to produce the optimal balance of quality performance and health care cost.
- Optimizing member's access to providers that provide value to the member in clinical outcomes and member experience, ensuring that members are informed in their choices of high value providers.
- Engaging and supporting providers to promote practice transformation and integration, through financial and technological resources that forge partnerships to support them through this transformative phase.

Our parent company, Centene Corporation (Centene), is the national leader in developing, deploying and supporting Medicaid-centric VBP programs. Leveraging this knowledge and experience, we have demonstrated innovation and leadership in VBP strategies in Arizona through the experience gained in all three of our AHCCCS programs.

CRITICAL ELEMENTS OF SUCCESS. As a learning organization, AZCH has identified many of the critical elements of success through the lessons learned from our VBP efforts. AZCH has demonstrated our ability to provide providers with the resources to support these elements of successful practice transformation: *Flexibility.* Through flexible payment models and timing, providers need accommodations for their varying levels of financial stability, data system sophistication, and current placement on the VBP continuum; *Accurate and Timely Data.* To ensure accurate data at just the right time, AZCH has provided VBP dashboards and sophisticated risk stratification data based on utilization (including blind spot) and Social Determinants of Health (SDOH) that can be integrated into Electronic Health Records (EHR); *Communication.* As an example of the need to deliver transparent and collaborative communication with providers regarding future VBP strategies, AZCH hosted a two-day physical health (PH) and behavioral health (BH) provider CEO retreat to prepare the network for whole person care. 66 providers attended and discussed integrated service delivery, outcome measurements and VBP models; *Practice Transformation Support.* We partner with providers to assist them in making practice changes that move them towards integrated care, sharing best practices amongst providers as well as Lean Six-Sigma methodologies**.**

TRANSFORMATION SUPPORT THROUGH READINESS ASSESSMENT. AZCH partners with providers by employing our *Clinical Population Health Transformation Assessment* to evaluate their practice readiness to develop a pathway to integration and transformation that guides the specific VBP strategy. The Assessment considers **practice goals** (leadership, culture and aligned values, integration status); **infrastructure** (financial resources, data analytics, population health capabilities, health information exchange (HIE) participation, billing capabilities, outcome tracking); **member engagement** (appointment availability, member engagement process, screening tools, self-management practices); **clinical model** (care team integration, evidence-based practices, integrated care planning, transitions of care, high-risk case management, pharmacy management); Quality Improvement (**QI) infrastructure** (benchmarks, outcomes, initiatives, performance improvement); and **unique services** (population service needs and practice capabilities).

SPECIFIC AND DETAILED VALUE BASED INTEGRATION STRATEGIES. Three guiding principles support our specific VB strategies. We match providers to strategies that are consistent with their readiness and orientation. We employ a wide variety of strategies to broaden our range of VBP providers (particularly primary care providers (PCP)). We want to deepen our relationships with providers who have a demonstrated record of high value and a readiness for advanced LAN levels. These principles guide the following VB strategies. Some of the strategies are specific to an incentive approach tied to a given provider type. Other strategies describe methods for increasing provider success and movement along the VBP continuum.

- **Strategies for PCPs.** With PCPs it is critical to be inclusive and engage them in some type of VBP arrangement. By 10/1/18 we will make available a **"no PCP left behind" Pay for Performance (P4P) program for all PCPs**. This would be directed to PCPs, including rural providers, who are not ready for a higher level VBP or may not have a critical mass of members. The structure will be P4P with incentives based on quality measures that promote integrated care, e.g. use of screening tools for depression. For rural providers, we will create **easy entry VBP** by engaging them through our Provider Engagement Specialists.
- Our parent company, Centene, has a long history of working collaboratively with FQHCs in multiple states. Centene has developed a **customized FQHC VBP Model** based on a combination of the FQHC PPS reimbursement structure with a gain/risk share for other services (e.g., hospital and pharmacy costs) and tied to quality performance. We also know many AZ FQHCs are at more advanced levels of readiness for risk. By 10/1/19 we will implement this program in AZ through our long-standing relationship with the Arizona Alliance for Community Health Centers.
- Providers play a pivotal role in almost every initiative that we have described in this document. Specifically, PCPs often hold the relationship with our member to promote engagement in member-facing initiatives. We will **incent PCPs for the engagement of their members in specific initiatives** related to BH care (integration) or DM (chronic conditions), maternal and child health or other programs as part of the models described above.
- The screening for BH conditions (e.g., depression, Autism Spectrum Disorder (ASD)) is under-utilized in primary care; we will **incent the consistent use of validated screening tools promoting integration**.
- In our ALTCS program, we established successful VBP arrangements with integrated home based primary care with shared risk/reward and quality bonuses. Even though the Complex Care (CC) population is different from ALTCS, we believe that home based primary care can be effective for selected members and will **promote the implementation of integrated home based primary care through VBP** with incentives for quality and member engagement by 10/1/19.

Strategies for Specialty Care

- Centene has developed a specialized VBP program for OB/GYN providers, rewarding for quality care (NOP, clinical practice guideline/evidence based practice adherence, postpartum care, C-section rate) as well as promoting integrated care (referral for postpartum depression and substance use/opioid treatment). By 10/1/18 we will implement this **specialized VBP program for OB/GYN providers** in our awarded regions.
- There are selected medical specialties which see a high number of members who have co-morbid BH conditions. We will create **VBP incentives promoting integrated care for selected specialties, starting with endocrinology, GI and cardiology** by 10/1/19. We will implement by engaging a group of these specialty physicians to collaborate on the most appropriate type of VBP structure and integrated measures.
- In our ALTCS program, we employed VBP with SNFists to promote quality post-acute care and impact readmissions. Leveraging our ALTCS experience, we will **engage a select group of SNFists to incent them to reduce care gaps and impact inappropriate utilization** by 10/1/19.
- One of the challenges with small providers is their limited member base with any one plan. We will employ another successful strategy from our ALTCS program by **creating shared savings pools for small (typically specialty) providers** by 10/1/19. Incentives are pooled across multiple providers with like or overlapping services. This allows providers to participate in VBP who may be limited by size and create opportunity for cooperation among related providers.

Strategies for Behavioral Health Providers

- For BH providers, we must first understand existing VBP contracts with the RBHA. Our strategy will be to **leverage existing VBP for BH providers contracted with RBHAs** when appropriate (including ourselves in the South Region) to facilitate the transition to the CC program and build on the provider's success in those VBP arrangements.

- As with the PCPs, we want to be inclusive with BH providers – particularly given the changes associated with the CC program. By 10/1/19 we will make available a **"no BH provider left behind" P4P program for all BH providers**. This would be directed to BH providers who may not be under a RBHA VBP or may not have the critical mass to leverage that VBP with our membership. The structure would be P4P with incentives based on quality measures.
- We will **utilize VBP to promote BH provider transition from block payment** to FFS or other payment structures. This will be discussed later in this response.
- There are opportunities for some BH providers/programs to provide appropriate select medical services (e.g., BHRF providing wound care or PIC lines) providing more integrated care. By 10/1/19, we will identify these opportunities and **incent BH providers to provide specific medical services with quality outcomes.**
- From our RBHA experience, we believe that there are opportunities to increase alignment through creative VBP models. One strategy will be to move to **global monthly payments to BH providers specializing in identified high-risk populations** (e.g., peer support case rates for members with Substance Use Disorder (SUD)) by 10/1/19.
- The medical co-morbidities with SUD are well documented in medical literature. To promote care integration, we will **incent SUD providers for appropriate coordination with medical providers and services** by 10/1/19.

Strategies for Integrated Care Providers

- VBP is a powerful tool to promote the development of truly integrated care providers and Integrated Health Homes (IHH) are a core component of the AZCH delivery system strategy. By 10/1/19, we will **utilize VBP to promote the creation of additional IHHs** by establishing incentives that eliminate the distinction of PH vs BH costs/utilization. One direct strategy for accomplish this is to **use per member capitation or a global budget to create funding based on total cost of care (PH and BH)**.
- The CC program will produce opportunities for providers to create new and unique integrated programs. Our strategy will be to develop **customized VBP models for unique providers/programs** (e.g., clinic with multidisciplinary approach for ASD children) within the 2nd year of the contract so that the payment methodology incents atypical activities and positive outcomes.
- The effective provision of integrated care involves some sophistication in provider structure and processes. Centene has developed a **VBP program to incent integrated providers to achieve the elements of PCMH certification** which we will implement by 10/1/19. The actual certification is ideal but it may be prohibitive in expense for many providers so the Centene model provides incentives for adherence to the elements without the formal accreditation.

Strategies for either PH or BH providers

- By 10/1/19, we will **incent evidence of coordination between PH and BH** for either type of provider. This will likely be included in P4P with providers with less readiness for a more sophisticated VBP.
- We want to encourage innovation in service development particularly as integrated alternatives to high cost care. In the second year of the contract, we will incent the **development of new alternative services through prospective payments**. This payment methodology encourages the effort of program development with the funding tied to the ability to demonstrate cost savings/avoidance and quality performance.

Strategies for Facilities or Programs

- As with PCPs and BH providers, we want to maximize the percentage of facilities and programs that participate in VBP. For selected facilities, we will **incent facilities for external quality recognition** (e.g., Medicare STAR level for SNFs) by 10/1/19 to be replaced over time with more sophisticated VBP models.
- Centers of Excellence (COE) are a key element of the AZCH delivery system strategy. There are significant opportunities to upgrade the quality of member care and experience through expansion of COEs in PH and BH domains. For our members, we will **expand the breadth of COEs through VBP structures** that bundle service payment and incent integration activities and integrated quality outcomes. COE development provides opportunities for better service delivery for rural members. Our "hub and spoke" model enables the rural member to both utilize services at the COE location (hub) and virtually through telehealth (spoke). By 10/1/19, we will **incent telehealth and remote consultation** through the implementation of this hub and spoke model with COEs through VBP reimbursement. AZCH's current COEs include: *CODAC (adult HH); Easter Seals Blake (kids HH); Casa de los Ninos (kids HH); Valley Oximetry (Sleep); Cardiovascular Consultants (CHF); Children's Clinics Tucson (ASD). We are continuing to partner with providers to develop COE's for: Congestive Heart Failure (2018); Peer and Family Run Orgs (2018); Pain Management (2019); OB/GYNs that treat substance use (2019); Opioid Treatment (2019).*

- For medically complex members, the issue of step down to lower levels of care can create barriers to access and be complicated by misaligned incentives (e.g., discharging facility losing all payment). We will address this by **creating incentives for post-acute programs to facilitate appropriate step down** to alternatives by 10/1/19.
- We will **implement case rates and bundled payments with quality incentives for selected services in both PH and BH** (e.g., orthopedic surgery, opioid treatment) in the second year of the contract.
- To promote collaboration in care coordination, we **will incent specific elements in facility discharge planning to promote care integration** (e.g., BH follow up on medical admission) for select facilities by 10/1/19.

General Strategies

- To increase member access, by 10/1/19 we will **incent providers to increase access through the development of evening and/or weekend hours**.
- By 10/1/19, we will **incent positive practice patterns (e.g., appropriate referrals for imaging) through "Gold carding"** - a Centene non-financial incentive eliminating some PA requirements based on provider history.
- To achieve optimal system alignment, we will **align member incentives with provider VBP incentives**.
- To reduce provider burden, we will maximize our **common measure set with providers across AZ products**.
- We will maintain an ongoing **pipeline of those providers that are well positioned to succeed in more advanced VBP programs** through their success and increased readiness.

Global Strategies

- In this changing environment, providers are demanding consistency and commonality among health plans and AHCCCS incentive payments. AHCCCS has fostered a learning environment to facilitate sharing of best practices. To take this to the next level, we believe that **CC Plans and RBHAs should engage in a formal process with AHCCCS to create a 3-5 year plan on VBP, and we would take a leadership role in that process.** This would include AHCCCS direct incentives, a set of common measures among plans and continued ability for plans to innovate/customize VBP for their providers.

In AZCH's VBP continuum, providers are stratified into three categories based on our *Clinical Population Health Transformation Assessment*: Foundational Level, Intermediate Level, and Advanced Level. VBP strategies and goals are matched to the providers' level of integration, readiness and desire to move along the continuum.

FOUNDATIONAL LEVEL; LAN: LEVELS 1 AND 2	
Fee for Service (FFS) + Pay for Performance (P4P)	
VBP Strategy	**"No PCP left behind" P4P program for participation by all PCPs**
VBP in Action	Contract with **Kids Kare Pediatrics** – VBP for 1,059 pediatric members focused on child wellness and immunization measures.
Outcomes	Reduced $93 total cost of care per member from 2015 to 2016 while exceeding wellness visit goal by 7.5%.
FFS + Per Member Per Month (PMPM) for case management + P4P	
VBP Strategy	**Incent PCPs for the engagement of their members in specific initiatives**
VBP in Action	Pilot agreement with **Circle the City,** a non-profit dedicated to homeless healthcare in Maricopa County– 1,168 members proposed, with an incentive model based on a comparison of member costs and quality pre/post Case Management Program.
FFS + Case rates for Specific Populations + P4P	
VBP Strategy	**Implement case rates and bundled payments with quality incentives for selected services**
VBP in Action	Agreement with **HOPE Inc**., a peer run organization, to pilot a case rate model to improve outcomes for members with dual criminal system involvement and a SUD. The P4P incentive will apply if outcomes achieved, such as consistent engagement with IHH/PCP for PH, reduction of crisis, Emergency Department (ED) and inpatient utilization, no jail recidivism during six months of care in the program, and abstinence from substance use.
INTERMEDIATE LEVEL; LAN: LEVEL 3	
PMPM for Specific Scope Services + Shared Risk/Savings	
VBP Strategy	**Utilize VBP to promote BH provider transition from block payment**

VBP in Action	Moved 12 IHHs (42,819 members) off block payments to a PMPM with a shared risk/shared savings arrangement. The shared risk component resulted in greater IHH engagement in coordination across providers, providing appropriate utilization and less fragmentation of services across multiple providers.
Outcomes	6-month cost savings demonstrated over a $1.7 million (SMI) and $1.0 million (GMHSA) savings in total cost of care for members assigned to the 12 IHHs. The GMHSA inpatient BH readmissions decreased 6% and SMI adults ED visits decreased by 1.3% during this same time period for their assigned members.
ADVANCED LEVEL; LAN: LEVEL 4	
Sub-Capitation for Specific Conditions or Populations	
VBP Strategy	**Global monthly payments to providers specializing in identified high-risk populations**
VBP in Action	Engaged **El Rio FQHC** to fully manage a subset of our population with HIV. Our arrangement will allow El Rio to have autonomy to treat the members HIV condition, as well as their primary care, BH, and medication-assisted treatment for opioid abuse. Quality metrics and performance guarantees will be agreed upon to ensure proper access to care and coordination across the system of care.

OUR EXPERIENCE AND APPROACH TRANSITIONING PROVIDERS FROM BLOCK PAYMENT SYSTEM

Through our experience as a RBHA, we have unique expertise to effectively transition providers from the block payment system. The block payment system has created financial dependencies and misalignment of incentives, AZCH has made substantial strides in Southern AZ to transform the payment methodology with providers, seeking to align incentives with improved outcomes. ***AZCH has proactively moved 69% of all block providers representing 85% of the RBHA active membership off of block payment. Specifically, 36 BH specialty providers moved from block payment to FFS and 12 IHHs moved from block payment to a PMPM with shared savings/risk model tied to quality.***

PAYMENT STRATEGIES TO TRANSITION DELIVERY SYSTEM. We recognize that the role of one of several CC plans in addition to the RBHA has a different dynamic than our role as a single RBHA, but we believe that the models we introduced in the South can serve as options for providers to move from block payments in other GSAs. We will introduce our **model built for traditional BH providers who can operate as an IHH - a PMPM, shared savings/risk model tied to quality.** This model provides the cash flow to transition BH providers off block payment while incentivizing IHHs to focus on care coordination for members to impact ED and inpatient utilization. Based on our approach with specialty providers in southern AZ, we would **transition another set of block payment providers to FFS with a P4P component.** Large BH providers often offer other programs (e.g., opioid treatment) that may be a fit for **case rates with quality incentives for selected services.** For these large providers, the block payments may be replaced by a combination of these payment approaches. From our experience, equally important to the payment model is the approach with which it is introduced and implemented. The Success Elements referenced earlier apply to the successful movement off block payments. *Flexibility*. Giving providers a choice of payment model and flexibility on timing to optimize transformation. In the South, we provided financial bridge strategies to all IHHs on the model and full transition support to members to ensure their needs were met and service was not interrupted. We will leverage our flexibility to shape payment models to address those differences and bridge providers from one payment type to another with the right timing. *Accurate and Timely Data.* Equipping providers with data to drive decisions and chart the best course for transformation. We will employ our customized monthly VBP dashboard to provide actionable data during the transition. *Communication.* During the South transition, we met with providers over nine months to obtain their input, and held over 20 provider forums to foster collaboration between IHH's and specialty providers. We deployed a targeted member communications campaign encouraging member voice and choice. We will replicate this communication in each GSA ensuring providers have input into the process, including VBP model and timing.

Outcomes- The first six months under the new VBP model yielded over $1.7 million (SMI) and $1 million (GMHSA) savings in total cost of care for members assigned to the 12 IHHs on the new VBP model with increases in Diabetes HbA1C testing (12%) and follow up after BH hospitalization (4%) year over year. Stakeholders report providers are more engaged in their members' outcomes while quality and cost outcomes of members assigned to these IHHs are higher than for those members not assigned.

NARRATIVE SUBMISSION
RESPONSE #15

NARRATIVE SUBMISSION
RESPONSE #15

arizona complete health

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

15. Explain the Offeror's approach to monitoring and controlling health care cost trends. Describe a situation in…

APPROACH TO MONITORING HEALTH CARE COST TRENDS

Arizona Complete Health-Complete Care Plan (AZCH) brings state of the art tools, technology, data systems and Medicaid specific interventions designed to bend the cost curve and maintain quality through our parent company Centene Corporation (Centene)—the largest Medicaid MCO program in the country. We combine robust technology, our local knowledge and resources with a national perspective to bring AHCCCS a deliberate, data driven approach to monitoring and controlling costs. Through our established processes based on local AZ and national experience, clinical and administrative initiatives, and dedicated staff and infrastructure, ***our goal is to decrease medical expense per member per month (PMPM) by 5% in Year 2 and 10% in Year 3 over Year 1 baseline.***

ESTABLISHED PROCESSES TO MONITOR AND CONTROL COSTS. AZCH brings powerful data analytics and tools that allow us to quickly identify trends and interventions that have proven successful in Medicaid environments. AZCH reviews data analytics, dashboards, and financial performance results during our local AZCH cross functional month end review meeting. This reporting identifies cost trends, over utilization, and cost drivers, allowing us to review the success of our clinical program initiatives, including identifying additional clinical initiatives. These Month End Review meetings include functional leaders from finance, quality, medical management (MM), provider network, and pharmacy, at a minimum. The owner of this process is the AZCH Medicaid President, who is the driver of these efforts and accountable for our success, as measured internally and by AHCCCS.

Integrated Data System. Centelligence® is our proprietary, comprehensive family of integrated decision support and health informatics solutions, feeding our Population Health Management (PHM) Solution and other technology solutions designed to meet the Quadruple Aim of reduced costs, improved health outcomes, and positive member and provider experience. Centene's innovative Centelligence platform supports the management of 7.1 million Medicaid member lives nationwide. Centelligence includes an extensive array of executive dashboards updated daily enabling leadership to review specific, real-time information, refreshed daily, allowing for timely identification of leading risk indicators and monitoring of key performance metrics. Our analytical dashboards include comparisons of actual results to established goals, which are derived from contractual requirements, NCQA standards and other relevant sources. All metrics are calculated and stored for historical analysis and trending. Corrective action plans are established for metrics not meeting goals and are closely monitored to ensure remediation. Users can interact with the dashboards through extensive custom selection, drill-down, and export capabilities, to identify factors behind clinical and cost performance and view detailed information at the member, provider, diagnosis, or other customizable level. The result is a streamlined structure with real-time translation of data to actionable information made readily available to leadership to ensure actual results are aligned with objectives. To further improve the timeliness and effectiveness of our interventions, we have recently launched a new PHM Solution. Most PHM models have a lag time and require more than six months of data over time. Our PHM Solution combines time-sensitive, short term/real time data with member history to identify needs and stratify our population in real time, pushing daily insights and care gaps to the attention of our Integrated Care Managers (ICM) for action. For example, identifying pregnant women prescribed opiates, members due for preventive screenings, and care transitions to ensure appropriate follow up after discharge.

National Framework. Centene understands that funding for Medicaid services is limited and we have a fiduciary responsibility to manage these finite resources wisely. Leveraging the data and analysis available through Centelligence, Centene has created a national forum for encouraging, inspiring, and sharing national best practices, performance improvement projects, and other successful interventions. This allows AZCH to learn from the experience of Medicaid plans across the country, benchmark against and compare our experience in AZ, spot national trends, and be proactive and predictive in our initiatives and cost drivers. All Centene plans are required to submit clinical and cost saving programs and initiatives annually for review and possible adoption as a national best practice. Information is shared across states through monthly plan and quality calls, and quarterly in-person Clinical Program Updates including the VP of MM from each plan, as well as regular CEO and CMO calls. Centene has also created a searchable, enterprise wide library of initiatives, ***Outcomes Improvement Central***, available on our Intranet site, with over 450 pilots and programs. Centene currently has seven enterprise initiatives that have demonstrated national best practices and savings, as

highlighted in the table below. AZCH is following these programs to reduce cost and drive positive outcomes for our members in Arizona.

Program	Description	National Demonstrated Savings	AZCH Expected Annual Savings
Opi-End	Opioid Use Disorder prevention through policy, provider, and member initiatives, including the use of the Pharmacy Home program.	$7-9M annualized savings if 5% of opioid use disorder prevented	$1.2M
Start Smart for your Baby	Award winning pregnancy management program supporting educational and social needs.	$10-20M Annualized	$500K
Re-Admission Reduction	Centene-wide post discharge outreach program aimed at decreasing preventable PH and BH readmissions. Identifies members at first admission and assigns a readmission risk score to drive engagement strategies.	$10M Annualized	$2M
Emergency Department (ED) Diversion	Preventable ED Overuse program uses data to identify priority interventions for appropriate segments of ED users.	$14M annualized savings if 1% decrease	$3M
Diabetes	Uncontrolled diabetes, as measured via HbA1c tests, drives significant additional spending PMPM in the pharmacy, emergency room, and most of all the inpatient cost categories.	10% decrease in poorly controlled diabetes = $6.3M annually	$1.0M
Sickle Cell	Comprehensive program which focuses on improving hydroxyurea utilization and decreasing ED and IP use for pain crises and other SS complications.	Over $2M Annualized	Small population
FluVention	Centene-wide initiative to improve flu vaccination rates.	Over $10M Annualized	Rolled into IP and ED savings

Local Application. In addition to following best practices, AZCH maximizes tools and technology available to us through Centene by augmenting with comprehensive and real time data sources available locally. For example, incorporating external data sets such as AHCCCS Blind Spot data, DEF files (transition data), Health Current/HIE, Jail feeds, and social determinants of health (SDOH) data, including the Homeless Management Information System (HMIS) and Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), for SDOH, member assessment results. Enhancing our data analytics with these additional sources gives us insight into the whole person allowing us to more accurately identify root causes and tailor interventions to our local situation. For example, through our enhanced data we were able to identify that some of our members with highest service utilization were members experiencing homelessness. Below we describe how we responded to this cost driver.

CLINICAL AND ADMINISTRATIVE INITIATIVES. Leveraging the process described, we have developed and implemented initiatives that demonstrate our ability to effectively identify and impact negative cost trends. Health care costs can be assessed based on total cost, cost per unit, and cost avoidance. Described below are programs and initiatives that address each of these cost factors, including local outcomes and results.

Reducing Total Health Care Cost. We successfully impact health care costs through clinical initiatives targeting high cost populations. Our process starts with member risk identification through risk stratification and trend reporting. Based on this information we design and implement clinical interventions that reduce cost, for example, improving access to the most appropriate level of service (e.g. community versus facility-based; PCP/health home versus ED), improve member self-management and health literacy, and more effectively engaging members into care.

Risk Stratification. Risk stratification allows AZCH and our providers to implement tailored interventions before members become high risk and high utilizers. In late 2015, AZCH took a proactive approach to population risk stratification to focus on the whole person, including SDOH and Blindspot data, to identify opportunities for cost and quality improvement. Based on all available data, our integrated risk stratification identifies members requiring interventions and matches them with appropriate integrated care and coordination bringing value to the members and our system. For example, we identified a cohort of low need, high cost members with asthma, and through targeted interventions designed to address inappropriate, ineffective, and unnecessary services***, costs were brought down by 18% over six months***. Members identified as high need and high cost are engaged in care management. In April 2017, we identified 17 members with four or more inpatient stays, engaged them in intensive care management, and by October 2017 ***costs were reduced by over $47 PMPM***, resulting from a drop in unnecessary Emergency Department (ED) visits and inpatient stays. By driving our Integrated Care Management and Care Coordination (ICMCC) strategy, value-based purchasing (VBP) contracts, quality improvement, and cost savings efforts based on risk stratification, we are aligning the plan and

our provider network towards the same goal of meeting members' integrated physical health (PH), behavioral health (BH) and SDOH needs while reducing waste.

Utilization and Quality Trend Reports. As a function of our Quality Management Performance Improvement (QMPI) program, we employ several mechanisms to detect under and overutilization. Centelligence compiles data to produce reports on PH, BH, and pharmacy utilization. Example metrics include length of stay (LOS) data, inpatient days, ED visits, admissions/discharges, readmissions, PCP visits, pharmaceutical and poly-pharmacy use, referral to ancillary providers, preventive screening rates, and super-utilizers. AZCH reviews a variety of utilization data "snapshots" at aggregate and detail levels including by member, provider, specialty, type of service, diagnosis, place of service, as well as cross-sectional data points such as identifying members on antipsychotics with no therapy visits and other potential triggers. The data is reviewed against industry benchmarks, affiliate plan performance and AZ-specific standards to put outliers into context. For example, after seeing a provider's high rate of unnecessary transportation usage, MM referred the issue to contracting who revised contract incentives to prevent inappropriate use. On a quarterly basis, the MM Committee and QMPI Committee review data to isolate both troubling trends that require action and successes that should be replicated. For example, upon seeing a spike in readmissions among members leaving the hospital against medical advice, the committee implemented a targeted intervention that included referrals to case management, BH services, and other community resources as appropriate. As a result, AZCH saw an overall ***decrease in readmission rate for those leaving against medical advice by 3%*** with a corresponding increase in mental health utilization, demonstrating members were using preventive services. Findings from QMPI are reported up through the cross functional Month End Review process to be included as part of our overall cost control effort and process.

Managing High Cost Populations. Based on our risk stratification and utilization trends, we have identified sub-populations who utilize high cost services and worked with providers to tailor interventions to their needs.

Opioid Use Disorder. Based on national best practices, AZCH has implemented Centene's Opi-End program, involving a Pharmacy Home, care management interventions and chronic pain management alternatives using evidence-based practices such as Medication Assisted Treatment (MAT), education and network optimization geared towards high volume prescribers. For members appropriate for pharmacy home, the pharmacy team works closely with our ICMs to identify a pharmacy home for eligible members identified as obtaining controlled substances from multiple doctors and pharmacies. ICMs outreach to the member to explain the goals of the program and provide education on using controlled substances safely. Our medical directors reach out to high prescribing providers to offer them information and assistance on alternative treatment options. A pre-and post-enrollment analysis of utilization shows that members in the pharmacy home program experienced an average savings of just ***over $123 PMPM or $1,482 for 2017***. Through our chronic pain disease management program we have ***reduced the number of high risk benzodiazepine utilizers by 72% and the number of high risk Opioid utilizers by 54%*** over a six month period. ***Additionally, through the expansion of the pharmacy home program AZCH estimates an additional savings of $1 million dollars in CY18.***

Maternal and Child Health. From our experience, when pregnant members receive early interventions, they are more likely to see better birth outcomes and avoid the NICU. AZCH has implemented Centene's Start Smart for Your Baby® program (Start Smart), drawing best practices from our affiliate plans, to help identify and address potential high risk pregnancies. In 2016, our Texas affiliate ***saved over $15.7 million or about $500 per case implementing Start Smart***.

Members Experiencing Homelessness. In reviewing our current integrated membership we found that four of the top 16 members with the highest service utilization had a reduction in ED visits after being connected to housing. Our estimates show that a reduction in homelessness reduces healthcare costs by at least $9,000/member engaged. We use the HMIS to locally coordinate and prioritize housing for members based on risk. By the end of May 2017, the number of our members who are ***homeless decreased by over 24% and the rate of homelessness decreased by over 8%***. For our 65 members who entered housing between April and September of 2016, there was a ***57% decrease in ED visits and 5.5% decrease in inpatient stays***. ***AZCH will seek to sustain that reduction and further reduce overall homelessness for AZCH members by 5% annually through our intensive care coordination and community collaboration.***

ED and Inpatient Diversion. Based on a monthly identification of the top ED utilizers (two or more ED visits in 90 days), AZCH has developed a best practice ED and inpatient diversion program. The goal is to maximize the number of members engaged in care management, review barriers to success with a weekly meeting of our internal Integrated Care Team, and educate providers on strategies to reduce ED and inpatient utilization. For example, we worked with CODAC Health, Recovery and Wellness to implement intensive case reviews for members with four or more ED visits in the last six months. ***ED utilization among the sample decreased 31%*** since the intervention and the change has been

maintained for seven consecutive months. Cost ***savings is estimated to be over $200,000***. Due to these results, the intervention has been made a regular, ongoing practice and shared across the network. Leveraging our PHM Solution, if a hard to engage member presents in the ED, a designated ICM is immediately notified and can deploy a Community Health Worker (CHW) to engage the member while still in the ED, connecting with needed resources to prevent an admission or future ED visits. We schedule members for earliest available PH and BH appointments through ***MyHealthDirect*** to directly schedule appointments with providers prior to ED discharge. Through proactive engagement, we have ***reduced ED utilization by 6% in our integrated membership.***

Addressing High Pharmacy Utilization and Cost. We initiated interventions to optimize pharmacy utilization through targeted clinical reviews and strategies such as formulary refinement and counter-detailing to change problematic prescribing patterns. For example, during our monthly review of financial and utilization reports, thirteen drugs were trending significantly higher yet had lower cost alternatives available. Prior Authorization criteria was re-reviewed and updated to ensure cost effective alternatives were used first when clinically appropriate. Upon updating the criteria, the plan has experienced ***$127,267 in savings*** since August 2017. We implemented a polypharmacy pilot, using pharmacists to review medication profiles of our members prescribed 8 or more medications. The program generated an average reduction of 2.57 drugs per member enrolled as well as dose and therapy reductions resulting in ***PMPM savings averaging $100 while reducing risk for unnecessary medications***. We have initiated a Medication Therapy Management program that uses a proprietary algorithm using number of medications and disease states, and high numbers of providers per member to capture care coordination opportunities. All medications over $2000, even if they meet AZCH criteria for approval, are reviewed by a Pharmacist for trends. In addition, these meds are reviewed monthly at Pharmacy Rounds with the CMO to ensure the medications are appropriate and equally-effective alternatives have been considered. AZCH has estimated ***over a $1 million dollar savings*** related to MTM efforts in FY18.

Leveraging Telehealth to Drive Improved Access and Lower Costs. Telehealth not only supports member access but can help reduce costs associated with transportation and appropriate utilization of care. In a recent review of our telehealth services for the 12-month period from 8/1/2016 to 7/31/2017, the average monthly costs for members ***decreased from $1,309 PMPM to $996 PMPM, a 24% decrease***. ED visits for the population utilizing telehealth services ***decreased from 1,869 to 1,134, a 47.1% decrease***, and inpatient ***days decreased by 12%.***

Reducing Cost Per Unit. ***The most direct way to reduce unit cost is through our contracting efforts.*** To maximize the use of Medicaid dollars, AZCH is expanding VBP and prioritizing relationships with efficient, high value providers. AZCH incorporates all AZ business lines to identify where we can optimize contracts with high performing providers. For example, AZCH ***saved $443,000 in 2017*** by renegotiating contracts with our transportation provider across our lines of business. We recently implemented Rowdmap, a software program built on a multi-payor database to rank providers in terms of efficiency, highlighting the higher value providers in our network beyond our own data. Contracting, MM, and finance staff review this data to find opportunities to optimize our network to higher value providers so members have the best high value choices, while ensuring access to care. For example, we have terminated the contract with a health system promoting free-standing ERs, which drive up cost without improving quality, and have added partnerships with providers like Banner Health who have developed accountable care neighborhoods. As part of our overall VBP initiative, we are piloting new payment models, such as case rates for opioid treatment (Q1 2019) and for peer and family support (Q3 2018), to free up provider resources for individualized treatment, including enhanced incentives for meeting quality goals**.** In 2018, we will pilot Pay for Performance incentives with OB/GYN providers to reduce the number of high risk pregnancies and babies born with Neonatal Abstinence Syndrome (NAS) and to promote proper care after delivery*. **Our goal is to have 80% of AZCH spend made to high value, integrated providers under VBP by 2020.***

Between July 2016 and 2017 AZCH recorded over $1.2 million in pre-payment savings based on discovery of up-coding, overutilization and other forms of FWA

Reducing Cost Through Cost Avoidance. AZCH reduces overall cost and improves operational efficiencies through cost avoidance, eliminating duplication and waste in the health care system and appropriately coordinating benefits.

Operational Efficiency. Throughout our system, we have implemented the Lean Six Sigma Method to drive out waste internally and optimize plan efficiency. AZCH currently has 1 black belt, 8 green belts, and 12 green/yellow belts in progress. There are 12 ongoing Lean Six Sigma projects at AZCH with an expectation to save ***over $3 million in avoidable costs***. Our Quality of Care Investigations Process Improvement project has already demonstrated a return on investment

of up to ***$1.1 million in savings***. AZCH commits to offering Lean Six Sigma training twice per year to approximately 50 staff.

Fraud, Waste, and Abuse Monitoring. Inappropriate billing is another source of unnecessary health care cost. Based on affiliate health plan experience and emerging fraud trends, our parent company Centene's Special Investigative Unit, in collaboration with AZCH's Compliance Officer, develops a plan for reviewing provider claims, updated annually. We utilize a two-pillar approach, similar to that used by CMS, which takes advantage of both prospective and retrospective fraud detection methods. We use specialized algorithms designed by industry experts to detect FWA in high-risk specialties such as providers with cycle/auto billing activities, providers offering DME, home health, BH, and transportation services. Between July 2016 and 2017, AZCH recorded ***over $1.2 million in pre-payment savings*** based on discovery of up-coding, overutilization and other forms of FWA.

Coordination of Benefits. We make every effort to identify the liability of third parties to pay for services rendered to members to ensure Medicaid is the payer of last resort. Year-to-date 2017, AZCH on its Medicaid side saved over $11 million by processing charges as the secondary payer versus primary, over $1.6 million in costs avoided from denial of claims with probable TPL, and recovered over $137,000 from claims that were paid primary for members who had other commercial insurance.

AZCH IN ACTION: CASE STUDY

IDENTIFICATION OF UNFAVORABLE TREND. In 2016, our RBHA finance and MM teams identified a trend of an 11% increase in BH readmissions each quarter in the prior 12 months. Upon further analysis, members with high readmissions were attributed to many of our largest providers on block payments. As we analyzed the services being provided within the block payment, we identified that case management had increased by 35% over the same timeframe. Ideally, more case management should have resulted in lower, not higher, readmissions. Further analysis showed that a high proportion of case management was being encountered for members with lower acuities who were easier to engage but less at risk. This analysis reinforced that block payment did not align service delivery with member need or improved member outcomes.

STRATEGIES AND ACTIONS TAKEN TO CONTROL EXPENDITURES. Based on this trend identification and root cause analysis, we moved 12 Integrated Health Homes (IHH) in 2017 from block payments to a PMPM VBP model with shared savings/shared risk tied to readmissions and other measures. This VBP model better aligned service delivery with member acuity, driving efficient and targeted care coordination by incentivizing providers for meeting quality outcomes. We designed a model that moved providers along the Health Care Payment Learning and Action Network (HCP-LAN) continuum aligning the payment methodology with member need. Before implementing the change, AZCH held multiple provider meetings to explain and refine the new payment model with a commitment to transparency and flexibility in the process. In April 2017, 12 IHHs moved to the PMPM, shared savings/risk payment model. The IHHs percentage of savings was based off performance on quality metrics in addition to cost/utilization measures. The shift proved challenging, but we learned to increase flexibility to accommodate providers with varying levels of financial stability and data system sophistication. We offered providers a robust dashboard for tracking with monthly risk stratification reports so that they could closely track member need and cost. We worked with providers on partnering and/or engaging in MOUs to create a more aligned network.

OUTCOMES. This shift to VBP represents a dramatic culture change for BH providers both financially and operationally that requires our continued support and flexibility. Participating providers, members and system partners report providers are much more engaged in their member's outcomes and utilization than ever before. Overall, quality and cost outcomes of members assigned to these IHHs are higher than for those members not assigned. In the first 6 months of the new VBP model, the RBHA demonstrated over ***a $1.7 million (SMI) and $1.0 million (GMHSA) savings in total cost of care*** for members assigned to the 12 providers on this model. The ***GMHSA inpatient BH readmissions have decreased 6% and the adults with SMI ED visits decreased by 1.3%*** during this same time period for their assigned members. Furthermore, ***Diabetes A1C testing and Follow up after BH hospitalization has increased 12% and 4%*** year over year respectively. This Case Study illustrates how systematic trend analysis can generate creative solutions to positively impact medical costs as well as member satisfaction and quality outcomes.

NARRATIVE SUBMISSION
RESPONSE #16.A

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

16. GSA Specific Submission Requirement

A. If bidding North GSA: Describe the unique aspects of service delivery to members in the North GSA. What…

Arizona Complete Health-Complete Care Plan (AZCH) is committed to providing a coordinated and integrated service delivery system that addresses members' physical health (PH) and behavioral health (BH) care needs, while working to address geographic and cultural diversity and social determinants of health (SDOH) that impact members' needs and engagement in service delivery. AZCH understands the unique challenges to service delivery in the North GSA and has built service coordination processes, service supports, and community relationships to ensure effective delivery of services. Additionally, through our experience as a RBHA, we understand the importance of coordination with HCIC, the RBHA in this GSA, to bringing forth transformative integration for members. There are many factors that make each community in the GSA unique; the aspects of service delivery we focus on for this response are cultures and populations, geography and access patterns, and network solutions for service delivery. We understand that health care is local, and to deliver the best care we must fully understand the unique strengths and challenges of each community. We bring an in-depth knowledge of the goals of AHCCCS and have developed an understanding of the unique needs in the North through investing time learning from stakeholders, providers, families, County officials, community members and tribal representatives in the region and will continue to increase our knowledge and relationships. We have established contracted relationships with providers in this GSA through our other lines of business including five years serving as an Acute Care Plan in Yavapai County.

UNIQUE ASPECTS IMPACTING SERVICE DELIVERY IN THE NORTH GSA

UNIQUE CULTURE AND POPULATION. The unique cultures in the GSA, specifically the high percentage of Native Americans (75.4% of Apache County population and 27.5% of Coconino County population), requires that we understand and have programs to support culturally responsive service delivery. Ten tribal nations each with their own unique language, customs and community characteristics are located in the region. The Navajo Nation has the largest land area (almost 25% of AZ), is the most rural, and hosts the largest tribal population. Our Tribal Coordinator has worked with tribes in Arizona since 2015, and is a member of the Navajo Nation. Navajo members frequently travel to Gallup, NM to access health care. The Hopi Tribe is located in the center of the Navajo Nation with most members traveling to Flagstaff or Holbrook for services. The Havasupai Tribe is the most inaccessible as it is located at the bottom of the Grand Canyon and presents some of the greatest challenges for emergency and crisis care. The Kaibab-Paiute Tribe is the northernmost community, separated by the Grand Canyon. There is also a strong Latino population in three of the five counties, with Mohave, Yavapai and Coconino all having greater than 10% Latino populations. Spanish is the second most commonly spoken language. We make available programs, materials and providers that are linguistically and culturally appropriate; working to incorporate evidence based practices that address cultural differences. In this GSA, we will recruit and train CHWs/Promotoras that mirror the culture and linguistic preferences of the communities served.

SERVICE COORDINATION WITH TRIBAL COMMUNITIES. AZCH has worked closely with Indian Health Services (IHS) facilities, Tribal Health Facilities and Urban Indian Clinics (I/T/U). We approach our partnerships with I/T/Us by developing a trusting relationship that combines a sense of understanding unique needs and a willingness to adapt to tribal goals. To effectively work with Tribal Nations in this GSA, we will build on our successful tribal health coordination program as we expand our relationships in the North. We recognize that tribes like the Navajo have territories in multiple states. We have established relationships with tribal leadership and providers in New Mexico and Colorado. We have added Tribal Transition Coordinators to assist tribal members to navigate of the various health and community systems and to support the transition of Tribal members during the Complete Care implementation. Our **Tribal Warm Line** is a culturally-responsive telephonic peer support program, staffed by Tribal Support Partners (TSP) who live and work in tribal communities. The TSPs are peer support certified and trained in motivational interviewing. TSPs receive inbound calls for support and request for resources. They also conduct outbound calls for follow-up and care coordination.

COLLABORATING WITH TRBHAS IN THE NORTH GSA: We developed coordination of care points of contacts to ensure appropriate coordination of care for TRBHA members that switch their enrollment. We are working with the White Mountain Apache Tribe to develop their own peer support curriculum. We provided the Tribe with all our online curricula to meet AHCCCS training requirements. We have worked with the Navajo and White Mountain Apache TRBHAs as members of the planning committee for the AZ American Indian Behavioral Health and Integrated Care Forum.

SERVING THE LATINO POPULATION. In addition to the Native American population, there is a strong Latino population in three of the four counties, with Mohave, Yavapai and Coconino all having greater than 10% Latino populations with Spanish being the second most commonly spoken language. In order to meet the needs of this population it is critical to have available programs, materials and providers that are linguistically and culturally appropriate; this includes offering evidence based practices, such as the Promotoras model, that consider cultural differences. Through our ***Promotoras/Community Health Workers (CHW)*** model for community outreach and understanding of "high-touch" approaches to community engagement we are well positioned to support the GSA in a culturally responsive manner. In the GSA, the rural and frontier nature of many of the counties will require recruiting and training Promotoras/CHWs to be able to expand these services. We will partner locally to develop trainings or provide tuition reimbursement to expand this resource. Promotoras/CHWs come from the communities they serve and facilitate coordination for hard to find members. We work to identify Promotoras/CHWs that mirror the culture and linguistic preferences of the communities served. This model has proven effective in engaging Latino and Native American communities in the rural areas where they have been employed.

CARE FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER (SUD). This GSA has been particularly impacted by the Opioid epidemic, with Mohave County being the highest hotspot per capita in the State. We will capitalize on our successes in the Southern rural counties: expanded the availability of MAT services, increasing Suboxone certified prescribers, and introducing MAT services into behavioral health residential facilities. Additionally, we have experience in Prescott with the high number of SUD treatment providers, particularly the presence of numerous sober-living homes. We partnered with the state and the local community to ensure that these providers are offering high-quality, cost effective care which operated within state and local guidelines. Recent reports indicate that due to our investigative efforts into fraud, waste and abuse in this system, the number of sober-living homes in Prescott has dropped from 200 to 33.

CHALLENGES TO ACCESS TO CARE. This GSA is vast with the majority of the GSA being sparsely populated and designated as rural and frontier. The communities have told us that accessing care is challenging due to limited transportation and long distances between remote areas and the nearest physicians and facilities. For example Mohave County is a federally designated Medically Underserved Area (MUA) and is identified as a Health Professional Shortage Area (HPSA); the eastern part of Coconino (excluding the city of Page) is also a Dental Health Professional Shortage Area, and the entire County is a Mental Health Professional Shortage Area. Specialty providers are often scarce leading many to go to Phoenix to get services. Current analysis indicates the following specialists are scarce in Apache: Rheumatology, Cardiothoracic Surgery; Coconino: Endocrinology, Infectious Disease, Rheumatology, SNF; Mohave: Endocrinology, Oncology; and Navajo: Pulmonology. While these many provider shortages result in service delivery challenges, it also creates opportunity for creatively developing unique virtual health homes and collaborations.

To address geographic service delivery challenges, members can take advantage of a highly developed telemedicine program, and solutions like our Project ECHO program (a telemedicine training program) that would further strengthen the capabilities of PCPs to offer more screening and treatment. Unique access patterns have developed, with members residing in border communities, (as defined in ACOM Policy 436) such as Colorado City, often choosing to access care in neighboring states due to proximity. AZCH through our contracts and those of our parent company Centene has contracted providers in surrounding counties in California, Nevada and New Mexico.

STRATEGIES TO ENSURE EFFECTIVE DELIVERY OF SERVICES

To ensure effective delivery for members include (1) Developing Provider and Community Stakeholder Partnership; (2) Continuing Development of Access to Service; (3) Leveraging Centers of Excellence (COE) and Value Based Purchasing (VBP) (4) Monitoring Outcomes to Ensure Effectiveness.

DEVELOPING PROVIDER AND COMMUNITY STAKEHOLDER PARTNERSHIPS. In order to address scarcity of services, unique challenges and ensure effective service delivery, the Complete Care plan must develop strong relationships with

providers and community stakeholders. While AZCH currently does not have Medicaid membership in this GSA, we have been actively meeting with provider, Tribal Nations and community stakeholder such as law enforcement, probation, and County governments to understand their needs and build relationships. If awarded this GSA, we would escalate these meetings to our current levels in our present service areas.

CONTINUING DEVELOPMENT OF ACCESS TO SERVICES. AZCH recognizes providers in this GSA have built a strong **telehealth** system of care. Strong provider and community partnership allow AZCH to address access to services impacting unique populations. We are committed to partnering with existing telehealth providers, Health Choice Integrated Care (RBHA) and other Complete Care plans to maximize this service. We will support members in accessing ***specialty telehealth visits*** at health home sites such as FQHCs and RHCs, and we will provide home telehealth visits and SafeLink phones for high risk members. We are actively identifying local sites that can support access to targeted specialties in all counties, while much of this is already available for BH, these services can be expanded to cover other specialties like dermatology and even teledentistry. We are currently contracted with North Country HealthCare which provides telemedicine visits at 14 locations. We support telepsychiatry at integrated health homes (IHH) and outpatient BH providers, and many of our current BH provider partners in the GSA offer telepsychiatry or have expressed an interest in expanding. We will add to the telehealth capabilities in the GSA with ***Virtual Provider Visits through TelaDoc*** for members to access PH/BH/specialist services 24/7 at home for conditions including: depression, addiction, domestic abuse, dermatology, and general health symptoms. Through TelaDoc, members can speak directly to a provider using web, phone or mobile application.

While **transportation** is a concern in all GSAs, we have learned with the great distances it can be a barrier to service delivery. AZCH has created a Network Provider Coordinator role to monitor transportation services on a daily basis. They will monitor supply and trip volume on a daily basis, and coordinate with transportation vendors to adjust vehicle capacity as needed.

Crisis Aftercare Services are a critical BH service has limited availability in this GSA, as it is difficult to maintain the service in sparsely populated areas. We would partner with HCIC, local law enforcement and first responders to develop unique solutions to enhance access to Crisis Aftercare Services. In rural South GSA communities we have effectively worked with first responders to develop protocols for working with individuals with a BH crisis when Crisis Aftercare services are not available. This type of solution can prevent unnecessary ED utilization and avoidable incarceration, working instead for solutions that support community stabilization options.

LEVERAGING CENTERS OF EXCELLENCE AND VALUE BASED PURCHASING. AZCH currently has six COEs - Congestive Heart Failure, Sleep Apnea, Integrated Health Homes and Autism. Within the next two year, we will also identify COEs in Pain Management, SUD, and OB care. As part of being a COE, the provider will provide hub and spoke services to non-urban communities in which members can receive services at the primary location (hub) or receive services through telemedicine or provider consultations (spoke). COEs will also provide training to rural providers either through on-site collaborations or Project ECHO, a telemedicine training solution. Each provider within a community will have a different ability to participate in VBP. A unique aspect of Southern AZ BH providers is that 69% of them have moved off block payment to either a FFS or shared risk model through our RBHA. AZCH will continue to collaborate with providers to enter into a VBP arrangement to continue to address integrated care and barriers to care in this GSA.

MONITORING OUTCOMES TO ENSURE EFFECTIVENESS. We monitor outcomes through our Medical Management Committee, a subcommittee that reports up to our Quality Management Performance Improvement Committee. Through this process, we continually identify new trends unique to a population or county in this GSA. As that occurs, we use our plan-do-study-act process to identify interventions leading to outcome improvement.

NARRATIVE SUBMISSION
RESPONSE #16.B

NARRATIVE SUBMISSION
RESPONSE #16.B

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

16. *GSA Specific Submission Requirement.*
B. If bidding South GSA:…

UNIQUE ASPECTS OF SERVICE DELIVERY IN THE SOUTH GSA

Certain facts about the South can be known by anyone: AHCCCS membership in this GSA represents approximately 25% of the total membership included in this bid; the GSA counties vary from rural, frontier and border communities, to reservations, and the second most populated city in AZ. But we bring first-hand knowledge of these seven counties with diverse geographies, cultures, care patterns and needs; knowledge built on serving the Southern AZ communities today through our RBHA program, as well as serving this region through the ALTCS program for over 10 years. Through our 13 years of experience in Southern AZ, data obtained through our real-time Population Health Management solution, and our relationships with members, providers, community agencies, law enforcement, county governments and other stakeholders we have developed a direct, personal understanding of the uniqueness of service delivery in the South. Our local, field-based staff, member and provider forums and community engagement create dynamic and responsive mechanisms for continual learning. Our innovative PHM Solution and "hot spot" data analysis enables us to have a greater understanding and provide data informed solutions for service delivery needs in our communities. We will describe the many unique aspects of service delivery by focusing on how the unique needs of our members, their culture and cohorts require a tailored approach to service delivery followed by our strategies to ensure accessible and culturally responsive services in the South.

UNIQUE CULTURE AND POPULATIONS. The cultural diversity in this GSA, the border to Mexico, presence of six Tribal Nations, military bases and other sub-populations require culturally responsive services, staff and care coordination. We work with providers and Tribal communities across the GSA to increase provider awareness and cultural competency, in order to tailor services for these groups. In the South, the key member sub-populations are Latino, American Indian, Veterans, Migrant/Rural, certain chronic disease states and members with Substance Use Disorder (SUD).

SERVING THE LATINO POPULATION AND BORDER COMMUNITIES. One barrier to care for the Latino community is the stigma of mental illness and BH treatment. To reduce this stigma we created the "Mente Sana Cuerpo Sano Project" (MSCS) using Certified Community Health Workers/Promotoras to outreach individuals eligible for services and thus increase engagement. Promotoras use a high touch, culturally responsive approach to educate, advocate and assist members to access integrated health services and provide follow-up and support to keep them connected to care and support PH and BH outcomes.

SERVICE COORDINATION WITH TRIBAL NATIONS. Our experience in the South has taught us that each Tribal Nation is unique and that no one strategy will work with all Nations. We learned to build relationships, listen and adapt to their needs. The Tohono O'odham Nation has the largest land base (22k square miles/size of Connecticut) and is the most rural and largest Southern tribal population. The Colorado River Indian Tribe is in the town of Parker, and members often access providers and system partner services (AZDES and RSA) in Lake Havasu City. We work closely with each Tribal Nation in this GSA to ensure services are tailored to each community and building on our existing infrastructure in the south. Examples are:

- Tribal Warm Line: Telephonic peer support service where calls are answered by Tribal Support Partners (TSPs), who live and work in their tribal communities.
- Tribal Peer Support: We have worked with several tribes to help them develop their own Tribal Peer support curriculum and training programs.
- Community Re-entry Program: We are currently working with the Tohono O'odham Nation to implement a community re-entry program in their tribal detention centers.
- Trauma Focused Cognitive Behavior Therapy (TF-CBT): To increase access to trauma informed care in and near Tribal communities, we are contracting with Dr. Dolores Bigfoot (Oklahoma University) to implement the "Honoring Children, Mending the Circle" curriculum, a modified version of TF-CBT tailored for working with Tribal members.
- Crisis Aftercare Services: We provide crisis aftercare services on all reservations within our current service area, including onsite on the Tohono O'odham Nation in Sells, AZ.

COLLABORATING WITH TRBHAS IN THE SOUTH GSA: AZCH has a strong history collaborating with TRBHAs to support coordination of care. We have shared 1079 online courses with the Pascua Yaqui Tribe (PYT) TRBHA with a total of over 8600 courses completed by the TRBHA through the collaboration. We have developed points of contacts to ensure appropriate coordination of care for members that switch their enrollment. We participate in the PYT quarterly coordination meeting, share information on our services and partner in community wellness events. We have assisted the PYT staff with the development of their own Peer Support Curriculum, including training their first class and providing ongoing technical assistance – a program that has received national recognition.

SERVICE COORDINATION FOR VETERANS. This GSA has a strong Veteran population with Yuma Marine Corps Air Station and an influx of retired military during our winter months. Several counties in the GSA are home to military bases: Fort Huachuca, Davis-Monthan AFB, Yuma Proving Ground Army Base and the Marine Corps Air Station. We currently employ veteran representatives and a dedicated ***Veteran Outreach Specialist*** who collaborates with our IHHs, specialty providers and community resources specializing in Veteran populations. We will employ a ***Veteran's Member Advocate***. Our Integrated Care Management and Care Coordination (ICMCC) team includes specially training Integrated Care Managers (ICM) to serve veterans. Our team has developed a Veterans Care Plan template to facilitate specialized care management and coordination for the integrated care needs of our veteran and military members with access to additional resources. We have developed a Veteran's Pod with the Pinal County Detention center and have community providers working with Veterans who are detained. We are collaborating with Ft. Huachuca, working with first responders and base contacts to develop processes for **crisis aftercare teams** to enter the base.

CARE FOR MIGRANT/RURAL INDIVIDUALS. Migrant and rural members have particular challenges in addressing SDOH, which exacerbate PH and BH conditions. We work with Portable Practical Education Preparation, Inc (PPEP), which has tailored programming for migrant workers and rural populations that includes education, health, housing, counseling, employment, job training, and humanitarian services. Supports for children and families that are available in Tucson may be scarce or non-existent in rural Southern AZ communities. AZCH has invested in projects that support resilient communities and increasing family and community protective factors including: supporting fundraisers for Boys & Girls Club in Santa Cruz; funding a community skate park in Willcox, bike track in Douglas, and park infrastructures in Clifton; supporting a summer recreation program in Willcox (multi-year); sponsoring youth leadership programs at Graham County Substance Abuse Conference; supporting community kitchen for Sonoita and for the Graham County Safe House.

CARE FOR INDIVIDUALS WITH CHRONIC DISEASE. Our AZCH data supported by ADHS findings have identified a higher prevalence of some disease states in certain Southern AZ counties. We have developed multi-tiered disease management (DM) programs, built networks and identified community resources for these chronic conditions. Examples of this are: Cardiovascular Disease. It is the leading cause of Arizonan deaths, with a hot spot in Cochise County. In addition to our DM program, we connect providers and members to a CDC-funded Chronic Disease Self-Management Program (CDSMP) through the county health department designed to help serve members in this community. Asthma. Children in Cochise and Graham counties have a higher prevalence of asthma. Both the Chiricahua FQHC in Cochise and Canyonlands in Graham have DM programs with which we augment our DM efforts.

CARE FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER (SUD). Based on the extent of SUD that we have seen in Southern AZ, AZCH has increased ***Medication Assisted Treatment*** (MAT) availability to members and has successfully increased member participation in these services through education and community outreach. AZCH has increased MAT capacity by sixteen percent (16%). AZCH has established MAT services in rural areas, such as Santa Cruz, Cochise, and Graham counties through co-locations to provide Buprenorphine through telemedicine. AZCH contracts with approximately 70 Office Based Opioid Treatment (OBOT) including MDs, DOs, PAs and NPs. Our OBOTs include fifty providers in Pima County, fourteen providers in Yuma County, and two providers in Graham County. AZCH has collaborated with Community Medical Services to expand MAT Medication services for our rural areas including Graham, Santa Cruz, Cochise and La Paz counties.

STRATEGIES TO ENSURE EFFECTIVE DELIVERY OF SERVICES

Our Southern AZ strategies to ensure effective delivery for members include (1) Developing Provider and Community Stakeholder Partnerships; (2) Continuing Development of Access to Service; (3) Leveraging Centers of Excellence (COE) and Value Based Purchasing (VBP) (4) Monitoring Outcomes to Ensure Effectiveness

DEVELOPING PROVIDER AND COMMUNITY STAKEHOLDER PARTNERSHIPS. In order to address scarcity of services, unique challenges and ensure effective service delivery, the Complete Care plan must develop strong relationships with providers and community stakeholders, as AZCH has demonstrated in the South. Each county in this GSA has its own unique challenges and each County Administration and/or community has developed their own unique approaches to addressing these challenges. This often results in unique processes related to COEs/COT, justice services, detention procedures, court processes and programs, first responder protocols, ED processes and provider interactions. AZCH regularly meets with each County/community to adapt to the needs of that community. We also have monthly provider meetings and calls to address concerns specific to that community.

CONTINUING DEVELOPMENT OF ACCESS TO SERVICES. Strong provider and community partnership allow AZCH to proactively address access to services impacting unique populations. AZCH has been able to develop 17 IHHs supporting 90 clinics in this GSA. We provided many examples earlier about how we have addressed specific disease prevalence including SUD, populations like Latino and AI, and geography disparities between urban and rural. Some other specific examples would be expansion of Peer and Family Run Organizations services from three to eight communities in the past two years, Jail Liaisons in Pima, Cochise and Yuma to facilitate coordination of care; protocols with system partners to clearly identify roles and responsibilities; and expanded crisis aftercare services tailored to the unique challenges of each County. AZCH has also supported **Telemedicine sites in this GSA.** With an urban center and smaller communities in the GSA, telemedicine is important for members needing ***specialty and BH services***. We are currently contracted with Canyonlands FQHC which provides telemedicine services at several locations in Southeastern AZ allowing members to have face-to-face encounters remotely through high-tech cameras, digital stethoscopes, and other clinical tools. We **facilitated a partnership between SEABHS and Canyonlands FQHC to provide integrated care**, creating opportunities to co-locate in small communities, sharing EHRs and maximizing access to care by making best use of limited resources.

LEVERAGING CENTERS OF EXCELLENCE AND VALUE BASED PURCHASING. AZCH currently has six COEs - Congestive Heart Failure, Sleep Apnea, Integrated Health Homes and Autism. Within the next two year, we will also identify COEs in Pain Management, SUD, and OB care. As part of being a COE, the provider will provide hub and spoke services to non-urban communities in which members can receive services at the primary location (hub) or receive services through telemedicine or provider consultations (spoke). COEs will also provide training to rural providers either through on-site collaborations or Project ECHO, a telemedicine training solution. Each provider within a community will have a different ability to participate in VBP. A unique aspect of Southern AZ BH providers is that 69% of them have moved off block payment to either a FFS or shared risk model through our RBHA. AZCH will continue to collaborate with providers to enter into a VBP arrangement to continue to address integrated care and barriers to care in this GSA.

MONITORING OUTCOMES TO ENSURE EFFECTIVENESS. We continuously monitor outcomes through our Medical Management Committee, a subcommittee that reports up to our Quality Management Performance Improvement Committee. Through this process, we continually identify new trends unique to a population or county in this GSA. As that occurs, we use our PDSA process to identify interventions leading to outcome improvement.

NARRATIVE SUBMISSION RESPONSE #17

NARRATIVE SUBMISSION RESPONSE #17

arizona complete health

AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

NARRATIVE SUBMISSION RESPONSE

17. Describe, in detail, the steps the Offeror will take to engage and collaborate with tribes for the delivery of services.

Arizona Complete Health-Complete Care Plan (AZCH) is honored to have over 12 years of experience building positive working relationships with Tribal Nations and serving American Indian (AI) members in Arizona. Since our inception, we have been grateful for the opportunity to develop ground-breaking programs for AI members often going beyond contractual requirements. We have, and will continue to adopt, a collaborative and culturally-respectful approach in developing effective and trusting relationships, working with each Tribal Nation individually to provide responsive and culturally-appropriate services. We respect and honor tribal sovereignty and self-governance and we are humbled to be invited as a system partner with Tribal Nations. All Tribal Nations in Southern Arizona have executed formal Letters of Agreement with AZCH, which allows our providers to deliver services on reservation land to support AI members who live on/off the reservation. We will continue to nurture our relationships with Tribal Nations in our current service areas and in newly awarded Geographic Service Areas (GSA), using our experience to build upon existing strengths and co-develop new solutions/programs to meet and exceed identified needs, and address health disparities identified by each tribe. ***Our goal is to partner with Tribal Nations to achieve improvement in mutually agreed upon health outcomes for our shared membership tailored to the unique priorities of each tribe.***

ENGAGING AND COLLABORATING WITH TRIBES FOR THE DELIVERY OF SERVICES TO AMERICAN INDIANS

Our steps to engage and collaborate with Tribal Nations for the delivery of services to AI members include: 1) Maintaining a culturally-competent Tribal Programs Team to meet AI member needs and provide culturally-competent advocacy; 2) Engaging tribal communities and tracking program development activities; and 3) Matching service delivery to mutual goals and provide culturally-appropriate treatment.

1) CULTURALLY COMPETENT TRIBAL PROGRAMS TEAM. AZCH's service delivery to AI members is led by our ***Tribal Programs Supervisor*** and supported by our Tribal Programs Team who with our Tribal Programs Supervisor, carry out tribal engagement activities. All Tribal Programs staff have over 17 years of combined tribal program experience and are members of a federally-recognized tribe, or have experience working with AI members. This team serves as a prime advocate for AI members, linking them to the State/Federal health care system, actively identifying existing and evolving needs, and striving to meet those needs. To achieve this, our Tribal Programs Team participates in internal monthly ***Tribal Services Cross-Departmental Workgroup*** meetings, which provides an opportunity for our Tribal Programs Supervisor to update AZCH leadership on the progress of developing and implementing programs and services for AI members. We employ a Tribal Program Supervisor, Tribal Programs Specialist, Tribal Transition Coordinator, Tribal Technologist, and a specialized AHCCCS American Indian Health Program (AIHP) Transition Coordinator, all dedicated to improving service delivery for AI members on and off tribal land as shown in Table 1.

Table 1. Tribal Programs Team Structure
Tribal Programs Supervisor. Functions as the primary liaison with Tribal Nations, Tribal Leaders, and TRBHA leadership. This role is responsible for addressing issues related to tribal structure/organization and acts as the single point of contact regarding delivery of health services concerning AI members and oversees our team.
Tribal Programs Specialist. Acts as a secondary liaison with Tribal Nations, and with our Tribal Programs Supervisor, supports tribal program development/system improvement, engaging Tribal leaders and TRBHAs.
Tribal Transition Coordinator (TC). This position coordinates care and member transitions as outlined in AMPM Policy 520 and ACOM Policy 401, 402 and 403. The position works with other health plans, tribal/non-tribal treatment providers/stakeholders to facilitate effective transitions.
Tribal Technologist. Works with tribal system partners on coordination of data management across the multiple service sources, Tribal Nations, and AI members who access the service delivery system. Provides technical support including data management/utilization training, developing telemedicine capabilities, electronic health records (EHR) and Health Current- Health Information Exchange (Health Current). Our Tribal Technologist also facilitates training sessions to educate tribal program staff on how to access and analyze population health data. Presently, no other acute plan has a role who is dedicated to assisting Tribal Nations with technology adoption and data use to improve coordination of care.
AIHP Transition Coordinator. Works with AIHP, tribal system partners, tribal health care providers and tribal members to assist members transitioning between AZCH and AIHP, paying particular attention to tribal members transitioning their BH services from the RBHA to AIHP on 10/01/2018.

2) ENGAGING TRIBAL COMMUNITIES AND TRACKING PROGRAM DEVELOPMENT. Our steps to engage Tribal communities include: **Participating** in ongoing tribal community outreach to nurture our relationships with Tribal

Nations, **Tailoring** existing and newly developed programs based on specific tribal community needs, and **Listening** to Tribal Nations about their service goals and working with them to support those goals. Our Tribal Programs Supervisor and Tribal Programs Specialist meets with Tribal Nations and providers serving AI members monthly or as requested by Tribal Nation leaders to develop and track mutual goals and partner related to advocacy through the following venues:

Tribal Collaboration Meetings. Our Tribal Programs Team participates in monthly meetings with tribal leadership, tribal 638 facilities, IHS providers, and other system partners to discuss service-related issues. Monthly meetings allow us to have open dialogue with Tribal stakeholders to refine how we work together, solve for barriers, share AZCH updates/other information, and receive information directly from Tribal Nations about their experiences, needs, and preferences. For instance, in Q1 2019, we will begin offering three versions of the ***Navigating American Indian Health Care with AHCCCS*** packet. Each packet will be tailored to engage, educate and bring awareness about Contract changes and how the changes differ from current services and options related to receiving or providing BH/PH services for members, providers, and Tribal Nations. Our Tribal Programs Team will introduce and offer packets during Tribal Collaboration Meetings to ensure we have an opportunity to answer questions. We will continue to partner with Tribal Nations to ensure an understanding of service delivery options for AI members and will support each tribal community.

Committed to Collaboration …

Since 2015, AZCH has awarded approximately $60,000 in Community Reinvestment funds to the Tohono O'odham and San Carlos Apache tribes. Community Reinvestment dollars have helped purchase:

- *Playground equipment*
- *Conference room technology*
- *Kitchen equipment*

Tribal Community Wellness and Awareness Conference. Our annual conference brings together tribal community members from around the state to increase awareness of PH, BH, substance use disorders, and wellness topics such as cultural preservation and cultural identity issues. This event has hosted over 200 tribal staff, youth, parents, and elders from across Arizona each year since 2011. We have participated in the planning and facilitation of the Bi-Annual Arizona AI BH Forum since 2012. We will continue to work collaboratively with other Contractors to facilitate similar events for with IHS, Tribes, Tribal Organizations and Urban Indian Organizations (I/T/U).

Work Plans. We complete a tribe-specific work plan with Tribal Nations to track all activities and/or tasks. Work Plans track the activity itself, assigned staff member (to each task), timeframes, and status of each activity. Our Tribal Programs Team updates Work Plans routinely with summaries to provide detailed information about progress, outcomes, and future activities. As required in sec. D, paragraph 23 of the Complete Care Contract, we complete and update the **Tribal Coordinator Report (TCR)** annually. The TCR includes information specific to each tribe such as delivered trainings, meetings conducted/attended, services offered, and current/future initiatives. We use analytical tools to track/monitor TCR activities to measure engagement with Tribal Nations. Analytical tools are monitored monthly by our Tribal Programs Supervisor and reviewed at the Tribal Services Cross-Departmental Workgroup meeting. ***In 2017, we participated in over 300 Tribal Nation engagement activities.*** We are able to accurately measure AI ***member engagement*** as our providers use a demographic file that captures tribal affiliation. ***As a result, out of the 7,321 AI members assigned to AZCH, 72% of those members are actively receiving AZCH services.***

3) MATCHING SERVICE DELIVERY TO MUTUAL GOALS AND CULTURALLY-APPROPRIATE TREATMENT. We will implement collaboration activities (as described below or as they are requested by Tribal Nations) in awarded GSAs and/or other tribal areas.

Collaborative Relationships. We have developed collaborative relationships with I/T/Us serving tribes in assigned GSAs (including TRBHAs) by bringing together providers and I/T/U staff in monthly collaboration meetings to provide AZCH updates, close gaps, and to address concerns that Tribal partners may have identified related to accessing services and coordinating care. We invite other AHCCCS Health Plans serving the tribes to join us in these meetings. We continue to collaborate with I/T/U facilities within our GSAs to care for members needing additional PH, BH or specialty services from AZCH providers, as well as contracting with I/T/Us as needed. One example is our upcoming partnership with The Haven to expand the delivery of traditional healing services. Future Activities. We will hold an Annual Tribal Leaders Meeting that will include AZCH executive leadership, I/T/U leadership, other AHCCCS Health Plans, AHCCCS AIHP staff and providers to proactively plan, identify, address and coordinate community health, network, and coordination of care issues. This meeting will commence in Q1 2019. AZCH's Tribal Programs Team prioritizes attendance at AHCCCS Tribal

Consultation Meetings to ensure our system processes are aligned with AHCCCS and tribal community needs. We will attend and participate in all Tribal Consultation Meetings and collaborate with AHCCCS to implement changes.

Transition Coordination. Our Tribal TCs will ensure the safe and effective transitions of AI members to and from AZCH to AIHP and other health plans, including members with special health care needs. Our Tribal TCs work with AI members, system partners, other Health Plans and AIHP to effectively complete transitions, following up to close the loop. Recognizing that many RBHA members will be able to obtain their integrated PH/BH services through the AIHP effective October 1, 2018, we will collaborate with AIHP to educate members and tribal leadership about this transition and continue to coordinate care as members move between AIHP/Health Plans and service providers. AZCH will comply with all AMPM and ACOM standards for member transitions and will maintain policies consistent with the nine member transition policies and procedures identified in the RFP, including the development of guidelines and protocols as required for effective transitions for AI members moving between AIHP/Health Plans under contract with AHCCCS.

Treatment Team Coordination. Our Population Health Management (PHM) Solution automates the processing of Health Current, pharmacy and treatment claims data to provide real time assessment of member needs and escalation of care gaps, giving our Integrated Care Managers (ICM) daily updates and insights to action to optimize member engagement. AZCH ICMs collaborate with the Tribal TC to coordinate care among treatment providers (incorporating treatment activities from multiple payers) to ensure all members, including AI members, receive effective coordination of care. This coordination includes children in residential placement, which involves arranging face to face meetings with children in residential facilities located off tribal lands to ensure the child has communication with the tribal community. The Tribal TC supports Child and Family Teams (CFT) and community based treatment team to ensure effective coordination between involved parties, including but not limited to parents/guardians and I/T/Us. If there are coordination issues, an AZCH CFT Coach will be assigned to assist the team in reaching a resolution. Future Activities. We will add a second Tribal TC upon Contract award to cover newly awarded regions.

Court-Ordered Evaluation/Court-Ordered Treatment (COT) Coordination. We work with our tribal partners to understand each Tribal Nation's view of involuntary commitment and the availability of a Tribal process. We collaborated with the San Carlos Apache Tribe to co-develop a tribal involuntary commitment process for San Carlos Apache members. The process was developed in partnership with the tribal BH program, the tribal attorney general's office, IHS, and the San Carlos Apache Healthcare Corporation. We offer education on the tribal involuntary commitment processes as it relates to ARS 12-136. To ensure continuity of care for AI members under COT/transition to the community, we will continue to collaborate with Tribal Nations on an individual basis to develop tribal involuntary commitment processes for AI members as determined by each tribal community. Future Activities. We are working with the San Carlos Apache Tribe and Tohono O'odham Nation to implement a community justice re-entry program in tribal detention facilities. We learned about this need through engagement activities, in which high recidivism was identified. We led this initiative to ensure tribal detention facilities have the same resources as detention facilities off tribal land.

Specialized Tribal Services. AZCH is the first and only health plan to provide onsite assessment services at the Sells Adult Detention Center on the Tohono O'odham Nation and the San Carlos Healthcare Corporation on the San Carlos Apache Reservation. Our Tribal Warm Line (TWL) is a telephonic peer support service operated by our Nurse Assist Line. This line is answered by Tribal Support Partners (TSP) who live/work in their tribal communities. TSPs offer telephonic support, coordination services, and link members to resources within their community. Our TSPs are trained to recognize members in crisis and link members to the appropriate crisis services. Future Activities. We are working with the San Carlos Apache Healthcare Corporation to provide technical support for telemedicine services. We will partner with tribes to bring mobile health clinics to tribal communities for special community events. Services may include mammograms, primary care, and prevention services. We are arranging to set up mobile dental services for tribal communities in 2018. We will enhance our TWL by adding a texting feature to be available across our service areas. If awarded the Central region, we will fund and embed a Tribal Treatment Coordinator within a high utilization hospital to coordinate care for AI members who visit the Emergency Department (ED) or are hospitalized to ensure continuity of care.

Urban Settings. The American Indian population is not static and AZCH is uniquely prepared to address the needs of Urban Indian members through our robust network, including a longstanding partnership with Native Health, as well as connecting members to other culturally competent providers in the community, such as Native American Connections who provide housing and employment supports, and expansion of our Tribal Peer Supports program. Additionally, AZCH is proud to have a longstanding relationship with the Tucson Indian Center and other Urban Indian Organizations such as Native Health. Future Activities. We continue to work collaboratively with the Phoenix Indian Center, Native Americans for Community Action and Native American Connections, to maximize member engagement opportunities and partner on programs tailored for the Urban Indian community.

Tribal Care Coordination…

The complexities of the I/T/U system and lack of on-reservation capacity often result in tribal members seeking care in urban hospital EDs, such as Flagstaff Medical Center or Banner University Medical Center Phoenix. We will fund a Tribal TC in CY 19 within a high volume hospital to coordinate care for AI members and support members receiving care from their American Indian Medical Home or AZCH HH.

Technology Support. We collaborate to improve communication through use of Health Current by developing a Health Current panel to receive alerts when AI members utilize the ED and are admitted and discharged from the hospital. We use real time alerts to proactively coordinate with tribal providers to improve health outcomes for AI members. Our Tribal Technologist provides education on Health Current to Tribal Nations within the Southern region and has provided technical support to the Ak-chin Indian Community on the implementation of an EHR system for their Health Department. We are working with Tribal Nations to establish Data Sharing Agreements (DSA) to allow data exchange among Tribal providers, other providers, and facilities. DSAs enable access to our Provider Portal, which enhances coordination for shared members. A DSA with the Cocopah Tribe was successfully finalized in June 2017. We collaborated with tribes to build and/or use existing technological infrastructure for telemedicine and telepsychiatry on tribal lands. Onsite access to mobile telemedicine services was established for Cocopah AI members on the Cocopah reservation through a partnership with Community Health Associates, the Cocopah Wellness Center, and the Cocopah Alcohol and Drug Abuse Prevention Program. Future Activities. We assist Tribal 638 providers on the development and implementation of EHR systems, and work with Tribal Nations to establish DSAs and Business Associate Agreements. DSAs are being reviewed by Tohono O'odham Nation and Colorado River Indian Tribes for approval. We are working with other tribes to assess their infrastructure and identify opportunities to design technology solutions that meet their needs. We are partnering with Project ECHO to offer clinical training and support via virtual visit conference software. Our Tribal Technologist will work with tribes to enhance, equip, and provide technical support for telehealth accessibility. AZCH will provide support and access to telehealth resources, including telehealth specialty providers. Our Tribal Technologist will be available to tribes for training on utilizing data to enhance and guide the delivery of quality services.

Education and Workforce Development Activities. We have made available, and provided education courses to all personnel working on tribal lands. Past education provided included cultural competency training, Mental Health First Aid, Crisis Response Training, CFT Process Training, and Peer Support Certification Training, of which training was delivered to staff from five Tribal Nations, resulting in 47 certified Tribal staff. We have assisted the development and delivery of in-service education on the service utilization and BH resources available to AI communities:

- Education on Access to Care, Crisis Services, and our TWL service to I/T/Us throughout the year
- Tribal Judicial Summit to educate on justice services and to explore opportunities for collaboration and partnership for the justice-involved population on the Tohono O'odham Nation
- Service Coordination Overview training for Tohono O'odham/Sells Hospital staff and the Law Enforcement/Detention staff from the Tohono O'odham Nation and Ak-chin Indian Community
- Tribal peer support trainings, the first in Arizona, in collaboration with Tribal Nations and Peerlink National Technical Assistance Center, which is a federally funded technical support center through SAMHSA. We empower Tribal Nations to own the curriculum to teach AI members to become certified as Peer Support Specialists. Three tribes have completed their curriculum which have been submitted to AHCCCS for approval

Future Activities. Through a contract with Dr. Dolores Bigfoot, we will implement the "Honoring Children, Mending the Circle" curriculum, a Cultural Adaptation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training program, for BH and PH providers working with AI members. TF-CBT provider training includes the initial training, consultation calls

after the training, and completion of a five-year certification program. We will also be implementing the Read It +Eat It program in Tucson to support healthy eating habits. Our partnership with Native Health, who is a contracted provider, began in January of 2016 and has allowed for Native Health to provide nutritional education and cost conscious cooking demonstrations during monthly classes. In 2016, we had nearly 60 families attend program activities, many of which are repeat participants. After each class, families are given a reusable tote bag with seasonal produce.

IDENTIFICATION PROCESS FOR UNIQUE BARRIERS TO SERVICE DELIVERY ON AND OFF TRIBAL LAND

We proactively identify unique barriers and service coordination challenges:

IDENTIFICATION OF BARRIERS. We have developed relationships with Tribal Nations to attempt to capture potential barriers before they occur for this unique member population. We attend and/or conduct meetings/conferences/activities to ensure we continue to learn about each Tribal Nation's specific preferences on a continuous basis to avoid possible barriers. Activities include monthly Tribal Collaboration Meetings, Annual Tribal Community Wellness and Awareness Conference, Annual Tribal Leaders Meetings (will commence in Q1 2019), AHCCCS Tribal Consultation Meetings and engagement activities as described throughout this response. AZCH uses PHM software to produce real time alerts for potential barriers such as: Member's clinical data and risk adjustment scores to improve quality of care; Health Current alerts allow us to coordinate care with tribal providers identifying unique barriers such as trends with ED use; Care gap identification in real time to provide ICM daily guidance on how best to help members reach their health care goals.

SERVICE COORDINATION BARRIERS. We identify unique barriers by multiple service coordination identification processes including but not limited to:

- Calls to Customer Service/TWL allow us to hear directly from members with requests to help them resolve for barriers to service delivery. In addition, our Customer Service staff alert our Tribal Programs Team if they identify service delivery barriers when speaking to our AI members.
- Community Health Representatives within the tribal system alert us of potential barriers.
- Tribal Services Designated Email, which captures referrals and/or requests by members, providers, and/or Tribal Nations. Emails are monitored daily and responses are sent within 24 hours.
- Identification of barriers through ICMs activities, which includes ongoing collaboration with our Tribal TC to coordinate care for AI members with complex BH and PH needs.
- We conduct a one-question survey after each interaction between members and ICMs. We ask members "*Did I meet your needs today*?" to capture member feedback. AI member survey data are reported to Quality Management Process Improvement to be monitored on a monthly basis.

ESCALATION AND RESOLUTION OF BARRIERS. Our Tribal TC works directly with our ICMs to resolve barriers, including homelessness, transportation, cell phone access, provider access, ED use, and/or remoteness of location or unpaved tribal land roads. We understand that for AI members, barriers are often greater because of the complexities related to multiple payers and multiple means of care available to AI members. Our Tribal TC uses our integrated clinical record to identify the ICM assigned to the member and generate a task to the ICM to alert them of the barrier. Our ICM and Tribal TC collaborate to identify all Tribal Program staff/tribal representatives that need to be consulted and coordinate with members' PCPs and/or HH to address barriers as needed. Integrated coordination activities and care plan updates are documented in our integrated clinical record and provide action items/timelines until the barrier is resolved. If needs are not met, aggressive escalation includes a Quality of Care (QOC) review as appropriate. Quality Management staff investigates the barrier, contacts the entities involved, and works to resolve it. Our Tribal TC and Tribal Programs Supervisor receive follow-up after each QOC barrier submitted. If unique barriers are systemic, our Tribal Programs Supervisor escalates by working with AZCH leadership to develop solutions during our monthly Tribal Services Cross-Departmental Workgroup meeting. We consult with AZCH staff/leadership as needed to resolve barriers. An example of a unique barrier that was resolved includes the development of the TWL. The San Carlos Apache Tribe and AZCH identified the need for a coordination service that linked AI members with other AI members. We developed the TWL, which allowed a qualified AI member to work for our Nurse Advice Line, and arranged for them to work from home, on reservation, with appropriate equipment, to serve members through the TWL.

NARRATIVE SUBMISSION
RESPONSE #18

NARRATIVE SUBMISSION
RESPONSE #18

NARRATIVE SUBMISSION RESPONSE

18. In accordance with 42 CFR 438.66, Medicaid agencies complete reviews of their contracted health plans at least every three years. AHCCCS will incorporate the past performance of the Offerors as noted below. The Offeror must identify which category applies to its organization and submit the information specified below.

Category 1: Current AHCCCS Contractor or Affiliated Organization of a current AHCCCS Contractor	***AHCCCS will review the most recent Acute Care Operational Review (CYE16). No submission required. If the Offeror is an Affiliated Organization with a current AHCCCS Acute Care Plan, AHCCCS will review the subsidiary's Acute Care Operational Review (CYE16). Scoring preference will be given to Offerors included in this category.***
Category 2: Not a current AHCCCS Contractor nor an Affiliated Organization of a current AHCCCS Contractor	***The Offeror is required to submit its most recent review in compliance with 42 CFR 438.66 for a business line with physical or integrated physical and behavioral health services from another state. The Offeror will also describe how the services delivered in the business line for the submitted review are comparable to the Scope of Services for this AHCCCS Complete Care RFP. The Offeror's submission shall not exceed one page plus attached review. AHCCCS reserves the right to validate the submitted review.***

Arizona Complete Health – Complete Care Plan is a ***Category 1 Offeror*** with a current AHCCCS contract, therefore, no submission is required. The legal entity submitting this bid is Health Net Access, Inc., and as such, Arizona Complete Health-Complete Care Plan will be the DBA for that legal entity with Cenpatico Behavioral Health of Arizona, LLC as the Affiliated Organization. As such, we expect that AHCCCS will review the most recent Acute Care Operational Review for Health Net Access.

A.R.S. §35-393.01
ATTESTATION

EXHIBIT D: A.R.S. §35-393.01 ATTESTATION

Recognizing legislation has been enacted to prohibit the State from contracting with companies currently engaged in a boycott of Israel, to ensure compliance with A.R.S. §35-393.01, this form must be completed and returned with the response to the solicitation and any supporting information to assist the State in making its determination of compliance.

As defined by A.R.S. §35-393.01:

1."Boycott" means engaging in a refusal to deal, terminating business activities or performing other actions that are intended to limit commercial relations with Israel or with persons or entities doing business in Israel or in territories controlled by Israel, if those actions are taken either:
(a) In compliance with or adherence to calls for a boycott of Israel other than those boycotts to which 50 United States Code section 4607(c) applies.
(b) In a manner that discriminates on the basis of nationality, national origin or religion and that is not based on a valid business reason.
2. "Company" means a sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company or other entity or business association, and includes a wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate.
3. "Direct holdings" means all publicly traded securities of a company that are held directly by the state treasurer or a retirement system in an actively managed account or fund in which the retirement system owns all shares or interests.
4."Indirect holdings" means all securities of a company that are held in an account or fund, including a mutual fund, that is managed by one or more persons who are not employed by the state treasurer or a retirement system, if the state treasurer or retirement system owns shares or interests either:
(a) together with other investors that are not subject to this section.
(b) that are held in an index fund.
5."Public entity" means this State, a political subdivision of this STATE or an agency, board, commission or department of this state or a political subdivision of this state.
6. "Public fund" means the state treasurer or a retirement system.
7. "Restricted companies" means companies that boycott Israel.
8. "Retirement system" means a retirement plan or system that is established by or pursuant to title 38.

All Offerors must select one of the following:

__X__ My company **does not** participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01.

_____ My company **does** participate in a boycott of Israel as defined by A.R.S. §35-393.01. :

By submitting this response, proposer agrees to indemnify and hold the State, its agents and employees, harmless from any claims or causes of action relating to the State's action based upon reliance on the above representations, including the payment of all costs and attorney fees incurred by the State in defending such an action.

Health Net Access, Inc.	
Company Name	Signature of Person Authorized to Sign
1870 W. Rio Salado Parkway	Paul Barnes
Address	Printed Name
Tempe / Arizona / 85281	Plan President and CEO
City / State / Zip	Title

AFFILIATED ORGANIZATION ATTESTATION

Exhibit E: Affiliated Organization Attestation

Affiliated Organization means a party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an entity.

Offeror Name: Health Net Access, Inc.

Affiliated Organization Name: Cenpatico Behavioral Health of Arizona, LLC

All Offerors must select one of the following:

_X_ The Offeror is bidding as an Affiliated Organization and attests to the following:

The Offeror shall come into compliance with the Affiliated Organization requirements of the RFP YH19-0001 no later than October 1, 2018.

- If the Offeror awarded an AHCCCS Complete Care Contract (the AHCCCS Complete Care Contractor) has an Affiliated Organization that holds an AHCCCS RBHA contract serving one or more counties in the same Geographic Service Area (the RBHA affiliate), the Offeror shall make arrangements for a single legal entity to hold both the RBHA and AHCCCS Complete Care Contract effective on or before October 1, 2018. This requirement does not apply to Gila or Pinal County.

- The Offeror shall establish a single brand and market the services provided under both the AHCCCS Complete Care Contract and the RBHA contract as a single product.

____ The Offeror is not bidding as an Affiliated Organization.

Health Net Access, Inc.	
Company Name	Signature of Person Authorized to Sign
1870 W. Rio Salado Parkway	Paul Barnes
Address	Printed Name
Tempe / Arizona / 85281	Plan President and CEO
City / State / Zip	Title

STATE ONLY PREGNANCY TERMINATION AGREEMENT

Exhibit F: State Only Pregnancy Termination Agreement

THIS AGREEMENT is entered into by and between the Arizona Health Care Cost Containment System (AHCCCS), located at 701 E. Jefferson, Phoenix, Arizona 85034, and Health Net Access, Inc. (Offeror).

WHEREAS, it is the intention of AHCCCS to use the services of the Contractor for medically necessary pregnancy terminations.

WHEREAS, the Contractor represents itself to be qualified for such services in accordance with all applicable laws and regulations governing this profession.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements hereinafter set forth, the parties hereto, and legally intending to be bound thereby, do covenant and agree for themselves and their respective successors and assigns as follows:

1. The Contractor agrees to provide those services described below:

   1.1 Pregnancy terminations which are medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

      1.1.1 Creating a serious physical or mental health problem for the pregnant member,

      1.1.2 Seriously impairing a bodily function of the pregnant member,

      1.1.3 Causing dysfunction of a bodily organ or part of the pregnant member,

      1.1.4 Exacerbating a health problem of the pregnant member, or

      1.1.5 Preventing the pregnant member from obtaining treatment for a health problem.

   1.2 Conditions, Limitations and Exclusions:

      1.2.1 The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the *Certificate of Necessity for Pregnancy Termination* and clinical information that supports the medical necessity for the procedure, as referenced in the AHCCCS Medical Policy Manual (AMPM), Chapter 400, Policy 410, *Maternity Care Services*. This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief Medical Officer or designee for Fee-For-Service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

1.2.2 Pregnancy terminations must be provided in compliance with AMPM Policy 410, *Maternity Care Services*.

2. All outpatient medically necessary covered services related to the pregnancy termination, for dates of service only on the day the pregnancy was terminated, will be considered for reimbursement at 100% of the lesser of the contractors paid amount or the AHCCCS Fee Schedule amount. Adjudicated encounters for these covered services provided to enrolled members will be used to determine reimbursement.

3. Any changes, modifications or revisions to this Agreement shall only be executed through a written amendment, issued and signed by the authorized AHCCCS procurement officer.

4. Either party to this Agreement may terminate this Agreement without penalty by giving the other party written notice of such termination at least thirty (30) days prior to termination.

5. This agreement shall be governed by the laws of the State of Arizona.

6. The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its service hereunder.

7. The Contractor shall not assign any interest in this Agreement, and shall not transfer any interest, whatsoever, in the same (whether by assignment or novation), without the prior written consent of AHCCCS.

8. The initial term of this Agreement shall be for the term **October 1, 2018** through **September 30, 2024.**

9. Termination – Availability of Funds: If, funds are not presently available to support the continuation of performance under this Contract beyond the current fiscal year, this Contract may be terminated at the end of the period for which funds are available. No legal liability on the part of AHCCCS for any payment may arise under this Contract until funds are made available for performance of this Contract.

   Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

   IN WITNESS WHEREOF, the parties have executed this agreement the day and year first written above.

10. Termination For Conflict of Interest: AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the Contract or any extension of the Contract is in effect, an employee of, or a consultant to, any other party to this Contract with respect to the subject matter of the Contract. The

cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided by A.R.S. §38-511.

Health Net Access, Inc.	
Offeror Name	Signature of Person Authorized to Sign
1870 W. Rio Salado Parkway	Paul Barnes
Address	Printed Name
Tempe Arizona 85281	Plan President and CEO
City State Zip	Title