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	3
Offeror's Completed and Signed RFP Solicitation and Offer Page	RFP Section A Refer to Bidders' Library	4
Offeror's Signed Signature Page(s) for **each** Solicitation Amendment	Refer to Bidders' Library	6
Capitation Non-Benefit Costs Bid Submission		
Signed Agreement accepting capitation rates	RFP Section H, Instructions to Offerors	8
Non-Benefit Costs Bid Submission workbook	RFP Section H, Instructions to Offerors	9
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Executive Summary	RFP Section H, Instructions to Offerors	50
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9.	RFP Section I, Exhibit C	97
10.	RFP Section I, Exhibit C	102
11.	RFP Section I, Exhibit C	107
12.	RFP Section I, Exhibit C	112
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	117
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15.	RFP Section I, Exhibit C	127
16. A (North) *If applicable*	RFP Section I, Exhibit C	132
16. B (South) *If applicable*	RFP Section I, Exhibit C	135
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Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	164
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	165

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

BID CHOICE FORM - PART 1

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

OFFEROR'S NAME

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	1st choice
☒	**North**: Mohave, Coconino, Apache, Navajo and Yavapai Counties	3rd choice
☒	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties	2nd choice

Authorized Signature — January 24, 2018 Date

Mark Fisher — President and CEO
Print Name — 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.**

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

OFFEROR'S NAME

	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 — January 24, 2018 Date

Mark Fisher — President and CEO
Print Name — Title

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*)

86-0527381

Federal Employer Identification No.:

Dun and Bradstreet (DUN) No.

E-Mail Address: perrys@mercycareplan.com

Mercy Care

Company Name

4350 E. Cotton Center Blvd., Bldg D

Address

Phoenix AZ 85040

City State Zip

For clarification of this offer, contact:

Name: Shareé Perry

Title: Sr. Project Manager

Phone: (602) 659-1854

Signature of Person Authorized to Sign Offer

Mark Fisher

Printed Name

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 / XX 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

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: Mark Fisher	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President and CEO	TITLE: Chief Procurement Officer
DATE: January 24, 2018	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: Mark Fisher	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President and CEO	TITLE: Chief Procurement Officer
DATE: January 24, 2018	DATE:

mercy care

January 24, 2018

Arizona Health Care Cost Containment System (AHCCCS)
701 East Jefferson, MD 5700
Phoenix, Arizona 85034

RE: AHCCCS Complete Care RFP# YH19-0001 – Agreement to Accept Capitation Rates

As a requirement of the capitation submission for the AHCCCS Complete Care Contract, this letter shall serve as an agreement that Mercy Care will accept actuarially sound capitation rates computed prior to October 1, 2018.

Mercy Care	
Company Name	Signature of Person Authorized to Sign
4350 E. Cotton Center Blvd., Bldg. D	Mark Fisher
Address	Printed Name
Phoenix AZ 85040	President and CEO
City State Zip	Title

Northern GSA

Member Months to Use for Bidding	990,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 24.63
% of Admin PMPM that is Fixed	18.27%
% of Admin PMPM that is Variable	81.73%
Detail Admin Break Out	
Compensation	$ 13.10
Occupancy	$ 0.28
Depreciation	$ 0.00
Care Management/Care Coordination	$ -
Professional and Outside Services	$ 9.13
Office Supplies and Equipment	$ 0.76
Travel	$ 0.06
Repair and Maintenance	$ 0.00
Bank Service Charge	$ 0.17
Insurance	$ 0.14
Marketing	$ 0.25
Interest	$ -
Other Administrative	$ 0.72
Total Admin PMPM	$ 24.63

Underwriting Gain Component

	Year 1	Year 2	Year 3
Underwriting Gain	1.00%	1.00%	1.00%

Central GSA

Member Months to Use for Bidding	3,170,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 25.83
% of Admin PMPM that is Fixed	13.55%
% of Admin PMPM that is Variable	86.45%
Detail Admin Break Out	
Compensation	$ 13.74
Occupancy	$ 0.29
Depreciation	$ 0.00
Care Management/Care Coordination	$ -
Professional and Outside Services	$ 9.58
Office Supplies and Equipment	$ 0.80
Travel	$ 0.06
Repair and Maintenance	$ 0.00
Bank Service Charge	$ 0.18
Insurance	$ 0.15
Marketing	$ 0.26
Interest	$ -
Other Administrative	$ 0.76
Total Admin PMPM	$ 25.83

Underwriting Gain Component

	Year 1	Year 2	Year 3
Underwriting Gain	1.00%	1.00%	1.00%

Southern GSA

Member Months to Use for Bidding	1,630,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 23.74
% of Admin PMPM that is Fixed	16.85%
% of Admin PMPM that is Variable	83.15%
Detail Admin Break Out	
Compensation	$ 12.63
Occupancy	$ 0.27
Depreciation	$ 0.00
Care Management/Care Coordination	$ -
Professional and Outside Services	$ 8.80
Office Supplies and Equipment	$ 0.74
Travel	$ 0.06
Repair and Maintenance	$ 0.00
Bank Service Charge	$ 0.17
Insurance	$ 0.14
Marketing	$ 0.24
Interest	$ -
Other Administrative	$ 0.70
Total Admin PMPM	$ 23.74

Underwriting Gain Component

	Year 1	Year 2	Year 3
Underwriting Gain	1.00%	1.00%	1.00%

MERCY CARE

AHCCCS Complete Care Request For Proposal YH19-0001

Cost Proposal Narrative for Central, North and South Geographic Service Areas

October 1, 2018 through September 30, 2019

Prepared by:
Jason Strandquist
FSA, MAAA
Senior Director, Actuarial Services

Steve Clark
FSA, MAAA
Director, Actuarial Services

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INTRODUCTION AND EXECUTIVE SUMMARY

BACKGROUND (AHCCCS COMPLETE CARE)

This letter provides documentation of the assumptions and loads used in the development of the Central, North and South Geographic Service Area (GSA) Cost Proposal submissions for Mercy Care as required in Section H.19 of the AHCCCS Complete Care (ACC) Request for Proposal YH19-0001.

The purpose of this rate narrative is to provide documentation, including the assumptions and methodologies, used in the development of the October 1, 2018 through September 30, 2019 (CYE19) Non-Benefit Cost Proposal that the Arizona Health Care Cost Containment System (AHCCCS) will use in evaluating Mercy Care's Cost Proposal submission and incorporate into the capitation rates paid to Mercy Care for CYE19.

This rate narrative was prepared for AHCCCS and the Division of Health Care Management (DHCM) Actuarial Team, the state's actuarial department. This rate narrative may not be appropriate for any other purpose. If this rate narrative is made available to third parties, then this rate narrative should be provided in its entirety. Any third party reviewing this rate narrative should be familiar with the AHCCCS Complete Care program, the provisions of 42 CFR § 438 applicable to this rate narrative, the 2018 Medicaid Managed Care Rate Development Guide, Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

To facilitate review, this document has been organized in the same manner as the 2017-2018 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in April 2017.

APPENDICES

Appendix 1 shows the projection of the administrative expenses for Mercy Care for contract year ending 2019 using the historical expense level methodology.

Appendix 2 shows the projection of the administrative expenses for Mercy Care for contract year ending 2019 using the staffing model methodology.

NON-BENEFIT COST PROPOSAL

	GSA		
	Central	South	North
Member Months to Use for Bidding	3,170,000	1,630,000	990,000
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 25.83	$ 23.74	$ 24.63
% of Admin PMPM that is Fixed	13.55%	23.17%	24.36%
% of Admin PMPM that is Variable	86.45%	76.83%	75.64%
Detail Admin Break Out			
Compensation	$ 13.74	$ 12.63	$ 13.10
Occupancy	0.29	0.27	0.28
Depreciation	0.00	0.00	0.00
Care Management/Care Coordination	-	-	-
Professional and Outside Services	9.58	8.80	9.13
Office Supplies and Equipment	0.80	0.74	0.76
Travel	0.06	0.06	0.06
Repair and Maintenance	0.00	0.00	0.00
Bank Service Charge	0.18	0.17	0.17
Insurance	0.15	0.14	0.14
Marketing	0.26	0.24	0.25
Interest	-	-	-
Other Administrative	0.76	0.70	0.72
Total Admin PMPM	**$ 25.83**	**$ 23.74**	**$ 24.63**
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	1.00%	1.00%	1.00%

Notes:

1. The per member per month values are not rounded to the nearest $0.01, therefore, the total may not equal the sum of the subcomponents.

SECTION I. NON-BENEFIT COST PROPOSAL

1. GENERAL INFORMATION

The assumptions and loads included with this rate narrative are considered "actuarially sound" for purposes of 42 CFR § 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements under 42 CFR § 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial Standards of Practice (ASOP) applicable to Medicaid managed care rate setting: ASOP 5 (Incurred Health and Disability Claims), ASOP 23 (Data Quality), ASOP 25 (Credibility Procedures), ASOP 41 (Actuarial Communications), ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies) and ASOP 49 (Medicaid Managed Care Rate Development and Certification).
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- Throughout this document, the term actuarially sound is defined in Actuarial Standard of Practice (ASOP) 49, as:

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

A. RATE DEVELOPMENT STANDARDS

i. Rating Period

The CYE19 capitation rates for the ACC program are effective for the twelve (12) month time period from October 1, 2018 through September 30, 2019.

ii. Required Elements

(a) Actuarial certification

This narrative does not include an actuarial certification for the final capitation rates, as the state's Actuary will be creating the rates that will be certified to CMS. This narrative does include an actuarial certification that the non-benefit cost proposal bid for Mercy Care is actuarially sound and was developing using generally accepted actuarial practices.

(b) Certified capitation rates

The cost proposal does not include certified capitation rates; the AHCCCS Actuary will create the final capitation rates. This cost proposal includes the bid administrative expense and underwriting profit loads for Mercy Care. The member months represent the required values, provided by AHCCCS, to be used for the non-benefit cost proposal submission for CYE19.

(c) Certified rate range

Not applicable, a rate range was not developed.

(d) Program information

(i) Summary of program

This narrative was developed for the ACC program, the Medicaid managed care program operated by the State of Arizona.

AHCCCS is Arizona's Title XIX Medicaid program operating under a Section 1115 Waiver and Title XXI program operating under Title XXI State Plan authority. In 1982, Arizona introduced its innovative Medicaid program by establishing the Arizona Health Care Cost Containment System (AHCCCS), a demonstration program based on principles of managed care. The ACC program is proposing to fully integrate the physical and behavioral health services for the individuals eligible for the ACC program. The physical and behavioral health services for the eligible individuals were previously segmented between the Acute program contractors, Regional Behavioral Health Authority (RBHA) contractors and Child Rehabilitative Services (CRS) contractors.

AHCCCS continues its work to reduce fragmentation of service delivery and to create a more effective health care system. AHCCCS' efforts to further integrate care delivery systems and properly align incentives are designed to transition the structure of the Medicaid program to improve health outcomes and manage limited resources.

(A) Type and number of managed care plans

The ACC program currently expects to contract with two (2) contractors in the North Geographic Service Area (GSA), at least four (4) contractors in the Central GSA, two (2) contractors in the South GSA and one (1) additional contractor for Pima County only.

(B) Covered services

The ACC program's benefits are comprehensive in nature including all physical and behavioral health expenses, retail pharmacy, dental, and vision.

(C) Areas of state covered and length of time of operation

The ACC program has operated on a statewide basis, in all 15 counties, since 1982. The AHCCCS Care <106% FPL program has been in effect since 2001. The AHCCCS Care >106% FPL program started in January 2014 after passage of the Patient Protection and Affordable Care Act allowed for the expansion of Medicaid coverage to those individuals that have income less than 138% of the federal poverty level (FPL). All other programs have been covered since the inception of the Medicaid program, in 1982.

(ii) Rating period

The CYE19 capitation rates for ACC are effective for the twelve (12) month time period from October 1, 2018 through September 30, 2019.

(iii) Covered populations

The following populations are **included** in the ACC program:

TITLE XIX

- ***Parents/Caretaker Relatives***: Eligible individuals under the 1931 provision of the Social Security Act, with income at or below 106% of the FPL.
- ***SSI Cash****:* Eligible individuals receiving Supplemental Security Income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or who have a disability and have income at or below 100% of the Federal Benefit Rate (FBR).
- ***SSI Medical Assistance Only (SSI MAO) and Related Groups***: Eligible individuals who are aged, blind or who have a disability and have household income levels at or below 100% of the FPL.
- ***Freedom to Work (Ticket to Work)***: Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.
- **Pregnant Women:** Eligible pregnant women, with income at or below 156% of the FPL,
- **Children:** Eligible children with incomes ranging from below 133% to 147% of the FPL, depending on the age of the child.
- **Breast and Cervical Cancer Treatment Program (BCCTP):** Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.
- **Title IV-E Foster Care and Adoption Subsidy:** Children who are in State foster care or are receiving federally funded adoption subsidy payments.
- **Young Adult Transitional Insurance (YATI):** Transitional medical care for individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.

- **Adult Group at or below 106% FPL:** Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (Adults <= 106%).
- **Adult Group above 106% FPL:** Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (Adults > 106%).

TITLE XXI

- **KidsCare:** Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).

STATE-ONLY

- **State-Only Transplants:** Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility under a category other than Adult Group may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:
  1. The individual has been determined ineligible for Title XIX due to excess income,
  2. The individual had been placed on a donor waiting list before eligibility expired, and
  3. The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

(iv) Eligibility criteria

The populations covered under ACC are required to choose or be enrolled with one (1) of the contractors.

(v) Special contract provisions

This cost proposal narrative does not include any special contract provisions.

(vi) Retroactive adjustment to capitation rates

This cost proposal does not include or incorporate a retroactive adjustment to the current contract year rates.

iii. Differences Among Capitation Rates

Any differences between the proposed non-benefit costs, according to each GSA, are based on valid resource requirement differences based on the membership volume, concentration/dispersion of the eligible individuals and acuity by category of aid. The proposed non-benefit costs do not vary based on the rate of federal financial participation associated with the covered population.

iv. Cross-Subsidization of Rate Cell Payment

The non-benefit cost proposal rates were developed at the GSA level as required for the RFP submission and are intended to be self-sufficient for each GSA.

To avoid cross-subsidization by rate cell within each GSA, we recommend applying the fixed per member per month to all rate cells, except the maternity kick capitation rate. The variable non-benefit cost should be converted to a percent of revenue and applied as a uniform percentage load to each capitation rate, including the maternity kick capitation rate.

We expect the capitation rate, prior to the application of the premium tax, to be calculated as follows:

$$\frac{\text{(CYE19 Projected Medical Expense – Reinsurance Offset + Fixed Non-Benefit Cost)}}{\text{(1 – Variable Non-Benefit Cost Percent – Underwriting Margin Load Percent)}}$$

v. Effective Dates

The CYE19 capitation rates for the ACC program are effective for the twelve (12) month time period from October 1, 2018 through September 30, 2019.

vi. Generally Accepted Actuarial Practices and Principles

(a) Reasonable, appropriate and attainable

In our judgement, the fixed general administrative expense, variable general administrative expense and underwriting margin bids reflect reasonable, appropriate and attainable costs. To our knowledge, all reasonable, appropriate and attainable costs have been included in the cost proposal.

(b) Outside the rate setting process

To our knowledge, the only adjustment to the rates outside the rate setting process will be adjusting the capitation revenue paid to each contractor to account for the acuity of the individuals that have enrolled with each contractor.

(c) Final contracted rates

This cost proposal reflects Mercy Care's best estimate of the reasonable, appropriate and attainable costs of the non-benefit costs to manage the ACC program assuming the membership levels provided by AHCCCS for the non-benefit cost proposal. The final contracted rates will be developed by the AHCCCS Actuary.

vii. Rate certification for effective time periods

This cost proposal is intended to be effective for the 2019 contract year, from October 1, 2018 through September 30, 2019.

viii. Procedures for rate certification and amendment

This section is not applicable since the AHCCCS Actuary will be certifying the final rates and any amendments that may occur.

B. APPROPRIATE DOCUMENTATION

i. Documentation of Required Elements

This narrative contains appropriate documentation of all the elements described in the non-benefit cost proposal, including inflation assumptions, membership volume adjustments to the general administrative expense projections, addition of the necessary resources to manage the behavioral health and child rehabilitative services and development of the underwriting margin load. The methods for developing and analyzing the reasonableness and source of those assumptions are also included.

ii. Index

The index to this cost proposal narrative is the table of contents, found immediately following the title page. Sections not relevant to this narrative continue to be provided, with an exception noted if they are not applicable.

iii. Differences in FMAP

Not applicable since this cost proposal narrative is not dependent on the FMAP from CMS nor will it be provided to CMS.

iv. Assumptions and Methodology for Development and Certification of Rate Ranges

Not applicable, a rate range has not been developed for this cost proposal.

v. Documentation of Development and Certification of Rate Ranges

Not applicable, a rate range has not been developed for this cost proposal.

2. DATA

Section 2 is not applicable to this non-benefit cost proposal narrative. We have relied upon the state and its Actuary to have audited the base data and reviewed it for reasonableness and appropriateness.

We did not perform an independent audit of the data, comparison to the supplemental financial reports from the current contractors, nor did we independently value each of the programmatic and fee schedule changes.

We did perform a reasonableness check against Mercy Care's own experience and found the base data provided by AHCCCS to be reasonable. We also performed our own projection of the medical expenses to CYE19 to develop our own expectations of the final capitation rates that will be used solely to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

3. PROJECTED BENEFIT COST AND TRENDS

Section 3 is not applicable to this cost proposal narrative; Mercy Care is not submitting a full capitation rate cost proposal.

We performed our own projection of the medical expenses to CYE19 to develop our own expectations of the CYE19 medical expenses. The sole use of that projection is to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the incentive programs in the ACC program RFP.

ii. Appropriate Documentation

(a) Description of the incentive program

(i) Time period and purpose

The incentive arrangement is measured on a contract year basis. The proposed measures are primarily focused on improving quality, health outcomes and access to care while also reducing costs.

(ii) Description of the total incentive

The ACC program provides for two (2) incentive programs: a Quality Measure Performance program and Performance Based Payments program. Any one (1) Contractor cannot receive greater than 5.0% of its annual capitation revenue as incentive payments.

Quality Measure Performance (QMP)

The program incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for performance on select quality measures identified in ACOM Policy 306. Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by Alternative Payment Model (APM) strategies defined in ACOM Policy 307. AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year and the computation of the quality measures.

Performance Based Payments (PBP)

The program incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care.

(iii) Estimate of percent to be earned

Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no assumption of the estimated amount to be earned. However, the ability of a Contractor to achieve the incentive measures will be dependent on the reasonableness of the expected improvement in the measures and communication of the targets prior to the start of the measurement year.

(iv) Reasonableness of incentive arrangement

The incentive program arrangement is reasonable for measures that can be impacted and for levels of improvement that can be attained within a twelve (12) month period.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the ACC program.

ii. Appropriate Documentation

(a) Description of the incentive arrangement

(i) Time period and purpose

The withhold arrangement is measured on a contract year basis. The proposed measures are primarily focused on targeting an improvement in quality of life, access to care and quality of care.

(ii) Description of total withhold

The Alternative Payment Model (APM) Initiative – Quality Measure Performance (QMP) incorporates a withhold arrangement of 1.0% of the Contractor's capitation and a portion of, or all of, the withheld amount will be paid to the Contractor for performance on select quality measures identified in ACOM Policy 306. Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by APM strategies defined in ACOM Policy 307. AHCCCS will apply the withhold after the completion of the contract year by recouping the full amount of the annual withhold. Also after the completion of the contract year and the computation of the quality measures, AHCCCS will reconcile the Contractor's earned portion of the withhold against the withheld funds and will make a lump sum payment to the Contractor. The Contractor will not be paid greater than 100% of the withhold.

(iii) Estimate of percent to be returned

Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no assumption of the estimated percent to be returned. However, the ability of a Contractor to achieve a high rate of return of the quality withhold will be dependent on the reasonableness of the expected improvement in the measures and communication of the targets prior to the start of the measurement year.

(iv) Reasonableness of withhold arrangement

The withhold arrangement is reasonable for measures that can be impacted and for levels of improvement that can be attained within a twelve (12) month period.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk sharing mechanisms in the ACC program.

ii. Appropriate Documentation

(a) Description of risk-sharing mechanism

AHCCCS will reconcile the Contractor's total medical cost expenses (prospective and PPC) to total net capitation paid (prospective and PPC) to the Contractor. For CYE19, this reconciliation will limit the Contractor's profits and losses as follows:

MCO Profit/(Loss) prior to Reconciliation	MCO Share	AHCCCS Share	Max MCO Profit/(Loss) in Corridor	Cumulative MCO Profit/(Loss)
> (2.0%)	0%	100%	0%	(2%)
<= (2.0%)	100%	0%	(2%)	(2%)
<= 2.0%	100%	0%	2%	2%
> 2.0% and <= 6.0%	50%	50%	2%	4%
> 6.0%	0%	100%	0%	4%

(b) Medical loss ratio

There is no minimum medical loss ratio mechanism in the ACC program.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

This section provides documentation of the delivery system and provider payment initiatives in the ACC program. Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no provision for these delivery system and provider payment initiatives included in this proposal.

ii. Appropriate Documentation

(a) Description of delivery system and provider payment initiatives

Access to Professional Services Initiative (APSI)

AHCCCS seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Contractor's rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the definition outlined in ACOM Policy 325.

The APSI, which began on October 1, 2017, allows the Contractor to provide a 40% increase to the otherwise contracted rates to Qualified Practitioners as defined in ACOM Policy 325 for all claims for which AHCCCS is the primary payer. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Because APSI is a new initiative and utilization of Qualified Practitioners will vary across Contractors, AHCCCS will mitigate the Contractor's risk associated with overpayment or underpayment through a risk corridor which will include a -/+ 0% risk band, further described in ACOM Policy 325.

AHCCCS may amend the APSI components effective October 1, 2018.

Targeted Investments (TI)

The Targeted Investments (TI) program is authorized under AHCCCS' Section 1115 Waiver for five years beginning in CYE 17. The TI program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care.

In order to ensure the stability of AHCCCS' delivery system efforts, the Contractor is strongly encouraged to contract with eligible PCPs, behavioral health providers, integrated clinics and hospitals participating in TI beginning October 1, 2018. The Contractor will provide financial incentives (referenced below) under the TI initiative to the participating providers who demonstrate performance improvement by meeting certain benchmarks for integrating and coordinating physical and behavioral health care. Contractors are encouraged to:

1. Maintain membership numbers for those members assigned to contracted/TI eligible participating providers, as appropriate, and
2. Increase member assignment to high performing contracted/TI eligible participating providers, as appropriate.

The Contractor is required to contract with eligible TI providers serving adults transitioning from the criminal justice system participating in the TI program. In the event the Contractor and the provider fail to negotiate a contract, the Contractor shall permit members to continue receiving services from these providers and shall reimburse the provider at 100% of the AHCCCS FFS rates.

AHCCCS will collect information via the Provider Affiliation Transmission (PAT) file and evaluate the Contractor's network. If AHCCCS determines a material impact to TI participating provider(s), AHCCCS may require the Contractor to take steps to rectify the material impact.

AHCCCS will compute the participating provider financial incentives after completion of the contract year and will make available to the Contractor a list of TI providers and associated amounts of financial incentive payments owed for the contract year. Also after completion of the contract year, AHCCCS will adjust capitation rates in the form of a lump sum payment to the Contractor in an amount equal to the financial incentive payments due to TI providers plus an administrative payment for the Contractor. Requirements are further delineated in ACOM Policy 324.

This delivery system reform initiative:

1. Makes participation in the delivery system reform initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the reform initiative,
2. Uses a common set of performance measures across all payers and providers,
3. Does not set the amount or frequency of the expenditures, and
4. Does not allow AHCCCS to recoup any unspent funds allocated for these arrangements from the Contractor.

Differential Adjusted Payments (DAP)

AHCCCS has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. AHCCCS may amend the DAP components effective October 1, 2018, including but not limited to, the qualifications, rate adjustments, and/or providers eligible for the increases. The Contractor will support the Rate Differential in accordance with 42 CFR 438.6(c)(1)(iii)(B). The DAP effective October 1, 2017 require that the Contractor shall adjust payments for specific providers and provider types as described below:

1. Nursing Facility

For CYE18, for qualified AHCCCS-registered Arizona Nursing Facility providers meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 1.0% or 2.0%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria: Nursing Facilities that meet or exceed the Medicare Nursing Home Compare Arizona Average for the pneumococcal vaccine measure qualify for a 1.0% Differential Adjusted Payment increase.

1. The pneumococcal vaccine measure is the percent of long-stay residents assessed and appropriately given the vaccine
2. The facility's results on Medicare Nursing Home Compare for this quality measure will be compared to the accompanying Arizona Average results for the measure, for the most recently published rate as of April 30, 2017

AND/OR

Criteria: Nursing Facilities that meet or exceed the Medicare Nursing Home Compare Arizona Average for the influenza vaccine measure qualify for a 1.0% Differential Adjusted Payment increase.

1. The influenza vaccine measure is the percent of long-stay residents assessed and appropriately given the vaccine
2. The facility's results on Medicare Nursing Home Compare for this quality measure will be compared to the accompanying Arizona Average results for the measure, for the most recently published rate as of April 30, 2017

Nursing Facilities will be eligible for a 1.0% increase for meeting each variable, thus having the potential to earn up to a 2.0% Differential Adjusted Payment increase if both criteria are met.

2. Hospital subject to APR-DRG Reimbursement

For CYE18, for both inpatient and outpatient services for qualified AHCCCS-registered Arizona Hospital providers (provider type 02) meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 0.5%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria: The hospital must participate in the Network, the state's health information exchange, by May 15, 2017 as evidenced by an executed agreement with a qualifying Health Information Exchange organization, and electronically submit laboratory, radiology, transcription, and medication information, plus admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying health information exchange organization.

3. Other Hospitals and Inpatient Facilities

Effective for dates of admission from January 1, 2018 through September 30, 2018, for both inpatient and outpatient services for qualified AHCCCS-registered Arizona Psychiatric Hospitals (Provider Type 71), Subacute Facilities (1- 16 Beds) (Provider Type B5), Rehabilitation Hospitals (Provider Type C4), and Long Term Acute Care Hospitals (Provider Type C4) meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 0.5%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

1. The hospital must participate in the Network, the state's health information exchange, by October 1, 2017 as evidenced by an executed agreement with a qualifying health information exchange organization, and electronically submit admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying health information exchange organization.
2. Facilities must have an executed agreement and initiate activity with the state's HIE by May 15, 2017 to meet this October 1, 2017 deadline. Additionally, the Network will conduct a readiness assessment of all interested facilities and will determine, based on the results of the assessment, whether or not the facility is approved to proceed with connectivity and meeting the program deadlines

4. Integrated Clinic

For those dates of service in CYE18 that coincide with the provider's registration as a qualified AHCCCS-registered Integrated Clinics (IC) with claims for behavioral health services accounting for at least 40% of total claims, meeting criteria as set forth below, the Contractor is required to increase the rates that the Contractor would otherwise pay for select physical health services by 10.0%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

1. Providers registered with AHCCCS as Integrated Clinics and licensed by the Arizona Department of Health Services as Outpatient Treatment Center which provide both behavioral health services and physical health services and whose claims for behavioral health services account for at least 40% of total claims
2. AHCCCS will compute claims for behavioral health services as a percentage of total claims as of May 15, 2017 to determine which providers meet the 40% minimum threshold by utilizing

claims and encounter data for dates of service from October 1, 2015 through September 30, 2016

3. Select physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code

5. Physicians, Physician Assistants, and Registered Nurse Practitioners

For CYE18, for all services billed on the CMS Form 1500 by qualified AHCCCS-registered physicians, physician assistants, and registered nurse practitioners (Provider Types 08, 31, 18, 19) meeting criteria as set forth below, the Contractor is required increase the rates that the Contractor would otherwise pay by 1.0%, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider. Due to the operational issues related to contracting arrangements with entities rather than individual practitioner, the Contractor is permitted pay the increase in a manner other than on an individual claim basis, The Contractor would need to pay the increase on at least a quarterly basis. The Contractor shall ensure that the qualifying practitioner is paid the same amount that would have been paid on a claims basis, regardless of the payment methodology.

Criteria:

1. The provider must have written at least 100 prescriptions for AHCCCS members, and must have written at least 50% of their total AHCCCS prescriptions as Electronic Prescriptions (E-Prescriptions)
2. E-Prescription statistics will be identified by the AHCCCS provider ID for the prescribing provider, and computed by AHCCCS
3. The Differential Adjusted Payment will apply to claims for covered AHCCCS services where the rendering provider ID on the claim is the same as the prescribing provider ID that was identified and found to meet the criteria described above.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

This section provides documentation of the pass-through payments in the ACC program. Since the cost proposal is only for the non-benefit expense portion of the final capitation rates, there is no provision for these pass-through payments included in this proposal.

ii. Appropriate Documentation

(a) Description of pass-through payments

In accordance with A.R.S. §36-2905.02, small rural hospitals shall receive additional payments from AHCCCS in order to increase inpatient reimbursement. The Contractor shall be required to pass-through payments to qualifying network providers. AHCCCS will compute the participating provider payments during the contract year and will make available to the Contractor a list of small rural hospitals and associated pass-through payment amounts for the contract year. At the same time, AHCCCS will adjust capitation rates either as a per member per month adjustment or in the form of a lump sum payment to the Contractor in an amount equal to the pass-through payments due small rural hospital providers. The pass-through payments shall not supplant any payments to eligible providers.

5. PROJECTED NON-BENEFIT COSTS

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR § 438.5(e), the development of the non-benefit components of the cost proposal includes reasonable, appropriate, and attainable expenses related to a bidder's administration on the ACC program.

The remainder of this section provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the cost proposal.

ii. PMPM versus Percentage

The non-benefit costs were developed as per member per month costs, and then segmented into the fixed and variable portions according to the non-benefit cost bid template provided by AHCCCS.

iii. Basis for Variation in Assumptions

Any differences between the proposed non-benefit costs, according to each GSA, are based on valid resource requirement differences based on the membership volume, concentration/dispersion of the eligible individuals and acuity by category of aid. The proposed non-benefit costs do not vary based on the rate of federal financial participation associated with the covered population

iv. Health Insurance Providers Fee

As an not-for-profit organization Mercy Care will receive more than 80% of its revenue from governmental programs; therefore, it is not subject to the health insurance providers fee.

B. APPROPRIATE DOCUMENTATION

i. Development of Non-Benefit Costs

(a) Description of the data, assumptions and methodologies

Data

The primary sources used in the development of the CYE19 non-benefit costs are listed below:

- Mercy Care's historical administrative expenses
- Aetna Medicaid's standard staffing model
- The ACC RFP contract staffing requirements
- The ACC RFP contract capitalization requirements

Assumptions and Methodology

The administrative expense per member per month costs were developed by accounting for the resource requirements as described in the ACC RFP Contract as well as incorporating Aetna Medicaid Administrator's standard administrative management expense levels. Since Mercy Care Plan is currently a contractor in the Acute Care Program, we developed projections using two (2) different methods:

1. We used the historical expense levels of Mercy Care for calendar year 2017 (CY17), adjusted to account for the actual volume vs. the required assumed volume in the bid template, trended forward to account for inflation, added on the additional resources necessary to support the behavioral health and child rehabilitative services expenses to be integrated into the ACC program from the separate programs beginning October 1, 2018. This method is the primary methodology used to create the non-benefit cost proposal.
2. Aetna Medicaid Administrators is the sole administrator for Mercy Care. Aetna Medicaid Administrators utilizes a proprietary staffing model to evaluate the administrative expenses based on resource requirements but can also be used to evaluate the appropriateness of current market expenses. This method is the secondary methodology used to evaluate and validate the reasonableness of the primary methodology, described in #1 above.

Historical Expense Level Methodology

The base data year used was from January 1, 2017 through December 31, 2017. In consultation with Mercy Care's Finance Team, we split the expenses into Fixed vs. Variable expenses within the base data year. To adjust the expenses from the base period to contract year ending 2019, we included a 1.0% annual inflation adjustment to the fixed expenses and a 2.0% annual inflation adjustment to the variable expenses.

We also included the benefit expenses we project not to be accepted by AHCCCS. Mercy Care has a long history of submitting encounter data to AHCCCS, yet is still not able to achieve greater than a 99.0% acceptance rate. The roughly 1.0% of encounters not accepted are primarily due to eligibility changes that occur after claims are processed and paid that cannot be recovered from the provider. Aetna Medicaid Administrators is in the process of updating the encounter data submission software package in their claims processing system such that they expect the encounter acceptance rate to increase but still expect some level of encounters to remain unaccepted. Since AHCCCS bases the benefit portion of the capitation rate solely on the accepted encounter records, we have incorporated the expected unaccepted encounter expenses within the historical non-benefit expenses since those expenses are borne by Mercy Care, but are not accounted for in the benefit expenses. The historical unaccepted encounter data is 1.0% of the CY17 benefit expenses for Mercy Care. We have included a (8.0%) annual adjustment factor to account for the expected improvements in the encounter data accepted during the rating period.

Mercy Care Plan is currently a Contractor in the Maricopa and Pima Only GSAs. They have nearly a million member months more than the 3,170,000 required by AHCCCS for the non-benefit cost proposal in the Central GSA and over a million member months less than the 1,630,000 required in the South GSA. Therefore, a membership volume adjustment must be incorporated to adjust the fixed administrative expense per member per month value.

Along with Mercy Care's Finance Team, we consulted the Medical management and other subject matter experts to determine the necessary additional resources to support the behavioral health and child rehabilitative services benefits in the ACC RFP.

Mercy Care is currently not a Contractor in the North GSA. Therefore, we have developed the North GSA non-benefit cost proposal using the South GSA non-benefit cost proposal as the starting point. It was determined that the South GSA is a better starting point than the Central GSA due to the similarities in member month volume, geographic concentration and dispersion and the limitation of any Contractor being awarded the entire state and likelihood Mercy Care would be awarded only one (1) of those two as an incremental addition to the Central GSA. To adjust the South GSA to the North GSA, the fixed expense was adjusted for the member month volume difference and the variable expense was adjusted by 2.27% to account for the additional geographic dispersion in the North GSA.

Staffing Model Methodology

General administrative costs were built from the ground up based on the standard Aetna Medicaid Administrators staffing model, assuming the member month levels as required by AHCCCS for each GSA and assuming that Mercy Care would, at a minimum, be awarded the Central GSA. The North and South GSAs were then modeled as additional incremental additions to the Central GSA. The GSA combinations were performed such that the fixed administrative expenses would be distributed over more member months and more regions. It is highly unlikely any Contractor would be willing to accept being a Contractor for the North or South GSA only. A single GSA Contractor can only be viable and have a competitive administrative expense bid in the Central GSA.

Medical management and other subject matter experts were consulted to provide, confirm, and review staffing standards to support the resource requirements set forth in the ACC RFP.

(b) Material changes

Since the prior RFP, the administrative expense load in the capitation rates has been based on the Contractor's per member per month administrative expense RFP bid. No adjustments for inflation, volume or resource requirements were incorporated into the per member per month rate during each year's capitation rate update. The administrative expense load within this non-benefit cost proposal accounts for all those adjustments plus the additional resources necessary to manage the behavioral health and child rehabilitative services benefits.

(c) Other material changes

The prior RFP and prior per member per month rates did not include a separation of fixed versus variable expenses.

ii. Non-Benefit Costs by Category

(a) General administration

Historical Expense Level Projection

The administrative expenses were projected using actual expenses from January 1, 2017 through December 31, 2017. The detailed calculation for each GSA is included in Appendix 1.

Staffing Model Projection

The results from the staffing model for each GSA are included in Appendix 2. The staffing model does not account for the unaccepted encounter expenses so those were included based on the historical expense level projection.

Administrative Expense Bid

The results of the staffing model projection are greater than the historical expense projection, for each GSA. During consultation with the Mercy Care executive management team, we have concluded that Mercy Care has been able to perform more efficiently than the staffing model due to their size and long standing history of managing the various Medicaid programs in Arizona. They have been able to achieve a level of efficiency that the staffing model does not contemplate.

Therefore, Mercy Care has decided to use the historical expense level projection for the administrative expense bid.

(b) Underwriting gain load

The underwriting gain load is intended to include items such as cost of capital, risk mitigation, contingency, and profit.

Cost of Capital

Cost of Capital = Required Capital as a % of Revenue * Required Return on Capital / (1 – Tax Rate)

The ACC RFP Contract requires Contractors to maintain capital at $150 per member in CYE19, $200 per member in CYE20 and $250 per member in CYE21 or $12M in the Central GSA, $10M in the South GSA, or $7.5M in the North GSA, whichever is greater. Due to Mercy Care's size, we fully expect the per member capitalization requirement to prevail as the greater amount, each contract year. In our estimation, the capital requirements would equate to roughly 3.9%, 5.2% and 6.5% for CYE19, CYE20 and CYE21, respectively, of the annual revenue that must be set aside. It would also be financially prudent to hold more than the minimum required to allow for cash flow fluctuations, catastrophic losses and/or expenses that exceed revenues such that the minimum capital requirement will not be breached on a regular basis. It would be reasonable to increase the minimum capital by 15% to create a buffer against the aforementioned potential issues; that would set the capitalization assumption at 4.5%, 6.0% and 7.5%, respectively, of the annual revenue.

A reasonable return on capital is 7.00%, based on expected required returns on retained earnings versus expected returns from an investment portfolio invested moderately in corporate bonds, corporate equities and other investments.

Mercy Care is a 501.(c).(3) organization. As such, the company is not subject to federal, state or local taxes. Therefore, the corporate tax rate is 0.0%.

CYE19 Cost of Capital = 4.5% Required Capital * 7.0% Return on Capital / (1 – 0.0% Tax Rate) = 0.31%

Risk Mitigation and Contingency

We have studied the volatility that is typical and standard within Medicaid programs. The results vary by Medicaid program because of the inpatient facility fee schedule style (per diem, percent of billed charges, as well as interaction of the DRG schedule version and outlier provisions), acuity of individuals in the program and membership/revenue volume of the program and number of contractors. Prior to adjusting for other risk mitigation provisions within a program, it would be reasonable to set the risk mitigation and contingency load between 1.0% and 2.0%.

For the ACC program, prior to accounting for the AHCCCS provided reinsurance, we think it would be reasonable to include 1.0%. The inpatient facility reimbursement is DRG based which helps reduce the volatility caused by long and catastrophic inpatient stays, the membership/revenue volume is quite substantial due to the limited number of contractors and any changes to the covered populations, features and acuity of the ACC program is moderate and/or stable.

AHCCCS also provides reinsurance coverage for: 1) inpatient hospital expenses above a $50k threshold, 2) select, high cost, pharmaceuticals, and 3) transplants. As a result, it would be reasonable to reduce the 1.0% load to 0.5% since the contractor will not be subject to the expenses, which drive a large share of any monthly and/or annual expense volatility.

Profit

The cost of capital and the risk mitigation and contingency loads are calculated as the amounts to make the contractor whole based on best estimates of the minimum capital requirements and volatility risks. However, the contractor should also expect to generate a profit for taking on the risk of managing the program such that the business decision would be to invest the capital into the management of the program rather than investing that capital in a different investment opportunity. It would be reasonable to include 0.25% to 1.00% to cause the business to choose investing the capital into this opportunity rather than another investment opportunity.

Underwriting Gain Load

All combined, cost of capital + risk mitigation and contingency + profit, it would be reasonable for Mercy Care to expect an underwriting gain load between 1.06% and 2.02% to compensate and account for the risks they are taking in the ACC program. Within the ACC RFP, the bidding contractors are limited to bid the underwriting gain load between 0.0% and 1.0%. Therefore, 1.00% is included for years 1, 2 and 3 within the cost proposal.

	CYE19	CYE20	CYE21
Cost of Capital	0.31%	0.42%	0.52%
Risk Mitigation and Contigency	0.50%	0.50%	0.50%
Profit			
Low	0.25%	0.25%	0.25%
High	1.00%	1.00%	1.00%
Underwriting Gain Load			
Low	1.06%	1.17%	1.27%
High	1.81%	1.92%	2.02%
Proposed UW Gain Load	**1.00%**	**1.00%**	**1.00%**

(c) Premium tax

The premium tax is 2.00%. The final CYE19 capitation rates will incorporate a separate load for the premium tax during the final capitation rate development process. Therefore, the premium tax is not included within the non-benefit cost proposal.

iii. Health Insurance Providers Fee

As a not-for-profit organization Mercy Care will receive more than 80% of its revenue from governmental programs; therefore, it is not subject to the health insurance providers fee.

6. RISK AJDUSTMENT AND ACUITY ADJUSTMENTS

This section provides information on the risk adjustment included in the ACC program.

A. RATE DEVELOPMENT STANDARDS

i. Overview

The ACC program capitation rates will be developed as full risk rates. The Contractors assume risk for the cost of services covered under the contract and incur losses, limited to (2.0%), if the cost of furnishing the services exceeds the payments under the contract. The capitation rates for each of the TANF <1, TANF 1-20, TANF 21+, SSI with Medicare, SSI without Medicare, AHCCCS Care <106% FPL, AHCCCS Care >106% FPL rate cells will be prospectively risk adjusted by Contractor to reflect the estimated cost differences in the underlying population enrolling in each Contractor.

ii. Risk Adjustment Model

Due to the integration of the behavioral health and child rehabilitative services into the ACC program beginning October 1, 2018, AHCCCS intends to perform non-diagnostic based population risk adjustments for the first few years of the contract under the ACC program and then move to diagnostic based population risk adjustment. This will include non-diagnostic based population risk adjustment necessary for the movement (member choice) of behavioral health utilizers. AHCCCS intends to review member placement quarterly during the first year to see if the non-diagnostic based population risk adjustment factors should be adjusted.

The non-diagnostic based population risk adjustment factors will be developed using historical encounter and member month data and member placement files. The historical data and the member placement files will be compared to determine where each historical member is enrolled. The non-diagnostic based population risk adjustment factors will be developed by rate cell, by Contractor, and will be budget neutral. Development of the non-diagnostic based population risk adjustment factors involves taking the relationship of historical encounter PMPM data by rate cell by Contractor to the total historical encounter PMPM by rate cell. The capitation rates will be developed by rate cell by GSA and thus will represent the average of all Contractors in that GSA and rate cell. The non-diagnostic based population risk adjustment factors will then be applied to the average capitation rates to get each Contractor's specific capitation rates. Since this will be budget neutral, some Contractors will have non-diagnostic based population risk adjustment factors above 1.00 and some below 1.00.

B. APPROPRIATE DOCUMENTATION

i. Prospective Risk Adjustment

Section I.6.B.i is not applicable to this non-benefit cost proposal narrative.

ii. Retrospective Risk Adjustment

Not applicable; the population acuity adjustments will be a prospective methodology.

iii. Changes to the Risk Adjustment Model

The current Acute Care program capitation rates are prospectively risk adjusted using the Episode Risk Group (ERG) model v9.1, calibrated and calculated by Wakely Consulting Group.

Due to the integration of the behavioral health and child rehabilitative services into the ACC program beginning October 1, 2018, AHCCCS intends to perform non-diagnostic based population risk adjustments for the first few years of the contract under the ACC program and then move to a diagnostic based population risk adjustment model.

iv. Acuity Adjustments

Not applicable; the non-benefit cost proposal was developed assuming a 1.0 risk adjustment factor. No adjustment or load for acuity was included.

We recommend including an adjustment to the variable administrative expense load in the final capitation rates to account for the resources impacted by the acuity of the Contractor's enrolled individuals.

SECTON II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

Section II of the CMS Medicaid Managed Care Rate Development Guide is not applicable to the ACC program.

SECTON III. NEW ADULT GROUP CAPITATION RATES

AHCCCS expanded coverage for childless adults up to 100% of the federal poverty level (FPL) in 2000 under Proposition 204. In January 2011, this population was subject to an enrollment freeze. Effective January 2014, AHCCCS opted to expand Medicaid eligibility for all adults up to 133% FPL (Adult Expansion) and restored coverage for the childless adults up to 100% FPL program (Childless Adult Restoration). Collectively these two populations are considered new adult groups under Section III of the CMS Medicaid Managed Care Rate Development Guide.

The ACC program capitation rates include separate rate cells for the Adult Expansion and Childless Adult Restoration populations, which are also referred to as “Adults >106% FPL” and “Adults <=106% FPL”, respectively.

Essentially, the new adult group will be treated as any other ACC program rate cell.

1. BASE DATA

Similar to Section I.2, this section is not applicable to this non-benefit cost proposal narrative. We have relied upon the state and its Actuary to have audited the base data and reviewed it for reasonableness and appropriateness.

We did not perform an independent audit of the data, comparison to the supplemental financial reports from the current contractors, nor did we independently value each of the programmatic and fee schedule changes.

We did perform a reasonableness check against Mercy Care’s own experience and found the base data provided by AHCCCS to be reasonable. We also performed our own projection of the medical expenses to CYE19 to develop our own expectations of the final capitation rates that will be used solely to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

2. PROJECTED BENEFIT COSTS

Similar to Section I.3, this section is not applicable to this cost proposal narrative; Mercy Care is not submitting a full capitation rate cost proposal.

We performed our own projection of the medical expenses to CYE19 to develop our own expectations of the CYE19 medical expenses. The sole use of that projection is to review the reasonableness of the final CYE19 rates once the AHCCCS Actuary performs their calculation.

Since we are not submitting a full capitation rate cost proposal, we are not including our internal calculations within this rate narrative.

3. PROJECTED NON-BENEFIT COSTS

A. CHANGES IN DATA SOURCES, ASSUMPTIONS OR METHODOLOGIES SINCE LAST CERTIFICATION

i. Changes in Data Sources, Assumptions and Methodologies

Non-benefit cost development for the Adult Expansion and Childless Adult Restoration populations are consistent with the development documentation included in Section I.5 of this narrative.

ii. Assumption Changes Since Previous Certification

Since this is an RFP cost proposal, this section is not applicable to this narrative.

B. KEY ASSUMPTIONS

There are no key assumptions specific to the New Adult Group populations, separate from the other populations in the ACC program.

4. FINAL CERTIFIED RATE OR RATE RANGES

This section is not applicable to this rate narrative since AHCCCS will be developing the full capitation rates.

5. RISK MITIGATION STRATEGIES

A. DESCRIPTION OF RISK MITIGATION STRATEGY

The ACC program does not include any risk mitigation strategy or methodology specific to the New Adult Group populations. The New Adult Group populations are subject to the same risk corridor methodology as described in Section I.4.C.ii.(a).

B. DOCUMENTATION

i. Changes in Risk Mitigation Strategies

Beginning with the introduction of coverage for the Adult Expansion population in January 2014, the Acute Care program applied a distinct risk corridor specific to that population, by contract year, until CYE18. The risk corridor limited the Contractors to expenses ± 1.0% of the projected expenses.

As noted in Section III.5.A above, the New Adult Group populations are subject to the same risk corridor as the other rate cells, in the ACC program.

SECTON IV. CAPITALIZATION TO MEET MINIMUM EQUITY REQUIREMENTS

This section, not included in the Medicaid Managed Care Rate Development Guide, is provided to meet the requirement of *Section F – Non-Benefit Cost Bid Requirements* that the Actuarial Certification include a statement and description of why the bidding Contractor has no concern meeting the capitalization requirements in the ACC program.

Mercy Care, formerly Mercy Care Plan, has been a Contractor within the Acute Care, ALTCS and DDD Programs for many years. They are currently well capitalized, holding $77.7M in net equity for their Acute Care contract versus a minimum requirement of $42.3M, as of December 2017.

The ACC RFP Contract requires Contractors to maintain capital at $150 per member in CYE19, $200 per member in CYE20 and $250 per member in CYE21 or $12M in the Central GSA, $10M in the South GSA, or $7.5M in the North GSA, whichever is greater. Due to Mercy Care's size, we fully expect the per member capitalization requirement to prevail as the greater amount, each contract year.

We are estimating that Mercy Care will need to maintain net equity levels of approximately $70M in CYE19, $95M in CYE20 and $120M in CYE21, taking into account the increased per member capitalization requirements and expected membership volume growth from a decrease in the number of Contractors as well as consolidation of the GSAs from 7 to 3.

There are three (3) different resources by which Mercy Care intends to capitalize the ACC program to meet the minimum equity requirements:

1. Retained Earnings from Current Operations

Mercy Care, formerly Mercy Care Plan, is currently an Acute Care program Contractor. Mercy Care expects to be able to increase the retained earnings of their Acute Care contract through current operating earnings. The owners of Mercy Care understand they will not be able to receive any distributions from the retained earnings in order to ensure the Acute Care / ACC program meets the minimum equity requirements.

2. Transfer of Retained Earnings from other AHCCCS Contract Accounts

Mercy Care, formerly Mercy Care Plan,s currently a Contractor for the ALTCS and DDD programs. Each of those contracts is capitalized well in excess of their minimum requirements. The ALTCS contract is $48.6M and the DDD contract is $16.3M in excess of their respective minimum equity requirements, as of December 2017. Mercy Care could request to have a portion of those excess funds transferred to the Acute Care / ACC program contract, if the retained earnings from the ongoing operations in #1 above are inadequate to meet the minimum equity requirements.

3. Capital Infusion from the Parent Organizations

Mercy Care is a joint venture between Dignity Health and Ascension Health. Both parent organizations are currently well capitalized, have the means and are prepared to infuse additional capital into Mercy Care, if the funding from #1 and #2 above are exhausted and inadequate to meet the minimum equity requirements.

LIMITATIONS

The information contained in this report has been prepared for the Arizona Health Care Cost Containment System (AHCCCS) and Department of Health Care Management (DHCM) Actuarial Team to provide documentation of the development of the contract year 2019 non-benefit cost proposal for Mercy Care. The data and information presented may not be appropriate for any other purpose.

The information contained in this narrative, including the attachments, has been prepared for AHCCCS, the DHCM Actuarial Team and their consultants. Any distribution of this narrative should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modelling so as not to misinterpret the information presented herein.

We have relied upon certain data and information provided by AHCCCS and the DHCM Actuarial Team in the development of this non-benefit cost proposal. We have relied upon AHCCCS and the DHCM Actuarial Team for the reasonableness and accuracy of the data, the programmatic change impacts and the fee schedule impact changes without audit. To the extent the data provided is not accurate, the non-benefit cost proposal may need to be modified to reflect the revised information.

Guidelines issues by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this narrative are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis contained within this narrative.

ATTESTATION

I, Jason Strandquist, am an employee of Aetna Life Insurance Company, the contracted administrator for Mercy Care, formerly Mercy Care Plan. I am also a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have reviewed the assumptions and methods used to develop the non-benefit cost proposal submitted for the AHCCCS Complete Care RFP. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

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

In my opinion, the assumptions used in developing the non-benefit cost proposal for RFP YH19-0001 are actuarially sound for the purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements under 42 CFR § 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial Standards of Practice (ASOP) applicable to Medicaid managed care rate setting: ASOP 5 (Incurred Health and Disability Claims), ASOP 23 (Data Quality), ASOP 25 (Credibility Procedures), ASOP 41 (Actuarial Communications), ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies) and ASOP 49 (Medicaid Managed Care Rate Development and Certification).
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

For the purposes of this attestation, and consistent with the requirements under 42 CFR § 438.4(a), "actuarial soundness" is defined as in ASOP 49:

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

_____ January 24, 2018

Jason Strandquist, FSA Date

Member, American Academy of Actuaries

APPENDIX 1: Administrative Expense Projection -

Mercy Care Historical Data Methodology

State of Arizona
Arizona Health Care Cost Containment System
AHCCCS Complate Care RFP
CYE 2019 Administrative Expense Development
Historical Expense Methodology

	Calendar Year 2017		Annual	Inflation	Inflation	Bid MM	ACC Program Changes		Contract Year Ending 2019	
	MMs	PMPM	Inflation	Factor	Adjst'd PMPM	Volume Adj	Add BH	Add CRS	Bid MMs	PMPM
Mercy Care										
Fixed Expenses		$ 3.81	1.0%	1.0175	$ 3.87					
Variable Expenses		18.49	2.0%	1.0352	19.14					
Unaccepted Encounters		2.82	(8.0%)	0.8644	2.44					
Total	**4,549,599**	**$ 25.11**			**$ 25.45**					
Maricopa/Central GSA										
Fixed Expenses		$ 2.67	1.0%	1.0175	$ 2.72	1.2873	1.0000	1.0000		$ 3.50
Variable Expenses		18.75	2.0%	1.0352	19.42	1.0000	1.0163	1.0080		19.89
Unaccepted Encounters		2.82	(8.0%)	0.8644	2.44	1.0000	1.0000	1.0000		2.44
Total	**4,080,653**	**$ 24.25**			**$ 24.57**				**3,170,000**	**$ 25.83**
Pima/South GSA										
Fixed Expenses		$ 13.66	1.0%	1.0175	$ 13.90	0.2877	1.0000	1.0000		$ 4.00
Variable Expenses		16.14	2.0%	1.0352	16.71	1.0000	1.0261	1.0089		17.30
Unaccepted Encounters		2.82	(8.0%)	0.8644	2.44	1.0000	1.0000	1.0000		2.44
Total	**468,946**	**$ 32.62**			**$ 33.05**				**1,630,000**	**$ 23.74**
					South GSA PMPM	**Conversion to North GSA**				
North GSA										
Fixed Expenses	Not applicable since Mercy Care is not currently operating in the North GSA.				$ 4.00	1.1250				$ 4.50
Variable Expenses					17.30	1.0227				17.69
Unaccepted Encounters					2.44	1.0000				2.44
Total					**$ 23.74**				**990,000**	**$ 24.63**

APPENDIX 2: Administrative Expense Projection -

Staffing Model Projections

State of Arizona
Arizona Health Care Cost Containment System
AHCCCS Complate Care RFP
CYE 2019 Administrative Expense Development
Staffing Model Methdology

	GSA		
	Central	**South**	**North**
Member Months to Use for Bidding	3,170,000	1,630,000	990,000

Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 25.39	$ 27.39	$ 30.20
Unaccepted Ecnounters	2.44	2.44	2.44
Total Non-Benefit Costs (excluding UW Gain)	**$ 27.83**	**$ 29.83**	**$ 32.64**

Executive Summary

As affiliated organizations, Mercy Care Plan and Mercy Maricopa Integrated Care are committed to the success of the Arizona Complete Care (ACC) program and will further this goal by forming a new single entity and brand – Mercy Care. Mercy Care's only authorized business is to provide services under this Contract to AHCCCS-eligible persons enrolled with Mercy Care. In addition, we operate a CMS-approved, State-contracted D-SNP serving beneficiaries eligible for both Medicare and Medicaid.

Mercy Care is a not-for-profit, locally owned and operated company with strong roots in Arizona and an over 30-year history of serving Medicaid members in Arizona. Mercy Care brings a unique understanding of the AHCCCS system due to our experience in managing integrated physical health (PH) and behavioral health (BH) benefits in the AHCCCS system for multiple populations - Arizona Long Term Care System (ALTCS) members, Mercy Care Advantage members, ALTCS members with CRS-eligible conditions, persons with a serious mental illness, and dual-eligible members with General Mental Health/Substance Use needs. As one of the largest Contractors in Arizona, Mercy Care delivers services to more than 528,000 members and offers fully integrated care to over 53,000 AHCCCS members. ACC members who choose Mercy Care will benefit from a positive member experience notable for ready access to high-quality, high-value health services at a variety of locations and settings. We will apply lessons learned from our existing programs to enhance service delivery for every ACC member.

Mercy Care works closely with providers, stakeholders, and AHCCCS to develop and deliver programs and services that improve health outcomes and member satisfaction while bending the cost curve. Members who choose Mercy Care benefit from an outstanding member experience notable for its easy access to high quality, high value health services at a variety of locations and settings. Mercy Care will leverage existing organizational practices and scale innovative programs to implement the principles and components of a delivery system that meets members' PH, BH and psychosocial needs. Based on our experience delivering quality care through an integrated approach, we have identified the following key elements that are critical for system integration. These components align with AHCCCS' values, principles of BH and PH service delivery, goals, and strategic plan.

Member-centered care – Our approach to integration is based on the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, the Arizona Practice Model and 12 Principles, and incorporates member and family voice and choice. As part of our unwavering pledge to treat each member, family, and system partners with dignity and respect, Mercy Care provides an environment for collaborative, responsive, culturally and linguistically competent care that emphasizes recovery and improved clinical outcomes. We engage members and family members in decision-making and seek input on service delivery at all levels.

Accessible and culturally competent service delivery – Our network supports members' ability to access care in rural and urban communities and includes PH, BH, specialty (including Multi-Specialty Integrated Clinics) and community-based providers. Mercy Care's provider network is in place today and ready to serve ACC members. In collaboration with providers and stakeholders, Mercy Care develops programs that deliver accessible, high quality care, such as Centers of Excellence for members with autism spectrum disorder, Centers of Excellence for pain/substance use disorders and medication-assisted treatment (MAT). We will expand these programs in each GSA based on community need.

Integrated, evidence-based, best practice care management and care coordination – Our care management program offers preventive strategies and interventions that help members make healthy lifestyle choices that improve their quality of life, lower their disease burden, and lower current and future health costs. Program components include predictive modeling, risk stratification, health risk screenings, comprehensive assessment, chronic condition management, person-centered planning, outreach, prevention programs, health promotion and wellness programs, education, and coaching. Our

care coordination program offers assistance with making and keeping needed medical and/or BH appointments, health coaching, and referrals related to a members' immediate needs, primary care provider (PCP) reconnection, and resources and materials related to wellness, lifestyle, and prevention. Mercy Care's care coordination program integrates care management and chronic disease management strategies to help members take charge of their health.

Stakeholder and Community Collaboration – Mercy Care collaborates with members, families, and stakeholders to meet members' whole health needs in a coordinated way. We work side-by-side with system partners and community-based organizations to connect members to services and supports and coordinate care. Through our community reinvestment program, Mercy 360 Community, we partner with community organizations to address the social determinants of health in the communities we serve. Some of the programs we fund include school-based clinics, family services, community gardens, financial management training, the Fresh Express mobile market, and expansion of housing options. We will partner with organizations in all awarded GSAs to implement Mercy 360 Community to reduce health inequities and improve health outcomes.

System Innovations – As part of Mercy Care's mission to increase access to high-quality, cost-effective health care, we seek opportunities to develop and implement new programs, processes, systems, organizational structures, and technologies to add value to the service delivery system. Mercy Care is expanding the use of technology to support integration, engage with members, and share actionable information with providers. We are leveraging Health Current to enhance data flow, improve member satisfaction, facilitate coordination of care, increase quality of care, reduce costs, and facilitate a collaborative approach to service delivery. Further, Mercy Care is using mobile technology to offer members a personalized, self-directed experience. Members will have access to 24/7 support through mobile applications and a mobile integrated health platform that allows members to speak with an Arizona-based physician on the phone or via HIPAA-compliant video teleconferencing.

Continuous Quality Improvement – Mercy Care conducts ongoing self-monitoring to achieve and maintain improvements on quality measures to determine the level to which the system is efficient, coordinated, and person-centered and increases health outcomes. As a result, we have achieved scores of 97 percent compliance with AHCCCS' standards on operational reviews for our ALTCS, Acute, and RBHA programs and a 99 percent compliance score for the Division of Developmental Disabilities program. Additionally, positive outcomes for members include:

- 43% decrease in readmission rates after provider follow-up upon discharge from a BH facility
- 39% decrease in readmission rates after follow-up upon discharge from an inpatient facility
- 16% decrease in 30 day all cause readmission rates
- 76% of members live in community-based settings and receive quality, cost-effective services
- 95% of adults received preventative/ambulatory health services
- 82% of those diagnosed with diabetes completed testing to measure HbA1c levels

As a quality leader recognized formally and informally by AHCCCS, CMS, and NCQA, we bring unparalleled experience in developing high-quality service delivery systems.

Mercy Care Adds Value to the ACC Program Through New Strategies and Innovations

Mercy Care adds value to the ACC program by bringing innovative programs that improve individual health outcomes, enhance care coordination and increase member satisfaction. These include:

Community Comprehensive Health Program (CCHP) – This program, which was awarded the Housing Hero award from the Arizona Department of Housing, provides a fully integrated model for members experiencing homelessness, with substance use needs, and who are high risk. Services include MAT, housing and employment support, PH and BH services, biopsychosocial supports, and care coordination.

Community Health Workers (CHWs) – CHWs help members navigate the service delivery system and access care. In southern Arizona, a number of local hospitals and physician groups are using CHWs to provide support services that promote improved continuity of care and chronic disease management.
Reach-out program – Probationers receive support to transition from jail into residential substance abuse treatment, reducing the risk for recidivism and helping them to successfully re-enter the community.
Center of Excellence for pregnant women – We are working with Arizona Mother-Baby Care, which will function as a clinically integrated network focusing on obstetrical, perinatal, and post-neonatal care outcomes. We will designate the network as a Center of Excellence and it will become part of our approach to delivering high-quality care in accordance with evidence-based practices.
Housing partnerships – We partner with housing providers that administer Housing and Urban Development (HUD) housing, including:

- Arizona Department of Housing and Housing Continuum of Care to provide service dollar match to further increase housing security for members
- Counties' and cities' housing authorities to address the housing needs of our shared members
- Other agencies, such as United Way and Arizona Housing Coalition

Mercy Care will continue to work collaboratively with housing agencies to expand these opportunities and include partnerships with public housing authorities in each GSA we serve.
Collaborating with oral health providers – We coordinate low-cost or no cost-to-the-member services for pregnant women at risk of pre-term labor, adult persons with oral health challenges resulting from substance use disorder who are engaged in recovery and whose oral health challenges may be limiting their achievement of recovery, and people with developmental disabilities whose oral health may be impacting larger outcomes such as cardiovascular health.
Implementing community paramedicine contracts – We contract with paramedics to perform risk assessments, conduct referrals to primary care doctors and skilled home services, conduct medication reviews, and provide preventive services such as immunizations. Mercy Care will work with emergency medical services providers, hospitals, and health care and social services providers to implement paramedicine programs, as needed in each GSA.
Increasing the use of peer and family support – Peers assist members and families (including members receiving MAT, members with diabetes, and refugees) in navigating the service delivery system.

Mercy Care Meets Medicare Requirements

Since 2006, Mercy Care has provided high-quality, cost-effective, and culturally competent care to dual-eligible members in our Mercy Care Advantage (MCA) D-SNP, which serves over 18,300 dual-eligible members in Pima, Pinal, Gila, Santa Cruz, and Maricopa counties. MCA is approved to operate in all GSAs in Arizona and meets AHCCCS' requirements for value-based contracting. CMS designated MCA as a Fully Integrated D-SNP. In May 2016, Mercy Care received approval from CMS to process Seamless Conversion Enrollments. We coordinate seamless conversion enrollment of newly Medicare-eligible individuals who are currently enrolled in our Medicaid plan. ***Among our MCA members, 96% are fully aligned with Mercy Care for their Medicaid benefits.*** We will continue to collaborate with AHCCCS to develop and implement additional strategies to enhance alignment of dual-eligible members.

Mercy Care is unique among ACC bidders in our ability to offer a fully integrated organizational structure that meets ACC requirements on day one of contract launch. We are invested in transforming the Arizona Medicaid system and are committed to the success of the ACC program. We look forward to continuing our partnership with AHCCCS, other health plans, stakeholders, and providers to implement best-in-class innovative approaches to deliver excellent services, create administrative efficiencies, and improve member outcomes.

Moral or Religious Objections

Mercy Care (MC), the single brand and legal entity for the AHCCCS Complete Care contract, will continue to offer family planning benefits in the same manner that Mercy Care Plan has done for many years, as explained below. Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan (MCP) was formed as an Arizona nonprofit corporation in 1985, after representatives of the state's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), invited Catholic hospitals to participate in the Medicaid program.

Two Arizona-based provider organizations, Ascension Arizona (a ministry of Ascension Health, formerly known as Carondelet Health Network) and St. Joseph's Hospital and Medical Center (a Dignity Health member), created MCP as a mission-based entity to serve Medicaid members in Arizona. The sponsors strongly believed that the formation of MCP was an important extension of the Catholic mission to serve the poor and persons with special needs.

Federal law mandates that state Medicaid agencies provide coverage for certain identified "family planning services." Some of these benefits conflict with Catholic teaching and values, and MCP's corporate members have religious and moral objection to providing those conflicting benefits listed in the AMPM Section 420. In the early years of Arizona's Medicaid program, AHCCCS contracted directly with providers for these benefits. However, AHCCCS discontinued direct contracting in 1997 and moved responsibility for all family planning benefits to health plans contracted with AHCCCS to administer Medicaid benefits.

At that time, MCP presented a plan to engage a third-party administrator for family planning benefits to Arizona Catholic leaders and AHCCCS. A third-party administrator was engaged in April 1997, and began providing the benefits on October 1, 1997. This third-party arrangement continues today.

MCP has entered into a separate contract with Aetna Medicaid Administrators (Aetna Medicaid) to administer those family planning benefits that MCP will not provide for religious or moral reasons. This arrangement, originally implemented in 2003 with approval by AHCCCS, continues today. All covered and medically necessary services will be available to AHCCCS members by MCP or its subcontractor Aetna Medicaid to meet the covered services requirement. Any payments due to Aetna Medicaid for the activities defined in their contract will be the responsibility of MCP.

In accordance with A.R.S. §36-2907(A)(8), MCP's election does not disqualify MCP from delivering all other covered health and medical services, and MCP selects Aetna Medicaid for administering family planning and certain OB/GYN services. Therefore, all covered and medically necessary services will be available to AHCCCS members.

1. Mercy Care's Experience

Mercy Care is the only contractor in Arizona that is currently managing care for every member category served by the AHCCCS managed care system. We have been an active part of the Arizona health care community since 1985 and offer high-quality, person-centered health care, support systems and recovery opportunities that promote resiliency and self-reliance for our members and their caregivers.

Mercy Care delivers comprehensive, individualized care solutions. We are proud to oversee service delivery for members' medical, behavioral, substance abuse, long term care, developmental, and special health care needs, including members with CRS conditions, through our Long Term Care program. Every one of the members we serve and the providers in our network benefit from our long presence in Arizona. They experience high levels of satisfaction due to our outstanding customer service, innovative programming, and integrated approach.

Arizona Medicaid Contracts

Mercy Care Plan holds the following contracts **in good standing** with AHCCCS to provide Medicaid Managed Care for the citizens of Arizona. Our programs for Arizona Medicaid members include:

Acute Care

As a recognized leader in the AHCCCS Acute Care program, Mercy Care delivers integrated person-centered acute care service to approximately 377,000 children and adult members in the current GSAs 10 and 12. Mercy Care is proud to be the health plan of choice in Maricopa and Pima counties, with a large number of our new enrollment each month coming from members and families who choose us as their health plan. We continue to earn the trust of our members, families and providers. Through our Acute Care program, we provide medical services to members through a network of PCPs, OB/GYNs, pediatricians and specialists in every area, including transplantation services, ancillary, and hospital providers.

Arizona Long Term Care Program

Mercy Care is contracted to provide fully integrated services through the Arizona Long Term Care System (ALTCS) program, which is designed for people who are 65 years or older and/or physically disabled or developmentally disabled and need the services of a Skilled Nursing Facility or Assisted Living Facility. We have a current enrollment of approximately 12,400 members, making us the largest ALTCS contractor serving enrollees in Maricopa, Gila, Pinal and Pima counties. We have been actively contracted with AHCCCS for these services and have remained in good standing since October 2000. Long Term Care services are fully integrated with general mental health and substance use treatment. Additionally, we serve over 1,000 individuals who have been determined seriously mentally ill and 250 members with CRS conditions.

Subcontract with the Division of Developmental Disabilities

The Division of Developmental Disabilities (DDD) is a part of the Arizona Department of Economic Security (DES). It helps people with developmental disabilities achieve independence. It also provides support to family members and other caregivers. Mercy Care Plan has contracted directly with the Division of Developmental Disabilities (DDD) to provide comprehensive medical services to approximately 12,000 DDD members in the counties of Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz and Yuma since 2011 and remains in good standing. Through this contract, we offer acute care services to members who have developmental disabilities and connect members to behavioral health services. This contract is for acute medical services; however, Mercy Care also holds the contract for behavioral health services for this population, enabling us to coordinate care.

Additionally, we serve over 4,000 members who are involved in the Children's Rehabilitative Services program, offering primary care and behavioral health services.

Regional Behavioral Health Authority (RBHA)

Mercy Maricopa Integrated Care, our affiliated organization, is currently the Regional Behavioral Health Authority (RBHA) for Maricopa County. We have served as the RBHA for the current GSA 6 since 2014 and have remained in good standing. We serve over 949,000 children and adult members with PH, BH and biopsychosocial needs. The members we serve include priority populations, such as children and families involved in child welfare, justice involved members, tribal members and members with opioid use disorders. Through this contract, we have increased access and utilization of services, implemented evidence-based practices to address social determinants of health (i.e. housing, employment, etc.), engaged community partners and multi-systemic stakeholders in collaborative protocols to close gaps and reduce duplication, and have worked to reduce administrative burden on providers and maximize cost savings for the State.

Non-Medicaid Contracts

In addition to AHCCCS-related programs, Mercy Care also contracts directly with the Centers for Medicare and Medicaid Services to provide services for dual-eligible members. Mercy Care Advantage is contracted with AHCCCS and with CMS to offer Medicare covered services and prescription drug coverage. Serving approximately 19,000 enrollees in Maricopa, Pima, Pinal, Gila, Yuma and Santa Cruz counties since January 2006, Mercy Care Advantage D-SNP is an integrated plan, delivering behavioral health and medical benefits to ensure quality care and coordination of Medicare and Medicaid covered services. Mercy Care Advantage remains in good standing with the State and CMS; we are prepared to scale the success of our D-SNP contract in all GSAs across the State of Arizona.

To further support AHCCCS' goals, Mercy Care brings a unique contribution: the Practice Innovation Institute (Pii). Pii is helping to transform more than 2,400 clinical practices across Arizona that are preparing to participate in CMS's Merit-based Incentive Payment System (MIPS) and alternative payment models. Pii is a collaborative effort between Mercy Care and Health Current to secure a $14.6 million grant from CMS's Transforming Clinical Practice Initiative—the only one awarded to an Arizona entity and one of only 29 grants across the country. Pii currently supports 49 different practice organizations that represent more than 2,400 clinicians at 450 practice locations throughout Arizona.

Through Pii, Mercy Care providers have access to tools, resources and support to move toward full integration, including adopting alternative payment models that reward providers for helping members achieve improved health outcomes, enhance members' experience in care and reduce system costs.

Summary

Through our experience and programs, we have developed an award-winning continuum of programs that support members to achieve their individualized goals, while curating population health outcomes. We have mechanisms and systems in place to adhere to all current Federal and State requirements and continue to work closely with our partners to quickly move forward with them as requirements evolve.

2. Strategies to Implement the Components and Principles of Behavioral and Physical Health Service Delivery

Improving members' health and wellness through an integrated, recovery-focused approach is at the core of Mercy Care's mission. We have integrated clinical and administrative functions to deliver an individualized, coordinated, and accessible approach to care that is consistent with clinical guidelines, evidence-based practices, and consensus from the clinical and member communities. This includes, for example, providing a single member services toll-free phone line and a single nurse triage line. Based on our experience delivering quality care through an integrated approach, we have identified the following key elements that are critical for system integration. These components align with AHCCCS' values, principles of behavioral (BH) and physical health (PH) service delivery, goals and strategic plan:

- **Member-and family-centered care** – Our approach is based on the Adult Service Delivery System-Nine Guiding Principles and the Arizona Vision-Twelve Principles for Children's Service Delivery, and incorporates member and family voice and choice in accordance with AMPM chapter 430.
- **Accessible and culturally competent service delivery** – Mercy Care works to strengthen the availability of culturally and linguistically relevant BH resources, PH services, and biopsychosocial services within the integrated delivery system.
- **Care management and care coordination** – Mercy Care recognizes that members are entitled to care and assistance navigating the service delivery system and provide care management and coordination to ensure that members and families receive necessary services. We coordinate across systems and providers to reduce fragmentation in care, while moving toward a fully integrated system, assisting members to navigate the service delivery system and ensure they receive necessary services.
- **Stakeholder and community collaboration** – We partner with stakeholders, system partners, community organizations, and health care providers to meet members' whole health needs. We recognize that health care providers are an essential partner in the delivery of PH and BH services and work alongside them to drive high quality care through innovative programs.
- **System innovations** – In collaboration with AHCCCS and stakeholders, we develop creative solutions and programs that offer collaborative, integrated care that improves health outcomes, enhances care coordination, and increases member and family satisfaction.
- **Continuous quality improvement** – Mercy Care self-monitors and self-corrects to improve health outcomes, operational efficiencies and regulatory compliance.

We have implemented these components in the AHCCCS programs (long term care, integrated care for members with SMI, dual-eligible members, acute care, developmentally disabled) we administer in Maricopa, Pinal, Gila, Santa Cruz and Pima counties. For the AHCCCS Complete Care (ACC) program, we will leverage input from members and families, our extensive experience, lessons learned from our other programs, and relationships with stakeholders and providers to implement the principles of PH and BH service delivery while maintaining a high standard of care. The following sections demonstrate how we have implemented the concepts of integrated care in our existing programs and the innovative strategies we will implement under the ACC contract.

Member-and Family-Centered Care

Members and their families are at the center of everything we do. As part of our unwavering pledge to treat each member, family, and system partner with dignity and respect, Mercy Care provides an environment for a service delivery system that is collaborative, responsive and culturally and linguistically competent, which emphasizes recovery and improved clinical outcomes. We engage members and family members in decision making and seek input on service delivery at all levels. ***Our governance structure currently includes approximately 50 peers and family members on our***

committees, exceeding AHCCCS' requirement as outlined in the ACC contract, Section D, Paragraph 5. Our Member Advocacy Committee and Youth Leadership Council obtain direct input from members and families on the quality and effectiveness of our service delivery system. Committee members provide feedback and oversight on quality initiatives, training, and opportunities to improve the system. Additionally, Mercy Care holds forums in every GSA we serve to gather feedback on community needs and the effectiveness of our strategies for meeting them.

As further evidence of our commitment to members and families, ***Mercy Care established an internal Office of Individual and Family Affairs (OIFA), focused on advocacy and obtaining member and family feedback***. OIFA fosters a culture that respects peers and family members, actively embraces their thoughts and opinions, and incorporates voice and choice at all levels.

We monitor to ensure that services are based on the member's and family's own goals and that care plans reflect their goals to increase quality of life. We emphasize services to help develop life skills, increase education retention, obtain employment, improve social skills, understand finances, and live independently. ***In 2016, Children's System of Care Practice Reviews indicated that 98 percent of the services and supports provided to children and families through Mercy Care are respectful of the family's cultural traditions.***

Accessible and Culturally Competent Service Delivery

Our vision for integrated care is a service delivery system that provides a comprehensive array of coordinated behavioral, medical, health promotion/prevention, wellness, and psychosocial services that address members' whole health needs. This member-first principle is a priority for Mercy Care. To that end, we: 1) consistently and frequently monitor the adequacy and accessibility of our provider network; 2) execute value-based contracts that encourage improvement and promote access to care; 3) implement integrated programs that engage members and families and provide whole health care; and 4) educate providers on service integration and care coordination. We will deploy these same strategies to ensure services are readily accessible for ACC members.

Provider network monitoring – Our network allows 24-hour access to covered services through extended provider office hours, urgent care, emergency services, retail clinics, and telephonic triage. We monitor the accessibility and availability of services through appointment availability audits, complaints, grievances and appeals, utilization reports, AHCCCS' 1800 report, ongoing member, family and stakeholder feedback, geoaccess reports, provider change requests, and satisfaction surveys. We use these data to identify network gaps and access to care issues and improve timely access to care. Mercy Care tracks provider compliance with appointment availability on a quarterly basis by provider type using the reporting templates in ACOM 417. Our Provider Relations staff completes ongoing site visits, reviews appointment logs, and conducts secret shopper calls.

Culturally competent services – Mercy Care's Cultural Competency Administrator oversees our strategies to ensure the delivery of comprehensive services that meet members' and families' diverse needs according to ACOM 405. These strategies are designed to eliminate racial and ethnic health disparities and include: 1) monitoring service delivery, including oversight from the Cultural Competency Committee; 2) ensuring our provider network meets the service needs of culturally and linguistically diverse members and families; 3) providing members and families with educational resources in easily understood formats and multiple languages; 4) engaging with community stakeholders for continual system improvement; 5) developing a workforce of providers and employees with expertise to serve members with unique needs; and 6) recruiting providers that reflect the diversity of our members.

Value-based contracts (VBCs) – Mercy Care has over 50 VBCs with integrated and BH providers representing a broad array of innovative programs and approaches to improve outcomes for our members. Our VBCs align incentives across providers for delivering effective care that improves the

member's experience and health while reducing costs. Provider reimbursement is tied to engaging members and families in preventive, health promotion, and wellness services. We also incent achieving positive outcomes, such as reduced emergency department (ED) visits, readmissions, opioid use and homelessness, along with improved A1C control and member health literacy.

Integrated care programs – Mercy Care has an array of integrated care programs that integrate clinical and non-clinical health care related programs and services. We have substantial experience over many years in partnering with providers and stakeholders to develop and implement innovative programs. These programs are inclusive of, but not limited to, integrated treatment, rehabilitation and support services. For example, we contract with Circle the City to provide mobile health clinics in locations where members congregate, offer medical respite to help members experiencing homelessness recover from illness or injury in a safe place, and provide primary care and preventive services. Additionally, we are funding a medical respite program for homeless individuals in Pima County as part of our *Mercy 360 Community* reinvestment program.

Provider education – Mercy Care supports provider integration through education and guidance regarding service integration and care coordination. We provide online education via our learning management system (LMS), communities of practice and face-to-face training, our website, provider manual, training manuals, and mailings. Provider education includes:

- AHCCCS BH Tool Kits, including tools for PH providers to identify and screen for BH conditions and resources to help BH providers identify and screen for PH services
- Evidence-based practices, such as medication assisted treatment (MAT), supported employment, permanent supportive housing, and Trauma-Focused Cognitive Behavioral Therapy
- AHCCCS and Mercy Care referral, consultation and coordination policies and procedures
- Providing contact information for our BH Coordinator, Tribal Coordinator, Housing and Employment Specialists, and Member Services staff and information on how they can support care coordination

Additionally, we have implemented the following strategies for educating providers on service integration and care coordination. We will continue to offer these resources to all network providers.

Mercy 360 Academy – In place since 2012, the Mercy 360 Academy offers providers a host of trainings to help them adopt practices that support integration. We have delivered trainings to hundreds of providers on evidence-based practices and offer continuing education credits.

Integrated Care Community of Practice – The Community of Practice brings providers together in a space where they can learn, share, and engage in problem solving as they implement and operate integrated care programs.

Practice Innovation Institute – The Practice Innovation Institute (Pii) helps providers adopt population health strategies and quality initiatives in order to provide better care and thrive under value-based contracting. Pii trains providers to use the state health information exchange (Health Current), promoting care coordination and population health management. Pii also supports providers' participation in the AHCCCS Targeted Investments Program.

Practice Transformation Consultants – Mercy Care provides participating providers with a Practice Transformation Consultant (PTC) to assist the practice as they progress to a fully integrated health home model. The PTC is a key contact between health home leadership and Mercy Care's cross-functional leadership team. The PTC supports integration efforts and ensures that effective communication and technical assistance are provided to the health homes during their path to integrated care implementation. The PTC conducts regular visits with the health homes to meet with onsite clinical and leadership staff to support the organization's integrated care implementation efforts.

Care Management and Care Coordination

Mercy Care recognizes that Medicaid members with special health care needs or chronic health

conditions require care coordination, and we provide that coordination in collaboration with providers and stakeholders. Our care management program offers preventive strategies and interventions that coordinate care and help members make healthy lifestyle choices that improve their quality of life, lower their disease burden, and lower current and future health costs. Program components include proactive identification through predictive modeling, risk stratification, health risk screenings, comprehensive assessment, chronic condition management, person-centered planning, outreach, disease management, self-management support, prevention programs, health promotion and wellness programs, education, and coaching. We also offer targeted care management for justice-involved members, members eligible for CRS, victims of sex trafficking, members who have substance use disorders (such opioid use disorder), members who have high needs and high costs, and all members identified as having special health care needs.

Our care coordination program offers assistance in making and keeping needed medical and/or BH appointments, health coaching and referrals related to a members' immediate needs, primary care provider (PCP) reconnection, and resources and materials related to wellness, lifestyle, and prevention. Mercy Care's care coordination program integrates care management and chronic disease management strategies to help members take charge of their health. We connect members to preventive and health promotion and wellness services by:

- Contacting members telephonically and meeting face-to-face to identify and resolve barriers to care.
- Offering members health coaching, materials on wellness, lifestyle choices, and prevention.
- Leveraging the OIFA to build partnerships with individuals, families, youth, and key stakeholders to promote recovery, resiliency, and wellness. Based on input from members and families, ***we created the Welcome to Mercy Care Orientation, which is offered monthly to provide information on available services and navigation assistance to newly-enrolled members and families***.
- Using peer and family support specialists, community health workers, and promotoras to connect members to preventive, health promotion, wellness services, and member education by developing a workforce that links members to services and supports in their communities.
- Coordinating with and enhancing (but not duplicating) provider-based case management services, including children in High Needs Case Management and other case management programs.

Additionally, we are planning to implement new technology tools in 2018 to enhance member engagement and care coordination, including:

Our **brand-new Mobile Engagement Platform,** which will create a personalized, self-directed experience for members and families. Platform features include:

- HIPAA-compliant telemedicine visits via the member's mobile device (e-visits)
- Real-time communication via SMS (text) messaging between the member and a care coordinator
- Circle of Trust feature, which allows the member to add friends or families to their account in the event they need assistance from their circle to be able to access care
- Mapping features that show the closest provider or pharmacy based on the member's location
- Warm handoffs between the care coordinator and the e-visit provider to promote access
- Shared information from the mobile platform to Health Current and CareUnify via secure messaging

Expanded social media offerings: We will launch a series of health and wellness videos in 2018 that will be available on our current social media platforms, as well as Instagram and YouTube.

Mobile applications: Members will have access to health information through new mobile applications:

- *myBaby* – Helps pregnant members track pregnancy milestones, identify symptoms and issues, and connect to services, such as nurse support. Pregnant members can track their weight, watch weekly educational videos, and receive daily highlights.

- *myHome* – Allows members to find providers and list them as favorites, schedule and view appointments, and fill out forms. It provides a secure portal that allows members to view clinical information, send secure messages to their health care team, see provider notes from previous visits, view lab and radiology results, and get a list of their current medications.
- *myStrength* – Offers web and mobile self-help resources, empowering members to be active participants in their journey to becoming – and staying – mentally and physically healthy.

These tools will be implemented in all GSAs we serve in compliance with applicable ACOM and AMPM requirements, as well as those included in contract Attachment F3, Contractor Chart of Deliverables.

Stakeholder and Community Collaboration

Mercy Care collaborates with members, families, and stakeholders to meet members' whole health needs in a coordinated way. We work side-by-side with system partners and community-based organizations to connect members and families to needed services and supports and to coordinate care in accordance with AMPM Chapter 1050. We maintain positive relationships by:

- Developing Collaborative Protocols with system partners, as required in the ACC Contract Section D, Paragraph 23, Medical Management. We will expand these collaborative protocols to all GSAs.
- Participation in the Arizona Partnership for Healthy Communities to create economic development opportunities and develop strategies to implement healthy community concepts.
- Coordinating with schools and school districts to serve members with special needs, including sharing treatment goals and medical information and participating in team meetings, as appropriate. ***Mercy Care currently works with 191 schools in 39 school districts***. We will partner with schools in all GSAs to improve care for members and families in the ACC program.
- Collaborating with state and local Departments of Housing to increase housing options and expand supportive housing.
- Partnering with system partners to develop and implement trainings, such as the Crisis Intervention Training (CIT) to local police departments. ***We have expanded CIT from four classes a year to 12 classes, training over 292 newly trained CIT officers from 26 different law enforcement agencies, including the FBI.***
- Linking members to Rehabilitation Services Administration/Vocational Rehabilitation services.
- Facilitating coordination between our Tribal Coordinator, AHCCCS and Indian Health Services to use the HIE to enhance coordination and improve health outcomes for American Indian members as required in Contract Section D, Paragraph 23, Medical Management.
- Connecting with advocacy groups in each GSA, such as the National Alliance on Mental Illness, Raising Special Kids and Ability 360 to gather input on how we can best meet members' needs.
- Providing information and attending monthly Maricopa County Human Rights Committee meetings.

Partnering to Improve Member Outcomes
Mercy Care partnered with Maricopa County Adult Probation, Correctional Health Services, Public Defender's Office, County Attorney's Office, County Manager's Office, and the Sheriff's Office to implement the Smart Justice Committee to promote best practices to improve public safety. ***Mercy Care worked with Smart Justice partners to create the Criminal Justice Engagement Team, which has resulted in successful jail diversion for 229 members since February 2016.*** *The Smart Justice partners received the 2016 Desert Peaks Award for Public Partnership from the Maricopa Association of Governments.*

Through *Mercy 360 Community*, we fund numerous partnerships with community organizations to address the social determinants of health in the communities we serve. Some of these programs include

Centers of Excellence, community gardens, financial management training, Fresh Express (a mobile produce market), and expansion of housing options. We will partner with organizations and stakeholders in all GSAs to implement *Mercy 360 Community* to promote integration, reduce health inequities and improve health outcomes.

System Innovations

As part of Mercy Care's mission to increase access to high-quality, cost-effective health care, we seek out opportunities to design, develop, and implement new programs, processes, systems, organizational structures, and technologies to add value to the service delivery system and to ultimately transform the system. Below we describe innovations in technology and evidence-based practices (EBPs) that will be available to members and providers in all GSAs we serve.

Innovations in Health Information Technology Facilitate Integration

Mercy Care is expanding the use of technology to support integration, engage with members, and share actionable information with providers. We are leveraging Health Current to enhance data flow, improve member and provider satisfaction, facilitate coordination of care, increase quality of care, reduce costs, and facilitate a collaborative approach to service delivery. Our planned improvements, which will be available to all Mercy Care members at contract start, include:

Mobile Integrated Health – ***In January 2018, Mercy Care launched a mobile application that allows members to speak with an Arizona-based physician on the phone or via HIPAA-compliant video teleconferencing.*** The physician can diagnose symptoms, prescribe medication, and send prescriptions to the member's network pharmacy of choice. This is an option for accessing non-emergency care and will enhance access to PH and BH services.

CareUnify – We offer our care management platform, CareUnify, to providers at no cost. CareUnify is integrated with Health Current to link services and facilitate improved communication between treating providers, Mercy Care, members and their caregivers. It provides near real-time actionable data via event notification (e.g., ED and inpatient admissions, discharges and transfers); high risk, high cost member identification, and provides reports on quality (gaps in care) and utilization (readmissions, ED visits, provider visits).

Promoting Evidence-based Practices through Innovation

To facilitate member access to high-quality care, Mercy Care adopts evidence-based practices system-wide, gives providers the tools they need to achieve fidelity to practice guidelines, and monitors to ensure adherence. Mercy Care's Medical Management Committee adopts and disseminates practice guidelines for PH and BH services that are based on valid and reliable clinical evidence, have considered members' needs, and include peer-reviewed articles. We disseminate guidelines to all providers and make them available to members and providers via links in our website or upon request in accordance with the AMPM chapter 1020. We promote the use of EBPs through:

Mercy 360 Academy – Through Mercy 360 Academy, we support the use of EBPs (such as Adolescent Community Reinforcement Approach, Assertive Community Care, Global Appraisal of Individual Needs, First episode psychosis programs, and Transition to Independence model) through provider training and ongoing coaching. Providers also receive six months of supervision, which includes help with implementing EBPs and regular feedback.

Care management – Our Care Managers coordinate care with members and providers to make sure that services and supports align with EBPs and emerging practices.

Quality management – Through our Quality Management/Performance Improvement program, we track and monitor provider adherence to EBPs and the delivery of high-quality care. Through value-based contracts, we reward providers for adhering to EBPs such as trauma informed care, and the Transition to Independence program.

Other innovative programs and strategies that we will bring to the ACC program include:
Community Comprehensive Health Program (CCHP) – This program, which was awarded the Housing Hero Award from the Arizona Department of Housing, serves members experiencing homelessness, members with substance use disorder needs, and members who are high risk through a fully integrated model. Services include MAT, housing and employment support, integrated PH and BH services, biopsychosocial supports, and care coordination. This program has been successful in helping members obtain housing and reducing the need for inpatient and crisis services.
Reach-out program – This program helps probationers transition from jail into substance abuse treatment, reducing the risk for recidivism and helping them successfully re-enter the community.
Centers of Excellence – The Center of Excellence for Autism Spectrum Disorder (ASD) offers, but is not limited to, primary care and specialist services, family support, and a range of behavioral health services, such as comprehensive applied behavioral analysis. The Center of Excellence for Pain Management provides alternative pain management treatments to opioids and medication-assisted treatment for substance use disorder. We are also working with Arizona Mother-Baby Care, which will be designated as a Center of Excellence for pregnant women and will become part of our approach to promote the delivery of high quality care.
CRS Member Advisory Council – Facilitated by OIFA, the CRS Member Advisory Council will educate and engage members and families, improving satisfaction.

Continuous Quality Improvement Strategies

Mercy Care conducts ongoing self-monitoring to ensure the system is efficient, coordinated, and results in improved health outcomes. We maintain a comprehensive Quality Management/Performance Improvement (QM/PI) Program in accordance with the AMPM, Chapter 900. Our QM/PI program uses detailed policies and procedures, written work plans, activities and performance improvement projects to accomplish clinical goals and objectives. As part of our QM/PI program, we monitor integration through measures such as:

- Member: the level to which integrated care models lead to improvements in member's health, well-being, functionality, health literacy and satisfaction.
- Organizational: the provider's success in obtaining an integrated license; shared electronic health record; co-location of PH and BH, health promotion, prevention and wellness services.
- Provider: the consistent application of a team-based approach to care, coordination of services, and communication; one health record, an integrated individual service plan with individual team member accountability, and the use of EBPs in service delivery.
- Financial: the level to which payment models incentivize the delivery of integrated care services (e.g., value-based contracting, pay for performance, per-member per-month).

We review these data in our multidisciplinary committees, which recommend actions and track implementation to ensure strategies effectively improve access to and the quality of member care.

As a demonstration of our commitment to continuous quality improvement, in 2017 we trained 1,200 Mercy Care employees in lean/six sigma: 100% achieved the first level (white belt), 93% of all managers/supervisors achieved the second level (yellow belt) and 8% of managers/supervisors reached the third level (green belt).

Summary

Mercy Care has the proven systems, processes and staff to operate a fully integrated service delivery system that improves member outcomes, respects the member's cultural identity and preferences, ensures access to care increases quality of care in a manner designed to enhance members' experience and satisfaction. For the ACC program, we will build on our innovative programs and strategies to implement the principles of integration while maintaining high standards of care.

3. Strategies to Implement and Monitor System Transition

Mercy Care has 16 years of practical experience implementing integrated care programs in Arizona and transitioning members to our plan. Mercy Care will ensure access to and continuity of care for all physical health (PH), behavioral health (BH) and support services for members during and after the contract transition through thoughtful transition planning and monitoring processes. Our experience with clinical and administrative integration, described below, is unique. Mercy Care offers a unified administrative and clinical structure through which we administer multiple integrated programs. Our strategies to assure a seamless transition and enhanced experience for members include actionable data mining, real time sharing of member information, and integrated care management programs with a focus on high risk populations.

Transition Experience

Mercy Care has extensive experience with AHCCCS program implementations, having successfully transitioned over 1 million members into the Arizona Long Term Care System (ALTCS), Regional Behavioral Health Authority (RBHA), and Mercy Care Advantage over the past four years – all of which integrate PH and BH care. As part of our transition planning and implementation process, Mercy Care anticipates needs, mitigates risks, and adapts flexibly to any and all situations. For example, 10 days before going live with the ALTCS program in Pima County in 2017, we learned that Mercy Care would be receiving 1,191 additional members who were not previously known to the Plan. We rapidly addressed member needs and assured continuity of care through care coordination and care management activities. ***Mercy Care called each of these members in 10 days*** and made sure they received their new member materials and welcome packet. Additionally, ***our Care Managers visited over 650 members residing in Assisted Living Facilities/Skilled Nursing Facilities within the first 7 days of the transition.*** Further, ***Care Managers conducted in-home visits with 540 members within the first 90 days.*** We continued to add providers to our network to ensure access to care. We honored prior authorizations from relinquishing plans for 180 days, rather than the required time period of 90 days. We will be just as responsive to members' needs during the AHCCCS Complete Care (ACC) Contract transition.

Transition Approach and Monitoring Activities

Leveraging our experience conducting multiple transitions for integrated AHCCCS programs, we have outlined key strategies that we will employ for the ACC implementation. We offer a thoughtful and well-planned implementation strategy, continuing our legacy as a strong, committed AHCCCS partner. Table 3-1 describes our specific strategies.

Table 3-1. Mercy Care Offers Concrete Strategies to Ensure Continuity of Care

Transition Best Practices	Implementation and Monitoring for the ACC Program
Facilitating Member Access to Medications	• Review of historical medical and pharmacy claims to identify gaps in medication fills/refills • Extend pharmacy prior authorizations for at least 90 days to facilitate continuity of care • Coordination with pharmacies and Care Managers to address any potential gaps in services or barriers to filling medications
Network Adequacy	• Maintaining an open network to facilitate continuity of care • Network needs identified across all GSAs for PH and BH service needs
Timely resolution of provider and member needs	• Member Services and Provider Relations representatives are trained and empowered to resolve PH and BH issues at the time of the call • Ongoing training and support for care management staff to meet members' needs

Transition Best Practices	Implementation and Monitoring for the ACC Program
Members with high needs/high risks require close coordination	• Uninterrupted provision of care management services for at-risk individuals including members with special needs, individuals with intellectual or developmental disabilities (IDD), justice-involved members, members with multi-morbid chronic conditions, members who are experiencing institutional stays, members in treatment for substance use disorders, and children in foster care • Provider Case Managers/Navigators coordinating care between specialists, PCPs, BH services, community resources, and peer support groups • BH and CRS case management resources allocated to health plan and providers • Training and support of provider-based case management
Effective and ongoing communication with members and stakeholders	• One-on-one assistance from the Ombudsman and member advocacy from the Office of Individual and Family Affairs team • Member education on how to navigate the service delivery system to help them access the full continuum of integrated services • Distribution of member education materials on how to access primary, specialty, BH, and social support services as well as how to use services that were authorized under a relinquishing plan, or the prior program • Bi-monthly member and community forums in each GSA prior to implementation • Meetings with stakeholders serving high priority populations (e.g. probation) • Maintain an Implementation Advisory Committee comprised of providers, members, and stakeholders to gather feedback on operational issues that impact member transitions, enabling us to prevent issues before they arise and quickly respond
Provider communication	• Bi-monthly provider forums in each GSA prior to implementation • Our Provider Portal and Provider Manual will be updated to include ACC requirements and will be available prior to contract implementation date • A single integrated provider services phone line with 24-hour accessibility for two weeks prior to and six months following implementation until stability is achieved • Accessing and using the care management documentation system • Ongoing training and support (technical support calls, claims education, orientation)
Frequent communication with AHCCCS	• Mercy Care will align our Transition Plan with AHCCCS' Transition Plan • Designated point of contact that is available 24/7 to respond to concerns or requests • Regular updates and immediate notification to AHCCCS of any issues identified through our self-monitoring activities

Mercy Care will build on existing integrated clinical and administrative functions; assemble an interdisciplinary Transition Team, which will be led by a licensed clinician per AMPM 1020; conduct timely data-driven planning and decision making, network development activities, care management service delivery, and other activities; use feedback from members, families, and other stakeholders; and communicate with members and providers, AHCCCS, stakeholders, and relinquishing plans.

Proactive Interdisciplinary Transition Team Approach: Our Transition Plan will include input from all key units within Mercy Care, each of which will be assigned specific transition management activities. Many of our staff actively assisted in prior transitions and will apply their knowledge and experience to the ACC transition. Our Transition Plan will detail all key transition and monitoring activities to capture key indicators that will be collected and reviewed at frequent intervals.

Mercy Care's ACC Transition Team is responsible for transition oversight and for guaranteeing member access to integrated care benefits on day one of the new contract. In addition to our executive leadership team, management and key operational staff from all integrated business units participate in the transition, including the Office of Health and Clinical Services led by the Chief Medical Officer.

The Transition Team will evaluate, plan, and act on transition issues that require immediate attention from a particular department, team, or individual within the plan. The team will monitor access to integrated care and services for all transitioning members during the testing period that will run one month prior to Contract launch and throughout the entire transition. Frequent enrollment updates, new member/provider concerns, and care coordination meetings will be held throughout the day following the transition to identify and address the needs of individual members and to continuously improve overall ACC operations and care delivery. Meetings will continue until all members have been successfully transitioned and the system is stabilized.

Our clinically-licensed Transition Coordinator, already in place, will manage the day-to-day ACC transition activities. Under the direction of our executive leadership team, the Transition Coordinator will oversee the Transition Team. The Transition Coordinator will monitor and resolve specific transition issues pre-contract award and for at least six months following the ACC launch date. This individual will be responsible for the oversight of service integration, service coordination, and member complaint resolution.

For all implementations, we maintain an Implementation Advisory Committee comprised of providers, members, and stakeholders. Facilitated by the CEO, this committee provides feedback on operational issues that impact member transitions, enabling us to prevent issues before they arise and quickly respond.

Transitioning Members with Complex Needs

Mercy Care clinicians will immediately identify and prioritize transitioning members consistent with ACOM 402 and ACOM 520, including members with high risk pregnancies, members with special health care needs (SHCN), children with CRS conditions and those receiving ongoing services for serious conditions. Mercy Care will not delay the timely delivery of services and supports to a member as the result of missing or incomplete information. We will deliver services to members with SCHN without disruption, consistent with ACOM 402.

Mercy Care's clinicians will comprehensively assess each member identified as having SHCN in order to identify whether the member requires a course of treatment or regular care monitoring, or transition to another AHCCCS program consistent with AHCCCS' requirements. Mercy Care will use early identification methods and integrated service plan development strategy for all members with SHCN in full compliance with AMPM 540. We will follow all requirements for initial contact with members per AMPM 920. Members with SHCN will be triaged by clinicians to the appropriate transition team that will contact the member and/or their provider to facilitate continuity of care. The team will facilitate a seamless member transition through prior authorization extensions, concurrent review, proactive discharge planning, justice system liaison reach-in, care management outreach and engagement, or care coordination.

Self-Monitoring Plan to Ensure Access to Integrated Care and Services

Mercy Care will continuously and proactively communicate with AHCCSS during the transition and beyond and will report regularly to AHCCCS on the transition implementation. Mercy Care will develop collaborative and proactive relationships with relinquishing plans to ensure that members in transition receive all services in a seamless and satisfying manner. We will maintain ongoing communications with members, families, and other stakeholders to inform transition activities and identify opportunities for improvement. Mercy Care's Transition Team will obtain and analyze data to monitor continuity of care during the transition, ensure compliance with AHCCCS requirements, and develop and implement actionable performance improvement plans and follow-up to ensure resolution.

Our care management documentation system will capture all transition activities including: PCP/specialist assignment and outreach, BH/PH services, community-based services, durable medical

equipment (DME), pharmacy prior authorization extensions, initial and concurrent review for institutional stays, care management and justice system liaison outreach, member complaints, and care/service plan development. Daily reports are generated from these systems, which will enable the Transition Team to ensure all transition activities are completed and meet all ACC Contract requirements. Specific measures we will track and monitor include Member Services calls, provider calls, transportation issues, service utilization, appointment availability, pharmacy issues, potential quality of care concerns, member complaints, grievances and appeals, and authorization requests.

Mercy Care will monitor all aspects of the transition. During regular Transition Team meetings, we will: review daily enrollment files; triage issues to the appropriate department; review utilization management and care management reports for gaps in care; and evaluate high-risk clinical interventions identified in our initial Failure Mode Effects Analyses (FMEA). FMEA is a highly structured technique used by trained staff to proactively identify, avoid, and mitigate potential complications that can arise during implementation. Additionally, our Integrated Care Management team will monitor care management alerts for all newly transitioned members and collaborate with providers to coordinate PH and BH care for a minimum of six months and/or the duration of care management services.

Mercy Care staff will continuously improve transition processes using a Plan-Do-Study-Act cycle; conduct FMEA, causal chain analysis, and root cause analyses to identify potential transition process challenges. We will minimize disruptions in care during, and following, the transition process related to geographic, temporal, cultural, and linguistic access for our service areas. Specifically, we will monitor:

- Geographic, temporal, and appointment access standards based on ACOM 417; requests for services from out-of-network providers; multi-lingual service; adequacy of access to specialty providers; access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics; access to maternity care (pregnant members at high risk); additional access-related issues identified as the result of data mining or as required by our contract with AHCCCS; and network adequacy-based requests for out-of-network usage
- Member, family, and other stakeholder complaints and input obtained via community forums
- Timeliness of receipt and processing of needed quantitative data and medical records from relinquishing plans, the health information exchange (HIE) and other sources
- Adherence to referral management procedures and standards to ensure access to specialty care
- Adherence to contract requirements regarding continuity of care for members in treatment
- Timely fulfillment of transportation requests
- Completion of provider training plans

If we identify issues, the ACC Transition Team will take action to quickly resolve them.

Use of Data-driven Planning and Decision Making

Based on our past transition experience, we will use advanced data analytics to:

- Plan transitions for high risk members and members with unique needs (members with CRS conditions, members with developmental disabilities, justice-involved members, members with multi-morbid chronic conditions, and hospitalized members).
- Monitor and respond to issues related to access, safety, efficiency, and effectiveness.
- Evaluate, monitor, and respond to member experiences related to the transition.
- Implement an integrated provider network strategy that supports the comprehensive needs of the ACC population based on historic use of providers among our own and relinquishing plans.

We will proactively load all transition file types into our care management documentation system, making sure that all accepted files are tested and corrected when necessary. We will also develop and implement processes to address any file management issues as they arise. Mercy Care will establish a

designated repository for all member transition documentation including Enrollment Transition Information, DEF files, and medical records from relinquishing contractors. We will use historical claims data provided by AHCCCS to develop short- and long-term strategies to coordinate care for all new members transitioning to the plan. We will further use the ongoing monthly encounter, Blind Spot data, and claims data to identify all services provided to members three years prior to transitioning to Mercy Care. Mercy Care's Transition Team will expedite case reviews to facilitate continued authorizations and care management interventions for transitioning members.

Mercy Care will promote continuity of care for individuals who are part of a T/RBHA, RBHA or other delivery system. Mercy Care will maintain and bolster our agreements with tribes to address the PH and BH needs of tribal members. Specific strategies to support data-driven planning and decision making are described below.

Using data to define service delivery needs and access to care -- A key part of Mercy Care's transition process will include activities to obtain all medical records for high risk members, prior to, and throughout the transition, with the specific goal of supporting continuity of care and service delivery. We will use data to develop and implement a surge staffing strategy, if needed. Based on our experience, call center services, transportation, and pharmacy have historically exhibited high demand during the transition. We will employ additional staff during the transition and train staff to resolve transition issues effectively.

Using data to assess and plan an integrated network strategy -- We will use data to plan and execute network contracting efforts by: comparing the contracted Mercy Care network and the networks of relinquishing plans; reviewing PH and BH needs of members by provider; reviewing data from relinquishing plans; and comparing RBHA network participation. If we identify a provider that is not contracted with Mercy Care and serves members, we will contact the provider to execute an agreement, facilitating continuity of care for members and a seamless member experience.

Member and Provider Communication

Member Communication: We will develop a member communication plan that addresses all member education needs including special populations such as foster care families and children, members with CRS-eligible diagnoses, and high-risk members. Mercy Care will use multiple means to assure that members have access to culturally and linguistically appropriate information that is easy to understand, including Member Handbooks and other member communication materials, our website, mobile applications, and a single integrated Member Services phone line with 24-hour accessibility. 24-hour accessibility will be available for two weeks prior to implementation, with extended hours until the system is stabilized.

Provider Communication: Mercy Care will assure that the entire provider network is knowledgeable about, and supports, the transition. We will hold bi-monthly provider forums and new provider orientation programs in all GSAs we serve. We will waive all non-participating provider requirements for six months after implementation date for all members (including CRS-eligible members).

Summary

As a trusted AHCCCS partner, we commit to continuous improvement in every transition we conduct. We are already preparing for ACC implementation and transition of members even in the absence of a contract, because of our commitment to AHCCCS and our members. We will use our experience to assure a seamless, safe, and efficient transition in the ACC system. We are fully prepared to accept all ACC members who select Mercy Care and those who are auto-assigned to our Plan. We aim for zero adverse impacts or breaks in coverage for members and their families. Mercy Care looks forward to working with AHCCCS, other contractors, members, providers, and stakeholders to facilitate an outstanding transition experience for all individuals and organizations participating in the ACC program.

4. Integrating Physical and Behavioral Health Services Under a Single Entity

Mercy Care offers extensive experience managing integrated physical health (PH) and behavioral health (BH) benefits and services for multiple AHCCCS populations including: ALTCS, Mercy Care Advantage members, members with CRS-eligible conditions, persons with a serious mental illness (SMI), and dual-eligible members with General Mental Health/Substance Use (GMH/SU) needs, totaling over 56,000 members. For the AHCCCS Complete Care (ACC) program, we will leverage and scale our existing organizational practices and programs to meet or exceed AHCCCS requirements. These include:

- Integrated best practice care coordination and care management services that address physical, behavioral and psychosocial needs in a person-centered manner, including:
    - Proactive, data-driven identification and stratification of high-risk members who require further assessment, outreach, and engagement in care management
    - Ongoing collaboration with the member and their family to review and select care management options with a focus on education and self-care
    - Collaboration and communication among PH and BH providers, including provider-level Case Managers, through records-sharing and telephonic and in-person meetings
    - Evidence-based protocols to guide the delivery of services and supports
- A single, toll-free Member Services phone line with Arizona-based staff who are cross-trained in PH and BH needs
- A Nurse Line offering coordinated follow-up via warm hand-offs and immediate support to members
- Network development and value-based contracting practices that align outcomes across disciplines, rewarding PH and BH providers for meeting members' whole health needs
- Robust member engagement through motivational interviewing and community-based outreach
- Organizational designs and operational systems and practices that support the delivery of integrated PH and BH services as described throughout this response

Mercy Care is a trusted partner with the unique ability to offer a fully-integrated system, including our governance and leadership structure and integration of administrative and clinical functions.

Governance and Leadership Structure

Mercy Care's Board of Directors oversees our entire local, not-for-profit organization and is responsible for ensuring we meet the goals of the AHCCCS program. Our management team administers the day-to-day activities of our integrated organization by establishing member-and family-centered priorities and reviewing data to identify opportunities to improve member care and enhance integration. The leadership team's depth of experience in delivering integrated care brings the expertise necessary to implement a comprehensive integrated service delivery system for members in the ACC program.

Mercy Care demonstrates our commitment to member and family voice and choice by including peers and family members in our governance structure. We continually seek input from members and families to address their needs, as *they* define them. We engage peers and family members in both governance and service delivery as demonstrated through our robust Member Advisory Committee (MAC) and member- and provider-facilitated peer and family advisory councils. ***Approximately 50 peers and family members participate on our existing committees (including our Governance Committee), exceeding AHCCCS' requirements.*** A key strength is our continued commitment to incorporate significant member, family, and peer involvement in ACC governance to meet or exceed AHCCCS' requirements**.**

Integration of Administrative and Clinical Functions

At Mercy Care, we are organized to support the coordination of person-centered, integrated care to members. Our program aligns clinical and administrative functions by organizing departments into functional operational units that work in multidisciplinary teams. These teams work together to make

sure that the service delivery system is operating efficiently and effectively to ensure member access to services, coordination of referrals and ongoing care consistent with AMPM 580, as well as data-sharing and collaboration between PH and BH providers, court systems, and other health delivery systems. These systems include tribal programs and the Veterans health system. This organizational structure supports our ability to sustain and improve member outcomes.

Our Member Services staff are cross-trained to assist members with PH and BH needs across disciplines, including questions regarding benefits, network and services among other issues. Under ACC, members will benefit from a single Arizona-based, toll-free Member Services phone number and a single Nurse Line where staff will answer calls in a manner that meets or exceeds AHCCCS performance standards as required by ACOM 435. ACC members will have a single membership card, one provider directory, and a single delivery system to support their needs, building on our existing processes. Member Services staff coordinate a variety of services for members such as referrals and transportation. Network Management staff contracts with providers to deliver care through an integrated model to members. We will expand these contracts for ACC members in each GSA to increase integration, improve outcomes, and increase member satisfaction by encouraging members to use high-value, integrated service settings.

Mercy Care's Role in Care Coordination, Care Management and Case Management

Meeting members' integrated health care needs is the primary focus of our daily work. Mercy Care's member- and family-centered integrated care management model provides the right types and intensity of support so members and families can realize improved health outcomes and achieve their goals. Our care management services help members achieve wellness and autonomy through advocacy, communication, education, and identification of services and community-based resources, while facilitating member choice and access to services. Case management, a service delivery process that most typically occurs at a provider level, engages members and families, helps them coordinate and navigate complex systems and provides support and direct services.

As described in the ACC contract, care management is time limited in nature and includes assistance with making and keeping needed PH and/or BH appointments, following hospital discharge instructions, and health coaching. Case management also includes referrals related to the members' immediate needs, PCP reconnection, and other resources or materials related to wellness, lifestyle, and prevention. ***Mercy Care maintains full responsibility for the delivery of care management services and ensures that members receive all necessary services and supports as required.***

Mercy Care will identify, monitor, and implement care management interventions with a focus on high-risk members with complex needs. As we do today, we will stratify the ACC population by risk level into low-, moderate- and high-risk categories, using the combined information obtained from: a validated Health Risk Assessment tool; predictive modeling data from our Consolidated Outreach and Risk Evaluation tool; provider, self or other referrals; Blind Spot; and other data. Additionally, Mercy Care identifies individuals with targeted needs (e.g. victims of sex trafficking, children with CRS-eligible conditions, members who are involved in the justice system, court ordered evaluation, children in high needs case management) and those with complex and chronic conditions including members with special health care needs. All members receive care coordination and care management services, as needed, at an intensity level that matches their identified risk level.

Members at high risk for poor health outcomes receive intensive care management that includes care planning, interdisciplinary team assessment and planning, and high-touch, frequent contact, including face-to-face meetings as necessary. Moderate risk members receive episodic but intensive support with a focus on preventing their level of risk from escalating. We provide care to members at moderate risk

with coordinated services and programs based on member needs. Mercy Care serves low-risk members via a population health-based approach which maintains health, promotes prevention, and encourages effective and efficient use of health care services. Our care management process is flexible, and members may move fluidly between different levels based on needs.

Mercy Care is fully staffed to deliver all facets of care management services at all levels to any member. Our integrated Care Management Teams deliver interventions in provider practices, in the member's home, during an inpatient stay, and other community settings as needed. We recruit, hire, and train Care Managers to ensure they have expertise in member self-management, member advocacy, motivational coaching, navigating complex systems, and communicating with a wide spectrum of professional and lay persons including family members, physicians, specialists, and other health care professionals. Care Managers perform functions as required in AMPM Chapters 500 and 1000 and offer expertise in PH and/or BH and social determinants of health with additional training in BH issues such as trauma-informed care. Teams collaborate to identify the member's needs, develop a member-centered care plan, and connect the member to appropriate services and supports with provider-based staff. We share information with the member and their providers via the CareUnify platform. CareUnify enables providers involved in the member's care and our Care Managers to view and share critical information such as assessments, care plans, medications, and member progress toward treatment goals in a HIPAA-compliant manner.

Mercy Care also oversees the delivery of case management services at the provider level through a collaborative approach where we engage and support members through case management activities at the provider level. We deliver the necessary tools and analytic support consistent with AHCCCS' requirements (e.g. AMPM 940). These efforts include:

- Offering provider education and actionable data on gaps in care and utilization
- Sharing admission, discharge, and transfer data in near real-time
- Gathering feedback from members and families on the effectiveness of, and their level of satisfaction with, case management services
- Incentivizing providers to meet performance measures and outcomes via value-based contracts
- Reviewing provider caseloads to ensure members have access to timely interventions
- Tracking completion of assessments and care plans and
- Conducting record reviews to verify that members are receiving care coordination and that services are delivered per the care plan
- Participating in care teams and Child and Family Team (CFT) meetings

Mercy Care ensures that case management programs at the provider level meet all AHCCCS requirements including staffing ratios, the use of standardized assessment tools such as the CASII, and the development of Service Plans for members with CRS-eligible conditions.

Mercy Care's Experience Administering Integrated Care Programs

As one of the largest AHCCCS contractors in Arizona, Mercy Care delivers services to more than 528,000 members and offer fully integrated care to over 53,000 AHCCCS members. This experience in administering integrated BH and PH services to Medicaid and Medicare members makes us an excellent choice to deliver services to ACC members. We describe our specific programs, level of experience with integration and provide select outcomes in the following response.

Members report high level of satisfaction with Mercy Care – the AHCCCS CAHPS survey indicated that ***both adult and child members rate Mercy Care at five stars.***

ALTCS – Mercy Care operates the state's largest ALTCS managed care health plan, providing over 12,400 members with integrated BH and PH services in the Central Geographic Service Area (GSA) and Pima County. Members in our ALTCS program have experienced positive health outcomes, including:

- 76% of members live in community-based settings and receive quality, cost-effective services
- 95% of adults received preventative/ambulatory health services
- 82% of members received flu shots
- 80% of members received follow-up services after discharge from BH inpatient within 30 days

Mercy Care will apply our experience managing this fully integrated program to our processes for implementing a comprehensive and coordinated approach to administrative and clinical integration of health care service delivery. Based on our lessons learned from managing the ALTCS program, we will apply the following strategies to the ACC program:

- A member-and family-centered care management approach that assists members in navigating the service delivery system, reduces fragmentation in care, and supports members to live as independently as possible in the community setting of their choice.
- A highly developed statewide network that supports members in rural and urban communities and includes BH and specialty providers as well as community-based providers that deliver care in the member's home and other community settings.
- Partnerships with stakeholders and local organizations to develop creative programs that address the social determinants of health that impact members' health outcomes.

Children's Rehabilitative Services (CRS) – In 2013, Mercy Care's ALTCS program started serving children receiving services through CRS. Through this experience, we are well-prepared to effectively manage the safe transition of members with specialized needs. We have relationships with all Multi-Specialty Interdisciplinary Clinics (MSICs) in Arizona, as well as a statewide network of specialty providers, BH providers, and physicians with the expertise to serve members with complex needs. Further, our care management program includes highly-coordinated processes administered by well-trained Care Managers who are experts in serving members with special health care needs. Finally, ***we will develop a CRS Member and Family Advisory Council to provide an opportunity for us to hear from CRS members and their families about their experiences in care and work with them to improve the delivery system.***

Integrated Care for Persons with Serious Mental Illness (SMI) - Mercy Care's affiliated plan, Mercy Maricopa Integrated Care, serves as the Regional BH Authority (RBHA) in Maricopa County, delivering integrated care to over 21,600 members. Our integrated care model leads to improved member outcomes, including:

- 82% of those diagnosed with diabetes completed testing to measure HbA1c levels
- 20% increase in screenings for breast cancer since plan inception
- 15% increase in screenings for colorectal cancer since plan inception

This experience makes us uniquely positioned to seamlessly transition members to our ACC program. We stand ready to support members with all levels of need and have the network and systems in place to serve them through the following processes:

- An effective transition process that supports all members, including those with specialized BH needs such as justice-involved members, high needs children, and members with substance use disorders.
- Coordinated care management processes that include close collaboration with provider-based case managers without duplication of effort, ensuring that members receive the right types and level of support necessary to meet their recovery goals.
- A comprehensive network of BH providers and relationships with stakeholders that spans all GSAs.

- Collaborative protocols and processes for coordinating with system partners, including the justice system, schools, Division of Developmental Disabilities, Rehabilitation Services Administration, advocacy organizations and local municipalities.
- Member Advisory Councils include members and family members of children with special health care needs who provide valuable input on our daily operations and the service delivery system.

We will bring our deep knowledge of the BH system in Arizona to ensure the highest level of support for the BH system while working to safely and effectively integrate services across the continuum.

Medicare Services – Mercy Care has operated a Medicare Advantage Special Needs Plan (D-SNP) in Arizona since 2006. We expanded this program to include GMH/SU members in 2015. Through our D-SNP, we coordinate PH and BH benefits for over 18,700 dually eligible individuals. Members receiving services through Mercy Care's model of care have achieved positive health outcomes and experienced increased access to appropriate care, including:

- 43% decrease in readmission rates after provider follow-up upon discharge from a BH facility
- 39% decrease in readmission rates after provider follow-up upon discharge from a hospital or skilled nursing facility
- 7% decrease in ED utilization and a 16% decrease in 30 day all cause readmission rates

Further, an Avalere Health study done in 2012 reported that Mercy Care Advantage members experienced the following: 43% lower hospital days/1000 than the fee-for-service (FFS) population, 19% lower average length of stay and re-admission rates. These rates were **21% lower than the comparison FFS population.**

Our experience enables us to bring the following critical practices to the ACC program:

- Processes for assisting providers to ensure correct billing the first time, resulting in timely payment.
- Systems for helping providers become Medicare-certified and facilitating coordination of Medicare and Medicaid benefits.
- Effective care management processes that ensure the proper utilization of services and steps for coordinating care across systems and providers.
- Robust member engagement strategies and a comprehensive BH provider network that resulted in increased member utilization of BH services within the first year of the GMH/SU duals program.

RBHA –Through our affiliated RBHA, Mercy Care implemented whole health integrated care clinics that deliver integrated care to members with GMH/SU needs. Clinic providers participate in three-way contracts to provide PH and BH services to members who select the clinic as their primary care provider. This experience has prepared Mercy Care to deliver fully integrated care on day one of the ACC launch. Our departments, teams, practices, policies and processes are compliant with ACC requirements. We have practical experience with AHCCCS reporting requirements and the systems needed to administer a fully integrated program.

Using Technology and Social Media to Engage Members

Mercy Care believes that members should have a choice in how they engage with us. Increasingly, this engagement is enhanced by technology. Therefore, we will leverage existing, and implement new, technology tools to enhance the delivery of integrated care and services. We offer members communication choices and offer a variety of options in a culturally and linguistically sensitive manner to meet member needs and preferences. Mercy Care uses our website, mobile application, social media, and opt-in text messaging programs for chronic conditions, pregnancy, or other health-related needs to engage members. For ACC, we will increase our use of technology to serve at least 10 percent of the

total membership who may benefit from web-based or mobile applications. We will expand our use of technology to include the following:

A **brand-new Mobile Engagement Platform** will allow members to access care via their mobile device. This new platform includes the following features that will create a personalized, self-directed experience for the member, resulting in greater engagement, increased access to care and improved health outcomes:

- HIPAA-compliant telemedicine visits via the member's mobile device (e-visits)
- Real-time communication via SMS (text) messaging between the member and a care coordinator, who can schedule appointments, arrange transportation and provide information
- A Circle of Trust feature, which allows the member to add friends or families to their account in the event they need assistance from their circle to be able to access care
- Mapping features that show the closest provider or pharmacy based on the member's location
- Warm handoffs between the care coordinator and the e-visit provider to promote access
- Shared information from the mobile platform to Health Current and CareUnify, such as chart notes and clinical information shared via secure messaging with providers

Mobile Integrated Health: Mercy Care is launching a mobile application that allows members to speak on the phone or via HIPAA-compliant secure video teleconferencing to diagnose symptoms, prescribe medication, and send prescriptions to the member's network pharmacy of choice.

Smartphones: We collaborate with Lifeline, the federally subsidized program that provides financially-qualified individual households with smartphones at no cost to the member. Member calls to Mercy Care do not count against their minutes or monthly data and members with an existing device can opt to receive this service using their current device.

Expanded social media offerings: Because our social media analytics indicate the highest member engagement comes from posted videos, we are launching a series of health and wellness videos in 2018 that will be available on our current social media platforms (Facebook, Twitter), as well as Instagram and YouTube. Our social media offerings will comply with ACOM 425, Social Networking.

Mobile applications: Mercy Care members will also have access to readily available health information through other mobile applications, including:

- *myBaby* - helps pregnant members track pregnancy milestones, identify symptoms and issues, and connect to services, such as nurse support. Members can share educational e-mails, track their weight, how often their baby kicks, watch weekly educational videos, and receive daily highlights.
- *myHome* - allows members to find providers and list them as favorites, schedule and view appointments, and fill out forms. It also provides a secure portal that allows members to view clinical information, send secure messages to their health care team, see provider notes from previous visits, view lab and radiology results, and get a list of their current medications.
- *myStrength* - offers web and mobile self-help resources, empowering members to become and stay mentally and physically healthy.

We use these tools and platforms to reach members, family members, providers, and other stakeholders, and the community at large by providing health and wellness information, promoting events, and sharing trends and news. We regularly include information about integrated health issues such as maintaining a healthy and active lifestyle, good nutrition, men's and women's health, vaccines, heat safety, substance use, and depression screenings. We also share the latest news stories about integrated care. These tools will be implemented in compliance with applicable ACOM and AMPM requirements, as well as those included in contract Attachment F3, Contractor Chart of Deliverables.

New Strategies and Innovations

Mercy Care will add value to the ACC program by implementing innovative programs that improve individual health outcomes, enhance care coordination, and increase member satisfaction. New strategies and innovations that we will bring to the GSAs we serve include:

Implementing community paramedicine contracts, which use paramedics to perform risk assessments, conduct home medication reviews, refer members to primary care doctors and skilled home services, and provide preventive services such as immunizations and support to improve medication compliance. Mercy Care will work with emergency medical service providers, hospitals, and health care and social services providers to implement paramedicine programs, as needed in the GSAs we serve.

Partnering with housing providers and agencies that administer Housing and Urban Development (HUD) housing, including:

- Arizona Department of Housing and Housing Continuum of Care to provide service dollar match to further increase housing security for our members
- Local housing authorities (counties, cities, and towns) to address the housing needs of our shared members
- Other agencies, such as United Way and Arizona Housing Coalition

Mercy Care will continue to work collaboratively with housing agencies to expand these opportunities to include partnerships with public housing authorities in each GSA we serve.

Leveraging Community Health Workers (CHWs) to help members navigate the service delivery system and access care. In southern Arizona, a number of local hospitals and physician groups are using CHWs to promote improved continuity of care and chronic disease management in a culturally and linguistically appropriate manner – in the communities in which CHWs live and work.

Collaborating with oral health providers to improve oral health for special groups of members, including pregnant women with periodontal disease who are at increased risk of pre-term labor, adult persons who are engaged in recovery yet have oral health challenges resulting from substance use disorder, and people with developmental disabilities whose oral health may be impacting long-term outcomes such as cardiovascular health.

Increasing peer support to assist members in navigating the service delivery system. We have increased the number of peers to support members receiving medication-assisted treatment (MAT), members with diabetes and refugees.

Employing Care Coordinators with specific training and expertise to provide a high-touch care management program for members enrolled in MAT services. Care Managers will engage and educate members on how to navigate the system and will coordinate care across providers.

Summary

As we have been managing integrated service delivery systems that improve members' health and well-being for 16 years, Mercy Care is well-positioned to meet ACC requirements on day one of the Contract launch. ACC members who choose Mercy Care will benefit from a positive member experience notable for easy access to high-quality, high-value health services at a variety of locations and settings. We will apply lessons learned related to integrated care and care management to enhance service delivery for every ACC member.

5. Member Scenario

Our individualized, member-centered, strengths-based approach to care management is designed to support members like "Maria" to achieve optimal outcomes. We offer care management services to every member at the right time, in the right place, at the right level of intensity in accordance with AMPM 1000. For Maria, our primary focus is to facilitate an immediate discharge from the emergency department (ED) to a safe environment. Through the relationships we have built with providers across the State, Mercy Care has available resources to support Maria no matter where she lives. We will coordinate Maria's discharge from the ED, connect her with services and supports, assist her in navigating the delivery system, assure care coordination and facilitate access to high-quality services in alignment with the Nine Guiding Principles for a Recovery-Oriented System. We begin this response by first describing how we will meet Maria's immediate needs, which we believe is the number one priority. The response then describes the process we would use to engage her during the transition from the unsuccessful incumbent and our strategies for connecting her to services and supports.

Addressing Maria's Immediate Needs: Transition from the Emergency Department

Mercy Care receives admission, discharge and transfer (ADT) alerts in near real-time through CareUnify, our care management documentation system, when a Mercy Care member is in the ED. Additionally, because of our close relationships with local hospitals, the hospital contacts our ED Coordinator when they learn that Maria is enrolled with Mercy Care. The ED staff informs our ED Coordinator that Maria is exhibiting behavioral health (BH) symptoms and that she is on psychotropic medications. Though she is stable enough to be released, the hospital staff are not yet comfortable discharging her without a discharge plan that addresses her physical health (PH), BH and substance use needs in a safe environment. The ED Coordinator engages with Mercy Care's Care Manager to take immediate action to identify her needs and arrange for appropriate services. The Care Manager deploys an ED Navigation team, which is available through our Comprehensive Community Health Program (CCHP) program, to go to the ED to assess Maria's immediate needs and coordinate with Maria, the hospital, and our Care Manager to transition Maria from the ED. The ED Navigation team is onsite at the ED within an hour to engage with Maria, assess her immediate needs and formulate a discharge plan. Based on the assessment results, Maria's stated priorities and American Society of Addiction Medicine (ASAM) criteria, Mercy Care, Maria, and the facility determine that residential treatment to address her substance use is the most appropriate, immediately available setting. The Care Manager contacts local residential providers to identify options and coordinates with them and the hospital to arrange for Maria's entry into treatment that same day. Our Care Manager ensures the residential treatment facility has Maria's discharge instructions and medications, and can meet her needs. The ED Navigation team transports Maria from the ED, assists her with the intake process, and makes sure she is settled.

Transitioning Maria to Mercy Care

Mercy Care's efforts to transition Maria from the relinquishing plan begins at contract award. We use available data to identify her for care management, including PH and BH claims, Blind Spot data, enrollment files, pharmacy data, records from the relinquishing provider, and other clinical data including information available in Health Current. Our Transition Team, led by our Transition Coordinator, would have identified Maria as high risk based on her utilization history and her diagnoses of schizophrenia, brittle diabetes, and opioid use disorder as well as her homelessness.

Once Maria is identified for care management, we assign a Care Manager with experience in serving members experiencing homelessness and who also have BH needs, substance use needs, and chronic medical conditions. The Care Manager is Maria's single point of contact while she is enrolled in care management services. Maria's Care Manager is well prepared to address Maria's whole health needs as

he/she has received training on connecting members to resources and services that address their PH and BH needs and social determinants of health, such as housing, food, employment, and transportation. Thus, our Care Managers are able to work with members such as Maria who face multiple challenges. In addition, the Care Manager is trained in motivational interviewing, Mental Health First Aid, trauma-informed care and safeTALK suicide prevention. Maria's Care Manager knows how to assist members, along with their family of choice with obtaining and using Nalaxone to reverse the effects of intentional or unintentional opioid overdose.

Engaging Maria in Care Management Services

As part of our transition management process, Maria's Care Manager would have attempted to call Maria using the contact information provided by the relinquishing contractor. The Care Manager makes several attempts at different times and days. The Care Manager considers that Maria's cell phone minutes may run out at the end of the month, so they call her at the beginning/middle of the month. The Care Manager also contacts providers that last served Maria, including her former primary care provider (PCP) and the pharmacy that filled her medications, to seek and obtain updated contact information and alert them to contact us if Maria schedules an appointment or attempts to refill her medications. Additionally, the Care Manager contacts local homeless shelters, with whom we have relationships, to ask if they have seen Maria and remind them to call us if Maria comes to the shelter.

Upon being assigned to serve Maria, the Care Manager gathers and reviews all available information to begin the comprehensive assessment. In addition, the results of the assessments completed in the ED and by the residential treatment facility provide valuable information to complete the assessment. Within three days of her admission to residential treatment, the Care Manager meets with Maria to explain the services and supports available through Mercy Care (including care management) and our provider network, and learns more about Maria's personal goals. The Care Manager also informs Maria that, while her current PCP does not contract with Mercy Care, she can continue to see her PCP for six months following her enrollment date to ensure continuity of care during the transition. Maria discloses that she is unhappy with her current PCP for abruptly discontinuing her pain medication and wants to discontinue services. The Care Manager educates Maria on the process for filing a grievance or appeal. If Maria decides to file a grievance, the concern will be forwarded to our Quality Department as a potential quality of care issue. As this provider is not contracted with Mercy Care, there is potential that records will not be forthcoming. We will however notify AHCCCS of the potential quality issue and our attempt to investigate. The Care Manager also offers PCP options in the Mercy Care network of high value providers that participate in value-based contracts, offer extended hours of operation, and provide case management. Maria states that she would like a new PCP so her Care Manager helps her to select a PCP and schedule an appointment, and arranges for her medical records to be transferred.

During their initial meeting at the facility, Maria and her Care Manager together identify participants for an Interdisciplinary Care Team (ICT): her Care Manager, Maria's new PCP, Housing and Employment Specialist, Pharmacist, Mercy Care Medical Directors (PH and BH), facility staff, and a Peer Support Specialist. If Maria chooses, the Care Manager will encourage her family to participate in her ICT and they will play an important role in the assessment process. As Maria's needs change, the composition of her ICT may change.

Individual Recovery Plan

Within five days of Maria's admission to the residential treatment facility, the Care Manager coordinates with the facility to convene the ICT. The purpose of the ICT meeting is to help Maria identify her priorities and goals and to develop the Individual Recovery Plan (IRP) that includes a discharge plan to effectively transition Maria to the community when rehabilitation goals have been achieved. Maria's

Care Manager, CCHP case manager, and ICT collaborate to ensure Maria receives services and supports to address her priorities and meet her goals, as outlined in Table 5-1 and discussed below.

Table 5-1: Maria's Identified Priorities and Goals

Maria's Priority	Care Plan Interventions	Goal
I want to live in a safe place	• Identify permanent supportive housing options that meet Maria's needs. • Arrange for in-home supports to assist Maria in achieving permanency.	• Maria secures housing in a setting of her choice. • Maria receives ongoing supportive services to maintain permanency.
I want to feel healthy again	• Connect Maria to integrated services to address diabetes, assess for pain management treatment and or referral, and to evaluate and treat her BH condition. • Arrange for health coaching, nutrition support, and education to help Maria manage diabetes. • Identify alternatives to opioids for pain.	• Maria reports reduced pain, more energy, and less emotional distress. • Maria adheres to care plan to manage diabetes and symptoms of mental illness. • Maria uses alternative pain management strategies as appropriate.
I want the pain to stop without using heroin	• Connect Maria to an outpatient substance use provider with the ability to address her unique needs such as a Center of Excellence for substance use/pain management. • Link to peer support services. • Connect to medication-assisted treatment (MAT). • Provide Maria with a Naloxone kit and educate her and her support system on how to use it in case of an overdose.	• Maria reports reduced substance use. • Maria participates in substance use treatment. • Maria participates in naloxone training with her Care Manager and reduces her risk for opioid overdose.
I want to have a better relationship with my family	• Connect Maria and her family to services, including family therapy, family psycho-education and community supports, such as National Alliance on Mental Illness (NAMI) Family to Family program.	• Maria and her family report that their relationship is improved. • Maria's family is involved in her care.

Maria's goal: I want to live in a safe place: To address Maria's goal, the ICT, which includes Mercy Care's designated Housing and Employment Specialist, who is an expert in housing options within the GSA, identifies housing possibilities for Maria. The ICT determines that Maria would benefit from supportive housing services, with a goal of quickly moving toward a permanent housing solution. Maria states that she would like to live near a bus line and close to her service provider, so the Housing Specialist identifies settings that meet these preferences. Maria's Care Manager suggests that Maria explore our award-winning CCHP, a high-value provider which can help to meet her housing needs and connect Maria to the full array of services she needs (PH, BH, substance use, biopsychosocial) through an integrated model. Maria states that she is interested in receiving services through CCHP as she likes the idea of having a single provider that can coordinate and arrange for her to receive all the services she needs. The ICT connects her to the CCHP provider that initially visited her in the ED to promote continuity and consistency in care. The CCHP case manager reminds Maria of her appointments, coordinate care with other providers and connect her to community resources.

Supportive housing – Prior to her discharge from the residential treatment facility, the CCHP case manager takes Maria to visit supportive housing settings so that she can choose the setting with which she is most comfortable. Maria decides on an individual apartment with supportive services. As part of Maria's discharge plan, the CCHP case manager helps Maria to complete the application and arranges

for Maria to move in at discharge. The Mercy Care Manager obtains funding to cover move-in costs such as the application fee and security deposits. Additionally, the Care Manager works with local community organizations to obtain furniture for Maria's apartment and puts together a Welcome Home box that includes basic cleaning supplies, household necessities, and hygiene supplies. The Care Manager also verifies that service to begin providing in-home supports when Maria moves in.

Transition to the community providers – Prior to Maria's discharge from the residential facility, the Care Manager provides Maria with appropriate materials regarding plan benefits and services and gives her a pre-programmed smartphone that makes it easy for Maria to contact her CCHP case manager, Care Manager, providers, Peer Support Specialist and other supports. On the day of Maria's discharge, the CCHP case manager and Peer Support Specialist meet her at the residential facility. They make sure she understands her discharge instructions and follow up appointments, introduce her to on-site staff that will be supporting her, answer any questions she may have, and help her move in. Mercy Care's Care Manager stands ready to address any issues or barriers that may arise and contacts the CCHP case manager to ensure the transition is seamless. The Peer Support Specialist calls Maria the next day to follow up, remind her of upcoming appointments and schedule a weekly in-home visit until Maria is comfortable in her new home.

Food security – As food insecurity has been an issue for Maria and significantly impacts Maria's health due to her diagnosis of diabetes, the CCHP case manager arranges for a local food pantry to provide a food box with healthy foods appropriate for individuals with diabetes. They also assist Maria in applying for Supplemental Nutrition Assistance Program (SNAP) benefits; when she is approved, her Peer Support Specialist educates her on how she can make the most of her benefits by accessing programs that offer Double-Up Food Bucks. Through this program, Maria receives a dollar for dollar match by shopping at farmer's markets and the Fresh Express bus sponsored by Mercy Care. Additionally, the Peer Support Specialist educates Maria on budgeting and healthy food options and connects her to diabetes self-management education and dietician services.

Income – At the time of Maria's enrollment, she is not receiving any income. As part of the IRP, the CCHP case manager helps Maria to apply for Social Security Disability Income. They assist Maria in locating medical records and other required information to complete the application process.

Coordination of Benefits – The ICT determines that Maria may benefit from an serious mental illness (SMI) evaluation and the non-Medicaid benefits available to persons with an SMI. If Maria lives in Maricopa County, she would gain additional State-funded benefits and can continue to receive services through Mercy Care even if she becomes ineligible for AHCCCS benefits. If she resides in another county, then we would manage a safe and effective transition to the Contractor serving the fully integrated SMI population in that region. If, during the process, she chooses to opt out of the SMI system, she can remain with Mercy Care for PH and receive BH services through the SMI Contractor. We will also investigate eligibility for other programs including Medicare Advantage or Long Term Care, if indicated.

Maria's goal: I want to feel healthy again: Maria's chronic pain is due to peripheral neuropathy, caused by diabetes. Maria's neuropathy management plan includes helping her to control her blood sugar levels to prevent further nerve damage as well as treating the pain itself. In coordination with Maria's Care Manager, the CCHP case manager helps to schedule Maria's initial appointment and arranges for the Peer Support Specialist to accompany her to the appointment, at Maria's request. Prior to the first visit, the Peer Support Specialist assists Maria in preparing for the appointment by helping her write down the symptoms she experiences, the level of pain she feels, questions for her PCP, medication or other allergies, what has worked for her in the past, and what does not work.

During the first appointment, the PCP assesses Maria's pain and the status of her diabetes. The PCP makes sure that she receives comprehensive diabetes care, including regular HbA1c testing, eye exams, blood pressure control, and treatment for neuropathy. They prescribe insulin and other medications to

help Maria manage her diabetes, assess her health literacy and need for home health nursing, and educate Maria on how to check her blood sugars and administer insulin. A Mercy Care pharmacist to assist with medication adherence and efficacy provides Medication Therapy Management. The CCHP case manager also helps Maria learn to care for herself including eating regular meals, taking her insulin and medications as prescribed, to control her diabetes and prevent worsening neuropathy.

Maria's goal: I want the pain to stop without using heroin: Maria's PCP discusses options with Maria for evidence-based treatment of her neuropathy, which may include tricyclics, topical anesthetics, Neurontin, or other treatments. Due to the extent of Maria's pain and associated substance use, the PCP recommends that Maria receive pain management and substance use services through Mercy Care's Center of Excellence (COE) for pain/substance use. The COE offers programs specifically designed for people with pain and opioid addiction. Maria agrees to this recommendation and the CCHP case manager connects Maria to the COE and assists in coordinating transportation and medical record sharing. Maria receives ongoing MAT and therapy through the COE, which is also prepared to address the symptoms of schizophrenia that Maria experiences and how that impacts her other health needs, or will coordinate services with a BH provider if Maria chooses that option. Maria's Peer Support Specialist helps her access MAT to increase participation and retention in MAT treatment and recovery supports as well as to identify local support groups near her home. Prior to Maria's discharge from the residential treatment facility, our Pharmacist reviews her medications for contraindications and negative side effects that may impact Maria's willingness to adhere to prescribed medications.

Maria's goal: I want to have a relationship with my family: Maria's Care Manager connects Maria and her family to family therapy services, which are available through CCHP, or another provider, based on their choice. The Peer Support Specialist provides options for family support services and community-based supports such as the NAMI Family to Family program. If requested, the Peer Support Specialist will attend the initial class with Maria and her family and provide Maria with ongoing coaching to help her develop the social skills to improve this relationship.

The Care Manager documents Maria's IRP in Mercy Care's care management documentation system, through their wireless tablet. The assessment and IRP are available to all providers involved in Maria's care through the system, which integrates with Health Current.

Ongoing Care Monitoring and Support

Maria continues to be engaged with her Care Manager, CCHP case manager and Peer Support Specialist as the focus shifts to longer term goals. The Peer Support Specialist maintains weekly (or more frequent, as needed) contact with Maria to help her navigate the service delivery system, access services, and use available community resources to support her recovery goals. The CCHP case manager coordinates with all providers involved in Maria's care to make sure she is receiving services according to the IRP, contacts Maria weekly during the transition, schedules in-home visits at times that are convenient for Maria and assesses her progress toward treatment goals.

Mercy Care's Care Manager reviews information available in CareUnify, which include gaps in care reports, service utilization data, predictive modeling (CORE) reports and ADT alerts from EDs and hospitals to verify that Maria has access to the care she needs and is receiving the right level and intensity of services and supports. If Maria's risk level or needs change, the Care Manager coordinates with the ICT to adjust the level and intensity of services accordingly. As Maria progresses toward her goals, the ICT discusses options for meaningful community activity with Maria, such as employment. With assistance from Mercy Care's Housing and Employment Specialist, Maria learns about how employment will affect the benefits she receives by participating in Disability Benefits 101 training. She also identifies potential options for vocational and employment services.

6. Member Scenario

Mercy Care's member-centered care management model meets each member where they are to address their health and care coordination needs. Our integrated clinical and administrative processes are designed to ensure all members have access to the services and supports they need to experience improved health outcomes. For members like "Mary" in this scenario, we have processes and partnerships in place to help her successfully transition from jail to the community and connect her to ongoing integrated physical and behavioral health services, substance use, and specialty services to help her have a healthy pregnancy and a healthy baby, and on an ongoing basis achieve the highest level of health outcomes even with complex conditions such substance use, depression, high-risk pregnancy and sickle cell anemia (SCA).

We make sure Mary receives supports throughout her pregnancy and beyond to address the social determinants of health that may impact her ability to achieve her recovery goals and care for her newborn. Our person-centered focus is on helping her to identify her priorities, establish her recovery goals, and help her achieve positive outcomes. Mercy Care immediately begins providing the covered services necessary to treat Mary's SCA as well as all other services necessary for her care. We identify SCA as a CRS qualifying condition and initiate the AHCCCS notification process (ACOM 426). Through Mercy Care and our care management program, all of Mary's services, including those CRS-qualifying conditions, are coordinated and served via a single service plan.

Identifying Mary for Care Management and Engaging Her in Services

At Mary's initial enrollment, care management staff obtain all available information about Mary's prior history with AHCCCS including utilization data, Blind Spot data, information from the 834 file, health information exchange (HIE) data, DEF data, CRS-related records, medical records, and data from the Controlled Substances Prescription Monitoring Program report on prescription opioid use. We will accept a historical CRS identification number, if available, for member identification and claims processing if applicable. We use all of this data to understand Mary's history and needs. Based on all available information, we identify that Mary has special healthcare needs and preliminarily stratify Mary into a high-risk group to receive care management. Mary receives support from a Care Manager with experience in serving members with high risk pregnancies complicated by chronic medical conditions, substance use, BH and biopsychosocial needs.

Initial Engagement: The Care Manager calls Mary to explain our care management program, gather information on her initial goals and service preferences, talk about the provider she wants to see, address any immediate needs, and schedule an in-person visit. During their initial discussion, Mary and her Care Manager decide that the following individuals will participate in Mary's interdisciplinary care team (ICT): Mary's Care Manager, family member, family support specialist, MSIC case manager (who will also serve as Mary's Transition Age Youth [TAY] Facilitator), the SCA team (pain and BH specialists) from the MSIC, a representative from the hospital where she may deliver, and her perinatologist. Other providers from the MSIC or the community may be asked to join the team as Mary's needs change.

Mary chooses to enroll in the High-Risk Perinatal Care Management program**,** which offers a comprehensive assessment; education on how to have a healthy pregnancy and give birth to a healthy baby; an integrated Service Plan; access to resources through the *myBaby* mobile application through which she can track pregnancy milestones, identify symptoms and issues, and connect to nurse support; assistance with navigating the system to access needed PH, substance use, and behavioral health (BH) services; links to community resources; family support and close care coordination. The Care Manager connects Mary with a contracted perinatologist with experience in managing women with SCA and is part of the Arizona Mother-Baby Care, which is a Mercy Care Center of Excellence for pregnant women. The Care Manager explains to Mary that she has the option to receive specialty services through a

Multispecialty Integrated Clinic (MSIC) or through community based providers in independent offices that are qualified to treat her condition. Mary reports that she previously received services through the MSIC in Phoenix and would like to receive coordinated specialty care at that location. In coordination with the MSIC and the SCA specialists who provide SCA specialty care, the Care Manager also recognizes that more frequent and additional services may be needed. The Care Manager works with all members of the care team and the MSIC to facilitate care coordination.

Assessing Mary's Priorities, Preferences and Needs and Creating the Service Plan

Within 14 days of Mary's enrollment (AMPM 560), Mary's Care Manager reviews all available data and begins to pre-populate the comprehensive assessment and develops an initial Service Plan and shares this information (via CareUnify, which is integrated with Health Current, the statewide HIE) with Mary's MSIC case manager. The MSIC case manager completes a comprehensive assessment and Strengths, Needs and Culture Discovery (SNCD) with Mary during her initial appointment, within 15 days of enrollment, exceeding AMPM chapter 560. The Care Manager meets Mary at the MSIC for her initial appointment to make sure her needs are being met; discuss the care planning process and; learn more about Mary's strengths, needs and preferences; coordinate care with the MSIC; and further educate Mary on available resources and benefits. Using information from the comprehensive assessment and SNCD, the ICT updates the Service Plan to include Mary's goals and identifies measures to evaluate her progress. The Service Plan integrates Mary's multiple treatment plans, including BH, into one document that she understands and documents desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified goals and objectives. It identifies Mary's immediate and long-term healthcare needs and includes an action plan. As Mary is in the transition age youth stage, her Service Plan also includes activities to support her transition into adulthood in accordance with the Transition to Independence Process (TIP) model. The services and interventions that may be identified in Mary's Service Plan are shown in Table 6-1 and discussed below.

Table 6-1: Mary's Priorities and Preferences

Mary's Goals	Mary's Service Preferences	Metric Demonstrating Achievement
Short Term Goal: I want to have a healthy baby.	• Help Mary to select a perinatologist that can meet her needs. • Assess tobacco use and use of other illicit substances. • Educate Mary on steps she can take to have a healthy pregnancy. • Help Mary download the *myBaby* application.	• Mary attends all prenatal care visits. • Mary enrolls in Teen Outreach Pregnancy Services (TOPS). • Mary's baby is delivered full-term in a setting where the proper newborn care is available. • Mary receives in-home support post-delivery to ensure she feels comfortable caring for her baby.
Short Term Goal: I don't want to feel pain.	• Connect to support groups and provide information on how to self-manage SCA • Seek alternative pain management strategies that are safe for Mary's unborn baby (monitored by the SCA team) • Access to specialty services through the MSIC and through Specialty providers in a coordinated fashion	• Mary uses sickle cell anemia specialty services and participates in ongoing disease management support at the MSIC. • Mary reports that she feels more comfortable managing her symptoms of sickle cell anemia. • Implementation of a long-term care plan for sickle cell anemia. The plan includes medically necessary options including therapeutic, transfusion, and chelation services as needed.

Mary's Goals	Mary's Service Preferences	Metric Demonstrating Achievement
Long Term Goal: I want to be a good mom to my baby.	• Link Mary to services to ensure food security, such as WIC and other supportive services in her community. • Help Mary select a pediatrician for her baby. • Arrange for Mary to receive an infant car seat and education on how to install the seat properly. • Remind Mary of well-baby appointments and provide a schedule of visits.	• Mary uses community-based education and resources regarding well-baby care and breast feeding, such as Families First, WIC, Supplemental Nutrition Assistance Program (SNAP), *myBaby*, Phoenix Day, and Holiday Angel Program. • Mary takes her baby to all well-baby visits in accordance with the EPSDT schedule. • Mary attends community-based pre-natal and post-partum support groups.
Long Term Goal: I want to earn a GED and obtain employment.	• Connect to GED classes via Housing Education Specialist. • Provide information on RSA/VR program to support Mary make an informed decision regarding program. • Provide DB101 planning session to educate Mary on financial gain related to employment. • Identify supports and resources to care for Mary's child while she attends classes.	• Mary obtains her GED. • Neuropsychological and educational services are provided and completed at the appropriate facilities and locations. • Mary obtains information about RSA/VR. • Mary understands she will gain by going to work following obtaining her GED. • Mary obtains employment or participates in vocational training.
Long Term Goal: I want to become independent.	• MSIC case manager engages Mary to: ○ Begin to earn her trust. ○ Help develop a safety net of support. ○ Develop goals related to work, living and independence.	• Mary is engaged in services and supports that help her move toward independence. • Mary learns critical decision-making and problem-solving skills. • Mary achieves her goals.

During the ICT meeting, the group identifies the following strategies and interventions to help Mary achieve her self-identified goals and achieve positive outcomes for her and her baby.

Mary's Goal: *I want to have a healthy baby*: Mary and her team review her medical and behavioral health needs and determine she would best be served by our care management program, which serves adolescents. This unique program provides intensive support over the first year of her baby's life through home visits, linkages to community services, and care coordination. They help Mary to schedule a visit and attends the first appointment with her to provide support and to assure that future needs are documented and coordinated appropriately. The Care Manager coordinates all of Mary's appointments with the MSIC case manager to ensure that Mary is seen by her SCA specialist and BH provider on her initial visit and coordinate care with Mary's perinatologist as part of a coordinated pregnancy plan. Throughout Mary's pregnancy, her Care Manager maintains telephonic contact and conducts in-home visits to educate Mary on proactive and healthy lifestyle measures that reduce risk factors throughout her pregnancy. They provide resources and coaching on perinatal care, birth alternatives, newborn care, pregnancy, wellness and risk factors such as substance use and smoking. If Mary's baby is exposed to opioids during pregnancy, we will coordinate services with Hushabye Nursery, a medically-monitored nursery for substance exposed newborns providing an environment that supports babies and their caregivers to facilitate withdrawal and family support.

Mary's Goal: *I don't want to feel pain*: Mary identifies SCA as her source of recurring pain. The Care Manager works with Mary, MSIC case manager, the SCA team and perinatologist to coordinate care and assure she receives all medically necessary care. Together, the MSIC case manager and Mary develop a

long-term care plan for SCA pain management. The plan includes medically necessary options including therapeutic, transfusion, and chelation services as needed. If Mary requires a service that is not available in our network, we will identify providers in state or out-of-state and work to assure they are registered with AHCCCS and open to payment using our Letter of Agreement process. After the pregnancy, PCP services that are integrated with the MSIC will be an option for Mary and her baby.

Mary's Goal: *I want to be a good mom to my baby*: Mercy Care introduces a series of services to help Mary take care of the baby after the birth ranging from assistance from organizations such as WIC to breast feeding classes, well-baby care, and other supports. Our care management team uses member and family-centric interventions to promote healthy outcomes through education, community resource referrals, and provider coordination of care. Our staff uses communication strategies such as motivational interviewing, and we provide written and oral communication for comprehension at a 6th grade reading level. Mary will have access to GED completion support, outreach programs specific for teens, infant care, and parenting classes that include the father, serve to strengthen family dynamics and can improve the social determinants of health.

In-home supports – The Care Manager, with the ICT, connects Mary to the Arizona Healthy Start program, which provides in-home services to assist Mary in learning to care for her child and herself. If Mary is substance free and chooses to breastfeed her child, her Care Manager helps her to access in-home and telephonic supports through La Leche League of Arizona (La Leche). La Leche offers parent-to-parent support throughout the child's life and provides evidence-based parenting resources.

EPSDT services – Prior to the birth, the Care Manager helps Mary select a pediatrician for her baby, educates her on the importance of EPSDT visits and provides Mary with a schedule of EPSDT services that she can put on her refrigerator along with the pediatrician's phone number. As Mary is also eligible for EPSDT services, the Care Manager educates her on accessing those services and monitors to assure that Mary and her child receive EPSDT services and that referrals are made, as appropriate.

Depression – As Mary experiences symptoms of depression, the ICT is concerned that her symptoms may be exacerbated postpartum. The Care Manager educates Mary on coping with stress, mood management, connects her to ongoing therapy and makes sure that Mary knows to contact her therapist or Care Manager if she recognizes those symptoms, and provides the 24/7 crisis line number. Additionally, the ICT assesses Mary for postpartum depression during visits and her Care Manager conducts evaluations during home visits.

Postpartum contraception – The Care Manager makes sure that Mary knows she has access to a full range of contraceptive benefits including Long Acting Reversible Contraception prior to her discharge.

Neonatal Abstinence Syndrome – If Mary is unable to abstain from substance use, and her baby is born with NAS, she and her baby can receive support through our NAS care management program. This program offers a specialized team of Care Managers who closely monitor substance exposed pregnant women and infants for up to one year to ensure that they receive appropriate medical treatment along with behavioral interventions and support.

Mary's Goal: *I want to earn a GED*: Mercy Care's Housing and Education Specialist engages with Mary regarding her interest in completing high school, provides information on the RSA/VR program and completes a Disability Benefits brief planning session to demonstrate Mary's earning potential with employment. We will help her obtain educational accommodations needed to navigate the Department of Education's community-based GED program.

Mary's Goal: *I want to become independent:* Mercy Care provides training to the MSIC on the TIP model, enabling the MSIC case manager to serve as Mary's TAY Facilitator. Mary and her MSIC case manager develop strategies to help her move toward adulthood focused on decision-making, goals for education, living and working, and services and supports to help her live as independently as possible.

Ongoing Care Coordination and Service Monitoring

Mary's Care Manager oversees implementation of services and ensures that all case management services are being delivered appropriately. The Care Manager, working closely with the ICT, expedites requests for prior authorization for all medically necessary services while also helping to secure housing, food, legal assistance, support for Mary to get her high school diploma, and transportation services as needed. Due to a number of factors, this may include neuropsychological testing, which will be managed in accordance with the guidelines identified in AMPM 320. The Care Manager coordinates with Mary's perinatologist and other providers to ensure that Mary delivers her baby at an appropriate facility that manages high-risk pregnancies and offers neonatal intensive care services. In addition, the Care Manager and MSIC case manager link Mary to local SCA and teen pregnancy support groups.

Mercy Care wants to empower Mary as she transitions from an adolescent to adult and ultimately into a parent. Her Care Manager introduces her to "Sally's Place", a supportive housing program offered by the National Council on Alcoholism and Drug Dependence (NCADD) for pregnant women who are struggling with substance use and BH disorders. If Mary chooses to receive services through Sally's Place, the program can provide Mary with a supportive environment to parent her newborn and teach her parenting skills. The goal is to re-introduce Mary and her child into the community with safe housing, support, and continued resources. The program can help Mary participate in the Women's Outpatient Program and to have access to all of NCADD's services including Educational and Vocational training.

Through information available in CareUnify, our Care Manager monitors for gaps in Mary's care, reviews utilization data to ensure appropriate service delivery, tracks adherences to reassessment timelines, and evaluates the need for an immediate change in Mary's Integrated Care Plan (e.g., if she needs help with food insecurity, or her SCA worsens). Mercy Care will specifically track and report on measures specific to members with CRS-eligible conditions (initial visit in 30 days) and will report quarterly on Grievances and Complaints summarizing, by month, the number of grievances and complaints filed by or on behalf of members with a CRS designation. The report will be categorized by access to care, health plan and provider satisfaction as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Coordination with the Justice System

If Mary was enrolled with Mercy Care prior to her incarceration, she would have participated in our Reach-In program. Our Justice Liaison would have identified her via daily reporting from the 834 file, which alerts us when members enter or leave the justice system. Mary's high-risk conditions and/or enrollment in care management trigger the Justice Liaison to immediately send a Justice Transition Notice to correctional health, even if she was incarcerated less than 30 days and no release date is scheduled, exceeding AHCCCS' requirements. Our Justice Liaison also notifies Mary's Care Manager of her incarceration, discusses her needs for services and supports, and provides regular updates on Mary's status and pending release date. Our Justice Liaison and Care Manager meet with Mary at the jail through an initial video visitation session. Using motivational interviewing, they help Mary identify her preferences for PH and BH services and biopsychosocial supports, including housing, prenatal care, and education. This information informs the Release Plan, which identifies who will pick Mary up from jail, where she will live, and her follow up appointments for services. Our processes for coordination with the justice system are described in a Memorandum of Understanding (AMPM 1020, 1050).

Expected Outcomes

With these supports and through care coordination, we anticipate that Mary will achieve her short-term goals. She continues to work toward achieving her recovery and health goals by participating in care management support through Mercy Care; case management from the MSIC; PH, BH and biopsychosocial supports in an integrated setting; disease management, ongoing coordination with probation, as appropriate, and ongoing coaching and education to learn to self-manage.

7. Improving Engagement and Implementing Best Practices

Mercy Care incorporates a systems of care approach that builds meaningful partnerships across systems and with youth, families and adults to address their cultural and linguistic needs and help them function better at home and in the community. We collaborate closely with members, families, system partners, government agencies and providers to connect members to services that help them achieve optimal health outcomes. We develop relationships with system partners and governmental entities, implement evidence-based programs and track and monitor results to ensure members and families receive needed services to improve outcomes, enhance their experiences, achieve recovery goals and promote resiliency. This response describes our strategies for improving member engagement, developing and implementing best practices, and tracking and monitoring outcomes for the specific populations identified in the ACC Contract.

Improving Engagement and Implementing Best Practices for Justice-Involved Members

Mercy Care coordinates with the justice system to serve justice-involved children, adults and families. As required in the ACC Contract, we already have Reach-In and Reach-Out programs in place in Maricopa County and are prepared to expand these programs to all awarded GSAs. We are working to implement evidence-based practices and partner with the justice system, providers and community organizations to meet members' needs, reduce justice system involvement and improve health outcomes. For example, Mercy Care is a member of the Maricopa County Smart Justice Committee, which consists of criminal justice partners that are individually and collaboratively promoting evidence-based practices to reduce recidivism, promote long-term public safety and improve cost effectiveness. For example, Mercy Care worked with Smart Justice partners to create the Criminal Justice Engagement Team, which has resulted in the successful diversion out of jail for 229 members since February 2016. ***The Smart Justice partners, in collaboration with Mercy Care, received the 2016 Desert Peaks Award for Public Partnership from the Maricopa Association of Governments.***

We actively engage with members involved in the justice system either face-to-face or through virtual visits using the following strategies, in accordance with ACC Contract requirements:

- Timely care coordination (AMPM 1020) and initial care plan development for all members at the time of incarceration, including short-term incarceration.
- Assistance from our Court Liaisons in identifying and connecting members to services available to address recidivism in each specialty court (Mental Health, Veterans, Juvenile Transferred Offender).
- Partnerships between Court Liaisons and the justice system, including defense attorneys to provide education on services and ensure all options are shared prior to sentencing or release decisions.

Mercy Care maintains collaborative agreements with the justice system, including probation departments, county jails, Arizona Department of Corrections and court systems in accordance with contract requirements in RFP Section D. Our experienced Justice System Liaison, Court Coordinator, and court services staff coordinate care and share data through a daily electronic justice transition report (AMPM 1020 and 1050). Using this report, we identify members who are incarcerated and coordinate the delivery of services throughout their incarceration and upon release. ***Our court services team attends over 400 court hearings each month to advocate for members who are justice-involved, and assist teams in developing comprehensive plans to address members' BH, PH, and criminogenic needs.***

An important strategy we use to serve justice-involved members is the Reach-In Program. Through this program we engage with members while they are in jail to connect them to services upon release. When we are notified that a Mercy Care member is incarcerated, we immediately begin to coordinate with the jail and outpatient providers prior to the member having a set release date, exceeding AHCCCS' requirements. Further, ***our Justice System Liaisons use video conferencing to engage with members and develop a Release Plan that identifies who will pick the member up from jail, where the member***

will reside and plans for ongoing services. The following member story highlights the effectiveness of our Reach-In program in engaging members, connecting them to care and reducing recidivism.

"Samuel" enrolled in our Mercy Care Justice Reach-In Program when he arrived at the Maricopa County Jail. He had multiple chronic conditions and previous hospital and ED use. Our Justice Care Manager, jail medical staff, and our Court Liaison collaborated to develop a Release Plan that outlined Samuel's living situation upon release and the services and supports he would receive. We arranged for equipment and medications to be available at the time of his release and scheduled PCP and specialty appointments within seven days of release. He received a forensic peer prior to release. Samuel has remained out of jail for over a year, continues to adhere to his terms of probation, and has not used the ED.

Mercy Care also works with providers to coordinate care for members incarcerated for 30 days or longer and for any adult member. We track and report outcome data based on these activities quarterly to AHCCCS. We are also contracted with eligible Targeted Investment (TI) providers and locations that serve adults transitioning from the criminal justice system. We have aligned performance measures in our value-based contracts with the TI program and continuously monitor provider performance. Through partnerships with providers and the justice system, we develop and implement best practices focused on improving quality of life and overall health for justice-involved members as shown in Table 7-1. We will use the knowledge we have gained and our experience to implement similar programs in all awarded GSAs, based on community needs and input from members, providers and stakeholders.

Table 7-1: Mercy Care Programs that Support Members who are Justice-Involved

Program	Program Description
Criminal Justice Engagement Team	Mercy Care's Justice Engagement Team collaborates with the court system to divert members from incarceration by connecting them to services. **Since February 2016 we diverted 219 members at initial appearance.**
Juvenile Probation Program	Our Justice Engagement Team coordinates with county juvenile probation programs to outreach and engage families of youth brought to detention to connect them to services and family supports, reducing the youth's risk of future justice system involvement.
Juvenile Justice Engagement Team	This team connects youth who are detained and their families to services, identifies upcoming court hearings, and arranges a Child and Family Team meeting to connect the youth and family to services and supports that reduce recidivism and promote permanency.
Collaborative Peer Support Program for Youth in Detention	In partnership with Arizona Department of Juvenile Corrections (ADJC). Mercy Care developed a project that connects the caregivers of youth that are in detention with other caregivers with similar experiences to offer support and engagement
Justice Reach-In for Youth in Detention	Through established protocols, detention centers notify our Justice Liaison when a Mercy Care youth is detained. The Justice Liaison coordinates with the center to ensure the youth continues to receive necessary services while detained and coordinates with outpatient services to connect the youth and family to ongoing services upon release.
Probation Community Reentry Unit Collaborative	Mercy Care's Justice Team connects incarcerated probationers to outpatient community treatment prior to release. **In 2017, 248 probationers attended outpatient appointments within a week after release.**
Maricopa County Adult Probation Drug Court Counseling	We facilitate continuity of care for members participating in drug court to offer intensive outpatient treatment and individual counseling to probationers as part of the comprehensive drug court program.
Crisis Navigation from Jails and Prison	Mercy Care's Justice Engagement Team collaborates with jails and prisons to connect members being released to services and supports such as transportation, finding shelter, a cell phone, and connection to ongoing BH and PH supports.

Program	Program Description
Evidence-based Programs	**Thinking for Change** - Mercy Care contracts with providers who deliver services according to this evidence-based practice, which Incorporates research from cognitive restructuring theory, social skills development, and problem-solving skills to reduce recidivism. **Hand in Hand** - We work with housing and service providers to identify high-risk justice-involved members that are frequently incarcerated and experience homelessness. We connect them to housing and support services to increase community tenure and reduce recidivism.
Reach-Out Program	Mercy Care's Justice Team coordinates with the jail system to transition probationers from jail into residential substance abuse treatment, improving access to SUD services and reducing recidivism. **In 2017, we placed 625 probationers in treatment and 65% completed the program.**

As demonstrated in the following member story, Mercy Care's programs and processes connect members to services that reduce their risk for further justice-system involvement.

When our Care Manager met "Daniel," he was homeless, using heroin, and on probation. Daniel had 8 BH inpatient admissions and 4 ED visits during a five-month period with claims costs of $95K during a 12-month period. Our Care Manager met with Daniel face-to-face and discussed his goals, which were "to be independent, have my own job, my own place, and feel free to succeed." Daniel and his Care Manager worked together to develop an Individual Service Plan to help him meet his goals. After a few months, Daniel called his Care Manager to say that he was almost off probation, compliant with his medications, had discontinued use of drugs and alcohol, and is working. When we asked the reason for the improvements, he stated that the conversation he had with our Care Manager prompted him to make a change in his life. Since February of 2017, Daniel has not needed the ED or hospital.

Improving Engagement and Implementing Best Practices for Members with Court Ordered Evaluations or Treatment

We collaborate with all community agencies and providers involved in the court order process including court systems, providers and tribal providers to ensure compliance with court-ordered evaluation (COE) and treatment (COT) processes. In Maricopa County, Apache Junction, Queen Creek, and San Tan Valley, we met with the courts and have a sufficient number of providers licensed to provide COT. For the ACC program, we will monitor to ensure that we have a sufficient number of providers that meet licensure requirements to provide COE and COT services in all awarded GSAs. To ensure members on COE or COT (including tribal members) receive support in their recovery and assist adherence to required court mandates, members on COT receive support from an assigned Care Manager, in accordance with AMPM 1020. The Care Manager conducts ongoing care coordination with BH providers to assist the member in working toward removal of the COT and achieve improved holistic health outcomes. Upon notification that a member is receiving a COE, we coordinate with the inpatient facility to ensure the member is connected to an outpatient provider for ongoing care. We will leverage our experience and knowledge of the COE and COT processes to coordinate COE and COT processes in all awarded GSAs.

Special Consideration for Members Going Through Rule 11

Mercy Care recognizes the special considerations for members going through the Rule 11 process. As part of the Justice Reach-In program, our Justice Liaison identifies members going through the Rule 11 process. If the member is later found not competent to stand trial and sent for COE, our Care Manager coordinates with the inpatient and outpatient teams to ensure the discharge plan addresses behaviors that lead to the criminal offence. Mercy Care uses a designated staff member assigned to members on Conditional Release Plan issued by the Psychiatric Security Review Board. In compliance with AMPM 1020, the Arizona State Hospital Liaison provides high-touch care management that includes

coordination with the Arizona State Hospital for discharge planning, participation in the development of the conditional releases plan, attendance in outpatient staffing (at least once a month), and care coordination with the member's providers.

Improving Engagement and Implementing Best Practices High Needs/High Cost Members

Mercy Care's care management program identifies members who are high needs and high cost using predictive modeling, utilization reports, and referrals from multiple internal or external sources. Through these sources, members, who at minimum meet AHCCCS stipulated criteria, are enrolled in care management and assigned a High Needs High Cost Care Manager in accordance with the ACC Contract. Our Care Managers engage members, address their needs and reduce risk though twice monthly telephonic outreach (at minimum) and at least once every other month face-to-face outreach in the community (AMPM 570). During these contacts and through our member- and family-centered care planning process, we educate members about how to access ongoing services, available supports and steps they can take to remain healthy.

Mercy Care's care management team coordinates care and meets with members to remove barriers to prevent future readmissions and unnecessary ED use. Our data-driven, member-centric approach includes face-to-face care management, offers real-time outreach, and connects members to increased resources and support. We offer care management supports to members with targeted needs (e.g. victims of sex trafficking, children with CRS-eligible conditions, members who are involved in the justice system, court ordered evaluation, children in high needs case management) and those with complex and chronic conditions including members with special health care needs. Our Care Managers use motivational interviewing to understand members' strengths, needs and preferences and connect them to evidence-based programs such as Applied Behavior Analysis, Transition to Independence Process model and First Episode Psychosis services through one of Mercy Care's contracted providers. Our goal is to engage with members and connect them to high-quality services to improve health outcomes, enhance their experience in care, reduce ED visits and inpatient admissions while supporting members in achieving their recovery goals.

In 2017, members receiving support through Mercy Care's High Needs High Cost program achieved the following outcomes: ***a 22% decrease in ED use, 14% decrease in inpatient use and 25% reduction in ED costs.***

Improving Engagement and Implementing Best Practices for Members with SUD

Mercy Care supports members with SUD in multiple phases of illness recognition and recovery using motivational interviewing and the American Society of Addiction Medicine guidelines to engage and connect members to appropriate services in accordance with the ACC Contract. We are committed to supporting and addressing the three main areas of Governor Ducey's opioid plan – administration, prevention, treatment. As part of our **administrative** initiatives, we implemented several prescription monitoring programs to identify prescribing practices for opioids, address risk and connect members to services. To **prevent** opioid-related deaths, we provide naloxone kits to members and their families/ natural supports and educate them on how to properly administer the medication. For **treatment**, Mercy Care also participated in and implemented the Arizona Opioid State Targeted Response grant, increasing access to medication-assisted treatment (MAT), peer support and care coordination.

We partner with state agencies and community organizations to improve identification and coordination of service delivery of members with Opioid Use Disorder and to implement a high-touch, service delivery approach within our care management team and provider network. For example, Mercy Care partners with the Arizona Governor's Office of Youth, Faith, and Families to provide Vivitrol (a MAT medication) to members prior to being released from prison. To engage and address members' immediate treatment needs, Mercy Care offers 23-hour crisis stabilizations and observations, substance use or

psychiatric stabilization (managed by the RBHA) and Level 1 sub-acute inpatient psychiatric services in Maricopa and Pima Counties through contracts with facility-based providers. We also develop and implement best practices to serve members with SUD as described in Table 7-2.

Table 7-2: Programs Supporting Members with Substance Use Disorders

Program	Program Description
CCHP	This program serves members experiencing homelessness, members with SUD needs, and members who are high risk, through a fully integrated model. Services include MAT, housing and employment support, integrated PH and BH services, biopsychosocial supports, and care coordination. This program has successfully helped members obtain housing, reducing the need for inpatient and crisis services.
Prescription Monitoring programs	**Benzodiazepine Program** -Identifies members at high-risk for medication abuse, notifies the prescriber and encourages coordination with other prescribers. **Opioid Prescription Reduction** - Identifies members with 10 or more opioid medication fills in a three-month period and coordinates care among all prescribers serving the member. **Exclusive Provider Program** – Offers care coordination, service referrals for MAT, detox, pain management, and peer support for members with opioid use disorders. **Since 2016, we reduced ED use by 57% and reduced the number of prescriptions with abuse potential by 59%.**
NAS Care Management	Provides care coordination and care management to the mother and baby through the first year of life, including member education, referrals, support, and special services to mitigate the effects of NAS, prevent future opioid use by the mother, and improve health outcomes.
Evidence-based programs for youth	Mercy Care contracts with providers to deliver evidence-based programs for youth with SUD. We contract with Jewish Family & Children's Services to provide services according to the Adolescent Community Reinforcement Approach (A-CRA), an intervention that seeks to replace environmental factors contributing to substance abuse with pro-social activities and behaviors supportive of recovery. In collaboration with AHCCCS and Chestnut, we have extended training for provider staff to become A-CRA certified to increase capacity. We contract with providers who deliver services that align with the Assertive Community Care practice and use the Global Appraisal of Individual Needs. Mercy Care has expanded its contracts with MAT providers to serve youth as young as age 16.
Center of Excellence for Pain/SUD	The Center of Excellence for SUD/Pain Management provides alternative pain management treatments to opioids and MAT for members with SUD. Members have access to PH, BH and SUD services as well as community supports to address the social determinants of health.
Peer Support	We have expanded the use of peer support services for members with Opioid Use Disorders to help members access MAT and increase participation and retention in MAT treatment and recovery supports.

Engaging and Implementing Best Practices for Members at Risk of Removal by the Department of Child Safety

Mercy Care provides support and services to families that may be at risk of DCS involvement. We work in collaboration with families and system partners to achieve permanency for children as quickly as possible if a child has been removed in accordance with the ACC Contract, including:

- **Completing a comprehensive assessment**—Mercy Care completes a comprehensive and trauma-informed assessment to identify social determinants of health needs for youth and families at risk.
- **Fast Pass**—Our collaborative process allows DCS to help a family apply for AHCCCS and connects the family to BH support and services if DCS determines it can prevent a removal.
- **Department of Child Safety (DCS) collaboration and In-home service workgroup**—Mercy Care coordinates with DCS to implement in-home services when a family is investigated by DCS and is in danger of having a child removed. If a child enters DCS custody, we collaborate to promote permanency and successful outcomes for the child until they can safely exit DCS custody.

- **Engaging with schools—We partner with 39 school districts and 191 schools** by providing services and after school programs, processing referrals, and bringing mental health awareness to families.
- **Provider trainings**—Mercy Care delivers provider trainings to identify a child at risk of removal and increases provider knowledge on infant toddler mental health. ***Over 320 staff received training in Maricopa County through the Infant Toddler Mental Health (ITMH) Series.***
- **Member and community-based trainings**—We provide education such as trauma informed care, BH navigation, and autism spectrum disorder. Trainings are held at churches, foster and adoption agencies, provider agencies, DCS offices, and community organizations***. As of April 2016, Mercy Care facilitated 27 Navigating Behavioral Health Forums with 774 participants.***
- **Member and community engagement**—We engage members, peers, natural supports, and families to improve processes and supports for children at risk of removal, such as attending community advocacy for autism groups to seek input and guidance for the Autism Centers of Excellence.
- **Family engagement model**—Our model includes three co-located providers within the DCS offices to engage with the biological family to assess their needs and facilitate access to services.

Mercy Care knows that supporting healthy children and families requires us to meet them where they are to address their immediate and long term needs, avoiding removal. In our experience, both children and their families need services and supports to promote resiliency and community tenure. To that end, we work with community organizations and government agencies to engage members and families in care and quickly connect them to services. As part of our approach, we educated kinship, foster, group home placements, and the Department of Child Safety about available services and how to access them. Additionally, we collaborate with stakeholders to reduce barriers to care and facilitate access to services that reduce the risk of removal as shown in Table 7-3.

Table 7-3: Programs Supporting Children at Risk of DCS Removal and their Families

Program	Program Description
Dedicated Child Welfare Care Line	Families can contact our toll-free number 24 hours a day, 365 days per year to learn about available services, address any concerns and get immediately connected to a provider to meet their needs, reducing the risk of DCS involvement.
No Wrong Door Initiative	This initiative facilitates timely access to services through Family Run Organizations, which complete an assessment and link members and families to needed services.
First Connections	A collaboration with a Children's Provider that offers care coordination to members to provide engagement, education, and connections to substance abused infants.
Centers of Excellence	**Family Center of Excellence** - A collaboration with providers, DCS, and CMDP to connect at-risk families to community services and supports to address their PH and BH needs and the social determinants of health. **Autism Spectrum Disorder (ASD) Centers of Excellence** - Provides complete care to children with ASD and/or developmental disabilities based on evidence-based practices, giving parents the support they need to care for their children in the home.
Co-located staff in DCS offices and group homes	Mercy Care providers co-locate in DCS offices and at Canyon State Academy to offer on-site services such as trauma therapy, telemedicine, and on-site crisis support to help families learn to care for their children in the home.
Partnerships with Family Shelters	Mercy Care partners with family shelters to provide assessments and treatment. Currently, we work with the Dream Center and Sojourner Center to coordinate care and provide easy access to youth and families that will benefit from interventions.

Engaging Children Transitioning from the Comprehensive Medical and Dental Program

Mercy Care currently tracks and monitors each and every child that is entering into the child welfare system through monthly removal reports from DCS. We make sure that each youth receives an assessment within 72 hours and is connected to ongoing behavioral health interventions, as needed. For

children transitioning from the Comprehensive Medical and Dental Program (CMDP) to Mercy Care, our oversight and monitoring will mirror the process in place for youth and families upon removal. The process will include assignment to a Care Manager that understands the unique needs of this population to provide support for the child, family during the transition and one year post reunification. Care Managers will work with families, youth and their Child and Family Teams (CFT) to make sure that the youth and family are receiving supports and services to promote resiliency and permanency. Mercy Care has the added advantage of being affiliated with a RBHA, which means that we can support the member and family prior to the transition and members will have access to the same providers after the transition, facilitating continuity of care. We will work with BH providers to make sure they understand the CFT's responsibility for supporting reunification efforts and ensuring that members and families continue to receive needed services.

Tracking and Monitoring Outcomes

We determine the effectiveness of our interventions through multiple mechanisms, such as outcomes measures, care management activities, and member and provider feedback. Mercy Care uses the results of our analyses to refine our interventions, identify additional opportunities for improvement, and revise performance measures. We list examples of the measures we track to improve health outcomes, in accordance with the ACC Contract in Table 7-4.

Table 7-4: Examples of Monitoring and Tracking Outcomes by Population

Population	Outcomes Measures
Justice-Involved Members	Number of justice-involved members, service engagement for Reach-In and Reach-Out programs, release plans developed, percentage of members attending appointments within seven days of release, and members identified for residential SUD treatment released from jail early directly into a residential program.
Members on COT and COE	Number of members on Court Ordered Treatment (COT) and Court Ordered Evaluation (COE) amendments, adherence to treatment, re-admission to inpatient, incarceration, and COT renewal.
Members with High Needs and High Costs	Number of ED and inpatient visits per 1,000, the total number of care coordination touches per 1,000, post inpatient admission outreach measures—member contact rates, identified gaps in care, and 30-day readmission rates; the use of preventive measures such as well woman, well man, EPSDT, and immunizations and adherence to treatment plans for physical, behavioral, and social determinants of health needs.
Members with SUD	Reduction in opioid related deaths, reduction in substance use, employment, stable housing, arrest rates, abstinence from drugs and alcohol.
Children at risk removal by DCS	Outreach attempts to engage families of children at risk of removal, member and family engagement in services, members and families receiving care management services, and calls to the child welfare line.
Children Transitioning from CMDP	Timeliness of assessment, access to care management, service utilization, gaps in care, permanency, timeliness of EPSDT services, and timeliness of BH services.

Summary

Mercy Care collaborates with system partners and providers to assist members in achieving their health and recovery goals. We have Collaborative Protocols in place as required by the ACC Contract and designated staff who work alongside providers and system partners to develop and implement innovative programs and best practices that improve member care. We regularly track and monitor outcomes and employ a continuous quality improvement approach to ensure that all members have access to the services and supports they need to achieve their recovery goals, promote resiliency and permanency, and improve health outcomes.

8. Strategies to Improve Outcomes, Add Value and Enhance Care for Pregnant Women

Our member-centric strategies and programs meaningfully engage Mercy Care members who are pregnant. We work daily to enhance the experience of members and their families, improve outcomes, and add value by approaching perinatal health in a systematic manner that goes above and beyond AHCCCS' Contract and policy requirements. In alignment with the March of Dimes report, *Toward Improving the Outcome of Pregnancy Third Volume: Enhancing perinatal health through quality, safety and performance initiatives (TIOP III),* our approach to serving pregnant women and their families focuses on the following essential strategies:

1. **Consistent data collection and measurement** to support the uptake of robust perinatal quality improvement and safety initiatives.
2. **Use of evidence-based initiatives**; adherence to clinical practice guidelines; and policies that support high-quality perinatal care to promote in safety and screening along the entire perinatal continuum, from preconception through postpartum care.
3. **Community services that are member- and family-centered**, culturally sensitive and linguistically appropriate to in recognition of the longitudinal interplay of biological, behavioral, psychological and social/environmental protective and risk factors related to birth outcomes.
4. **System transformation,** including increasing the role of payers in the both quality and outcomes of perinatal health.

This response describes our approach to serving and supporting pregnant women and their families, and the associated positive outcomes. It also discusses the barriers we have identified based on our experience, and strategies to overcome these barriers. The lessons we have learned from serving pregnant women and families across Arizona and evidenced-based practices will guide our approach to serving pregnant women and families in every awarded GSA.

Consistent Data Collection and Measurements

Mercy Care collects and uses data to identify opportunities to increase member engagement in prenatal and postpartum care and improve birth outcomes. We have developed dashboards and reports that allow us to track and trend perinatal health measures including access to prenatal care, pre-term births, low weight births, C-sections, births that require Neonatal Intensive Care Unit (NICU) and full-term births. We aggregate birth outcomes and compare the data to national and statewide benchmarks. Combined, these reports allow us to evaluate the effectiveness of our programs and to make changes or improvements as necessary. As shown in Table 8-1, our 2017 perinatal outcomes demonstrate that Mercy Care performs above state benchmarks, and we exceed Healthy People 2020 targets. As discussed in this response, we use these outcome measures for value-based contracts and provider scorecards to identify outliers and high-value providers.

Table 8-1: Opportunities for Measuring Outcomes and Making Improvements

Measure	HP 2020 Benchmark	Arizona	Mercy Care
Preterm Birth <37 weeks (lower is better)	11.4%	9.0%	**7.9%**
Low Birth Weight <2500g (lower is better)	7.8%	7.25%	**6.6%**
C-Section Rate (All) (lower is better)	23.9%	27.4%	**27.0%**
Full-Term Birth >37 weeks	88.6%	82.7%	**92.1%**

Barrier to consistent data collection: Claims-based data has significant lag and authorization data requires significant manual processing, both of which can delay implementation of performance improvement interventions.

Remediation Strategy: Our immediate strategy is to work with a newly formed entity, Arizona Mother-Baby Care, a partnership between Dignity Health and Phoenix Children's Hospital, which will function as

a clinically integrated network focused on obstetrical, perinatal, and neo-neonatal care outcomes. We will embed and align our high-risk maternity care management program with the network's providers and use clinical pathways to drive improved outcomes. This will allow us to use CareUnify, our care management tool, to access common medical records, and exchange data on shared priority areas (such as twin gestation) using real time data exchange processes. When supplemented with our claims-based data, this will allow us to engage in rapid improvement cycles and help us to further improve maternal and child health outcomes. Additionally, we are working to increase the number of providers connected to Health Current, the statewide Health Information Exchange (HIE), which integrates with CareUnify and facilitates consistency and timeliness in data collection and sharing.

Use of Evidence-Based Initiatives

Mercy Care uses data to identify pregnant women who are in high-risk categories and engage them in care management programs based on evidenced based practices to monitor the care they receive during pregnancy. Our perinatal care management program is designed to serve the unique needs of each member, including pregnant teens under the age of 15, pregnant members in long term care, and those with an intellectual or developmental disability. ***Mercy Care's program goes above and beyond traditional care management programs to support the member, their family and the baby throughout the prenatal period and for a year following the birth.*** We recognize that families are important support systems for pregnant women and play a critical role after the member gives birth; therefore, we provide education, assistance with service navigation, coaching and connections to community resources to support the entire family. Our Care Managers also work to mitigate the social determinants of health and do what it takes to help the member stay healthy during their pregnancy and prepare to care for their newborn.

Mercy Care's High-Risk Perinatal Care Managers are experienced Maternal Child Health Registered Nurses who outreach and engage with members and families. They are skilled in addressing specialized perinatal issues such as mothers with Opioid Use Disorder during pregnancy who are engaged in our Neonatal Abstinence Syndrome (NAS) care management program. Care Managers collect member information through continuous review of claims, utilization management documentation, completion of a perinatal assessments, condition-specific assessments (when applicable) and care plan formulation. The Care Manager and member collaboratively determine interventions to reduce risks such as alcohol, substance use during the pregnancy, history of pre-term delivery, pre-term labor, history of postpartum depression, history of gestational diabetes, pre-eclampsia, social and BH conditions, or PH co-morbidities.

Mercy Care also works to eliminate non-medically indicated early elective deliveries and to decrease prematurity rates by promoting evidence-based practice such as the American Academy of Pediatrics Guidelines for Perinatal Care and the American Congress of Obstetrics and Gynecology through:

Mercy Care implemented an initiative to increase the use of 17P/Makenna to reduce pre-term births. We educated providers on this evidence-based practice, monitored script fills, and shared data with providers. ***As a result, prescriptions for 17P/Makenna increased by 200 percent.***

- **Prenatal Screening**—An assessment of members' desire for pregnancy, tobacco use, substance use, depression, safety, intimate partner violence, stress, barriers to care, unstable housing, communication barriers, and nutrition.
- **Member Education**—We educate pregnant women and their families (using tools such as no-cost birthing classes in hospitals, our own *You and Your Baby* magazine, and mobile apps) on topics such

as healthy lifestyle choices; proper nutrition; smoking cessation; parenting; breastfeeding; developmental milestones and pregnancy risks.

- **Provider Education**—We educate providers on evidence-based practices such as prenatal care, depression and substance use screening and the use of 17P/Makenna to prevent pre-term labor.
- **Routine screening and management for postpartum depression and Post-Traumatic Stress Disorder**—Assessment and screening for post-traumatic stress disorder during the postpartum period.

Care Managers encourage members to adhere to care plan goals, provide follow-up to offer education and support, coordinate with community-based programs, and screen for postpartum depression after delivery. They work with the treating obstetrician and care team to assure the care plan is shared, and that members are engaged with the obstetrical team for ongoing prenatal care. Through this approach, we are able to achieve high rates of engagement and excellent perinatal outcomes as shown earlier in this response (Table 8-1).

Barrier to improving perinatal outcomes: We have identified an opportunity to increase the number of high-risk pregnant women who are engaged in prenatal health care. We have evaluated data and outcomes and found that nearly half of all NAS neonates were not identified until their stay in the Neonatal Intensive Care Unit (NICU). We surveyed our NICU concurrent review nurses to identify the barriers that prevented identification of cases before birth. We learned that pregnant women are often reluctant to self-report opioid use because of social and legal consequences. Often, these mothers experienced late prenatal care or were not receiving prenatal care at all, and had multiple prescribers. We also found that providers under-reported illicit or prescribed opioid use in pregnant members and that universal drug screening for pregnant women was limited. Finally, we identified that some methadone clinics were not referring pregnant members to care management.

Remediation Strategy: Mercy Care Plan responded to the growing population of pregnant women with opioid use disorder by developing a NAS care management program to reduce stigma and increase engagement. This program provides holistic care coordination services for mothers and infants through care planning and member engagement. We designed the NAS Program to enhance identification of pregnant women and infants with NAS; provide care management to the mother and baby through the first year of life; offer member education, referrals, support, and special services; address social determinants of health; enhance data tracking; and increase outreach and collaboration with providers. Two years following program implementation, we extended our focus beyond the member and provider to include family members and natural supports. We also increased our staff and enhanced monitoring tools to accurately report data. To further overcome these clinical barriers, we will develop clinical pathways that increase the treating obstetrician's ability to communicate with pregnant women about the risks about opioid use during pregnancy, identify members that use opioids, and connect members to Medication Assisted Treatment (MAT) services. ***51 percent of members in our NAS program are enrolled in MAT and 89 percent remained engaged postpartum.***

Member-and Family-Centered Community Services

Mercy Care combines integrated care approaches with community service programs to holistically address members' care needs. We meet the member *where they are* to overcome, physical, behavioral, and social determinants of health barriers. We work daily to improve each member's experience by connecting them to resources and education that increase their use of community resources that positively impact outcomes in the preconception, pregnancy, and growth and developmental phases. Selected activities and results are shown in Table 8-2.

Table 8-2: Mercy Care Programs and Community Partnerships for Members who are Pregnant

Program	Description
Medication Assisted Treatment (MAT)	MAT offers safe, alternative medication treatment for pregnant members with substance use disorder needs.
Birth-Spacing and Preconception Education	Stork's Nest, Coming of the Blessing, and Healthy Babies are Worth the Wait provide pregnant women with birth-spacing and preconception education. Referrals to Father Matters serve to empower men in becoming active participants in the life of their baby and community using a peer support model of care approach.
Perinatal Care Management	Mercy Care's team of Nurse Care Managers support pregnant women, their families and newborns throughout the member's pregnancy and for a year after birth. They connect members and families to services and community resources to keep moms and babies healthy. Care Managers help obtain basic necessities such as car seats, cribs, diapers and other supplies in addition to providing ongoing education and coaching on prenatal and postpartum care. Nurses are available 24/7.
Nutrition Support	As nutrition is crucial for a healthy pregnancy and infant development, we connect pregnant women to resources such as WIC and Feeding Matters, a national organization based in Phoenix, which offers parent-to-parent coaching, provider support, and resources to assist in the understanding of feeding disorders; community gardens; Fresh Express mobile market and programs that offer Double-Up Food Bucks.
Prenatal Dental Program	We collaborate with oral health providers to provide prenatal dental services to improve oral health for pregnant women with periodontal disease who are at increased risk of pre-term labor.
Teen Outreach Pregnancy Services (TOPS)	Perinatal Care Managers refer teen members to TOPS, an organization that provides educational interventions on sexual health and pregnancy while promoting positive interactions with other teens and young adults in a non-judgmental environment.
Housing Support	Pregnant members have access to housing supports such as Center for Hope and Sally's Place, supportive housing programs for pregnant women who are struggling with substance use and BH disorders.
Newborn services for Substance-exposed neonates	Care Managers can refer newborns to Hushabye Nursery is a medically-monitored nursery for substance exposed newborns providing an environment that supports babies and their caregivers to facilitate withdrawal and family support.

Barrier to member engagement with community services: We have identified an opportunity to increase the number of pregnant women who are aware of, and have the skills to navigate available community services.

Remediation strategies to increase engagement: Our health literacy programs and supportive services for pregnant members are designed to overcome social and health literacy barriers. We will use Community Health Navigators and Peer Support Specialists to address barriers to care, meet members' cultural and health literacy needs and assist members and families with system navigation. They will connect members to resources such as GED completion support, English as a second language classes, outreach programs for teen moms, infant care, and parenting classes that include the father to strengthen family dynamics and impact social determinants of health. We will also increase the use of technologies to engage members and create a personalized, self-directed experience. Members will have access to health information through mobile applications, including:

- *myBaby* – Helps pregnant members track pregnancy milestones, identify symptoms and issues, and connect to services, such as nurse support. Pregnant members can track their weight, watch weekly educational videos, and receive daily highlights.
- *myHome* – Allows members to find providers and list them as favorites, schedule and view appointments, and fill out forms. It provides a secure portal that allows members to view clinical

information, send secure messages to their health care team, see provider notes from previous visits, view lab and radiology results, and get a list of their current medications.

- *myStrength* – Offers web and mobile self-help resources, empowering members to be active participants in their journey to becoming, and staying, mentally and physically healthy.

System Transformation

Mercy Care will continue its work to transform the service delivery system when serving members through the ACC program. For example, we are executing a value-based contract with Maricopa Integrated Health System's Refugee Women's Health Clinic (RWHC) to support a Center of Excellence for refugees who are pregnant. This includes culturally and linguistically-appropriate comprehensive health services to refugees to promote wellness, self-sufficiency, and successful community integration. Cultural Health Navigators help members navigate the health system and accompany them to medical visits, provide interpretation services, assist with medication compliance, arrange transportation, and provide home visits to build trust. The RWHC also provides member-specific nutritional education that is culturally-sensitive and meets members' needs.

Additionally, we are partnering with Arizona Mother-Baby Care, which will function as a Center of Excellence for obstetrical, perinatal, and post-neonatal care with a focus on members with high needs, beginning with twin pregnancies and fetuses identified with gastroschisis. We will embed and align our high-risk maternity care management programs with the network's providers to implement and consistently apply evidenced-based clinical pathways to improve outcomes for mothers and infants.

Barriers to system transformation: Providers need support to adopt alternative payment models and transform service delivery practices.

Remediation strategies: We collect, validate, and evaluate data to build comprehensive models to track and reward value in maternity and newborn care. We will leverage the Practice Innovation Institute to build transformational capacity within the Centers of Excellence. Our value-based contracts will include measures of prenatal and postpartum performance such as: timeliness of prenatal care: cesarean section; live births less than 2500 grams; frequency of ongoing prenatal care; BH risk assessment—screening for depression, alcohol, tobacco and drug use (including opioids); intimate partner violence; and postpartum contraceptive use among women ages 15-44. Our strategies will include:

- **Contract Year 2019**—We will continue the RWHC value-based program and enter into a value-based agreement as part of the Arizona Mother-Baby collaborative, which is an expansion of our current value-based relationship. When fully operational, we expect the Arizona Mother-Baby Care clinically integrated network could serve as many as 25 percent of Mercy Care's nearly 12,000 births per year.
- **Contract Year 2020**—We will add the following measures to reward providers for improved performance and cost efficiency with a focus on integrating BH into maternity care. We will use existing funding approaches for the Medicaid population to develop the bundle with integrated care markers and targets.
  - Screening and treatment or referral to treatment for depression during the pregnancy and after
  - Screening for opioid or other substance use and treatment during and after pregnancy
- **Contract Year 2021**—We intend to expand the quality measures and bundling approaches to at least two more large maternity providers.

Summary

Our member-centric strategies and programs engage members who are pregnant and their families to improve outcomes, add value, and enhance their experiences. In all awarded GSAs, we will implement our NAS program, collaborate with community stakeholders and providers to implement innovative programs, promote evidence-based practices and guidelines, and execute value-based purchasing programs to improve the quality of care provided to members who are pregnant.

9. Identifying and Addressing the Developmental Needs of Young Children

Mercy Care has over 30 years of experience developing and implementing an integrated approach to health care service delivery. Our service delivery strategy addresses members' diverse needs and focuses on integration of care between our physical health (PH) and behavioral health (BH) providers. We foster strong collaborative relationships and support the full integration of health care services through initiatives such as our Centers of Excellence. Mercy Care assures that young children and their families have services readily available to meet their unique needs. Our Birth to Five services encompass all aspects of child development, enhance natural supports, and are tailored to the needs of the child, family, and/or the primary caregiver. Our approach ensures that members are accurately identified as early as possible and connected to early intervention services.

Early Identification and Treatment of Children's Developmental Needs

Primary care providers (PCPs) are central to the identification of possible developmental delays in young children as part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. We offer families choice of providers who conduct ongoing developmental surveillance in accordance with AMPM 430. Our PCPs receive formal training on the use of the following AHCCCS-approved developmental screening tools used with children ages 0-5.

- Ages and Stages Questionnaires Third Edition (ASQ) - a developmental screening tool
- Ages and Stages Questionnaires Social-Emotional (ASQ:SE) - a social-emotional screening tool
- Modified Checklist for Autism in Toddlers (M-CHAT-RF) - a screening tool to assess risk of Autism Spectrum Disorder (ASD) validated for use with children 16-30 months of age
- Parent's Evaluation of Developmental Status (PEDS) - a developmental screening tool validated for use with children up to 8 years of age

Mercy Care ensures that PCPs are educated about the expectations related to developmental screening, including completion of training on any AHCCCS-approved developmental screening tools. Providers are also required to upload evidence of training completion to the Council of Affordable Quality Healthcare (CAQH). Mercy Care tracks the rate of completion of developmental screening using claims and EPSDT form submissions, and completes quarterly audits of a random sample of providers who have completed developmental screenings. Our efforts to improve developmental screening also include monitoring CAQH for evidence of appropriate PCP training and ongoing provider outreach and education via mailings, face-to-face visits, trainings, conference presentations, and written educational materials. ***From 2016 to 2017, our developmental screening rates increased by 20 percent for 1-year-olds, 18 percent for 2-year-olds, and 39 percent for 3-year-olds.***

Mercy Care adheres to the AHCCCS Psychiatric Best Practice Guidelines for Children 0-5 Years of Age, which describe the role of the Behavioral Health Medical Practitioner (BHMP) in conducting psychiatric evaluations and providing treatment for young children who present with psychiatric or other BH issues, including developmental delays. Comprehensive psychiatric evaluations include a developmental assessment, the gathering of information regarding any current developmental concerns from persons who know the child best, and direct observation of the child with his/her parent or primary caregiver. In addition to psychiatric assessments, mental health practitioners complete 0-5 assessments within 90 days of intake. Additionally, we train providers on AHCCCS BH Tool Kits, including tools for PH providers to identify and screen for BH conditions and resources to help BH providers identify and screen members who need PH services to address special needs.

Mercy Care has established minimum elements of a 0-5 extended assessment, which includes a developmental assessment/screening and at least two documented observations by the practitioner. We complete these assessments on all children 0-5 who are receiving BH services to ensure that

children are assessed by a trained professional to avoid missing any red flags. Developmental checklists, including the Developmental Checklist for Children Ages 0-5, are used to evaluate the child's achievement of developmental milestones. Mental health practitioners also complete a trauma assessment to determine whether the child's presenting symptoms are related to trauma versus a developmental delay. We share the findings and recommendations from all screenings and assessments completed by PCPs, psychiatrists, or other trained professionals with the parents and members of the Child and Family Team (CFT). In addition, we coordinate referrals to programs such as Division of Developmental Disabilities (DDD) or Arizona Early Intervention Program (AzEIP). ***In 2017, Mercy Care initiated 403 referrals to AzEIP.***

Collaborating with the Community to Promote Early Identification

Mercy Care collaborates with parents, caregivers, and community partners to assist in the early identification and treatment of children with developmental needs. Our partners include AzEIP, Head Start programs, churches, day care centers, hospital-based programs and schools. ***We are currently providing BH services in 39 school districts and 191 schools in Maricopa County***. Mercy Care coordinates with multiple child-serving state agencies including the Department of Child Safety (DCS) and DDD. Mercy Care is joining with DCS in a pilot project called "Fast Pass" which connects families to BH services and supports to help prevent the need for removal of their children by DCS. We also work with babies with Neonatal Abstinence Syndrome (NAS) through a specialized team of care managers. This team closely monitors the substance exposed pregnant women and infants for up to one year to ensure that they receive appropriate medical treatment along with behavioral interventions and support and link them to early intervention services. They also coordinate with DCS and Comprehensive Medical and Dental Program (CMDP) when a child is placed in foster care. Our partners in this effort include Nurse Family Partnership, Healthy Families, Maggie's Place, and the Family Involvement Center, who assist parents and other caregivers with system navigation, training and support groups. We also have a close working relationship with the Refugee Women's Health Center and are collaborating to employ community health workers to enhance culturally relevant services for pregnant women.

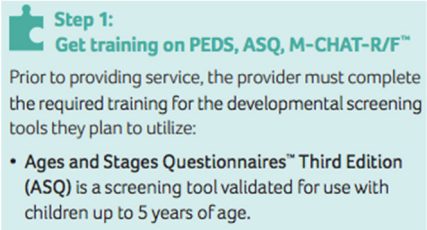
Training PCPs and BH Professionals to Screen for and Address Developmental Delays

Mercy Care offers training opportunities to PCPs and BH professionals working with children 0-5. Examples of provider training and education include:

- Creation of the Developmental Screening 101 Flyer, which is included in the EPSDT Provider Manual
- Early Identification and Management of ASD for Primary Care Providers presentation by a Mercy Care Medical Director
- *Developmental Screening and Integrated Care for ASD: Navigating the System* presentation by a Mercy Care Medical Director at the PCP Integrated Training Academy

To help providers complete developmental screenings and make appropriate referrals, Mercy Care developed a quick reference tool, shown in Figure 9-1. Our Children's System of Care staff facilitate meetings with the 0-5 Learning Consortium, a group of professionals working in Maricopa County who are dedicated to best practices for infants and toddlers. We also offer training to mental health professionals serving children 0-5 through an Infant Toddler Mental Health (ITMH) 10 -week training series. Since the implementation of the series, we have trained over 320 staff. ***In 2017, the total number of provider staff that meets at least one competency outlined by the Infant Toddler Mental Health Coalition of Arizona has increased by nearly 20 percent and is expected to grow.***

Figure 9-1: Mercy Care's Provider Reference Guide


Step 1:
Get training on PEDS, ASQ, M-CHAT-R/F™

Prior to providing service, the provider must complete the required training for the developmental screening tools they plan to utilize:

- Ages and Stages Questionnaires™ Third Edition (ASQ) is a screening tool validated for use with children up to 5 years of age.

Developing a Robust Provider Network to Serve Members with Developmental Delays

Mercy Care will build on our experience serving over 11,000 members with developmental disabilities, to develop and maintain a robust network that meets the needs of members with developmental delays in every awarded GSA. Our network will include: accessible, well-trained PCPs, pediatric specialists, providers that serve Transition Age Youth, PH and BH providers, developmental pediatricians, family medicine and internal medicine physicians willing to serve adults with developmental disabilities, speech, occupational, and physical therapists, audiology services, and providers of Applied Behavioral Analysis services. We will monitor multiple data points to ensure services are readily available and effectively meet members' needs, including geoaccess reports; member, family and stakeholder feedback; complaints and grievances; service utilization data; and appointment availability data. For rural and underserved areas, we will help develop field clinics and virtual clinics, expand the use of telehealth and telemedicine and assure transportation services are available. We will ensure that developmental services are accessible to members wherever they live in the state.

Identifying and Serving Members Eligible for Children's Rehabilitation Services

A significant number of members with Children's Rehabilitation Services eligible (CRS) conditions have developmental needs. The multispecialty interdisciplinary care clinics (MSICs) are among the most sophisticated providers in our State. We see a great opportunity to better support these members and their families through our strong promotion of, and support for the MSICs. Mercy Care identifies members with CRS-eligible conditions through multiple means (834 file, assessments, and provider, member and family referrals) and makes referrals in accordance with ACOM 426. Most importantly, we will immediately begin providing covered services to treat the member's CRS-qualifying condition and other needs and facilitate developmental screenings. Further, because we consider children with CRS conditions as having special health care needs, we assign a Care Manager to assist them and their family with navigating the delivery system wherever they choose to receive services.

We also see an opportunity to leverage the capacities of the MSICs to serve even more members and families using their integrated care models. The MSICs can serve as Centers of Excellence for additional ACC members and families. Feedback from community partners, members, and current CRS program providers support this approach. We will also work to bring innovative partnerships, expand services in key areas of need, and draw upon the strengths of the current MSICs to deliver services through field clinics, virtual clinics, telehealth and telemedicine.

Implementing Centers of Excellence to Serve Members and Families

Mercy Care is leading the way in integrated care for children at risk or diagnosed with ASD, including children ages 0-5. Mercy Care has collaborated with the community to open two new Autism Centers of Excellence and a Family Center of Excellence for children and families at risk for, or involved with child welfare. Mercy Care implements evidence-based practices through these Centers of Excellence and tracks outcomes for members with specialized health care needs in accordance with Section D, paragraph 11 of the Contract. The Autism Centers of Excellence include staff specially trained in the needs of members ages 0-5 with ASD, and provide services including assessments, training and PH and BH care for children and adults with autism and other developmental disabilities. Specific achievements include:

- The Southwest Autism Center for Excellence focuses on the physical and behavioral health of children, including ages 0-5, families and adults living with or at-risk of ASD. ***The Center has supported 251 members and families since October 2017.***
- The Autism Center of Excellence through Touchstone Health Services supports our goal to connect PH and BH providers so that children and families receive quality-driven health care. ***The Center has supported a total of 642 members and families since October 2017***.

A family with five-year-old twin boys was receiving occupational therapy, habilitation and applied early intervention service from DDD and transitioned to Mercy Care. We connected the family to the Southwest Autism Center for Excellence and a High Needs Case Manager who educated the family on how to proactively identify and track developmental milestones. The Case Manager coordinated services across providers and ensured the boys could continue to participate in occupational therapy and habilitation. The boys and their family received support without any disruption in care. Their mother reports a decrease in behaviors and is grateful for the continued support.

Monitoring Member Identification Processes and Service Provision

Mercy Care is committed to ensuring that all members, especially vulnerable and at-risk children, receive physical and behavioral screenings and appropriate treatment. We use the following reports and measures to ensure that children ages 0-5 are appropriately identified and receive needed services:

- **EPSDT standards and monitoring** – Mercy Care tracks completion of required EPSDT developmental screenings at 9, 18, and 24 months based on claims data and EPSDT forms.
- **Comprehensive Medical Record Review Tool (CMRRT)** – The CMRRT audit occurs biannually and reviews the accuracy and timeliness of required documentation in the member's medical record.
- **Direct Service Provider Audits** – DSP audits assess whether BH treatment services have been delivered per the child's Individual Service Plan and evaluate whether treatment provided has resulted in improved outcomes for the child and family.
- **System of Care Practice Reviews** – These include interviews and record reviews to document the service experiences of children and their families and provide feedback and recommendations for system improvements.
- **Psychotropic medication monitoring** – We review all psychotropic medication requests for children under the age of 6, regardless of the prescriber, to ensure that their use is clinically appropriate and justifiable and that we are not exposing them to the unnecessary adverse effects of polypharmacy.
- **Special health care needs designation** – Mercy Care runs reports and tracks Enrollment Transition Information forms to identify children with special health care needs, and those at risk of developmental delay. We provide care coordination services for this population in accordance with the ACC Contract, Section D, Paragraph 10, Special Health Care Needs.
- **BH Coordinator and DD Liaisons** – These staff help families navigate the delivery system, monitor services and coordinate across specialties as required in the ACC Contract, Section D, Paragraph 15.
- **AHCCCS Practice Tools** – We monitor and train to AHCCCS practice tools (including Working with the 0-5 Population; Psychiatric Best Practice Guidelines for Children 0-5).
- **ED claims monitoring** – Monthly, we identify any children with an ED claim and no prior PCP claims. We then assign a Care Manager to follow-up on connecting them with a PCP.
- **Level of Intensity Tool** – The tool is designed as a guide for the CFT when considering if High Needs Case Management is appropriate based on the individual needs of the child and their family.
- **Ongoing Surveillance** – We monitor prior authorization requests (multiple psychotropic medications) and data analytics (diagnoses on claims) to ensure services adhere to best practices.
- **0-5 CMDP Monthly Check in Tool** – This tool was developed with the Birth to Five Learning Consortium. The check in tool assesses developmental milestones, trauma, and behavior.
- **Access to care** – Mercy Care monitors BH penetration rates by age and take actions to ensure that BH services are readily accessible and that members and families know how to access them.

Mercy Care tracks, trends, and reports findings regarding the above quality measures to our Children's Quality Management Committee and to our System of Care Committee, which is co-chaired by the Mercy Care Medical Director and Children's System of Care Administrator. We also re-measure progress

on quality metrics to evaluate whether our interventions have been effective. For example, Mercy Care has an AHCCCS-approved Performance Improvement Project in place to increase developmental screenings for children ages 0-3. ***In one year, developmental screenings increased by 34 percent.***

Managing the Early Intervention Behavioral Benefit

Mercy Care provides coordinated, accessible, evidenced-based BH services to children and their families. Based on the child's needs, we rely on the CFT or PCP to help coordinate the overall care and treatment and manage the behavioral intervention benefit for children ages 0-5. Mercy Care identifies members who may require BH follow up via EPSDT forms and send follow up letters to both the PCP and the parents educating them on how to connect to these services. Services delivered by the CFTs are provided according to the AHCCCS Child and Family Team practice protocol. For example, children ages 0-5 with co-morbid chronic physical conditions require close monitoring by the PCP and other specialists in collaboration with the team. These children benefit significantly by the PCP participating as an active member of the CFT. We educate PCPs on the importance of attending CFT meetings and encourage them to participate by phone or video. We also encourage members with significant BH needs to receive care through an integrated health home to promote care coordination and PCP participation in the CFT.

Care Management and Prior Authorization

Mercy Care uses a family-centered approach to care management and service navigation that is responsive to all AMPM 500 requirements. Our Care Managers have expertise in pediatrics, member advocacy, navigating complex systems, and communicating closely with the child and family and health care professionals. With care management ratios at 40:1 for high needs members, we are able to meet members and families *where they are*: in the community or in their home and create care plans that reflect the member's and family's preferences and unique characteristics. At least bi-weekly, our Care Managers will identify members who have visited the ED and contact them to verify they have a follow-up appointment and address any barriers to care, such as transportation or child care. Care Managers also coordinate with PH and BH providers to make sure the member attends their follow-up appointment (within 5 days for a BH appointment and 7 days for PH services).

As required in AMPM 541, our Care Managers work closely with the CFT to coordinate care with child-serving State Agencies including CRS, DDD, DCS, juvenile courts, and the Arizona Department of Education. Mercy Care uses data and technology including the CareUnify tool to support care management. CareUnify provides Care Managers with information such as historical claims, real-time clinical alerts through Health Current and predictive analytics to easily identify members with high needs. The tool assists Care Managers in prioritizing daily activities and responding to emergency department and hospital admission alerts. Our prior authorization staff help manage children's PH and BH benefits. We identify new members that have transferred from other health plans via the ETI Form, identify conditions that may indicate the need for developmental screening and eliminate barriers to care. We facilitate and properly authorize therapies and medications related to developmental conditions to make sure members have access to all medically necessary services.

Summary

Mercy Care's experience in implementing integrated approaches to health care and in developing, implementing, and monitoring innovative programs for high-needs children ages 0-5 sets us apart from other managed care organizations. We understand the importance of providing high-touch services to this population and assisting families in navigating the multifaceted service delivery system that serves young children with complex needs. We also have the necessary processes and the administrative structure in place to support the early identification and treatment of children ages 0-5 with suspected developmental delays or developmental disabilities.

10. Minimizing Emergency Department Holds and Inpatient Use and Increase Access to Alternative Community-Based Services and Follow-Up Care

Helping members and families heal and move towards recovery in the community is central to Mercy Care's mission. In each geographic service area (GSA) we serve, we work with stakeholders, members, families and providers to assess community needs and take action to reduce emergency department (ED) visits and minimize ED holds, reduce psychiatric hospital admissions, increase alternative community-based services and ensure member access to follow-up care. Our approach has been proven effective as demonstrated by the following data:

- 54% increase in follow up within 30 days after discharge for behavioral health (BH) hospitalization from 2016 to 2017.
- 47% increase in follow up within 7 days after discharge for BH hospitalization from 2016 to 2017.
- 40% decrease in ED use for members receiving disease management services from 2016 to 2017.
- 74% decrease in children placed out of state from 2014 to 2017.
- 78% decrease in hospital holds from 2015 to 2017.

In each awarded GSA, we will leverage our experience to work with providers and stakeholders to address the needs of each community and the members we serve.

Overarching Strategies to Minimize Emergency Department Holds and Inpatient Use and Increase Access to Alternative Community-Based Services and Follow-Up Care

Mercy Care offers strategies and activities that decrease ED visits and inpatient admissions, increase use of community-based services and ensure follow-up care is provided. Our model incorporates a five-pronged strategy that includes: 1) network development and oversight; 2) care management, care coordination and assistance with navigating the system; 3) value-based contracts; 4) collaboration with stakeholders to create innovative solutions for meeting members' and family's needs; and 5) using technology to engage members. These strategies are described below.

1. Network Development and Oversight: We continuously evaluate data and gather feedback from members, providers and stakeholder to maintain an adequate network. Additionally, we educate members on how to access services, such as through our *Welcome to Mercy Care* new member orientation, which informs members and families about available benefits and resources and how we can help them navigate the delivery system. For example, in one of our existing programs, we determined the need to increase capacity for outpatient services, inpatient beds and transition support community feedback and utilization data. To meet this need we:

- Designated ED Coordinators to help transition members from the ED to the community.
- Opened Centers of Excellence to address community needs.
- Expanded community options for adults with medical needs through contracts with Maricopa Integrated Health System (MIHS) and St. Luke's Medical Center for additional beds.
- Developed a Special Needs inpatient unit to serve children with developmental disabilities.

We will work with stakeholders in each GSA to implement these and other strategies, as needed.

2. Care Management and Care Coordination: Mercy Care's health risk assessment and predictive modeling software enables us to predict members who are at risk for inpatient admissions or ED visits based on an analysis of diagnosis, service utilization, pharmacy and other clinical information. Through our care management program, we manage clinical interventions and connect members to alternative treatments to reduce risk and cost. We identify members with high-risk levels, and coordinate with their provider to engage the member, assess their needs, and connect them to community-based services and supports, averting an inpatient admission. Care management services include proactive discharge planning, a daily clinical review of their progress, and ongoing follow up. ***From 2016 to 2017, members***

who kept their follow-up appointment within 7 days had a 38 percent lower readmission rate than members who did not participate in follow-up care.

As part of our care management program, Discharge Coordinators collaborate with the inpatient facility and the member's outpatient providers to facilitate a coordinated discharge, preventing readmissions. They follow-up on the member's Discharge Plan, make referrals to providers for services, arrange for transportation, and facilitate service authorizations. For example, in southern Arizona, we have systems in place with the crisis system and Regional Behavioral Health Authority (RBHA) to receive notifications when one of our members accesses crisis services. These notifications enable providers, Discharge Planners, and Care Managers to take action to stabilize the member and prepare for discharge. This notification system will be expanded to all awarded GSAs. Further, data from our health equities dashboard shows that Native American members have higher rates of inpatient service use and lower rates of primary care visits. Our Tribal Coordinator works with local tribes to increase coordination for members who frequently use ED and inpatient services. Additionally, through the Reach-In program, we coordinate with the Department of Corrections to transition individuals to community mental health, substance abuse, and medical care upon release.

3. Value-based contracting: Mercy Care's value-based contracts with outpatient and hospital providers include performance metrics related to follow-up after discharge within 7 and 30 days and reductions in readmissions. Additionally, we provide funding for contracted inpatient facilities to hire designated staff to coordinate discharge appointments for members prior to discharge.

4. Collaboration with Stakeholders to Create Innovative Solutions: We will continue to work with stakeholders, providers, and members in each GSA to assess and expand service capacity to facilitate member access to necessary services. Our innovative strategies include:

Opioid Centers of Excellence – Mercy Care has opened two 24/7 Opioid Centers of Excellence that provide comprehensive services, including: medication assisted treatment (MAT), wrap-around services, and peer support. Upon award, we will open additional locations in each awarded GSA.

Community Comprehensive Health Program (CCHP) – This program, which was awarded the Housing Hero award from the Arizona Department of Housing, provides integrated services for members experiencing homelessness, members with substance abuse disorder needs, and members who are high risk. Members receive services such as peer support, intensive case management, permanent supportive housing, employment services, physical health (PH) and BH services, and in-home supports. Additionally, the CCHP ED Navigation team assesses members in the ED to facilitate discharge to community-based services***. CCHP has served over 300 members, resulting in an 11 percent decrease in hospitalization***.

First Episode of Psychosis Services – We contract with providers to offer this evidence-based intervention to prevent the exacerbation of mental health and psychotic symptoms through early intervention upon first episode of psychosis. ***This Center is the first of its kind in Arizona*.**

Treat and Refer program – We partner with first responders to assess members' needs and refer them to appropriate levels of care when they do not need to go to the ED.

Community paramedicine contracts – These programs train paramedics to perform risk assessments, medication reviews, and referrals to primary care doctors and skilled home services, and provide preventive services such as immunizations and support to improve medication compliance. Mercy Care will work with emergency medical services (EMS) providers, hospitals, health care, and social services providers to implement paramedicine programs, as needed in all awarded GSAs.

5. Technology Tools to Facilitate Data-Sharing and Member Engagement: Mercy Care leverages Health Current, the statewide Health Information Exchange to create enhanced data flow in the health care delivery system, improve member and provider satisfaction, facilitate care coordination, increase quality

of care, reduce costs, and facilitate a collaborative approach to keeping members healthier. Technology that will be available to all Mercy Care members, providers and stakeholders at contract start, includes:
CareUnify – CareUnify, our care management platform is integrated with Health Current to facilitate communication between treating professionals, the care team and Mercy Care's care management team. CareUnify enables providers involved in the member's care and our Care Managers to view and share critical information such as assessments, care plans, medications, and member progress toward treatment goals in a HIPAA-compliant manner.
Mobile Integrated Health – A mobile application that allows members to speak with a physician on the phone or via HIPAA-compliant secure video teleconferencing to diagnose symptoms, prescribe medication, and send prescriptions to the member's network pharmacy of choice.
Mobile Engagement Platform – A mobile application that allows members to access care via their mobile device. It collects health information about the member through a health risk assessment questionnaire and includes features that create a personalized, self-directed experience for the member, resulting in better engagement, increased access to care, and improved outcomes.

Minimizing Emergency Department Holds

In collaboration with hospitals, stakeholders, first responders, outpatient and crisis providers, and through data analysis, we have identified key factors that impact ED holds, including: 1) members who use opioids frequently; 2) members experiencing homelessness without a safe place for discharge; 3) the need for placement options for children and adults with special health care needs; and 4) limited care coordination to connect members to the right services. Our approach to addressing these issues includes: care management and care coordination, community-based services and housing, stakeholder collaboration, ongoing monitoring and targeted ED diversion strategies for children. ***Our efforts have resulted in a 66 percent reduction in the average member wait times in EDs for adults since 2015.***
Care Management and Care Coordination – We comply with all actions to reduce ED holds per the AMPM 1020. We identify and track members who use ED services four or more times within a six-month period, educate members, families, and guardians on appropriate use of the ED and divert members to the right care in the right place. We have dedicated ED Hold Coordinators that gather information on members who are waiting in an ED, work with outpatient providers to coordinate a face-to-face visit while the member is in the ED, and assist with discharge planning. Mercy Care also facilitates daily calls with representatives from urgent psychiatric facilities, crisis providers, and hospitals to identify capacity and help facilitate movement across the system to minimize ED holds.
Community-Based Services and Housing – To support members experiencing homelessness who are at increased risk for frequent ED use, Mercy Care has increased housing stipends, collaborated with public housing, developed the CCHP program (described above), implemented a medical respite program and leveraged Community Bridges to provide transitional housing. In January 2018, we are launching a permanent supportive housing development with 54 units that will help those experiencing chronic homelessness, job loss and health issues. The residence is central to medical, employment, social and educational centers.
Ongoing Monitoring – Mercy Care monitors the length of time adults and children wait to be discharged from the ED while awaiting BH placement or wrap around services per AMPM 1020. Through our Medical Management Committee and internal workgroups, Mercy Care also monitors monthly data and implements quality improvement efforts if trends are identified.
Stakeholder Collaboration – We train first responders to transport members experiencing a behavioral health crisis to a psychiatric urgent care instead of an ED.

Targeted ED Diversion Strategies for Children

Mercy Care has worked with families, providers and stakeholders to expand our network through the following strategies:

- Implemented Hospital Support Teams for children and adolescents that coordinate services with the assigned outpatient provider and facilitate discharge planning
- Added Family Crisis Training to educate families/ support systems on available services
- Conducted weekly meetings with crisis providers and hospitals to evaluate the effectiveness of our strategies and identify opportunities for further improvement
- Monitored ED holds through daily dashboards and work with providers to quickly resolve issues.
- Increased use of the Observation Stabilization Child and Adolescent Unit, a 23-hour BH unit that assesses youth and provides stabilization services
- Added crisis respite beds and contracted for additional inpatient beds

As a result, the length of time that a child waited in an ED for placement decreased by 20%.

Through conversations with providers and stakeholders, we understand that in other GSAs and rural areas, children with complex needs may experience ED holds. We will continue to work with providers and stakeholders to: 1) coordinate care; 2) develop protocols for hospitals to contact us when a child is in the ED and needs placement; 3) provide wraparound supports; 4) implement a hospital discharge program, which provides assessments and care coordination and links high need members to services; and 4) discuss joint efforts to manage network needs with the RBHA/crisis system in that GSA.

Reducing Inpatient Psychiatric Admissions

We recognize that ACC members are entitled to care and assistance with navigating the service delivery system. Based on our experience and data analyses, we know that the primary contributors to inpatient admissions include: 1) members not getting connected to services; 2) low health literacy; 3) substance use needs; 4) social determinants of health such as housing and employment; and 5) readmissions related to substance use. To assure members receive necessary services, Mercy Care has developed targeted initiatives and innovative programs to reduce hospital utilization for the members we serve, impacting these five areas. Our strategies include care management and care coordination, network development and oversight, and the use of technology tools to facilitate information-sharing and member engagement, all of which are described in detail above. Our first priority in reducing psychiatric admissions is to reduce readmissions by engaging members early after their initial discharge. ***To date, our processes and programs have resulted in a 54 percent increase in follow up within 30 days of discharge and a 47 percent increase in follow up within 7 days of discharge.***

Reducing Out of State Placements

The number of youth enrolled with Mercy Care who are in out of state placements has decreased by 73.7 percent from 2015 to 2017. This is the result of collaboration between our Children's System of Care staff, medical management and utilization management departments, and stakeholders (including other AHCCCS Contractors), who work together to identify the causes of out of state placements and develop creative solutions for serving children in their home communities. These strategies, which we will employ in awarded GSAs, as appropriate, include:

- The Mercy Care toll-free 24-Hour Crisis Line**,** which provides immediate help and intervention.
- Working with the Child and Family Team and care teams to identify alternative placements.
- Developing a specialized unit to serve children and adolescents with developmental disabilities.
- Increasing family support services to assist families and caregivers in caring for members at home.
- Developing a specialized program for youth with sexually maladaptive behaviors.
- Training ASD providers to provide functional behavioral analysis and complete Behavior Intervention Plans to help children with ASD or developmental delays remain in their home.

- Developing collaborative protocols with the justice system and Division of Developmental Disabilities that describe the process for connecting members to in-state services.

Increasing Access to Alternative Community-based Services

Community-based treatment and rehabilitation and support services such as respite, behavior coaching, housing, and substance use treatment have demonstrated efficacy for serving members with substance use disorder and BH needs, reducing the need for high cost inpatient services. Actions we have taken and will expand to all GSAs we serve (as appropriate) include:

- Providing housing subsidy support coordinated entry and one-time eviction prevention programs
- Expanding the number of Whole Health Integrated Clinics
- Implementing Centers of Excellence for Pain Management/Substance Use
- Expanding peer support, residential and 24/7 MAT services
- Expanding capacity to deliver services through the award-winning CCHP program
- Executing value-based contracts to increase BH penetration rates
- Increasing funding to enable family support providers to connect families to natural supports
- Expanding intensive outpatient program services for members with substance use needs to include step-down after hospitalization and partial hospitalization or residential care

We understand the correlation between member and provider education and utilization of community-based services. Therefore, we use multiple methods to communicate the availability of BH services:

- **Implementing a *Welcome to Mercy Care* program** to provide new members with an overview of available services, including peer support, employment, and rehabilitation services, and introduce members and families to the Office of Individual and Family Affairs and the Ombudsman.
- **Leveraging Peer and Family Advisory Councils** to educate members and families to solicit feedback from members and families.
- **Implementing a media campaign** regarding the availability of community-based services.
- **Conducting targeted outreach and navigation assistance** to educate members on available services.
- **Partnering with Equality Health** to provide BH training for PH providers.
- **Using our Housing and Employment Specialists** to educate staff, providers and members on housing and employment options.

Facilitating Follow-Up Care

Members who are engaged with a provider experience improved health outcomes, achieve their recovery goals, have increased community tenure, reduced crisis episodes, and have decreased risk for ED visits and inpatient admissions. ***Data from 2016 to 2017 shows that readmission rates decreased by 43 percent when members were seen by a provider following discharge from a BH facility.*** Strategies we currently employ and will expand in all GSAs to facilitate member access to follow-up care include:

Member-centered discharge planning – We include the member and family (as appropriate) as participants in the discharge planning process; understand the written discharge plan; are connected to community-based supports; access referrals and interventions to meet the member's needs; and receive call backs to verify they received the services identified in the discharge plan (AMPM 1020).

Admission notifications – The member's outpatient team and primary care provider is notified in near real-time when the member is admitted to an inpatient facility. This enables them to immediately begin facilitating the discharge planning process and arrange for services upon the member's discharge.

Hospital discharge teams – Our designated teams connect members to services and conduct visits in the facility to assess the member's needs and assist with the transition to an appropriate setting. We also conduct follow up calls for all dual-eligible members post-discharge to facilitate follow-up care.

'Through all of these strategies, Mercy Care connects members to the right care.

11. Strategies to Develop a Comprehensive Provider Network

Mercy Care is contracted with a statewide network of providers (including specialty and behavioral health (BH) providers that will be ready to serve AHCCCS Complete Care (ACC) members in every awarded geographic service area (GSA). Our culturally and linguistically diverse network of specialty and BH providers is available and accessible to meet each member's needs, including members with limited English proficiency, developmental or cognitive disabilities and members with special health care needs (ACOM 436). To ensure network adequacy, we: 1) evaluate data (such as geoaccess reports, demographic data, AHCCCS' 1800 report, grievances and appeals, appointment timeliness data, complaints, quality of care concerns, utilization data, gaps in care), and 2) gather feedback from members and families (through community forums and advisory committees), providers and stakeholders.

Mercy Care uses advanced analytical tools, including a health care disparities dashboard, to analyze the prevalence of conditions within ethnic groups to better understand and plan for member needs.

These data help us determine our approach for developing Centers of Excellence and health homes to reduce health disparities. If we identify potential network gaps or health disparities, we take action, such as recruiting new providers, expanding capacity with existing providers, using telemedicine and telehealth, or executing single case agreements with out-of-network providers. We use monthly, quarterly, and annual monitoring activities to inform the development of our Annual Network Development and Management Plan, which is overseen by our Network Administrator. In this response, we describe existing and planned network development strategies to link ACC members to specialty and BH services that help them achieve improved health outcomes.

Specialty Provider Network Designed for Children and Adults

Mercy Care maintains contracts with a wide array of specialists designed to meet the specific needs of ACC members, including but not limited to, ophthalmology, general surgery, neurology, oncology, cardiology, urology, orthopedic surgery, and gastroenterology, as required in the Contract, Section D, Paragraph 26, Network Development. Our network includes specialists that treat members with qualifying medical conditions (A.A.C. R9-22-1303), to reduce: utilization of emergency services, one-day hospital admissions, hospital-based outpatient surgeries (when lower cost surgery centers are available), and hospitalization for preventable medical problems. When developing our specialist network, we collect and analyze data related to members' health status and prevalent conditions. We use this information to monitor access to services for members with high utilization patterns or chronic conditions and determine the appropriate provider mix within the network.

Our current network in the Central and South GSAs is sufficient to meet AHCCCS' requirements; however, based on member and family feedback and our data analysis, we recognize the need for additional allergy, dermatology, endocrinology, and urology specialists in rural areas. We have a value-based agreement with Phoenix Children's Care Network to increase member access to specialists. For children with special health care needs, including children with CRS conditions who could benefit from a multi-disciplinary approach, covered services will be delivered through Multi-Specialty Interdisciplinary Clinics (MSICs), Field Clinics, Virtual Clinics, and in community settings. Based on input from families, we know that children with CRS conditions and their families benefit from the consolidated services that are available through MSICs. Mercy Care has relationships with the MSICs in all GSAs and will contract with the MSICs in all awarded GSAs as well as any MSICs that have served Mercy Care members. In the absence of a contract, we will reimburse the MSIC in accordance with the AHCCCS MSIC fee schedule. We have met with each of the MSICs to gather information on the specialists that are available at their

locations to make sure that members with CRS conditions have access to needed providers at a single location, as outlined in the Contract. Mercy Care recognizes the value of the family-centered care approach provided at the MSICs and supports broadening the types of services offered and intends to designate some MSICs as Centers of Excellence for High Needs Children. In addition, members will benefit from having access to Mercy Care's network of community-based providers, which include primary care, dental, and other specialty providers, giving members a greater choice in providers.

Mercy Care will pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their Contract status, when Individual Family Service Plans identify and meet the requirement for medically-necessary EPSDT covered services. We have the network and systems in place to provide excellent care coordination services and high-quality navigation tools to help families, and the organizations that assist them (e.g. Raising Special Kids) in managing their plan benefits and services.

Behavioral Health Provider Network for Children and Adults

Mercy Care ensures that members have access to medically-necessary BH services as determined by a qualified behavioral health professional. Our current network of BH providers in the South and Central GSAs meets AHCCCS' requirements and includes providers that deliver the following services: inpatient, rehabilitation, treatment, support, day programs, court-ordered treatment, outpatient treatment and residential. It also includes master's and doctoral-level clinicians in the fields of social work, counseling, and psychology that are trained in implementation of best practices for physical health (PH) and BH conditions. As required in the ACC Contract, Mercy Care is contracted with: 1) the Arizona State Hospital; 2) providers offering court-ordered evaluation services to ensure timely follow up and care coordination for members; 3) specialty service providers who deliver services to children, adolescents and adults with developmental or cognitive disabilities; sexual offenders; sexual abuse victims; individuals with substance use disorders; individuals in need of dialectical behavior therapy; transition age youth ages 18 through 20; and infants and toddlers under the age of five years [42 CFR 438.214(c)]; and 4) eligible Targeted Investment (TI) providers and locations specifically serving adults transitioning from the criminal justice system participating in the TI program. Leveraging our experience and relationships with providers and stakeholders, our BH network in all awarded GSAs will fully meet AHCCCS' requirements.

Mercy Care also has an expansive network of BH providers and integrated health homes that provide intake/assessment, psychiatric services, and treatment services for children, youth, and families in the Central and South GSAs. Direct support and specialty providers deliver support and rehabilitation services while specialty providers offer services based on evidence-based practices such as Transition to Independence, Adolescent Community Reinforcement Approach, Assertive Community Care, Global Appraisal of Individual Needs, dialectical behavioral therapy and/or programs to address specialty areas like eating disorders or youth with sexually maladaptive behaviors. Mercy Care also maintains a network of providers who offer early childhood BH services for children aged 0-5 and their families. We will leverage feedback from stakeholders and providers and input from the Birth and Family Consortium to enhance services for children and families in all awarded GSAs.

We recognize that ACC members may need assistance in navigating the service delivery system. Mercy Care will ensure peer and family support services are available in all GSAs we serve. We contract with organizations that provide peer and family support such as Southwest Network, CHEEERS, Family Involvement Center, Hope Lives, Hope Inc., and Recovery Innovations. Through our Office of Individual and Family Affairs (OIFA), we will expand peer support services that promote recovery provide education, empowerment and assistance with system navigation. For example, we are incorporating peer supports services into our Center of Excellence for SUD/Pain Management.

Integrated Care Network for Children and Adults

Mercy Care has agreements with 106 providers who are registered with AHCCCS as integrated care providers, many of whom offer services statewide, such as Community Bridges, Inc., Empact, Community Health Associates, Inc., and Terros. We are also collaborating with two of our clinically integrated networks - Arizona Care Network and Equality Health - to launch Complex Care Centers. Complex Care Centers are designed to serve members identified as high risk, high need that need close care coordination and assistance with accessing preventive care services. These settings offer integrated PH and BH services, chronic disease management, and wellness care delivered by family nurse practitioners, physician assistants, psychiatric nurse practitioners, and licensed counselors who work together to increase member health literacy and ability to self-manage. Using the lessons learned from our initial pilot sites, Mercy Care will expand this model in each awarded GSA. As part of our integrated model, our network includes organizations that address the social determinants of health that impact members and processes for serving priority populations as described below.

Network Design for Members with Unique Needs

Members experiencing homelessness: Mercy Care contracts with homeless clinics in Maricopa and Pima counties, such as Circle the City. We assign members who request a homeless clinic as a PCP to these clinics and may refer members to out-of-network providers for specialty services, as needed. We make resources available to assist homeless clinics with administrative issues such as obtaining prior authorization and resolving claims issues. Mercy Care also contracts with providers that deliver innovative programs such as mobile health clinics and medical respite to help members recover from illness or injury in a safe place. For example, we identified the need for respite services for members experiencing homelessness in the South GSA and we were the first health plan to commit funding for a respite program in Southern Arizona. We are also collaborating with the Crossroads Mission in Yuma, and are working with La Frontera Arizona, CODAC, Canyonlands Healthcare, and Chiricahua Community Health Centers, Inc. in Southern Arizona to provide mobile medication-assisted treatment (MAT) services in rural communities such as Globe, Sierra Vista, Safford, and Benson. We contract with both Chiricahua Community Health Centers, Inc, and Canyonlands Healthcare (both Federally Qualified Health Centers [FQHCs]), which offer mobile, community-based services. Further, in collaboration with Native American Connections, Mercy Care launched a new permanent supportive housing development with 54 units in January 2018. This development will help those experiencing chronic homelessness, job loss, and health issues. The location is central to medical, employment, social and educational centers.

Mercy Care also partners with housing providers and agencies that administer Housing and Urban Development (HUD) housing and local municipalities, including:

- Arizona Department of Housing and Housing Continuum of Cares to provide service dollar match to further increase housing security for our members
- Local housing authorities (counties, cities, towns) to address the housing needs of shared members
- Other agencies, such as United Way and Arizona Housing Coalition

We are expanding these partnerships to include Public Housing Authorities to provide greater choice and connection to the Public Housing Authority subsidy support. Mercy Care will continue to work collaboratively with housing agencies to expand these opportunities in each GSA we serve.

Transition Age Youth (TAY): Through our Youth Leadership Council, Mercy Care identifies opportunities to enhance and expand services for TAY. Using the Transition to Independence Process Model, we train providers to connect youth to services such as positive behavioral support, peer support services, and intensive substance use services. We have worked with key providers to enable them to serve both children and adults, promoting continuity of care for TAY who no longer have to change providers to

access adult services. Further, we opened the Institute of Mental Health Research Epicenter, an innovative outpatient clinic that serves members who have experienced their first psychotic break, providing support and treatment to help the member move toward recovery. Our Youth Leadership Council influenced all aspects of the build from the type of music playing in the lobby to the location of one of the buildings. We will implement a Youth Leadership Council in all awarded GSAs to guide our strategies for developing innovative programs and best practices for TAY.

Members with, or at risk for a developmental disability: Mercy Care holds contracts with several outpatient providers who offer services to members throughout the state, including Arizona Autism United, S.E.E.K., Terros, Touchstone Health Services, and Youth Evaluation and Treatment Center. Several of these providers employ specialty clinicians who provide technical assistance to pediatricians and primary care providers to help them enhance service provision to members with developmental disabilities and their families. Additionally, we develop specialty placements in collaboration with the Division of Developmental Disabilities (DDD) to meet members' specific needs. Mercy Care also employs a Liaison who coordinates with DDD and promotes access to care for members with disabilities.
We will also contract with Centers of Excellence that implement evidence-based practices and track outcomes for children with specialized health care needs, including children with Autism Spectrum Disorder (ASD) and children aged birth to five. We are currently contracted with two Centers of Excellence for children with ASD and a Family Center of Excellence that serves children of all ages and their families. We will use this valuable experience to expand this model to all awarded GSAs.

Pregnant Women and Children: Mercy Care has a vast network of obstetricians in the GSAs we serve to meet the needs of pregnant women, their families and children. In Maricopa County, pregnant women and their children also have access to services through the Women's Services Network, a group of providers that specialize in providing complete, whole health care and evidence-based services for women. We are also working in partnership with Arizona Mother-Baby Care, which will function as a Center of Excellence for obstetrical, perinatal, and post-neonatal care outcomes. We will embed and align our high-risk maternity care management programs with providers to implement and consistently apply evidenced-based clinical pathways to result in better outcomes for mothers and infants.
Other community-based specialty services for pregnant members include:

- The Refugee Women's Health Clinic, which provides access to comprehensive, culturally sensitive care for refugee women residing in and around Phoenix.
- Health Homes in Maricopa and Pima counties that offer a ***Nurse-Family Partnership*** program available to any woman who is less than 28 weeks pregnant with her first baby, meets low income requirements, and lives in a certain service area.
- The Teen Outreach Pregnancy Services, a program geared to support adolescents who are pregnant by providing educational interventions on sexual health and pregnancy while promoting positive interactions with other teens and young adults.

In addition, pregnant women and their children will have access to community-based supports including domestic violence groups, supportive housing, and child care to enable them to participate in treatment.

Mercy Care's Plans to Address Contracting Challenges

ACC members will benefit from having access to a full continuum of care in the GSAs we serve; however, Mercy Care also recognizes that challenges exist. Members, advocacy organizations, and providers tell us that there are potential network challenges that impact members' and families' ability to access care. These include a lack of available specialties and subspecialties in rural and underserved areas, the need for reliable transportation and differences in payment models and funding mechanisms between providers and GSAs. Using feedback from community forums and individual meetings with stakeholders we developed strategies for addressing these challenges as shown in Table 11-1.

Table 11-1: Mercy Care's Strategies to Address Contracting Challenges

Challenge	Mercy Care Solution
Lack of available specialties, subspecialties and pharmacies in rural and underserved areas	**Workforce development** – Coach pediatricians to screen children for developmental disabilities and BH issues and connect them to services; develop BH providers' capacity to provide Applied Behavior Analysis and work with children with ASD and their families. **Graduate Medical Education (GME) Residency Training Programs** – Contract with GME Residency Training Programs currently operating in the State and provide opportunities for resident participation in our medical management and committee activities; we will contract with graduating residents and providers that are opening new practices, particularly in rural and underserved areas. **Case Managers and Community Health Workers** – Contract with FQHCs, Rural Health Centers, and community health providers that provide access to Community Health Workers and Collaborative Health Education Programs to help families navigate specialty referral systems. **Community paramedicine** – Contract with programs that use trained paramedics to make follow-up visits, perform risk assessments, conduct medication reviews, provide preventive care (immunizations) and make referrals to primary care doctors and skilled home services. **Telemedicine and telehealth** – Expand the use of telemedicine and telehealth in rural areas by partnering local providers with hospitals and large providers that offer specialty services. **Pharmacy** – Most FQHCs and larger outpatient integrated BH providers and specialists have in-house pharmacies that are convenient for both members and providers to manage medication, timely dispensing and overprescribing; we also offer a convenient mail in option. **Value-based contracts** – Incentive plans to recruit and retain locally-based BH professionals and medical professionals in rural and underserved areas.
Need for reliable transportation	Mercy Care manages transportation for all members through direct contracts with transportation providers. Our direct oversight allows us to develop creative solutions to meet each members' need for transportation, including in rural areas.
Managing payment models and funding sources - Each GSA has different value-based arrangements and funding mechanisms	**Value-based contracts (VBCs)** – We have set specific, measurable and achievable goals for implementing VBCs, including: • Implementing VBCs with identified providers in all GSAs we serve • Increasing the proportion of current providers participating in advanced (alternative payment model [APM] 3 and 4) models • Working with the largest providers in each GSA to implement shared savings models that incentivize them to become accountable for members' entire care Mercy Care's approach to VBC is individualized to each provider's unique situation and considers members' needs. We offer flexibility in payment arrangements, enabling the provider to be successful in meeting performance metrics, leading to better member care and increased access to services. Through the Practice Innovation Institute, we help providers adopt practices that support integration and prepare them to participate in VBCs. Through our VBCs, we align performance measures across providers to promote integration and better member care. We are working closely with our partners to ensure that the education, technology, and payment mechanisms are robust and transparent.

Summary

Mercy Care currently contracts with a variety of specialty and BH providers and will be ready to meet and exceed network requirements in every awarded GSA on day one of Contract launch. As is our current practice, we will continue to monitor member demographics, prevalent conditions and solicit external input to ensure that our specialty and behavioral networks are tailored to meet the needs of our ACC members.

12. Managing Provider Relations

Mercy Care recognizes that health care providers are an essential partner in the delivery of physical health (PH) and behavioral health (BH) services and supports to address the social determinants of health. To that end, we operate in a manner that is efficient and effective for health care providers, promotes positive relationships and facilitates effective two-way communication. We work to reduce administrative burdens and increase transparency and mutual accountability by giving providers the tools they need to deliver high-quality integrated care and services to members and families. Our 18,000+ network providers offer geographic accessibility that maximizes choice (Section D, Paragraph 26, Network Development) and transitions members without disruption in care, keeping them with their same provider to the extent possible [42 CFR 438.206(b)(1)]. To retain our providers and foster positive relationships, we use high-touch, high-technology processes that are efficient and effective. We engage and work with providers and stakeholders to build and maintain a network based on the unique needs of our membership.

Mercy Care employs a skilled and experienced team of local provider network professionals, who live in the communities we serve, are trained to serve both PH and BH providers, and fully comply with AHCCCS Network Management requirements. Our **Director of Provider Relations has over twenty years in provider relations across the State of Arizona**, with significant experience working with rural and frontier providers. She is supported by over 45 Provider Relations staff that travel throughout Arizona to meet with providers in accordance with Section D, Paragraph 28, Network Management. Upon award, we will hire additional representatives *who live and work in our awarded geographic service areas* (GSAs) to promote collaborative relationships with providers in those communities. We will have offices in each GSA we serve to give providers, members and stakeholders ready access to staff with expert knowledge on our programs and local community resources.

Mercy Care's Strategies for Managing Provider Relations and Communications

Building collaborative relationships with providers begins from our very first introduction and continues throughout the lifespan of our association with them. We establish meaningful, supportive relationships that are grounded in meeting our member's needs. Our provider relations approach offers the right blend of supportive resources, transparency, and mutual accountability to ensure providers can remain focused on serving our members and reducing unnecessary administrative burden. Through our experience serving Arizona, we have learned the value of implementing effective communication as a mechanism to support positive relationships and reduce provider concerns.

In 2017, we retained 99% of our providers and had no material changes in our network.

Implementing Effective Two-Way Communication

We understand that not only must our communication to providers be effective, but **we must be effective listeners** to ensure our providers are heard, understood, and can function as effective advocates for the members they serve. We effectively communicate with providers to meet their needs and proactively resolve issues through the following mechanisms:

- Including PH and BH providers on our Board committees.
- Including providers on medical management committees (AMPM 1020) and quality management committees (AMPM 900), such as peer review and credentialing.
- Facilitating joint operating committees to solicit provider feedback and resolve concerns.
- Systems of Care leadership meetings with general mental health/substance use GMH/SU providers, Children's providers, Women's health providers, and Peer and Family Run Organizations multiple times per month.

- Convening stakeholder meetings (i.e. DCS, probation etc.) to facilitate collaboration and relationship building between stakeholders and our providers.
- Conducting quarterly provider forums (which exceed requirements of Section D, Network. Management, paragraph 4 of the ACC contract), including listening sessions and town halls. ***Between 2016 and 2017, we hosted 30 provider forums with over 1200 participants***.
- Facilitating listening sessions, town halls, and forums no less than monthly.
- Facilitating monthly training and technical assistance webinars.
- Completing an annual provider satisfaction survey specific to each Contract to understand the needs of all providers.
- Offering value-based contracts that include incentives for achieving targeted performance measures.
- Providing specialized supports to rural, frontier, tribal, peer, and family providers.

We have deployed a number of specific strategies to manage provider relations and communications, including maintaining an open-door policy, promoting transparency through information sharing and supporting providers through the Practice Innovation Institute (Pii).

Local, Community-Based Provider Relations Representatives

Each provider is assigned a local, community-based Provider Relations Representative, who is skilled and knowledgeable about PH and BH services. Our Provider Relations staff maintain an open-door policy and free flow of communication with providers in person, in the community, through phone calls, and via email. *In 2017, we responded to over 150,000 provider phone calls.* Our staff has frequent contact with providers to check-in, identify needs, provide technical assistance, support and education, share information, and address provider concerns. Provider Relations staff address claims processing issues, contracting or credentialing issues, and develop creative solutions to provider concerns to minimize complaints. Our open-door policy exceeds AHCCCS' requirements in the ACC Contract and creates the building blocks to support positive two-way communication with providers.

> *During recent on-site visits in Graham, Greenlee, Cochise, Santa Cruz, Yuma, and La Paz counties, providers shared that only Mercy Care representatives visit them in person and they asked us when we will be serving more members in their area.*

Promoting Transparency through Education and Information Sharing

Mercy Care provides resources and promotes transparency and mutual accountability through effective high-touch outbound communications strategies that ensure providers have access to all the right information they need to provide effective care. Mercy Care deploys an onboarding process with each provider as well as ongoing training and technical assistance over the life of their contract. When we execute a new contract with providers, we educate providers on contractual requirements, where to access claims processing information, and where to access operational materials, including provider dashboards and performance reports. Providers are educated about our Provider Manual, which fully complies with all requirements in ACOM policy 416, and providers are notified that our Provider Manual is an extension of their contract.

After initial training, we provide ongoing professional development that includes all required trainings in accordance with AMPM Policy 310; further, we include training on care coordination, BH, and referral and consultation procedures. Ongoing trainings are scheduled monthly, quarterly, and as needed. Trainings are available via Relias, our learning management system, as well as via webinar, traditional classroom setting, and in the provider office setting, as needed.

To further support providers in delivering excellent care, we host a provider portal, Mercy OneSource, where providers can search member eligibility, review their panel roster, access our provider directory, search claims status, manage prior authorizations, and check their performance against HEDIS requirements. In 2017, we developed stronger analytical tools including a health care disparities dashboard to analyze the prevalence of conditions within ethnic groups to help us and our providers better understand and plan for the needs of members.

We also send out formal provider communications through a variety of platforms to offer: educational opportunities, technical assistance to peer and family support agencies, updates to operational and/or regulatory changes, and notice of new Mercy Care quality improvement initiatives and performance improvement projects. We share information with our providers by:

- Disseminating dashboards that include providers' performance on key metrics.
- Assisting providers in connecting to the statewide health information exchange, Health Current, to facilitate data sharing between providers and Mercy Care.
- Implementing CareUnify, our care management tool, which offers near real-time sharing of critical information such as Admission, Discharge, Transfer alerts; member medications and other clinical information.
- Hosting provider training sessions via our learning management system (ACC Contract Section D, Paragraph 26, Network Development).
- Hosting monthly webinar trainings to increase access to live contact with our Provider Relations team, and to increase opportunities for providers to receive professional development training, system updates, and to ask questions directly of Mercy Care leadership.
- Facilitating cross-system collaboration with the Department of Child Safety, Department of Developmental Disabilities, Department of Corrections, probation departments, and the courts.
- Completing individual reviews of provider performance data.
- Disseminating quarterly provider newsletters available through email delivery and on our website.
- Sending provider notices via email or fax, which convey updates to policies, procedures, and other operational requirements.
- Conducting individualized provider outreach via phone call, personalized emails from Provider Relations Representatives and site visits. Provider outreach always occurs when there are updates to contract terms or critical information that may be time sensitive.

Mercy Care is a supportive partner that aims to position providers for success. Our proactive communication process builds and reinforces strong collaborative relationships with providers. We work to reduce administrative burden so providers can focus on providing high-quality care to members and their families. In addition, Mercy Care provides technical assistance and support to peer- and family-run organizations.

***97% of network physicians** state they would recommend us to other physician practices.*

Minimizing Provider Complaints

Mercy Care's high touch provider relations approach effectively minimizes provider complaints by giving providers an opportunity to voice their concerns and receive timely resolution. This proactive approach mitigates provider issues before they escalate or impact member care. When providers feel they need to file a complaint, Mercy Care offers providers an avenue to seek effective issue resolution. We work to resolve provider complaints timely and respectfully to maintain a positive relationship with providers. Our Provider Services Manager is responsible for the prompt resolution to provider issues, and providing education about participation in the AHCCCS program (Section D, Staffing Requirements, paragraph 32).

Complaint resolution is a core function for maintaining positive provider relationships. Mercy Care accepts provider inquiries and complaints in-person, orally, via mail, fax, and email related to any of our operational policies or fees. All provider inquiries and complaints are logged into our QNXT system, a powerful software solution that increases information transparency throughout our organization. Through this system we track issues, route real-time information to decision makers, analyze trends in provider complaints, and implement strategies to quickly respond to trends. Provider Relations staff are required to respond to provider inquiries and complaints within three business days of receipt, and resolve the issue within 30 business days of receipt. Managers meet regularly with staff and are responsible for monitoring compliance with requirements. ***For 2017, Mercy Care resolved 100 percent of provider complaints about claims appeals within 30 business days of receipt.***

Proactively Mitigating Contracting Issues

We proactively mitigate contracting issues by ensuring providers have a voice in the contracting process and that we remain transparent and mutually accountable about our expectations. We facilitate contract negotiations initially, and as needed, to customize provider contract terms to the specific scope and services they are offering, to explore value-based payment options, and to incorporate specialized supports. We ensure providers serving rural and frontier areas, tribal members, peers, and families have the resources they need to be successful. Providers can raise ongoing contracting issues or concerns to their Provider Relations Representative or directly to any of Mercy Care's leadership. We work with providers to fully document and explore their concerns and identify individual solutions to meet their needs –including re-negotiating their contract. When trends are identified in provider concerns or internally, we leverage Joint Operating Committees to implement system-level interventions.

Feedback from providers has influenced several enhancements to our provider portal, such as the Provider Intake Application Notification and Alerts screen and the Provider Deliverable Manager, an online tool for the submission and management of provider contract deliverables.

Joint Operating Committees: Mercy Care conducts Joint Operating Committees, facilitated by a member of the executive leadership team, with any provider, as needed, to maintain positive relationships, promote two-way communication, and resolve concerns or system issues. When a trend arises across multiple providers, we may also facilitate a Joint Operating Committee on the specific topic (i.e. timely claims submission or ensuring EPSDT screenings are completed), we share data that supports the concerns, conduct a collaborative, provider-led root-cause analysis, and identify strategies that will enhance the performance moving forward. Joint Operating Committees function much like rapid-cycle performance improvement projects, allowing us to identify underlying causes and implement changes to drive performance in a timely fashion. Providers are invited to include all relevant staff and decision makers who can meaningfully contribute to the root cause analysis and make recommendations to address concerns and improve the care members receive.

Supporting Providers through the Practice Innovation Institute (Pii)

Mercy Care providers benefit from ongoing coaching tools and resources that are available through Pii. Using a practice assessment tool, Pii works with practices to review current capabilities and develop a work plan to focus on areas of opportunity for improvement. A Practice Transformation Team is assigned to each practice to help them execute the work plan and access available tools and resources. This approach actively engages practices in transformation and fosters collaboration, learning and improvement across the health care system.

Streamlining Prior Authorizations to Expedite Member Care

Mercy Care is dedicated to providing timely care to our members through effective prior authorization processes. We streamlined our prior authorization process to reduce the process cycle-time. We have also implemented mechanisms to monitor our prior authorization process including:

- Waiving prior authorization requirements during implementation, eliminating gaps in care and allowing providers to focus on taking care of the member.
- Holding bi-weekly prior authorization process meetings to aid in the development of systems improvement, and to address any provider complaints related to the prior authorization process.
- Holding monthly operations meetings on prior authorization requirements and clinical review to ensure that all systems are operating consistently and efficiently.
- Holding monthly Utilization Management/Medical Management meetings where the team reviews prior authorization turnaround times and any new updates or changes to AHCCCS policies.
- Conducting annual audits to review prior authorization requirements and service utilization to identify opportunities to streamline the authorization process.

Due to our collaborative approach, survey results indicate that 86% of providers positively rate our provider relations.

In addition, Mercy Care uses feedback from our providers to increase process timeliness. For example, we: 1) removed prior authorization requirements for registered nurse and licensed practical nurse services, and wheelchair repairs; 2) updated our prior authorization request forms to facilitate quicker responses and decrease delays; 3) created an escalation process to assist members who may require out of state care or access to clinical trials; and 4) implemented a process to coordinate PH needs for members going out of state for BH treatment.

Supporting Provider Claims Processing

Mercy Care assures providers get paid accurately and in a timely manner, whether they are submitting claims electronically or on paper. ***We adjudicate 97 percent of claims in 30 days and over 99 percent of claims in 60 days, with over 99 percent accuracy, exceeding the requirements in the ACC Contract.*** We employ a team of individuals to support claims processing that includes our Claims Administrator, Encounter Manager, and Provider Claims Educator. The Claims Educator trends data on claims adjudication, themes in provider services calls, and provides training and technical assistance on how to submit claims accurately and timely to expedite the payment cycle time. ***When we became the Regional Behavioral Health Authority in Maricopa County, the average claims submission time was >78 days; today it is 36 days, with an average claims payment time of 9 days.***

We make every effort possible to resolve claims disputes and resolve concerns before they escalate the fair hearing process. Providers are directed and encouraged to use Mercy Care's Claims Inquiry/Claims Research Department for questions regarding their claims. Provider Representatives help providers with all aspects of the complaints and appeals processes to minimize provider frustration and improve resolution timeframes. Today, there are a total of 104 Customer Service Representatives trained to answer Mercy Care provider calls. Upon award, we will scale this department to meet additional demand in accordance with A.R.S. §36-2903 and §36-2904 and A.A.C. R9-28-701.10.

Summary

In our more than 30 years serving Arizona, we have learned the value of positive relationships with providers and effective two-way communication. We consistently engage providers as our partners and will continue to offer supportive resources, encourage transparency, and promote mutual accountability. We will expand our efforts into all awarded GSAs because we know that when providers have the tools they need to be successful, they can focus on providing high quality care to members and their families.

13. Obtaining and Using Member and Provider Feedback for System Improvements

Mercy Care uses input and feedback from members, families and providers to guide our strategies for improving the member and provider experience. We leverage new programs and improve existing supports to collect meaningful member and provider feedback, track and analyze trends, and use that information to create system improvements. Using feedback leads to some of our most important accomplishments and strengthens our partnerships with members, providers, and other vested key stakeholders. We align with Arizona's guiding principles and vision for adults and children with our member-centered, recovery-oriented approach. Mercy Care's Office of Individual and Family Affairs (OIFA) is the cornerstone of our approach to listening to member feedback and creates opportunities for those we serve to engage and participate as decision makers in our governance. Members of our OIFA team have personal, lived experience, or care for a family member with behavioral health (BH) needs. Our Provider Relations Department serves as the primary point of contact for our BH and PH network providers and engages with providers to ensure they have the tools they need to deliver excellent member care. ***We will build on our current processes and will scale to all awarded Geographic Service Areas (GSAs).***

Processes for Obtaining and Using Member Feedback

Mercy Care commits to continuous quality improvement through empowering and training all staff to incorporate feedback from members, families, providers, and other stakeholders. We gather feedback using our websites, social media platforms, member services inquiries, member surveys, advisory and advocacy councils, internal committees, community forums and outreach events, grievance and appeals, and OIFA member advocacy processes to engage members through:

- Best practices and performance improvement methodologies in accordance with AMPM 900
- Newsletters and social media campaigns to inform them about peers and family members and engagement strategies
- Member and family-focused clinical decision support tools for improved health outcomes, health literacy, and self-care
- Community engagement, education, and advocacy for members to navigate the delivery system
- Listening to members to monitor, act, improve, and repeat enhancements to member experiences

Using Feedback to Develop Targeted Programs
Mercy Care expanded our Forensic Assertive Community Teams (F/ACT) to reduce recidivism and avoid incarceration for members with serious mental illness. We initiated this expansion and other programs for justice-involved members, after receiving feedback from Correctional Health, which provides health care services to incarcerated individuals and the community. In 2017, Mercy Care won a national award for its F/ACT team work and outcomes. F/ACT members saw a 19% decrease in homelessness, an 84% increase in visits to medical providers, a 76% decrease in incarcerations, a 31% decrease in psychiatric hospitalizations, and an 18% decrease in emergency department (ED) use.

Advocating for Members: The Office of Individual and Family Affairs and the Ombudsman

Unique to Mercy Care is the role of the Ombudsman. Established in 2016 and currently housed within the OIFA, the Ombudsman serves as a neutral advocate and the Member Advocacy Administrator on behalf of those we serve responding to member, peer, and family concerns; assisting with system navigation needs; member and family rights and responsibilities; and stigma reduction. The Ombudsman and OIFA work with members, families, advocates, community stakeholders, and providers to ensure member and family voices are heard and elevated through formal reporting mechanisms to our leadership. Working closely with Member Services, Grievance and Appeals and other internal

departments, the Ombudsman ensures member and family input is represented throughout the system. Mercy Care established policies, procedures, and practices for evaluating and resolving issues raised by members and families. We promote a *no wrong door* approach to encourage and respond to feedback through the following mechanisms:

- **Mercy Care** tracks, reports and addresses concerns
- **Mercy Care committees, which already include approximately 50 peers and family members**, exceeding AHCCCS' requirements
- **Mercy Care Adult and Children's Community Forums** meet monthly to gather feedback from members and families, to offer information, and to answer questions from the community
- **Foster, Adoptive, and Kinship Care Workgroup** leads monthly meetings of providers, family members, advocates, and stakeholders to address issues and develop solutions to serve children and youth in the child welfare system
- **Welcome to Mercy Care Orientation** meets monthly to engage with members to provide system navigation assistance to adults and families of choice who are new to the BH system
- **Attendance by OIFA and grievance staff at all Human Rights Committee Monthly Meetings** to hear current issues and bring community feedback
- **Mercy Care's Annual Connections Conference** is an educational networking event with nationally known presenters on best practices geared to members, families and advocates
- **Mercy Care's Digital and Social Media tools** engage members through our presence on Facebook and Twitter to inform the community and encourage feedback—our feeds include breaking news, a listing of community events, and a Contact Us section we monitor daily

Using OIFA to Improve Transportation

In response to member, family, provider, and community stakeholder feedback regarding challenges with transportation, Mercy Care met with our transportation provider to address these concerns. The transportation provider engaged with our Member Advocacy Council to present their employee training and recruitment practices to a member panel. OIFA worked with the provider on technical assistance and staff trainings about cultural competency, special needs populations, person-first language, and stigma. OIFA is making recommendations for workforce development and training enhancements focused on member safety and security. The transportation provider continues to participate in Joint Operation Committee meetings and is responsive to feedback.

We encourage members to offer feedback during any interactions with Mercy Care staff and in accordance with ACOM 446. We have a well-established process for handling grievances, appeals, complaints, and other disputes. We educate members and providers about their rights to the grievance and appeals processes through the Member Handbook (ACOM 406), Provider Manual (ACOM 416), website (ACOM 404 and Attachment B), Member Services team. OIFA and the Ombudsman offer support to ensure we listen to the member's voice.

Encouraging Feedback through Peer and Family Involvement and Participation

Mercy Care's advocacy program oversees our advocacy councils and ensures representation of member, peer, or family member on all Mercy Care committees to provide input and feedback for decision making. Our Member Advocacy and OIFA Administrators manage our advocacy program and ensure communication between members, peers, family members, providers, Mercy Care, and AHCCCS—including the AHCCCS Human Rights Committee. We facilitate feedback and involvement through:

- **The Member Advocacy Council**, which consists of adult members and parents or guardians of a child member, Mercy Care executive management staff, providers, and community advocates.
- **Peer and Family Advisory Councils** meet monthly and share the same missions to place members' whole-health needs as the focal point of care within our contracted provider network. In Maricopa

County, we instituted these with 26 SMI clinics and four emergency psychiatric crisis centers. We will build on this experience to serve members in the ACC program.

- **Our Governance Committee** provides input on strategic planning, process improvement, and decision making for the Mercy Care delivery system. This committee meets twice a year and at least 25 percent of its membership is comprised of peers and family members.
- **Our Youth Leadership Council** has youth and young adults who offer their unique perspectives on services for this age group. Mercy Care used input from the Council to design the facility, layout, technology, and service approach to make the First Episode Clinic more inviting.

In continued response to member and family concerns and human rights issues, Mercy Care will create the Office of Healthcare Advocacy and Advancement (OHAA). The OHAA Director will provide operational oversight of the Office of Individual and Family Affairs, the Office of Member Advocacy, the Member Advocacy Council (MAC), all Mercy Care councils or committees with peer or family engagement and participation, and other councils and committees.

Using Member Surveys to Receive Feedback and Improve Our Systems

We administer annual surveys for each contract to receive feedback from members. We send member surveys to a random sample of adults and children who receive services from Mercy Care and ask them or their families to evaluate their experiences with physical (PH) and BH care, including access, timeliness, communications, and outcomes. Mercy Care participates in an AHCCCS-approved project to gauge member satisfaction with BH care and services. The cross-functional national team represents nine health plans, including clinical expertise from BH and PH services. We use survey results to evaluate performance, identify gaps in service, and initiate actions to improve experiences and outcomes. Mercy Care administers an additional survey related to BH services. Members report high rates of satisfaction with Mercy Care as demonstrated in the following select survey results:

- In 2015 and 2016, ***76 percent of the responses from adult and child members were positive related to BH providers treating them with respect, listening to their concerns, and being sensitive to race, gender, ethnicity, language, or disability.***
- The AHCCCS CAHPS survey indicated a high level of member satisfaction with Mercy Care, with ***both adult and child members rating Mercy Care at five stars***.
- ***More than eight out of 10 members are pleased with the services they receive from their BH provider and would recommend the plan.***
- In 2017, **79 percent of adult members and 91 percent of children participating in the survey reported a positive experience with Mercy Care** (both approximately 7% higher than national benchmarks).

Member Feedback Improves Social Media Strategies
In 2015, a member's grandmother posted on Mercy Care's Facebook page, after normal business hours, and included Protected Health Information (PHI) about the member. We contacted the family, resolved the issue, and deleted the posts that included PHI. We created a multi-disciplinary Social Media team, which can convene and make quick decisions to resolve member issues through social media platforms.

Additionally, we implemented improvement activities to increase the education provided by pediatric case management staff to parents to ensure they understand their child's medication. As a result, **our satisfaction survey results improved by 17 percent.** In addition, AHCCCS conducts CAHPS surveys to identify opportunities for further improvement. For example, in response to survey feedback expressing the need for more Spanish-speaking doctors, we executed a contract with Equality Health, a culturally sensitive Latino medical group with bilingual physicians. Member and family engagement through

technology are a critical component of our success. Mercy Care employs multiple technology and social media tools to engage members and their families which meet or exceed contract requirements ACOM 404 and 425. These include websites, mobile applications, social media—including Facebook and Twitter—and opt-in text messaging programs. These interactions with members, family and providers improve our processes and protocols to better engage and respond to members, particularly after hours. Mercy Care's Marketing and Member Communications team monitors social media platforms and alerts our team for resolution when appropriate. ***We resolved approximately 50 issues in the last two years that we received through direct messaging functions on Facebook and Twitter*.**

Processes for Obtaining and Using Provider Feedback

Mercy Care values our relationships with the provider community and does whatever it takes to demonstrate our commitment to simplify our processes and support the needs of providers. We obtain provider feedback through various methods, including: provider forums, provider in-services, Joint Operation Committees (JOCs), provider leadership meetings, direct and indirect provider contact, and provider surveys. As required, Mercy Care conducts an annual survey for all provider types. The survey is administered through random selections and analyzed using an outside vendor. The information we obtain allows us to measure how well we meet our providers' expectations and needs, and identifies opportunities for improvement. The provider survey assesses overall satisfaction—a comparative rating to other health plans—and identifies issues with utilization and quality management, network and coordination of care, our call center, and provider relations. We also use survey feedback received to reduce administrative burdens for providers, improve provider relationships, and enhance the quality of care our members receive**. *In 2017, the overall rating of Provider Satisfaction and Loyalty was 95 percent (acute), 92 percent (long term care), and 88 percent (RBHA).***

Provider Feedback Improves Mercy Care Processes
In 2016, the Provider Relations Department responded to provider concerns received through survey results, direct communication, and provider complaints about not getting a live person to talk to when they called or receiving response to emails, faxes, and phone calls as timely as preferred—even though we were meeting contract required timeframes. We shared information with team members and conducted a thorough analysis of the department. To address the provider concerns and improve our customer service delivery, we added new staff, created an Internal provider relations team, and initiated closer monitoring of staff metrics. ***As a result, the turnaround time to respond to providers improved and our provider survey results improved by 19%.***

Mercy Care's Learning and Performance, System of Care, Quality Management, and Provider Relations departments collaborate to implement our process for training providers. We use best practices to obtain and monitor feedback to improve provider relationships. We request feedback during our face-to-face provider education meetings and at our quarterly provider leadership meetings. We recently implemented a process where our provider relations managers contact providers at random to assess our relationships and obtain feedback. We track grievances and appeals, provider complaints and inquiries, and use survey results to identify any systemic issues needing a resolution. Our escalation committee addresses provider concerns as quickly as possible to determine any process improvements needed to enhance provider relationships and experiences. In 2018, Mercy Care will create a Provider Advisory Council that meets quarterly and enables providers to share concerns, offer suggestions for process improvements, and *serve as a voice* for the provider community. Our Provider Advisory Council will include all provider types, including specialty providers, obstetricians, providers that serve members

with developmental disabilities, providers that serve members with CRS conditions, multispecialty integrated clinics (MSICs), BH and other providers.

Improving Cultural Competency Trainings for Providers
During a Member Advocacy Council meeting, members requested cultural competency training improvements for providers. We asked the council to critique our current training program and adapt it to include their recommendations to improve the understanding of the various cultural beliefs among our members. One of our Member Advocacy Council members now participates in statewide trainings to enrich the Cultural Competency 101 course required of all network providers.

When we received the RBHA contract in Maricopa County, we facilitated multiple 360-degree assessments for crisis services, children's and adult systems of care, and payment reform. These assessments engaged over 400 members, family members, providers, and system stakeholders to listen to ideas about system operations and to identify strategies to enhance member outcomes. Based on this feedback we expanded and realigned services, streamlined processes, and introduced innovations that incentivize quality care. We intend to facilitate similar assessments in our contract areas to elevate providers' voice. For example, we received a call from a hospital CEO regarding the number of members accessing ED services. We listened to the concerns and collaborated with the hospital to develop solutions, which included: giving providers data on ED use to intervene and engage members – such as members with BH needs using the ED for PH needs. ***Our efforts have resulted in a 66 percent reduction in the average member wait times in EDs for adults since 2015.***

Using Feedback to Improve Tribal Provider Relationships

Our strong relationships with tribal health organizations and stakeholders are critical to improving health care among Native American members. Mercy Care's Tribal Coordinator meets regularly with tribal groups and health departments, including Indian Centers such as Native Americans for Community Action in Flagstaff, Tucson Indian Center, and the Phoenix Indian Center. We foster collaborative partnerships with groups such as Native Health and Indian Centers. We use forums and other informal opportunities to listen to and educate the community, showing respect for the tribal community's need for partnership and collaboration through informal means.

Summary

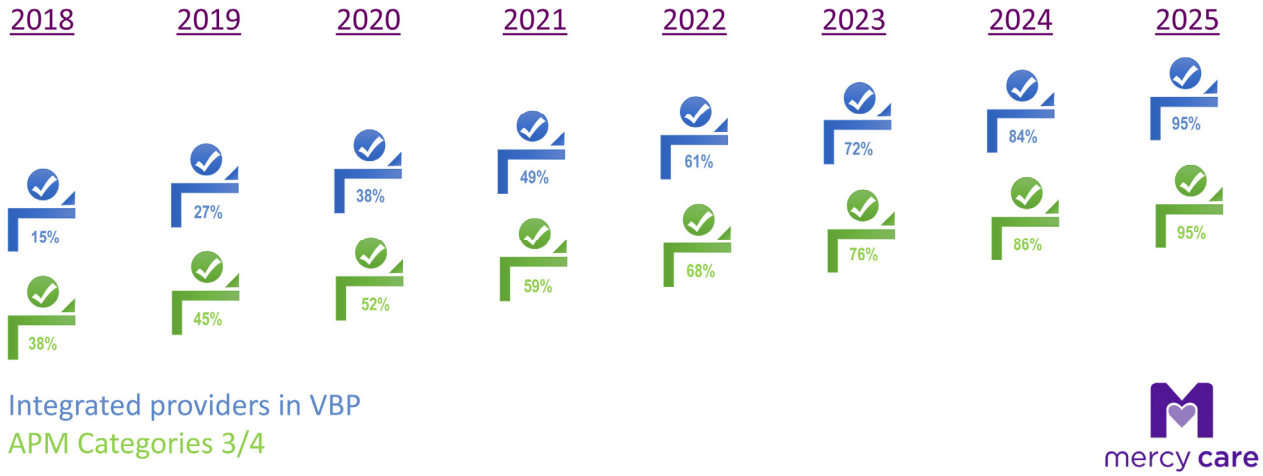
Mercy Care knows that hearing from the members who receive services and the providers responsible for service delivery is crucial for understanding the strengths and weaknesses of the service delivery system. We value member and provider feedback and use this information to inform the decisions we make and actions we take to ensure the service delivery system effectively meets members' needs.

14. Value-Based Purchasing

Mercy Care views value-based contracting (VBC) as a critical strategy for transforming the service delivery system into an integrated care model. We work with providers to execute VBCs that consider members' needs and providers' ability to remain sustainable while improving member outcomes. We do this by creating meaningful incentives and helping providers to develop processes that lead to success with value-based purchasing (VBP) models. In our current GSAs, we achieved a cost savings of 4.9 percent in the most recently completed performance year after implementing more advanced alternative payment models (APM). As we expand VBCs in each region, we anticipate achieving similar savings. Using our existing strategy of sharing 50 percent of cost savings with providers; when fully matured, ***we expect to share approximately $20 million with the delivery system***.

To further drive system transformation, Mercy Care has two main goals: 1) enhancing providers' ability to deliver integrated care; and 2) aligning provider, Mercy Care, and AHCCCS' initiatives to drive high quality, cost-effective care that improves member outcomes and creates value in the system. To achieve the first goal, we have created specific objectives and measurable annual targets for provider integration using SAMHSA's *Standard Framework for Levels of Integrated Healthcare*. When establishing targets, we analyzed data from our affiliated plans (over 1 million members). Our analysis showed that 11 percent of members have chronic PH and BH conditions, 23 percent have chronic PH conditions only, and 5 percent have chronic BH conditions. Based on this analysis, we established targets for value-based integration to match members' needs. To achieve the second goal, we used the Learning and Action Network Alternative Payment Model Refresh to establish specific objectives and measureable targets. ***Currently, 52 percent of the total spend in our Acute contract is in APMs and 76 percent of our current value-based spend is with providers in Category 3 and 4 APMs.*** We will increase our total spend in APMs to over 70 percent by CYE 21, and grow the percentage of providers in Category 3 and 4 APMs to 90 percent or higher by September 2025, exceeding AHCCCS' current requirements. Mercy Care's targets for value-based integration for each year of the ACC Contract are shown in Figure 14-1.

Figure 14-1: Mercy Care's Targets for Value-Based Integration by Contract Year



A. Value-based Integration Strategies for Integrated Providers

Mercy Care works in concert with our contracted providers to assist them in moving along the continuum of integration (from coordinated care to co-location and full integration) as described in the Substance Abuse and Mental Health Services Administration (SAMHSA) framework. As shown in **Table 14-1**, our VBCs include key metrics that drive improved member outcomes and advance integration

through population health management, participation in Health Information Technology (HIT), e-prescribing (in accordance with ACOM 321), addressing the social determinants of health (SDOH), and engaging members in PH and BH services.

Table 14-1: Value-Based Contracts for Integrated Providers

Provider Type and VBP Model	Examples of Key Metrics	Selected Target Outcomes
Clinics for members with a Serious Mental Illness (Performance-based, APM 2)	Reduction in inpatient admissions, follow up after discharge, treatment plan completion, decrease in members experiencing homelessness, timely claims submission, colorectal cancer screening, improved A1C control for members with diabetes, and cervical cancer screening	95% increase in follow up after discharge 44% increase in cervical cancer screening 16% decrease in BH inpatient admissions
Integrated Health Homes (IHH) (Performance-based, APM 2)	Reduction in inpatient admissions, achieving certification as integrated health provider, member participation in smoking cessation programs, follow up after discharge, treatment plan completion, decrease in members experiencing homelessness, timely claims submission, colorectal cancer screening, improved A1C control for members with diabetes, and cervical cancer screening	59% decrease in homelessness 45% increase in cervical cancer screening 33% increase in colorectal screening 22% decrease in BH inpatient admissions
Assertive Community Treatment (ACT) teams (Performance-based, APM 2)	Reduced inpatient admissions (PH and BH), follow-up after discharge, reduction in members experiencing homelessness, increase in employment tenure, reduction in members experiencing incarceration, and completion of annual well visits	115% increase in employment 67% increase in primary care visits 87% decrease in medical inpatient admissions 33% decrease in BH inpatient admissions 21% decrease in emergency department (ED) visits
Forensic ACT teams (Performance-based, APM 2)	Decreases in jail bookings, decrease in BH and PH hospital admissions, decrease in ED use, reduction in members experiencing homelessness, increase in employment, increase in PH visits	18% decrease in ED visits 19% decrease in homelessness 76% decrease in jail bookings 84% increase in PH visits 31% decrease in admissions

Additionally, Mercy Care has executed VBCs with providers delivering services through Centers of Excellence, Virtual Health Homes and Whole Health Integrated Clinics (WHICs). Measures focus on integration and include depression screening and follow-up, access to PCP visits, smoking cessation, improved health literacy, follow up after hospitalization for a PH or BH admission, improved A1C control for members with diabetes, diabetic eye exam, and well visits. We have also implemented shared savings agreements (APM 3) with accountable care organizations and clinically integrated networks that include measures related to well child visits, improved A1C control, depression screening, reduction in opioid use, decreases in health disparities, and increased BH penetration rates.

Planned Activities to Drive Integration for Integrated Care Providers

Mercy Care has strategies in place to: 1) move integrated care providers along the VBC continuum; 2) assist BH and PH providers in adopting integrated care strategies; and 3) increase the number of providers participating in VBCs. Mercy Care is implementing VBC models that shift accountability for care coordination, quality outcomes, and cost savings closer to the point of care. This shift from volume to value offers the potential to reduce costs and improve care for member and families. In each year of

the ACC contract, we will incorporate performance measures into provider contracts that address integration, including: 1) follow up after discharge from hospitalization; 2) completion of annual well visits; 3) percent of members receiving BH services; 4) percent of members with a completed depression screening; 5) opioid fills within guidelines; and 6) decrease homelessness. Mercy Care also builds providers' capacity to participate in VBP through coaching, training, data-sharing, and ongoing support. For example, we share member-specific and practice-level data on key measures such as ED visits, inpatient admissions, and preventive care visits. We also help providers understand how they can impact member care through engagement strategies, care coordination, and appointment accessibility.

B. Value-based Integration Strategies for Behavioral Health Providers

Mercy Care's VBCs with BH providers incorporate measures related to the SDOH and reward providers for coordinating with PH providers. These include:

- Housing: Performance-based contracts (APM 2) reward providers for achieving benchmarks related to members in stable housing, member contribution toward rent, access to housing within 30 days, timely response to referral for housing. To date, ***members served by housing providers with VBP arrangements have experienced a 64 percent decrease in BH inpatient admissions***.
- Comprehensive Community Health Program (an integrated health program that addresses SDOH): This performance-based contract (APM 2) includes metrics related to reduction in hospital admissions, ED and mobile crisis, member substance use and members experiencing homelessness. To date, ***program participants have experienced a 21 percent decrease in BH inpatient admissions and a 28 percent decrease in crisis utilization.***
- Employment: Performance-based contracts (APM 2) reward providers for achieving benchmarks related to first contact with employer in 30 days, ongoing employment support (maintaining job), and connections to Rehabilitation Services Administration.
- Temporary housing assistance (provides housing and employment services to members): Performance-based contracts (APM 2) reward providers for achieving benchmarks related to first contact with employer, inpatient stays, no eviction, and employment support (maintaining job).
- Inpatient: Performance-based contracts (APM 2) reward providers for achieving benchmarks related to reductions in readmissions and increase in follow-up after discharge within 7 and 30 days.
- Intake: Performance-based contracts (APM 2) reward providers for achieving benchmarks related to increase in follow-up after discharge within 7 and 30 days.
- First Episode Clinic (an evidence-based program for individuals who have experienced their first episode of psychosis): This performance-based contract (APM 2) rewards the provider for achieving benchmarks related to access to care (BH provider within 7 days of enrollment), employment/school participation, assessment within 30 days, and first appointment within 7 days of assessment.

We will build on our experience with performance-based contracts with BH providers to implement VBCs with Centers of Excellence.

Planned Activities to Drive Integration for BH Providers

To drive integration, Mercy Care incentivizes BH providers for transitioning to an integrated care model. We are incorporating PH measures into VBCs with BH providers, such as annual well visits, preventive screenings (cervical cancer, colorectal cancer), and opioid prescription fills within guidelines. We will include metrics that promote care coordination and incentivize providers to address SDOH. Additionally, we are incentivizing providers for decreasing the level of intensity of members' needs as measured by the Child and Adolescent Service Intensity Instrument (CASII). Further, we contract with eligible TI providers including those serving adults transitioning from the criminal justice system.

C. Value-based Integration Strategies for Physical Health Providers

Mercy Care rewards PH providers for delivering high-quality care, increasing member access to care, and working to improve member health outcomes as shown in **Table 14-2** below.

Table 14-2: Value-Based Contracts for PH Providers

Provider Type and VBP Model	Examples of Key Metrics	Selected Target Outcomes
Patient Centered Medical Home (Primary care incentives, APM 2)	Improved A1C control for members with diabetes, well child visits, cervical cancer screening, smoking cessation, reduction in ED visits, reduction in readmissions	54% increase in adolescent well visits 26% increase in e-prescribing 35% reduction in ED visits 125% increase in CDC-HbA1c tests
Dental providers (Performance-based, APM 2)	Dental sealants, preventive dental care, annual dental visits	Improvements in annual dental visits and dental sealants
Accountable Care Organizations/Clinically Integrated Networks (Shared Savings, APM 3)	Well child visits, improved A1C control for members with diabetes, increase BH penetration, shared savings based on reductions in total cost of care	In comparison to other providers: 6% higher rates of well child visits for members aged 15 months 8% higher rates of well child visits for members aged 3, 4, 5, and 6 years 29% high rates of adolescent well child visits $12.1 million in savings for CYE 16
ALTCS Primary Care Providers (Primary care incentives, APM 2)	Reduction in readmissions, increase in follow-up after discharge within 7 and 30 days	25% increase in LDL testing for diabetics 16% increase in blood pressure testing 5% reduction in ED visits

Planned Activities to Drive Integration for PH Providers

In our experience, PH providers are an important entry point for members seeking care for problems that are often related to BH needs. Therefore, we support our PH providers in serving members by increasing awareness of the prevalence of BH conditions and decreasing stigma. We incentivize providers through VBCs for completing BH screenings and making appropriate referrals to BH providers. Mercy Care will incorporate BH metrics (such as follow up after hospitalization), promote coordination (discharge planning, participation in the HIE), and include measures that address the SDOH into contracts with PH providers. Providers can also earn incentives for transitioning to an integrated model.

Supporting Providers in Adopting Alternative Payment Models

All of Mercy Care's departments work together to support providers in moving toward integrated care and adopting APMs. We have made significant investments in technology tools to help providers streamline workflows and improve their performance. We provide actionable member-level data to help providers make the best decisions about care, facilitate data and information-sharing through tools such as CareUnify, educate providers on using information to improve member care, and offer population health management tools.

Mercy Care brings a unique contribution to AHCCCS' system of care: the Practice Innovation Institute (Pii), which is transforming more than 2,400 clinical practices across Arizona to prepare them for the Centers for Medicare and Medicaid Services' (CMS) merit-based incentive payment system and APMs. We will apply our Pii experience to support the TI program and help providers successfully meet performance measures. Pii, which is currently serving providers in ***all 15 Arizona counties,*** offers Practice Transformation Consultants (PTCs) who provide outreach, education, coaching, direct assistance, and technical assistance on integrated care processes and workflows to clinicians and provider practices. PTCs educate providers on how to enhance their practices and programs to implement APMs, and provide tools such as population health data to help them meet performance

targets and better serve members. Mercy Care has also established an integrated care 'Community of Practice' as a forum for organizations to brainstorm, problem solve, and share information related to integration. These provider forums facilitate transformation, promote better communication, and lead to better member care and outcomes.

Transitioning the System off Block Payments

Mercy Care agrees that Arizona needs to eliminate block payments to promote service expansion, increase access to care, and help providers develop sustainable business models. We have invested in systems (developing provider reports, data-sharing tools), educated providers on developing workflows to decrease their dependence on block payments, and executed VBCs. As evidence of our commitment to moving the system off block payments, our contracts with providers we have added to our network do not include block payment models and we have helped many providers move to APMs. We continue to work with the legacy system to transition all providers to APMs.

Mercy Care has helped providers enhance revenue cycle management, manage vendors, expedite claims processing, and bill properly. As a result, the average time for claims submission has decreased from >78 days (2014) to 36 days, with an average of 9 days for claims payment (2017). Our thoughtful approach has also resulted in an increase in the number of unique members using BH services in Maricopa County for each of the last three years. We have also enabled BH providers to develop new programs, such as the ASD Centers of Excellence and the Comprehensive Community Health Program.

We recognize that providers are our partners and together we can implement payment models that work for both PH and BH providers. We established a Payment Reform Committee to align payment models with program requirements. The committee, with input from stakeholders, has identified the following payment models that provide us the flexibility to adapt to the wide range of providers' capabilities, financial situation, and resources:

- Partial capitation that supports member care (specialty BH providers, intake providers, BH health homes) – Fixed payment per member per month (PMPM) for a specific scope of services with a specific provider
- Fee-for-service (FFS) – Including FFS with tiered rates depending on provider performance and service value
- FFS with Quality Measure Incentives – Payment for each service provided with incentives for improvement in quality measures
- FFS with shared savings – Payment for each service provided with a targeted expected total cost amount and opportunity for shared savings
- Bundled Payments/Case Rates – Fixed payment PMPM for a specific scope of services based on member needs and expected services
- Full risk capitation – Population payment for all services; this requires Division of Financial Responsibility (DOFR) approval, and may or may not include inpatient, residential, other services

We are currently on track to transition all providers participating in the ACC program off block payment by October 1, 2018.

Summary

Informed by our experience, Mercy Care takes a systematic approach to continuously assessing the provider network's progress towards integration and using VBC to support the transformation. We provide technical assistance to help providers successfully transition to their highest level of integration and to an appropriate APM. In collaboration with providers, we will continue to offer resources and supports to assure that members have increased access to services and that our provider network thrives, facilitating continuity of care and maintaining a stable delivery system.

15. Monitoring, and Controlling Health Care Cost Trends

For over three decades, members enrolled in AHCCCS' programs have benefitted from Mercy Care's member-centric approach to continuously monitoring and controlling health care cost trends. Our approach aligns with AHCCCS' strategic plan by ensuring that all members receive medically necessary, cost effective, Federal- and State-reimbursable services in the highest quality setting with the best possible health outcomes. As a government-sponsored health plan, Mercy Care recognizes our fiduciary responsibility to ensure cost effectiveness and efficiencies throughout our program. We use a variety of tools and processes to effectively monitor and control health care costs and service utilization.

Processes to Track, Trend, Monitor and Control Health Care Costs

At Mercy Care, cost management is a discipline, not just an activity. Our comprehensive approach identifies costs before, during and after a health episode, as opposed to just reactively managing trends. Our approach and processes for monitoring and controlling health care cost trends focuses on shaping tomorrow's managed health care from today's experience, quality, and innovation. Mercy Care's strategies include: 1) integrated administrative and clinical processes, 2) value-based contracting, 3) program integrity activities, 4) the use of health information technology, and 5) continuous quality improvement initiatives.

Integrated administrative and clinical processes—Mercy Care is a fully integrated health plan with interoperable PH and BH operations and systems, provider relations, value based purchasing (VBP), medical management and quality management programs. For example, in our experience, PH providers are an important entry point for members seeking care for problems that are often related to BH needs. Therefore, we support PH providers in serving members by increasing awareness of the prevalence of BH conditions and decreasing stigma. We incentivize providers through VBP arrangements for completing BH screenings and making appropriate referrals to BH providers. Through these efforts, we have demonstrated savings in PH spend by facilitating access to BH services that address the underlying causes of members health seeking behaviors. ***In our duals population since the integration of GMH/SU, outpatient BH use increased by 40 percent, with a 4 percent decline in emergency department (ED) use and an 8 percent decrease in inpatient utilization for PH needs.***

Value based contracting (VBC) —We implement VBC models to bring accountability for care coordination, quality outcomes, and cost savings closer to the point of care. Inefficient care is one of the main causes of excessive cost in the health care system, especially for members with complex health care needs. To eliminate waste within the system it is imperative that Mercy Care reduces inefficient care, such as: a) mistakes (errors and preventable complications); b) care fragmentation; c) unnecessary use of higher-cost providers; and d) operational inefficiencies at care delivery sites. Our VBCs offer financial incentives to encourage providers to focus on improving health outcomes and to optimize costs of care. ***In our current GSAs, we achieved a cost savings of 4.9 percent in the most recently completed performance year after implementing more advanced alternative payment models (APM).***

Program integrity activities—Our fraud, waste, and abuse detection strategies improve coordination of benefits and align with AHCCCS' strategic goals. The Board's Audit and Compliance Committee is fully accountable for the Compliance Program and is composed of Board members, along with key Mercy Care executives. Committee members have expertise in regulatory compliance, internal audit, finance, operations, and health care law. Additionally, we have taken the unprecedented step of creating an internal position - the Fraud, Waste and Abuse (FWA) Coordinator. This position is staffed by an individual with a combination of technology skills, a business intelligence background, training in health care business practices, and a clear understanding of Federal and State laws and regulations.

Mercy Care also has full access to the investigative, administrative and technological expertise of a Special Investigations Unit (SIU). We maintain a toll-free 24-hour hotline (1-800-338-6361) for employees, providers and members to contact us at any time to report suspected FWA. Mercy Care also receives case referrals from law enforcement (Federal or State), State regulatory agencies, Medicaid agencies and Departments of Insurance, from customer service/claims personnel and other sources.

Health information technology—Mercy Care continually supports and develops innovative technology systems and integrations to improve member care, streamline administrative provider processes, and fully integrate community-based supports. We have transformed our data processes to have actionable information (authorization, pharmacy, and claims data processes) at our fingertips in the form of Tableau dashboards. We also deploy innovative technologies and specialized claim edit processes such as proprietary ClaimCheck® edits. Additionally, we monitor Coordination of Benefits (COB) and Third Party Liability (TPL) through routine reports, and train all departments to help identify and report COB and TPL opportunities.

To further enhance our ability to track service utilization and monitor health care costs, providers have access to CareUnify, our care management platform, at no cost. CareUnify is integrated with Health Current (the statewide Health Information Exchange) to link services and facilitate improved communication between treating providers, the health team, the member and caregivers. It provides near real time actionable data via event notification (ED, inpatient admission/discharge, transfers); high-risk, high-cost member identification, and enhanced provider performance by providing reports on quality (gaps in care, HEDIS data) and utilization (readmissions, ED visits, PCP visits).

*For 2017, our program integrity and cost control activities resulted in **$300 million in cost avoidance.***

Continuous quality improvement initiatives— In accordance with AMPM 900, Mercy Care employs clinical best practices and performance improvement methodologies to improve our administrative and operational processes. Our integrated Medical Management programs follow guidelines as outlined in AMPM 1000, including the use of nationally accepted guidelines, locally adopted prior authorization and concurrent review guidelines, and clinical policy bulletins. We continually monitor our ability to apply guidelines through Inter-Rater Reliability assessments and monthly auditing and oversight processes to ensure reliability in our clinical decision-making processes.

Mercy Care applies systematic, standardized approaches to achieve the best possible outcomes. We streamline our administrative processes to drive down costs, monitor the effectiveness of our prior authorization processes and maintain the fewest possible requirements to reduce providers' burden. We use code-specific service type and location of service-specific data including claims, authorizations, pharmacy prescriptions to monitor costs in near-real time and combine it with our Arizona-based expertise in network development, contracting, and utilization management personnel to control costs.

Through our multidisciplinary Healthcare Management Committee, collaboration between Mercy Care departments, and sophisticated data analytics, we can track and trend service utilization and quickly identify unfavorable cost trends. Our multidisciplinary Committee meets weekly to discuss and compare data such as national and state flu rates with our utilization data to identify emerging trends. When identifying frequently over-utilized services we apply our prior authorization and concurrent review processes, which are based on evidence-based practices and clinical guidelines, to better manage unnecessary high cost trends.

Example of Mercy Care's Ability to Monitor Health Care Costs: Laboratory Spending

Identification and Analysis of Cost Trends: In 2013 (as shown by the blue arrow in Figure 15-1), Mercy Care's multi-disciplinary Healthcare Management Committee identified an increase in claims and non-

participating provider payment requests for laboratory testing through a review of claims monitoring and authorization dashboards. We conducted further data analysis and determined that the cost driver was an increase in the number of newly created testing procedures that were ordered to help clinicians identify the use of prescription and non-prescription controlled substances in members being treated for chronic pain conditions.

In accordance with AMPM 1020, we reviewed the medical necessity of these new tests using our new technology review process. We also contacted providers to better understand their use of the tests and members' needs. We independently reviewed published literature, best practices, and applicable AHCCCS policies such as 310-N, Laboratory. Upon determining that these laboratory tests were medically necessary and served an important role in improving care for members with complicated conditions, we identified options for cost control that would not negatively limit members' access to care or increase providers' administrative burden.

Interventions: To reduce costs associated with these laboratory tests, Mercy Care developed a strategy for contracting with several new testing laboratories. We met with the laboratories and verified they were registered with AHCCCS and then competitively bid the service opportunity. Simultaneously, we participated in the Arizona Department of Health Services' workshop to help develop the Arizona Opioid Prescribing Guidelines. These guidelines included the use of a risk stratification process to guide appropriate urine testing. Our Provider Relations staff disseminated copies of the guidelines throughout our network.

Results: Mercy Care was negotiated with multiple laboratories that agreed to offer the testing at a new price per service that lowered the cost by nearly 40 percent and returned the cost to near our previous baseline, where it remained for over a year.

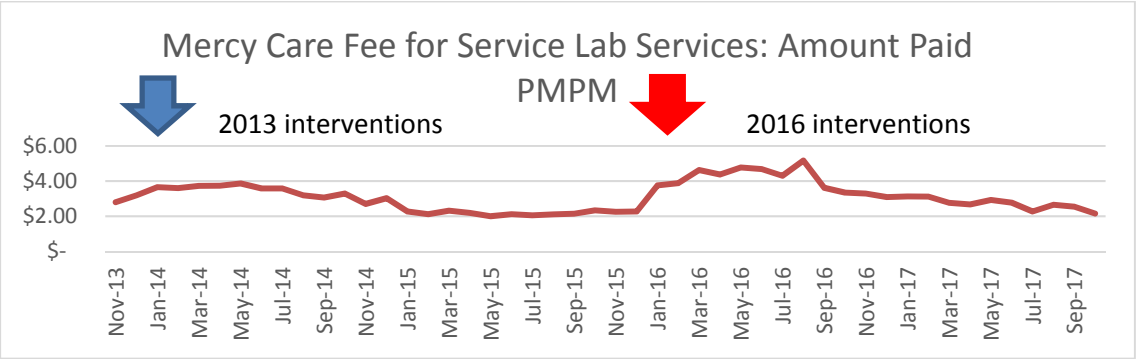
Ongoing monitoring: In 2016 (as shown by the red arrow in Figure 15-1), our multidisciplinary Healthcare Management Committee again identified an increase in claim volume and costs for laboratory testing through a review of claims and authorization dashboards. We conducted a drill-down analysis to identify the specific details for the change. This time, we identified the underlying reasons for the increase in costs as: 1) an increase in ordering of these tests, and 2) changes to the national coding process and fee structures.

Action: Mercy Care met with our largest laboratory provider and collaborated with them to understand why the utilization pattern had changed. While the total number of ordering providers was not significantly increasing, we identified an increase in the use of multiple tests in a single clinical episode. We determined that the pattern was not widespread but was specific to certain provider practices.

In collaboration with our laboratory partner, we developed a provider-specific report with peer comparison for use in provider-specific feedback. Together we developed a decision-support tool with well-defined ordering forms for practices to use. We also worked with our principle laboratory provider and AHCCCS to ensure that proper coding procedures and fee schedules were updated to reflect the changes that had occurred at the national level. We then assured that these changes were applied to all laboratory providers in our network.

Results: Mercy Care helped individual outlier practices to adapt evidenced-based testing practices, drastically reducing the use of multiple testing procedures at a single clinical episode. The fee schedule was also updated. As a result, the cost was again returned to baseline where it has since remained. Cost trends for this service are shown in Figure 15-1.

Figure 15-1: Cost Trends for Laboratory Testing



This example of an unfavorable trend and our response demonstrates several important guiding principles in our approach to cost containment. First, we take all cost trends seriously. While this cost increase of $1 to $2 per member per month may seem relatively small, for a large Contractor like Mercy Care, it would add $5 to $10 million per year in additional costs to the system. Second, this example demonstrates that cost control is a continuous process. Medical practice, medical technology, provider training, members' conditions and need for services, and the documentation and coding procedures all constantly evolve. We continuously track, trend, monitor, and take action to improve health care costs even after we have achieved established objectives.

Finally, and most importantly, this example demonstrates that we always put members' and providers' needs first while balancing our ability to control costs. ***We begin any cost trend analysis by understanding the needs of members.*** We then collaborate with providers to understand members' needs, make sure that providers have the information necessary to provide evidenced-based care and minimize administrative burden. For example, during this timeframe we had two major cost control initiatives that impacted care for members with opioid treatment or substance use disorders and simultaneously achieved an important objective: reducing prescription opioid use by approximately 10 percent per year. Further, we improved member and provider satisfaction survey results in each year.

Beyond Cost Control: Using VBP Programs to Increase Value in the System

Mercy Care offers VBP programs to selected network practitioners and providers to promote and reward quality improvement and high-value, member-centered care in accordance with ACOM 315. Our VBP program supports providers in delivering high quality services in accordance with member-centered principles, engaging members in care, coordinating care and achieving optimal health care management. We monitor program outcomes for members through a variety of metrics already in place including quality measures, provider performance reporting and profiling, and pay-for-performance incentives. To help providers meet established performance measures and improve member care, we publish and provide monthly and quarterly reports, such as:

- **Gap in Care Reporting**—Provides current month membership and member adherence with HEDIS and state performance measure metrics.
- **VBP Performance Report**—Published quarterly with performance trend on specific incentivized measures for the current measurement year.
- **Key Performance Indicator Report**—Provides additional metrics to support VBP programs and population health efforts that practitioners can use to drive everyday clinical decision-making.

Mercy Care's VBP program aligns with the principles identified by key national organizations such as the Substance Abuse and Mental Health Services Administration, American Medical Association, American College of Physicians, National Committee for Quality Assurance, the Joint Commission and Centers for

Medicare and Medicaid Services. Annually, Mercy Care selects measures for inclusion in our VBP program based upon the objectives in our Quality Management and Performance Improvement (QM/PI) program. Through our VBP program, we monitor cost trends and reward providers for delivering care that reduces costs while maintaining high quality standards.

Supporting Providers in Adopting Alternative Payment Models

Mercy Care supports providers as they transition from one model to another, with the goal of becoming an accountable care provider. To assist providers in successfully participating in VBP arrangements, we:

- Provide actionable member-level data to help providers make decisions about member care
- Facilitate data and information-sharing through tools such as CareUnify
- Educate providers on how to use information to improve member care
- Offer population health management tools

Our Integrated Health Department works in close collaboration with our Provider Relations Department, Systems of Care, and the Practice Innovation Institute (Pii) to help providers achieve success in their journey towards integration. Through Pii, providers have access to evidence-based trainings on ways to improve quality metrics. A support team, including a Practice Transformation Consultant, a Workflow Specialist and Data Analyst provide guidance and consultative services related to practice transformation and the use of technology to enhance member care. Local and national clinical advisors support clinicians and collaborate with peer-based learning networks.

Program Success: Mercy Care Collaborates with Arizona Care Network to Improve Care

Mercy Care contracts with Arizona Care Network (ACN) to manage care for approximately 100,000 Medicaid members with the highest level of needs. The goal of this care model is to improve quality outcomes and reduce the overall cost of care for members with historically poor overall health and high costs associated with frequent ED use. ACN serves members with the most complex needs by delivering high-touch care coordination through health coaches embedded in select primary care locations.

By improving access to care and health screenings, early intervention, and comprehensive care coordination, ACN demonstrated measurable improvement in the following outcomes:

- 16% improvement in HbA1c control (≤9)
- 20% reduction in ED visits
- $11.4 million in cost savings

We will leverage lessons learned from this program to implement similar strategies with providers in all GSAs we serve and expect to achieve positive outcomes and cost reductions.

Summary

Mercy Care will improve the efficiency and effectiveness of the ACC program while supporting providers in delivering high quality care to members. Our holistic approach identifies costs before, during and after a health episode, as opposed to reactively managing trends or establishing overly restrictive prior authorization processes. Mercy Care's effective monitoring approaches and data-driven decision making processes enable us to reduce costs while maintaining a high standard of care that results in improved member outcomes and increased member satisfaction. As is our current practice, we will continuously develop mechanisms to improve program efficiency, reduce administrative cost and increase value when administering the ACC program.

16. GSA Specific Submission

Mercy Care has been serving Arizona communities for over 30 years. We take pride in the relationships we have built with providers and stakeholders throughout the State. We are part of the fabric of Arizona and play an integral role in enhancing the health care delivery system across the State. We have worked closely with members, other health plans, providers, stakeholders, and AHCCCS to understand the needs of all communities in Arizona and helped to transform the delivery system to improve the health of all Arizonans. As described in this response, we will leverage the strengths and unique aspects of service delivery for members in the North and South GSAs and are prepared to ensure the effective delivery of integrated care services in these regions.

Unique Aspects of Service Delivery to Members in the North GSA

The North GSA is largely considered rural or frontier, with many individuals living in remote areas. The people who live in these communities and the providers that serve them are very resourceful and look for creative ways to have their needs met. For example, telehealth and telemedicine are well-developed in this part of the state. Telehealth is primarily used to improve member access to services. We intend to expand the use of telehealth to include access to other specialty providers. Additionally, there are many close-knit communities in the region whose residents support one another, despite social and environmental challenges. Local and regional organizations serving the area have an understanding of the social determinants of health and use this framework to support health and well-being. There are 22 American Indian tribes in the North GSA, each with its own cultures, governing structures, and health care needs. American Indian tribes in this region demonstrate resiliency and strong communities supported by cultural revitalization efforts, which are strengths on which we can build.

A few agencies within the GSA have implemented an integrated model of care. Spectrum Healthcare has integrated primary care into a behavioral health (BH) setting in their Cottonwood location. The agency has also adopted a health home model with centralized care coordination, and has expressed an interest in replicating this model in the future. Spectrum Healthcare is building a medication-assisted treatment (MAT) program and has recently purchased a site to provide the services in Cottonwood. Plans are also underway to add MAT services in Mohave County. Community Bridges, Inc. has implemented integrated care models in a number of locations including Winslow and Holbrook where it operates health homes using a care team. Their care teams include a medical practitioner, a BH professional, an integrated case manager, and a registered nurse.

Due to the rural nature of this region, there are access to care issues that must be considered when developing the provider network. For example, there is an identified shortage of primary care providers (PCPs) in many parts of the GSA such as Yavapai County where members in some communities have only one choice of a PCP. Additional network needs include dermatology; pain management specialists in Mohave, Navajo, and Apache counties; access to supportive housing; expanding supports for transition age youth; improving access to transportation; and increasing access to MAT. The Department of Health Services has designated all of Northern Arizona as a Mental Health Professional Shortage Area. Law enforcement often serves as the liaison to needed mental health care services. Specialty provider visits, especially for children, require residents to travel long distances, often traveling outside the region. However, families living in and around Flagstaff can access specialty services through Flagstaff Medical Center Children's Health Center, a Multi-Specialty Interdisciplinary Clinic (MSIC) that serves children with CRS conditions.

There are three acute care hospitals located in the GSA - Verde Medical Center is a 99-bed full service hospital located in Cottonwood; Flagstaff Medical Center which serves the Flagstaff area; and Yavapai Regional Medical Center in the Prescott area. Although the presence of these providers dramatically

improves access to inpatient care for members living in the surrounding communities, many members are forced to travel long distances to receive hospital care.

In community forums, families have expressed frustration with the lack of physician tenure and experience in serving children with special health care needs in rural areas, resulting in their children's needs not always being identified timely and treated appropriately. To access more consistent and reliable services, families report that they travel to Flagstaff and/or Phoenix for care. Families state that in some areas in the North GSA, they feel that providers do not respect parents' input and threaten to call the Department of Child Safety when parents have difficulties with managing children's behaviors or adhering to treatment recommendations. There is also a need for improved information sharing and education on the benefits of preventive health care, strategies for managing health (especially for those with chronic physical health [PH] or BH conditions), and system navigation.

Mercy Care's Strategies to Ensure Effective Service Delivery in the North GSA

Mercy Care has a long history of managing PH and BH provider networks. We have established processes to evaluate network sufficiency and a proven track record of working with providers to develop and implement innovative services and programs. We will employ comprehensive strategies to ensure effective service delivery under the AHCCCS Complete Care (ACC) Contract, including: 1) network expansion; 2) collaboration with stakeholders and system partners; 3) using technology to promote access to care; and 4) promoting evidence-based practices.

Network Expansion: Based on community feedback and data analysis, we determined the need to increase capacity for specialty and BH services and community-based supports by:

- **Launching Community Health Worker (CHW) programs** to help improve access to health
- care outcomes, especially in low income, cultural minority, and rural populations. Mercy Care will enhance existing strong relationships with North Country HealthCare and Canyonlands Healthcare to establish CHW, Community Dental Health Worker and Community Behavioral Health aid programs. CHWs are uniquely effective in providing education and capacity building for individuals and communities. They can serve as liaisons between health/social services and the community to facilitate access to services, improve quality and ensure services are culturally competent.
- **Expanding capacity to provide mobile health units to provide outreach, improve access to care, and prevent disease.** Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in the North GSA can provide health screenings (dental, mental health, cancer), child immunizations and vaccinations, health education to enhance access to prevention, and simple medical treatments. Mercy Care will collaborate with FQHCs/RHCs to expand their capacity to reach rural locations, schools, and accessible community locations.
- **Contracting with providers in bordering states**, such as Utah, New Mexico, and Nevada to serve members who live in remote and rural areas near the Arizona border.
- **Expanding the use of family support** through our partnerships with Raising Special Kids and the Family Involvement Center to assist families in navigating the service delivery system and accessing appropriate services and community-based supports.
- **Comparing our network against the existing Contractor's network** to make sure we are contracted with all eligible providers, promoting continuity of care for members.
- **Executing value-based contracts** to encourage providers to open practices in rural and underserved area, increase accessibility and deliver high-quality care.

Collaboration with Stakeholders and System Partners: We will continue to work with stakeholders, providers, and members in each GSA to assess and expand service capacity to facilitate member access to the services they need. Our strategies include:

- **Hosting quarterly Member Advisory Council** meetings in which members are invited and encouraged to share their experiences with Mercy Care, with our network providers. The Council hears successes in utilizing our member tools and suggestions for improvements. Meetings will be held in locations that are convenient for members.
- **Collaborating with existing community paramedicine contracts** to offer health and social services that can improve access to care among individuals with disabilities, members in rural areas, aging adult populations, and others with limited access to reliable transportation. The community paramedicine program trains paramedics to complete assessments, conduct medication reconciliation, and connect members to preventive services such as immunizations.
- **Partnering with the Arizona Health Collaborative (AHC),** which represents a network of urban and rural health systems located throughout Arizona. We support AHC initiatives to improve access to high-quality care, which include clinical quality collaborations and standardizing IT solutions including a comprehensive telehealth program.
- **Partnering with County Fire, Medical Departments and tribal first responders** to promote community health.
- Partnering with local law enforcement officials to **provide Crisis Intervention Training** to recognize mental health conditions and navigate the BH system to link members to services.
- **Implementing value-based contracts** to incentivize providers to deliver high-quality care that is integrated, timely, and accessible.
- **Designating local, regionally assigned Tribal Liaison(s)** to collaborate with the tribes to provide mobile BH and PH services; collaborate with AHCCCS, Indian Health Services and 638 tribal facilities to improve coordination through the use of the health information exchange; and build and/or use existing technological infrastructure, so that telemedicine can occur on tribal lands.
- **Working with Tribal Nations to serve members in community locations**, such as meeting the member at their family's home or local community center.
- **Leveraging the expertise of our existing providers**, such as Community Bridges Inc. and Terros, that already deliver services in this GSA.
- Partnering with social service agencies to **address social determinants of health** (housing, food security).

Using technology to promote access to care: Remote member monitoring, including telehealth, which uses devices to remotely collect and send data directly to their health care provider is available for members today. We are planning to implement new technology tools in 2018 to enhance member engagement and care coordination. These tools include a new mobile application platform that will allow members to obtain health information; track and manage their own health; and participate in online health education groups. Our mobile integrated health solution allows members to speak with an Arizona-based physician on the phone or via HIPAA-compliant video teleconferencing.

Promoting Evidence-Based Practices (EBPs): We will advance the use of EBPs by:

- **Creating Centers of Excellence** to serve children, youth and adults with Autism Spectrum Disorder and Down syndrome through partnerships with MSICs and stakeholders, as well as Centers of Excellence for Substance Use/Pain Management and for children aged 0-5 and their families.
- **Training PCPs and specialists through Mercy 360 Academy** to enhance their skills and knowledge to help them deliver, refer and coordinate specialty services, such as Applied Behavior Analysis.
- **Increasing the number of providers offering integrated care** using best practice tools for assessing provider capabilities, educating providers on adopting their systems, bringing technology solutions such as data-sharing tools and provider dashboards through the Practice Innovation Institute.

Unique Aspects of Service Delivery to Members in the South GSA

Mercy Care has a strong presence in the South GSA, including a comprehensive provider network and a local office. Our comprehensive provider network serves members in Yuma, LaPaz, Greenlee, Graham, Pima, Santa Cruz and Cochise counties. Members in this GSA benefit from having ready access to our knowledgeable staff in locally based offices with knowledge of the localities they serve. When determining community and network needs, we will leverage feedback from members, families, and community stakeholders, as well as the expertise of our local staff.

Most of the South GSA is rural, with several population centers in which health services are most available. Several tribal reservations are located in the region including the Pasqua Yaqui, the Tohono O'odham Nation, the Colorado River tribes, and the White Mountain and San Carlos tribes located on the western edge of Graham and Greenlee counties. The South GSA is diverse in language and culture. Due to its proximity to Mexico, it has a large population of Latino residents, many of whom are monolingual Spanish speaking. Up to 50 percent of primary care services are provided in neighboring states members that live near the border. The population of the service area is also aging, partly due to communities like Yuma that attract large numbers of winter visitors. There are three military bases in this GSA, contributing to the large veteran population and a strong Veterans Administration (VA) presence.

Individuals living in the South GSA are proud of their neighborhoods and communities in which they live. Neighbors work side-by-side to support each other and create stronger communities. Together, they develop creative solutions to meet community and individual needs, such as building community gardens, developing and maintain community parks, and supporting local businesses owned by their neighbors and friends. They take great pride in their ability to preserve their neighborhoods and solve problems locally through their strong relationships and willingness to help each other.

The providers who serve this community are typically long-standing community members and invested in improving overall community health. They work with community organizations and stakeholders to solve local needs, such as developing employment options for members with a serious mental illness and those with disabilities. Further, they collaborate with first responders to educate them on the availability of BH and other services for enrolled members.

Members and families in rural areas often travel to Tucson, which is home to a Multi-Specialty Integrated Clinic (MSIC), the VA Medical Center, and a comprehensive network of hospitals, PH providers, BH providers, and specialty providers. Members and families can access PH and BH services in Yuma, along with some specialty care, although access to specialists such as developmental pediatricians, neurologists, orthopedics, and endocrinologists is limited in this area. We are also aware that there are challenges in accessing habilitative and rehabilitative therapy services in some regions. The need to travel long distances to Tucson or Phoenix for specialty services creates additional burden for members and families who may need to take off work and plan to spend a full day attending appointments.

To address the need for specialty care, hospitals and providers in areas such as Benson, Bisbee, Safford, Yuma, and Wilcox are working to expand the use of telehealth and telemedicine, enabling members and families to receive services in their own communities. For example, one provider uses telepsychiatry to link members to psychiatrists and psychiatric nurses for medication reviews. This provider estimates that approximately 50 percent of therapy provided by independently licensed therapists at the agency is provided via telehealth technology. In Yuma, telemedicine is used extensively for subspecialties including some support services provided to members with CRS conditions.

Mercy Care's Strategies to Ensure the Effective Delivery of Services in the South GSA

Mercy Care's PCP network exceeds the AHCCCS standard in Tucson and includes internists, family practitioners, pediatricians, OB/GYNs, nurse practitioners, and physician assistants. We also have contracts with FQHCs/RHCs, FQHC Look-Alike, and qualified person-centered medical home (PCMH) providers including El Rio Community Health Center, MHC Healthcare, and St. Elizabeth's Health Center. ***Mercy Care maintains contracts with a wide array of specialists (including all specialties required in the ACC Contract) throughout the South GSA and our network is designed to meet members' specialized needs. We are also contracted with 95 percent of the BH providers in the South GSA.***

Mercy Care's specialist network in Yuma County contains the vast majority of community physicians as a result of our presence in the GSA and our specialist network in Parker and other communities. There are a number of contracted specialists available in Lake Havasu available to support coverage for the members in La Paz County where limited specialists are available. While most members have access to a specialist in Yuma, additional allergy, dermatology, endocrinology, and urology specialists would be of benefit. The MSIC in Tucson provides an excellent model for providing access to a responsive and high-quality provider network; there are formal and informal care coordination practices which are highly effective at managing complex care needs, and member satisfaction is very high.

Mercy Care will build upon these successful practices and programs to ensure effective service delivery in this region. Our strategies include: 1) network expansion; 2) coordinating with stakeholders and system partners; 3) promoting evidence-based practices; 4) using technology to connect members to services; and 5) value-based contracting.

Network Expansion: Our network efforts are focused on recruiting and maintaining a provider network that meets the needs of our culturally and linguistically diverse members and families by:

- **Expanding Community Health Worker (CHW) contracts** to help members navigate the service delivery system and access care. In Southern Arizona, a number of local hospitals and physician groups are using community outreach workers to provide support services that promote improved continuity of care and chronic disease management. For instance, one of our contracted hospital systems employs CHWs as navigators in its ED to help connect uninsured and homeless members to community health centers.
- **Contracting with providers in bordering states** such as California and New Mexico to serve members in rural and remote areas.
- **Expanding the scope of MSICs** to offer specialty services such as internal medicine to follow members through the age of 26 and serve as Centers of Excellence for members with special health care needs.
- **Providing members with access to the retail clinic locations** through our partnership with Walgreen's and CVS' retail clinics. This creates another support layer for members with non-emergent conditions who may not be able to secure a same-day PCP appointment.
- **Contracting with a variety of regional transportation providers**, including emergency and nonemergency ambulance providers, wheelchair and stretcher vans, as well as taxicab services, to ensure members arrive at their scheduled appointments on time, but no sooner than one hour before or more than one hour after the conclusion of the treatment. We will consider direct contracts with providers who offer transportation to their membership to improve timely access to services and increase member satisfaction.

Coordination with Stakeholders and System Partners: Mercy Care will collaborate with providers and system partners to meet the unique needs of members and local communities. Our strategies include:

- **Implementing community paramedicine contracts**, which use paramedics to perform detailed risk assessments, home medication reviews, referrals to PCPs and skilled home services, and provide

preventive services such as immunizations and support to improve medication compliance. Rio Rico is one community in this GSA that is currently using this approach.

- **Designating local VA liaisons** to work with our Veteran's Advocate to collaborate with the VA Healthcare System to facilitate member access to available resources.
- **Designating local, regionally assigned Tribal Liaison(s)** to collaborate with the tribes to provide mobile BH and PH services; collaborate with AHCCCS, Indian Health Services and 638 tribal facilities to improve coordination through the use of the health information exchange; and build and/or use existing technological infrastructure, so that telemedicine can occur on tribal lands.
- **Hosting quarterly Member Advisory Council meetings** in which members are invited and encouraged to share their experiences with Mercy Care and with our network providers, describe successes in utilizing our member tools, and offer suggestions for improvements.
- **Hosting Provider Forums and CEO meetings** in local communities at least quarterly to gather input and feedback on the accessibility and quality of services, and the effectiveness of our processes in reducing provider administrative burden and improving member care.
- **Partnering with the Arizona Health Collaborative (AHC),** which represents a network of urban and rural health systems located throughout Arizona. We support AHC initiatives to improve access to high-quality care. We support clinical quality collaborations and standardizing IT solutions, including a comprehensive telehealth program.

Promoting Evidence-Based Practices (EBPs): We will advance the use of EBPs by:

- **Creating Centers of Excellence** to serve children, youth and adults with autism spectrum disorder and Down syndrome through partnerships with MSICs, families, advocates, stakeholders, and providers. We are also planning to implement a Center of Excellence for substance use disorder/pain management that will offer members access to a full continuum of services, including alternative pain management treatments and medication-assisted treatment.
- **Training PCPs and specialists through Mercy 360 Academy** to enhance their skills and knowledge to help them deliver, refer to, and coordinate specialty services, such as Applied Behavior Analysis.
- **Increasing the number of providers offering integrated care** by assessing their capabilities, educating them on adopting their systems, offering technology solutions such as data-sharing tools and provider dashboards, and providing coaching through the Practice Innovation Institute.

Value-based contracting: Mercy Care is collaborating with providers to implement a payment model that ties reimbursement to access to care and the delivery of high-quality services. We have been discussing alternative payment models with providers and are drafting approaches that will help to move the system forward and support AHCCCS' goals for the ACC program.

Using technology to improve access to care: Mercy Care is implementing new technology tools that include a new mobile app that will allow members to obtain health information, track and manage their health, and participate in online health education groups. We are also creating a mobile integrated health solution that allows members to speak with an Arizona-based physician on the phone or via HIPAA-compliant video teleconferencing. Additionally, providers have access to CareUnify, our care management platform, which enables them and Mercy Care staff to view and share critical information, including gaps in care; admission, discharge, transfer alerts; and medications.

Our member-and family-centered processes help members to achieve their recovery and wellness goals, adding value to the ACC program. Navigating complex health systems is one of the greatest challenges for individuals and their families. We will apply our integrated care management model to facilitate access to services, assist members and families in navigating the service delivery system and improve their experience in care. Through our existing provider network and relationships with providers and stakeholders, Mercy Care is well-positioned to serve ACC members on day one of contract launch.

17. Engaging and Collaborating with Tribes to Serve American Indian Members

Mercy Care has a longstanding history of working closely with American Indian tribes and Indian Health Services (IHS) to improve coordination of care and outcomes for members of American Indian descent. We recognize that tribes are sovereign nations and have a standing equal to the federal government. We respect the diversity among Tribal Nations and work with each one based on their processes and preferences. We know that American Indians as a group are resilient and strongly value their culture and heritage, including their connection to traditional healing beliefs and practices, preservation of native languages and strong extended family/clanship support. There are 22 sovereign tribes in Arizona and AHCCCS population statistics indicate that approximately nine percent of AHCCCS enrollees are American Indians. ***Mercy Care currently serves approximately 35,000 American Indians.***

We recognize that navigating the complex health systems to obtain medically necessary services is a significant challenge for tribal members. Mercy Care honors the fact that American Indian members have choice in where they receive health care and works to reduce fragmentation and assist members in accessing services in the location they choose. We partner with IHS, Tribal Nations and urban tribal organizations to support timely access to care, effective care coordination and eliminate member and system level barriers. As described in this response, we have processes to engage and collaborate with tribes and identify, escalate and resolve barriers to service delivery. Our systems are in place today and scalable to all awarded GSAs.

Engaging and Collaborating with Tribes

Mercy Care's approach to engaging and collaborating with tribes is proactive and high touch. To address the challenges American Indians face when trying to navigate the health delivery system, Mercy Care employed a Tribal Relations Administrator (Tribal Coordinator) in 2014 to develop stronger relationships with the tribes and IHS, identify service barriers, and accelerate meaningful resolutions. Our Tribal Coordinator is an enrolled member of a federally recognized tribe and possesses over 20 years professional experience working in Arizona tribal and behavioral health non-profit sectors. He is adept at explaining Medicaid benefits to tribes and tribal members and can clearly describe the federal and tribal health care system to Medicaid providers serving tribal members. Having this blend of professional systems knowledge and cultural understanding of tribal communities provides the Tribal Coordinator with a unique ability to work with tribes and tribal members in an empathetic, culturally competent manner. Under the leadership of our Tribal Coordinator, we have developed and implemented a comprehensive approach to engaging and collaborating with Tribal Nations, which include:

*Above and beyond AHCCCS requirements, Mercy Care will have a **dedicated call-in line to support American Indian members** who need assistance with navigating the health care system. Staff will include individuals who are tribal members and/or who have experience in working with tribal communities.*

- Participating in tribal initiatives to form positive relationships and improve care
- Executing Memorandums of Understanding (MOUs) and other written agreements with tribes in the GSAs in which we operate
- Hiring regionally assigned Tribal Liaisons
- Providing in-service education

We will leverage the relationships we have with Tribal Nations in each GSA to continue to engage and collaborate to improve ACC members' access to high-quality care.

Participating in Tribal Initiatives to Form Positive Relationships and Improve Care

Mercy Care works closely with tribal leadership to facilitate relationship-building, identify unmet needs, discuss program development and implement culturally competent services. Our Tribal Coordinator outreaches to, and collaborates with tribes in all GSAs we serve, including the Navajo Nation, the Pascua Yaqui Nation, the Tohono O'odham Nation and the Colorado River Indian Tribes. Mercy Care has worked closely with these Tribal Nations since 2014 to build relationships based on mutual trust and respect, and improve care coordination. Mercy Care's Tribal Coordinator currently participates in Advisory Councils and outreach activities to support tribal members and tribal initiatives. We have partnered with tribes to implement initiatives that improve whole health outcomes, such as:

Increasing Access to Integrated Care for Tribal Members
In July 2017, Native Health, in partnership with Mercy Care, became the first urban Indian provider in Arizona to offer integrated care to GMH/SU members – a significant step forward in meeting members' whole health needs, treating chronic conditions and reducing the use of emergency and crisis services.

- **AHCCCS American Indian Health Program (AIHP)/Mercy Care High Cost/High Needs Initiative** - This initiative involves AHCCCS, Mercy Care, the Phoenix Indian Medical Center, and Salt River Behavioral Health coming together each month to develop strategies to engage high cost/high needs members identified by AHCCCS. Participating entities share member contact information, discussed reported health care needs, and review claims and utilization data.
- **Phoenix Police Department Native American Advisory Council -** This council meets quarterly with Phoenix Police Department leadership to hear department updates, address concerns regarding public safety affecting American Indians living in Phoenix, and collaborate with local tribal groups in community public safety awareness events/activities.

Through our participation in these initiatives, we identify opportunities to improve coordination and access to care. We will participate in similar activities in all awarded GSAs to improve care for tribal members and foster positive relationships with tribal entities.

Executing Memorandums of Understanding and other Written Agreements

Mercy Care develops structured and formal relationships with Tribal Nations to ensure expectations for collaboration at the member and system levels are clearly articulated. As required in the AHCCCS Complete Care (ACC) Contract, Paragraph 3, Enrollment and Disenrollment, we have MOUs with Tribal Nations that describe care coordination processes and how we work together to support American Indian members who choose to opt in or opt out of the ACC program. For example, MOUs describe the process for facilitating face-to-face meetings with children in residential treatment off tribal lands to facilitate communication between the child and his/her family. They also describe our processes for complying with state-recognized tribal court orders for tribal members.

Mercy Care currently has a MOU with the Tohono O'odham Nation that includes processes for delivering outpatient counseling and crisis mobile teams to the San Lucy District of the Tohono O'odham Nation. We also have a written agreement with the Fort McDowell Yavapai Nation for the provision of BH crisis mobile team response to their tribal lands. Further, we have working relationships with Tribal Nations located in the North and South GSAs, including the Navajo Nation, the Pascua Yaqui Nation, the Tohono O'odham Nation and the Colorado River Indian Tribes. In our experience, entering into written agreements with tribes is a complex process that takes time, trust, and a significant commitment to develop close partnerships with sovereign Tribal Nations. Mercy Care will leverage our Tribal Coordinator and regionally assigned Tribal Liaisons to build on our existing relationships with tribes across the state to establish MOUs with the tribal governments in all awarded GSAs.

Hiring Regionally Assigned Tribal Liaisons

Mercy Care will meet all AHCCCS requirements regarding the role of the Tribal Coordinator described in ACC Contract, Section D, Paragraph 23, Medical Management. ***Above and beyond the requirements of the contract, Mercy Care will hire local, regionally assigned Tribal Liaisons from the communities we serve.*** In our experience, regular face-to-face meetings are necessary for creating trust and developing positive relationships. Our Tribal Liaisons will be assigned regionally to allow for a high touch approach. We will work with Tribal Nations to hire Tribal Liaisons from the community and/or those with experience working in tribal communities. In our experience, hiring staff from local communities will enhance our ability to build trusting relationships with Tribal Nations, providers, tribal communities, IHS, 638 facilities, and Urban Indian Organizations. Regional Tribal Liaisons will respectfully collaborate with tribes and tribal entities to develop service solutions and service gaps and barriers by:

- Facilitating at least semi-annual forums with providers serving American Indian members and IHS and 638 facilities to identify and problem solve any outstanding issues related to service delivery
- Attending quarterly AHCCCS Tribal consultation meetings held throughout Arizona
- Collaborating with the tribes around issues regarding the involuntary commitment process for American Indians living on tribal lands so that tribal members receive these services in a timely manner per A.R.S. 12-136
- Actively participating in providing care coordination for American Indian members identified as high cost/high needs, including connecting members to ongoing care
- Using claims data, Blind Spot Data, and data sharing agreements to inform care coordination.
- Facilitating coordination of care to ensure that children who are placed in residential facilities off tribal lands have communication with their tribal community and family

Our Tribal Coordinator will convene weekly meetings with our Tribal Liaisons to identify common planning processes and gain an understand of outstanding issues in each of the three GSAs.

Providing In-Service Education

Mercy Care's Tribal Coordinator provides in-service education for health plan staff and contracted providers serving American Indian members to increase their understanding of the unique issues facing American Indian members. Trainings include best practices, general clinical requirements, information on the delivery of culturally competent care, the use of traditional healing interventions, and suicide prevention using the ASIST and SafeTALK curricula. Additionally, ***we will implement a Welcome to Mercy Care training for tribal members, stakeholders, families and tribes to educate them on available services and supports (e.g., care management) and how to access them***. Mercy Care will also assist AHCCCS in the development and provision of an educational and in-service training series for licensed and unlicensed staff working in Indian Health Facilities, tribally operated programs, IHS, and Urban Indian Health Program Clinics. Training will be provided by Mercy Care staff such as our Tribal Coordinator or Tribal Liaisons, who have an understanding of the issues faced by programs serving American Indians in each GSA.

Identifying, Escalating, and Resolving Barriers to Service Delivery

Mercy Care will leverage the expertise of our Tribal Coordinator and Tribal Liaisons, relationships with the tribes and multiple data sources including Blind Spot Data, claims, and information from IHS and tribal entities to identify barriers to service delivery. Tribal Liaisons will communicate with representatives from the tribes and IHS monthly to identify gaps in service and discuss program development opportunities. As another mechanism to engage with tribal members, Mercy Care will implement a Tribal Relations webpage on the Mercy Care website where members can submit inquiries, upon approval from AHCCCS. The page will also include community resources and information to assist tribal members in navigating the system and accessing available services and supports. Tribal Liaisons

will monitor the webpage and add pertinent community events or other relevant information, as appropriate. With other health plan staff, they will facilitate regional Listening Gatherings for members that reside on and off tribal lands to seek input on ways to improve integrated care, with the consent of respective tribal elected leadership. Additionally, Mercy Care will continue to review, track and trend member complaints, grievances and appeals on a monthly basis to detect and address trends related to challenges American Indian members face in negotiating the service delivery system. We also use data collected for the Tribal Coordinator Report submitted to AHCCCS to identify trends related to court-ordered evaluation/treatment, quality of care, access, timeliness, and availability of services. Data is shared with the Medical Management Committee, which is responsible for taking actions to improve service delivery and monitoring the effectiveness of interventions in achieving system improvements.

Mercy Care also monitors member-specific service utilization and gaps in care to identify and address potential barriers to care. For example, we identified tribal members that frequently visited the ED and partnered with their tribes to contact each member and offer care management and other supports to assist them in accessing preventive care. Our Tribal Liaisons also speak with members about their experience with the service delivery system and bust barriers in cases where there are identified obstacles to the member receiving care.

Escalating and Resolving Barriers to Service Delivery

To allow for the speedy resolution of obstacles to service delivery, our processes support barrier resolution at the lowest possible level. We empower our staff to take care of members' needs and resolve issues at the first contact, whenever possible. At the systems level, we track, trend and report data through our multidisciplinary committee structure. Our leadership addresses internal issues and partners with the tribes to resolve cross-system barriers. We describe these processes below.

Resolving Member Barriers – Mercy Care's care management staff coordinate with tribal social workers and staff to resolve member-specific barriers. In cases where resolution is not possible by Care Managers or other front-line staff, personnel are instructed to immediately contact their supervisor and/or the regional Tribal Liaison to resolve the issue. Complex cases are referred to our Tribal Coordinator who works with Care Managers and tribal staff to resolve barriers quickly, facilitating member access to the services they need. The following example highlights our effective strategies.

A tribal member, "John," was admitted to the Arizona State Hospital per a tribal court order. Our Tribal Liaison attended discharge planning meetings with the hospital, the member's guardian, and a residential treatment provider with expertise in treating American Indians to facilitate the member's return to the community. After discharge, the member entered the residential facility in the Phoenix area and was connected to a clinical team to support his ongoing treatment needs. ***The member is actively engaged in care and has not been hospitalized for BH reasons since his discharge in May 2016.***

Resolving Systems-Level Barriers - Our Tribal Coordinator holds an administrative position within the organization and has direct access to the Chief Executive Officer (CEO) and Chief Medical Officer (CMO) to ensure that service delivery issues are quickly escalated, as appropriate. Tribal leaders also have direct access to the Mercy Care CEO and CMO as needed to resolve and escalate barriers. The Mercy Care Tribal Coordinator is a member of the Mercy Care Cultural Competency Committee and provides an overview of key activities that impact American Indian members. Additionally, he participates in weekly Arizona Collaboration and Information Team meetings, which include executive team members and is designed to align business strategies and operations to support integration. Through participation in these meetings, the Tribal Coordinator is updated on Contractor concerns and has the opportunity to escalate issues, as appropriate.

Trends in barriers to service delivery are addressed through our Quality Management Committee and Cultural Competency Committee, which are responsible for taking action to resolve barriers to care. Barrier busting strategies may include helping to connect tribes to telehealth and telemedicine to improve access to services; educating tribes, IHS, and staff on available services; expanding the provider network, and modifying MOUs or policies to promote care coordination.

Mercy Care takes steps to quickly resolve barriers to service delivery. For example, when we identified high crisis utilization for American Indian members, we conducted a series of meetings with two providers - Native American Connections and Community Bridges. As a result, Native American Connections agreed to deploy counseling staff to Community Bridges prior to the member's discharge from detox to engage with the member so that they were more likely to voluntarily enter Native American Connection's substance abuse residential treatment program. This strategy has reduced readmissions to Community Bridges' crisis detox and decreased crisis service utilization for American Indian members receiving substance use disorder (SUD) services through Native American Connections. Additionally, through our relationship with Native American Connections and in collaboration with federal detention centers, tribal members being released from jails and tribal detention centers with SUD needs are prioritized for admission, facilitating successful re-entry to the community.

Program Success: Building and Utilizing Technology Infrastructure

Mercy Care works closely with Tribal Nations to enhance their technology infrastructure to deliver PH and BH care services to American Indians. For example, we will collaborate with tribes, IHS, 638 Tribal Facilities, Arizona's state universities and other educational entities to use community investment dollars to fund telehealth capacity in tribal communities. We will continue to collaborate with AHCCCS, IHS, with 638 Tribal Facilities and specific programs within these entities to facilitate the secure sharing of member data through CareUnify, which is integrated with Health Current, the statewide Health Information Exchange.

Mercy Care also uses technology for language translation and interpretation services for members speaking American Indian languages. Additionally, we connect American Indian members to federal programs (such as Lifeline) through which they can receive a smart phone that can be programmed with phone numbers for their PCP, Care Manager, specialty and BH providers, peer support worker and Mercy Care's call-in line for tribal members.

Using Technology to Expand Access to Care

Although Mercy Care provides counseling and other BH services to residents of the San Lucy District, there is currently no tribal physical health (PH) care within the District. The nearest IHS hospital is in Sells, Arizona, located 116 miles away from the San Lucy District. To provide immediate PH services to residents of the San Lucy District, Mercy Care is working with the San Lucy District of the Tohono O'odham Nation to bring telehealth technology to the community through a partnership with Native Health, an FQHC and integrated health care in-network provider. Moving forward, we plan to collaborate with the Indian Health Service and Tohono O'odham Nation to expand on-site medical services to the community.

Summary

Based on our extensive experience working with the tribes, IHS, and other tribal entities in Arizona to develop innovative programs and identify and resolve barriers, Mercy Care is well-positioned to expand its work under the ACC Contract. We recognize that all AHCCCS members are entitled to assistance navigating the health care delivery system and we will provide this support to American Indian members to reduce fragmentation in care, increase member access to services and improve clinical outcomes.

18. Past Performance

Mercy Care identifies as a Category 1 Offeror. Since November 1985, Mercy Care has held an Acute Care contract with AHCCCS. As such, we expect that AHCCCS, in accordance with 42 CFR 438.66 and as stated in Question 18, will review the most recent Acute Care Operational Review (CYE16). Therefore, no additional submission is required for this response. AHCCCS will note that we have achieved excellent scores on operational reviews across all Contracts, including a 97 percent compliance rate for the Acute and ALTCS programs and a score of 99 percent compliance score for the Division of Developmental Disabilities program.

We also encourage AHCCCS to review the Operational Review for Mercy Maricopa Integrated Care, our affiliate. We are proud that Mercy Maricopa achieved an overall score of 97 percent compliance with AHCCCS' standards. Mercy Maricopa's outstanding performance demonstrates our commitment to excellence in service delivery and exemplifies our ability to be an excellent partner for the AHCCCS Complete Care program.

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January 24, 2018

Arizona Health Care Cost Containment System (AHCCCS)
701 East Jefferson, MD 5700
Phoenix, Arizona 85034

RE: AHCCCS Complete Care RFP# YH19-0001 – Oral Presentations Resumes – List of Participants

Listed below are the individuals who will be participating in the Oral Presentations on behalf of Mercy Care Plan. Resumes for each of these individuals have been combined and can be found on the following pages.

- **Suzanne Buhrow**
- **Tad D. Gary**
- **Karrie Steving**
- **David Vargas**
- **Patricia Weidman**
- **Charlton Alan Wilson**

Sincerely,

Shareé Perry
Senior Project Manager

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Suzanne Morse Buhrow

MM Administrator / Vice President of Medical Management

CURRENT RESPONSIBILITIES

Supports Mercy Care's Medical Management operations by recommending appropriate actions, strategies and/or alternatives to meet business needs. Has responsibility for leading/managing all aspects of the program such as planning, coordination, development, implementation including the financial implications while prioritizing work, resources and time. Ensures the end state of the program and/or business operations meets business objective(s) and that all deliverables and due dates are met. Highly collaborative process often requires managing relationships across the segments or multiple functional areas.

PROFESSIONAL SUMMARY

Senior executive with 30+ years in health care administration including strategic planning, new program development, surgical and medical service line administration, change management, mentorship, staff development, patient care delivery redesign, financial and clinical outcomes analysis, revenue cycle management, provider productivity, physician and stakeholder engagement, service integration, team building, human resource management, performance/process improvement and patient safety expert.

CORPORATE EXPERIENCE

Mercy Care, 2015 – Present

Vice President of Medical Management, 2015 – Present

- Responsible for the administration and management of Prior Authorization, Utilization Management, Integrated Care Management, and Medical Management Operation with oversight and coordination of the following activities:
  - Evaluating MM activities specified in the AMPM Chapter 1000 for each medical management function or activity
  - Ensure adoption and consistent application of appropriate medical necessity criteria.
  - Development and adoption of evidence-based clinical practice guidelines [42 CFR 438.236(b)].
  - Conduct appropriate concurrent review and proactive discharge planning.
  - Monitor, analyze and implement interventions based on utilization data; identify and correct under and over-utilization of services [42 CFR 438-240(b)(3)].
  - Development and implementation of processes that ensure that providers are informed of all clinical information the plan may have regarding their performance while participating in the MC Patient Centered Medical Home (PCMH) or Patient Centered Clinical Care Home (PCCCH) models of care delivery.
  - Review general utilization data information on members and providers including services utilized the costs of those services and outcomes on data based on interventions.
  - Review and recommend approval, revisions or denial of criteria utilized in determining medical necessity of services for members and the criteria is based upon nationally recognized standards of care, when available.
  - The monitoring and evaluation of over- and under-utilization of services by members and providers.
  - The development and implementation of any interventions/ actions taken as a result of the variances.
  - The review of pharmacy utilization data by member, provider, and drug and the development of interventions based on the data to include the evaluation of the effectiveness of any interventions and the reporting those outcomes.
  - The review of utilization trends and variances by the core data set utilized to review the key metrics of

Mercy Care.
- Assessment of new technologies and new applications of existing technology and send recommendations to the Technology Assessment Committee at Aetna.
- The review, approval and dissemination of Clinical Practice Guidelines.
- The review and evaluation of the Disease Management / Chronic Care Program including outcomes of the program and modifying interventions based on the evaluation.
- The review utilization reports from delegated entities and report findings to the Interdepartmental MM committee, the delegated oversight committee and the MM committee.
- The review and approval, denial, or recommended revisions to existing policies related to MM/UM management.
- The review and evaluation of medical decisions to assure they comply with all coverage criteria.
- The consistent application of criteria used in making service determinations.

Banner Health

Senior Director- Inpatient Clinical Performance Assessment & Improvement (Quality Management), 2014 – 2016

- Responsible for driving and supporting clinical performance assessment and improvement programs, with a focus on quality of outcomes and superior service for 18 medical centers across the Banner system. Served as the primary advisor to the organization's senior leadership on matters related to clinical performance and identifying opportunities for improvement. Monitored compliance of customer service, stakeholder relations, workforce, and financial goals and objectives developed by the Board of Directors and senior executive management.
- Developed system-wide Quality Council structure and reporting schedule to align with CMS QAPI, tJC PI Chapter, and Banner's Quality and Safety Plan.
- Collaborated with facility C-Suites and Chief Medical Officers to identify opportunities for improvement to meet national quality measure and strategic initiative targets.
- Collaborated with Clinical Informatics, Analytics, and Abstraction leaders for EHR clinical decision support needs, identifying process and outcome metrics, developing executive dashboards and performance scorecards. Established performance targets for all facilities based on national benchmarks.

Buhrow & Ross Consulting, PLLC

President – Practice Management, Performance Improvement, and Patient Safety Consultants, 2009 – 2014

- Patient safety and performance improvement educator, researcher, author, and national speaker.
- Consulted with physician leaders and practice administrators on strategic planning, building strong teams, improving communication, and establishing a culture of safety.
- Administration of AHRQ patient safety and performance improvement culture surveys.
- Analysis of survey results and development of customized TeamSTEPPS™ training program for office-based surgeons and staff.
- Author of Commission on Dental Accreditation Initial application, self-study, and curriculum for Banner Good Samaritan Medical Center and Midwestern University Oral and Maxillofacial Surgery Residency program. Facilitation of successful site visits, faculty recruitment, and clinical rotations to meet accreditation requirements.
- Started the first IHI Open School Chapter for an advanced dental specialty residency program. Served as faculty advisor and member of IHI Open School GME interest group.
- Peer-reviewer - Journal of Patient Safety, American Journal of Nursing
- Academic Editor and Editorial Board – Medicine

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Suzanne Morse Buhrow

MM Administrator / Vice President of Medical Management

- National speaker- American Association of Oral and Maxillofacial Surgeons, Japanese and Korean Societies of Oral and Maxillofacial Surgeons' Annual Meeting: Primum non Nocere: Promoting a Culture of Safety in Oral and Maxillofacial Surgery.

Scottsdale Healthcare
Per Diem RN Case Manager, 2009 – 2013

- Per Diem Case Manager while pursuing doctoral degree.
- Utilization management, concurrent review for all SHC facilities and departments.

Buhrow, Gillis, & Sabol, PLLC
Practice Administrator, 2000 – 2009

- Established the largest board-certified OMFS group practice in metropolitan Phoenix.
- Increased provider productivity and significantly reduced overhead spending resulting in a highly profitable private practice.
- Reduced revenue cycle from >120 days to less than 30 days.
- Implemented EHR, practice management software, electronic claims system, and created documentation templates to reduce claim denials.
- Negotiated payer, provider, and affiliation contracts.
- Recruited diverse surgical specialists and industry leaders to create a full-service adult and pediatric practice.
- Exclusive Level 1 Trauma contracts at all major medical centers in Phoenix.
- Robust marketing and customer service strategies to improve patient satisfaction and perpetuate a large local and national referral base.

St. Elizabeth's Medical Center
Director, Patient Care Services- Surgical Service Line, 1997 – 2000

- Responsible for clinical and financial management of the surgical service line with over 150 direct reports.
- Designed and implemented new clinical programs to improve efficiency and provide effective and accessible patient care.
- Partnered with physician leaders and stakeholders to improve the quality of care, patient satisfaction, and clinical outcomes.
- Clinical areas included: Neurosciences, Neuroscience ICU, SICU, PACU, Orthopedics, General Surgery, Cardiothoracic Surgery, Vascular Surgery, CT Step-down Unit, Urology, Pre-admission testing.

Director, Patient Care Services- Medical Service Line, 1995 – 1997

- Successfully implemented a nationally recognized academic Neuroscience program.
- Expansion of Hematology-Oncology outpatient services to minimize inpatient utilization in this population.
- Created a short-stay observation unit to reduce length of stay and utilization of acute inpatient beds for 23-hour admissions.
- Implemented a cost-effective patient care redesign and skill mix model to maximize the professional RN role and patient engagement.
- Integrated Care MapTM clinical pathways across the service line to reduce length of stay, increase quality of care, and improve outcomes.
- Clinical areas included: Neurosciences, Urology, Hematology-Oncology Services, Geriatric Psychiatry, and Short-stay/Observation.

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Suzanne Morse Buhrow

MM Administrator / Vice President of Medical Management

Nurse Manager, Neurology/Urology/General Surgery/GYN, 1992 – 1995

- Collaborated with physician leaders in four medical and surgical specialties to meet departmental needs and academic program objectives.
- Downsizing of multiple surgical specialties and transition to outpatient services.
- Cross training of nursing staff to meet clinical needs of diverse patient population and maximize human resources.

Administrative Director, Nursing, 1985 - 1992

- Provided on-site administrative and clinical leadership in an academic medical center
- House nursing supervisor, all clinical areas.

SICU Charge Nurse, 1980 – 1985

- Cardiothoracic, Neurosurgical, Trauma, Vascular, and General Surgery Critical Care

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

Doctor of Health Administration

University of Phoenix, 2013

MS in Health Care Administration

Salve Regina University, Newport, RI, 1985

B.S.

University of Massachusetts, Dartmouth, MA

A.S.N.

Lasell College, Newton, MA

Licenses

- Arizona State Board of Nursing #RN113583

Certifications

- CITI Research/Ethical Human Subject Protection #11997465 (2010-present)
- NIH: Protecting Human Research Participants #1380569 (2014-present)

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Tad D. Gary

Chief Operating Officer

CURRENT RESPONSIBILITIES

Works with the CEO to provide day-to-day leadership, management and oversight of Mercy Care's operations.

PROFESSIONAL SUMMARY

- Experienced and effective healthcare leader
- Demonstrated ability to participate effectively in an interdisciplinary team environment
- Outstanding problem solving and conflict resolution skills
- Proven leadership skills
- Excellent written and verbal communication skills
- Effective program development and implementation skills
- Training and experienced in finance and accounting
- Certification as a rehabilitation counselor (C.R.C.) and licensed as a professional counselor (L.P.C.) in the State of Arizona

CORPORATE EXPERIENCE

Mercy Care, 2014 – Present

Chief Operating Officer, 2017 – Present

- Have specific oversight responsibilities for call center operations, grievance and appeals, systems of care, including housing and employment, and other operational areas that serve over 900,000 covered members.
- Provides timely, accurate, and complete reports on Mercy Care's operating condition.
- Develops policies and procedures for assigned areas, ensuring that other impacted areas, as appropriate, reviews new and changed policies.
- Develop and implement strategic and tactical plans to ensure growth and development of the organization and ensure positive financial results.
- Develop and establish operational mission statements, philosophy, policies, goals, objectives and strategy.
- Actively monitor legislative and political developments affecting the organization.
- Establish and maintain ongoing relationships with key agencies, providers, physicians, hospitals, advocacy groups and State officials

Chief Clinical Officer, 2013 – 2017

- Management of multiple departments, overseeing the majority of the behavioral health service delivery system across Maricopa County and parts of Pinal County for over 900,000 covered members. Responsible for clinical program development and oversight, including the Adult and Children's Systems of Care and the Maricopa County Behavioral Health Crisis System. Other responsible areas include, Integrated Care, Individual and Family Affairs, Clinical Operations, Cultural Diversity, Tribal Affairs and overall initiatives, strategies, and programs to address social determinants of health (housing, employment and etc).

Mercy Care, 2006 - 2014

Vice President, Integrated Care Management, 2011 – 2014

Director, Integrated Care Management, 2010 – 2011

- Direct the activities of a large department that includes functions related to behavioral health and complex case management. Work to enhance the quality of care and services provided to members by pursuing

opportunities to improve care coordination, integration, communication and use of resources within and across departments, as well as among the MCP provider network. Serve as technical, professional and business resource regarding integrated care, case management and behavioral health. Responsible to maintain positive inter- and intra-departmental relationships. Analyze and report department performance data. Develop policies and procedures. Recruitment and evaluation of staff. Assure department compliance with State and Federal regulatory requirements. Member of the Quality Management/Utilization Management Committee, Policy Committee, Medicare Joint Operating Committee, and the Quality Improvement Committee.

Clinical Services Manager, Behavioral Health Department, 2010 – 2010

- Responsible for all day-to-day operations of behavioral health functions for all MCP lines of business. Responsible for recruitment of behavioral health staff. Ongoing consultation and clinical supervision of staff. Develop and monitor behavioral health policies and procedures. Clinical and operational interface with behavioral health provider organizations. Oversee annual Organization Financial Review and CMS audit for all behavioral health standards and regulations. Participated in efforts to integrate behavioral and physical health services to improve healthcare outcomes.

Behavioral Health Coordinator, 2008 – 2010

- Facilitate and monitor referrals for behavioral health services. Function as a liaison between MCP providers and behavioral health agencies throughout the state. Provide education and direction to internal staff and providers regarding behavioral health disorders and services available to members. Review appeals for inpatient psychiatric hospitalization services. Work closely with behavioral health utilization department to address system improvements and concerns. Audited Primary Care Physicians' medical records to ensure best practice standards are being met for the diagnosis and treatment of depression, anxiety, ADHD, as well as coordination of care. In addition, audited behavioral health programs to ensure quality member care, as well as monitor corrective action plans that address clinical deficiencies.

Senior Care Manager, 2006 – 2008

- Managed a caseload of high acuity behavioral health members who had a diagnosis of a serious mental illness, as well as a range of chronic medical conditions. Utilized clinical skills in a collaborative process to assess, plan, implement, coordinate and evaluate options and services to facilitate positive outcomes for assigned members. Coordinated care with a range of service providers, such as physicians, nurses, residential staff, rehabilitation providers, psychotherapists, various hospital staff and etc. Conducted crisis assessments to determine level of care required to ensure the safety of members. Acted as a consultant to general case managers, as well as RN case managers, who have members presenting with behavioral health concerns. Assisted in the mentoring and training of new case managers.

State of Arizona, Rehabilitation Services Administration (RSA), 1999 - 2006

Unit Supervisor, 2003 – 2006

- Managed an office of vocational rehabilitation counselors (VRCs) and support staff that serviced over 750 consumers diagnosed with a serious mental illness and other co-occurring disabilities. Interpreted and applied regulations and policies to operations of the unit and service provisions. Supervised the allocation of funds to VRCs' caseloads, averaging a total of $1 million a year for the unit. Assisted with oversight and problem resolution relating to the Interagency Services Agreement (ISA) between the Arizona Department of Health Services (ADHS) and RSA. Participated in the ADHS/ValueOptions mentoring teams. Worked in partnership with ValueOptions Rehabilitation Department, rehabilitation service providers, and other RSA staff members to ensure the delivery of quality services for consumers. Assisted with state-wide trainings to

various Vocational Rehabilitation (VR) staff members, rehabilitation providers and community members. Conducted statewide case reviews in partnership with other state and federal staff members. Managed a caseload of individuals diagnosed with serious mental illness. Provided intensive counseling-related activities that included adjustment to disability counseling, symptom management, vocational counseling and other activities necessary for consumers to progress in their rehabilitation/recovery. Conducted assessments of consumers' abilities and vocational readiness to promote consumer success.

Program Representative, 2001 – 2003

- Assisted with the development and implementation of a VR program that serviced consumers civilly and forensically admitted to Arizona State Hospital (ASH). VR liaison between ASH and VR counselors in various geographical areas throughout the state of Arizona. Managed a caseload of individuals from Maricopa County admitted to ASH or transitioning from ASH, as well as consumers who had extensive involvement with the criminal justice system and/or chronically homeless. Provided training to various rehabilitation facilities on psychosocial rehabilitation. Assisted with the development and implementation of a training curriculum for ValueOptions' "New Employee Orientation" on VR as it relates to Maricopa County. Member of the executive committee for "Partners in Employment" conference. Developed policy for working with individuals who had sexual offenses that was implemented statewide. Provided training and consultation to VR staff relating to working with those who had sexual offenses. Additional job responsibilities as listed below under Vocational Rehabilitation Counselor III.

Vocational Rehabilitation Counselor III, 1999 – 2001

- Managed and oversaw caseload of individuals diagnosed with serious mental illness and other co-occurring disorders, such as substance abuse/dependence and/or various physical disabilities. Provided intensive counseling-related activities that included adjustment to disability counseling, symptom management, vocational counseling and other activities necessary for consumers to progress in their rehabilitation/recovery. Conducted assessments of consumers' abilities and vocational readiness to promote consumer success. Provided vocational consultations to ValueOptions' clinical teams, other rehabilitation providers and the general public. Prepared consumers to re-enter the job market through utilization of vocational adjustment, academic training, job development, job placement and supported employment. Mentored new counselors in VR policy and procedures, counseling skills and best practices. Assisted with vacant caseloads of consumers with various disabilities, such as back injuries, neurological impairments, respiratory disorders and etc. Member of the statewide Counselor Advisory Committee (2000-2003).

EMPACT-SPC

Crisis Therapist, 1998 – 2001 and 2002 – 2003 (PT)

- Provided brief, intensive, solution-focused counseling to individuals, couples and families. Conducted crisis assessments to determine level of care for individuals. Developed safety plans that allowed for community stabilization of individuals presenting as danger to self (DTS) or danger to others (DTO). Assisted individuals and families that were in crisis with obtaining additional community resources. Provided behavior management consultation to parents, schools and various other agencies. Conducted Critical Incident Stress Debriefings within the community. Assisted with answering EMPACT-SPC crisis hotline on an as-needed basis. Assisted with the training of new crisis therapists.

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

M.A., Rehabilitation Counseling

mercy care

Tad D. Gary

Chief Operating Officer

University of Arizona, Tucson, AZ

M.Ed., Special Education
Southeastern Louisiana University, Hammond, LA

B.S., Psychology

Northern Arizona University, Flagstaff, AZ

Licenses

- Licensed Professional Counselor (LPC, Arizona)

Certifications

- Certified Rehabilitation Counselor (CRC, national)

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Karrie Steving

Children's System of Care Administrator / DIR, BUS PROJ PROG MGMT

CURRENT RESPONSIBILITIES

- Oversight of the Children's System of Care for Mercy Care (CSoC), inclusive of all behavioral health service delivery for children and transition age youth
- Oversee the development and implementation of community support programs and processes that ensure the needs of children and families of the RBHA are met
- Serves as key liaision to State agencies including child welfare, juvenile corrections, juvenile detention systems, and other child-serving agencies, children's system of care governance and the wrap around agencies to outline goals and ensures programs developed reflect the goals and values of the CSoC as well as all Federal and State regulations and contractual requirements

PROFESSIONAL SUMMARY

Karrie Steving, serves as the Children's System of Care Administrator for Mercy Care, the Regional Behavioral Health Authority in Maricopa County. She is responsible for the oversight of the Children's System of Care in Maricopa County and a portion of Pinal County.

Karrie Steving has worked for over twenty years designing and leading effective programs that apply best practices to key areas in the behavioral health system. Karrie worked with many diverse agencies to develop collaborative systems, such as, juvenile detention and probation, developmental disabilities, child welfare and State Hospitals.

CORPORATE EXPERIENCE

Mercy Care, 2014 – Present

RBHA Children's System Administrator, 2014 – Present

- Collaborates with child welfare, juvenile corrections, juvenile detention systems, and other child-serving agencies, as well as internal teams to ensure coordination of efforts.
- Oversees the children's system service delivery system consistent with the Arizona Vision – Twelve Principles for Children Service Delivery.
- Oversees the design and implementation of the behavioral health delivery programs to ensure the needs of children and their families in the behavioral health system are met.
- Ensures collaboration with child welfare agencies and the juvenile justice system.
- Coordinates with members of various State agencies to ensure that programs developed reflect the goals and values of the CSoC.
- Develops and implements practice adjustments and policy and procedure revisions.
- Provides training and support in an effort to provide continuous improvement in serving children and families
- Coordinates the assimilation of measures with continuous quality improvement efforts at the provider and network levels.
- Establishes a positive organization and company image within the Arizona health care community.
- Participates in shaping the Arizona behavioral health system of care and resolving issues and challenges identified.
- Establishes and maintains on-going relationships with community organizations and contract stakeholders.
- Ensures that the behavioral health care needs of members are well served.

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Karrie Steving

Children's System of Care Administrator / DIR, BUS PROJ PROG MGMT

- Establishes and maintains ongoing relationships with key agencies, providers, physicians, hospitals, advocacy groups and State officials.

Child & Family Support Services
Practice Improvement Director, 2010 – 2014

- Managed and oversaw all initiatives and reporting specific to practice improvement processes and oversight including:
  - Responsible for the development and implementation of practive improvement strategies in each geographic area
  - Represent the agency and participate in designated System Meetings
  - Wrote, implemented and continually monitor Practive Improvement Plans for each geographical area
  - Consult with supervisory and direct staff regarding Child and Family Team practices and service planning

Piurek & Associates
Senior Consultant, 2005 – 2010

- Provided management consulting services to profit, non-profit and governmental entities including:
  - Consult with supervisor and direct service staff regarding effective behavioral health assessment and treatment planning
  - Design, develop and implement project management initiatives to achieve organizational goals and support administrative structures
  - Facilitate strategic planning and group work sessions
  - Assist with network development strategies and other managed care initiatives
  - Perform organizational assessments to identify areas for streamlining operations and supporting program objectives
  - Develop tools to support operational and program functioning including policies and procedures, workflows and documentation guidelines
  - Perform clinical record reviews and identify recommendations for enhancement at a staff and agency level

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

B.S., Psychology
University of Arizona, Tucson, Arizona

mercy care

David Vargas

Director of Operations

CURRENT RESPONSIBILITIES

Maintains oversight of functions in multiple service centers, including claim payments, claim rework, member or provider inquiries, billing, enrollment, accounts receivable, and/or implementation services. Executes strategic and operational plans in support of business segment customer services objectives and initiatives. Sets business area priorities, allocates resources and develops plans for multiple related teams. Ensures all critical service metrics and operational results are achieved. Leads multiple managers, highly specialized professional staff or significant outsourced operations.

PROFESSIONAL SUMMARY

Health Care Administration professional with over 21 years of experience. Professional, creative, flexible with proven analytical skills. Proven leader with experience working across functional areas managing complex projects and changes.

CORPORATE EXPERIENCE

Mercy Care, 2010 – Present

Director of Operations, 2017 – Present

- Oversees operating systems including policies and procedures, operating structure, and information flow across multiple service centers.
- Directs implementation of service standards for each location to ensure delivery of quality-focused, consistent cost effective service and administration.
- Analyzes operational practices for effectiveness and practicality, while creating a culture which is innovative in its approach to solutions.
- Establishes a clear vision aligned with company values; sets specific challenging and achievable objectives and action plans; motivates others to balance customer needs, budgets, and business success.
- Effectively and proactively manages to budget, analyzing and acting upon financial variances from plan by identifying additional cost saving strategies.
- Leads and builds high performance teams across units by providing leadership, mentoring and coaching in achieving understanding of the voice of the customer.
- Monitors and evaluates service center operational plans ensuring customer service standards are maintained during facility shutdowns (anticipated or unanticipated) and during business activity transfers between locations. Coordinates major plan modifications necessitated by unanticipated business or technology developments.
- Develops and implements business strategies to provide accurate and proactive customer service to members, plan sponsors and brokers aligned to service center. Provides operational support for market management of plan sponsors, members and network providers.
- Ensures compliance outcomes are included in all plans and goals.

Senior Project Manager, 2010 – 2017

- Supported the business by recommending appropriate actions, strategies and/or alternatives to meet business needs. Had responsibility for leading/managing all aspects of a project and or program such as planning, coordination, development, implementation including the financial implications while prioritizing work, resources and time.
- Ensured the end state of the project and/or business operations met business objective(s) and that all

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David Vargas

Director of Operations

deliverables and due dates were met. Highly collaborative process often required managing relationships across the segments or multiple functional areas.

Schaller Anderson, 2010 – 2016
Claim Auditor, 2010 – 2016

- Served the Audit Committee of the Board of Directors and assisted management in achieving Aetna's goals by conducting independent and objective assurance and consulting activities.
- Financial reporting, compliance, system development, fraud prevention, operational controls, and policies & procedures were analyzed consistent with the Institute of Internal Auditor's standards to evaluate and improve the effectiveness of risk management, control and governance processes, and to add value to business operations.

Paradigm Health Corporation, 2002 – 2016
Claim Auditor, 2012 – 2016

Claim Analyst, 1996 – 2002

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

- **B.A.,** English, University of California, Los Angeles
- **B.A.,** History, University of California, Los Angeles

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Patricia J. Weidman

Director, Provider Relations

CURRENT RESPONSIBILITIES

Oversee a team of 41 provider relations staff, one supervisor, and five managers that provide training and education to over 22,000 network and non-network health care providers throughout Arizona and other locations where members may have received treatment for Mercy Care.

PROFESSIONAL SUMMARY

Innovative and strategic program manager with a verifiable record of achievement in conceptualizing, developing, and managing diverse healthcare initiatives. Leverage business acumen, operations management, and insurance industry expertise to devise high-impact strategies that exceed expectations. Serve as a collaborative partner to interdisciplinary teams; drive participation and facilitate goal attainment. Create operational efficiencies and reengineer processes to yield cost containment, fuel productivity and profitability. Build and lead high-performing teams that maintain accountability for results.

CORPORATE EXPERIENCE

Mercy Care, 2013 – Present
Director, Provider Relations, 2013 – Present

- Maintain contract compliance for both Medicare and Medicaid contracts regarding Provider Relations and Network activities and ensure that providers receive accurate and timely responses to inquiries and concerns, track and trend provider inquiries/complaints/request for information, identify systemic issues and problem solution
- Monitor network compliance and appointment availability; assist with Provider Communications, including: Provider Manual, Newsletters, Notifications, Web Portal and Website content, etc.
- Assist and monitor Network Development, Network Adequecy, and Network Sufficiency to ensure adequent provider network and identify and network gaps
- Developed a comprehensive business plan for a non-profit organization, including: financial feasibility, market opportunities and strategies, business and operations requirements, policies and procedures, government health plan regulations, network contracting, and staffing needs. Instrumental with start-up implementation and staff hiring, training, and development. Created business acumen for Quality Assurance and Outcome Measures Monitoring, Compliance, and Reporting

Self- Employed, 2012 – 2013
Professional Healthcare Consultant

- Developed a comprehensive business plan for non-profit organization, including: financial feasibility, market opportunities and strategies, business and operations requirements, policies and procedures, government health plan regulations, network contracting, and staffing needs. Instrumental with start-up implementation and staff hiring, training, and development. Created business acumen for Quality Assurance and Outcome Measures Monitoring, Compliance, and Reporting.

Phoenix Children's Hospital, 2011 – 2012
Director, Managed Care Contracting

- Oversaw all contracting and operational activities within the Managed Care and Provider Enrollment Departments.
    - Conducted and initiated contract discussions with managed care entities and other health care service

providers and/or organizations.
- Managed contract negotiators to ensure that contract language and rate negotiations were in accordance with business and negotiation strategies; Ensured all contracts could be administered cost-effectively.
- Facilitated problem solving of operational issues through collaboration and managed care organizations.
- Restructured Provider Enrollment Department to work more efficiency, established clear definitions for accountability, and orchestrated hospital's move to establish Delegated Credentialing contracts with health plans to reduce claims denials by 20%.
- Spearheaded and collaborated with key hospital leaders on several process improvement initiatives, including: provider onboarding process, urgent care expansions, and physician integration.

Arizona Hospital and Healthcare Association, 2008 – 2011
Director, Workforce & Staffing

- Directed registry and recruitment partners programs; managed a $3 million operating budget; monitored expenses and analyzed financial performance. Hired, trained, and managed five program specialists. Developed and maintained key relationships, and strategic partnerships with senior hospital and agency staff. Partnered with legal team and hospital personnel to develop program criteria, contract requirements, compliance regulations, request for proposal (RFP) process for agencies, audit requirements, and performance targets.
  - Oversaw quality supplemental staffing program; administered contracts with 150 staffing agencies and 40 hospitals; conducted annual quality compliance audits.
  - Developed online training manual that equipped hospitals and agencies to be self-sufficient, reducing the need for customer support, and enabling the program to focus on quality and compliance initiatives.
  - Analyzed agency performance, provided feedback to hospitals through periodic reporting, and conducted monthly conference calls with hospitals and agencies to improve communication.
  - Administered penalties and sanctions policies for failure to meet contract requirements, which reduced administration by 85%, improved productivity, and generated revenue.
  - Improved and standardized internal processes, reallocated staffing resources, reduced travel expenses by 85%, developed process improvement protocols and communication plans to enhance customer service, and created database to track affiliated and unaffiliated healthcare providers.

Cenpatico of Arizona (Centene Corporation), 2005 – 2008
Provider Services & Contracting Administrator

- Contributed to the implementation team that transitioned behavioral health recipients as part of the newly acquired regional behavioral health authority (RBHA) contract for the state of Arizona. Developed a provider relations department; hired, trained, and managed a 10-person staff. Managed provider credentialing and negotiated managed care contracts with hospitals, inpatient and outpatient providers. Served as primary contact for state reporting and provider audits. Key contributions include:
  - Developed provider communication tools, including: provider manual, quick reference quides, provider newsletters, provider notifications
  - Maintained contract compliance and Appointment Availability Audits
  - Prepared and executed annual network development and cultural competency plans in accordance with state performance reporting and contract requirements.
  - Established network and managed provider relations for RBHA in 4 counties and for Bridgeway Health

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Patricia J. Weidman

Director, Provider Relations

Solutions, a long-term care plan for Medicaid recipients in 3 three counties.
- Reduced operating expenses by 65% through a reduction in staff and travel expenses.
- Responsible for Network Development, Network Sufficiency and Network Adequacy.

UnitedHealth Group / Evercare of Arizona, 1998 – 2005
Provider Services and Operations Manager

- Established and managed start-up operations to provide insurance products and healthcare benefits to Medicare and Medicaid long-term care clients. Directed enrollment, claims, grievance and appeals, and provider relations department; hired and trained staff and administered operating budgets. Developed and maintained a provider network; conducted credentialing, training, implemented and managed all provider contracts, including: Medicare and Medicaid, hospitals, and ancillary; Participated in cross-functional team lead meetings. Key contributions include:
  - Established and administered business model, operational processes, and procedures for 100,000 Medicaid and Medicare recipients.
  - Redesigned infrastructure and developed process improvement plans, including instituting a virtual office set up to enhance work flow efficiency in response to two downsizing initiatives. Transitioned 50 case managers, which yielded $100,000 cost savings, and improved employee satisfaction by 85%.
  - Reorganized grievance and appeals department; implemented process improvement enhancements and developed quality initiatives that exceeded expectations and reduced grievances by 50%.

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

B.S., Business Administration
University of Phoenix, Phoenix, AZ

Licenses
- Arizona State Licensed Practical Nurse

Certifications
- Paralegal, American Institute
- 91C-Clinical Health Specialist / Practical Nurse, U.S. Army

mercy care

Charlton Wilson

Medical Director/CMO

CURRENT RESPONSIBILITIES

Provide senior leadership for Mercy Care which is an Arizona-based, non-profit health plan that manages care and improves quality for members with Medicaid, Medicare Advantage, Long-term care, and other related benefits.

PROFESSIONAL SUMMARY

A respected physician executive, board certified in both internal medicine and healthcare management, with a record of success in achieving strategic, operational, financial, and clinical quality outcomes in highly competitive managed care markets on behalf of not-for-profit and for-profit organizations. Leading and motivating people from all skills and professions in complex ambulatory and hospital settings in manner that improves employee engagement, fosters retention, and improves the quality of healthcare and health outcomes for the people we have served. Fostering innovation and research in complex public-sector healthcare systems which have improved the ability to achieve the objectives of Medicare, Medicaid, and Indian Health Service programs. Bringing together multiple stakeholders and building sustainable programs for the benefit of high-risk, high-needs populations in our community.

CORPORATE EXPERIENCE

Mercy Care, 2010 – Present
Medical Director/CMO, 2010 – Present

- Account for all clinical performance measurement, quality of care, quality improvement, member and provider complaints, credentialing, adverse actions, and fair hearing processes in a manner that brought consistency, fairness, and resolution, while increasing the respect for the plan among community physicians.
- Directed, designed, and improved clinical programs for utilization and prior authorization management, clinical and non-clinical case management, discharge planning, and quality improvement across the entire network. The efforts reduced hospitalizations by 4%, readmissions by 30%, and increased member access to preventive and specialty services. Worked with providers, vendors, and finance to assure accurate capture of CMS-HCC data.
- Maintained top-tier quality ranking among peer health plans through achievement of high performance in and improvements of HEDIS, CMS Star, and other State-directed performance measurement processes.
- Implemented new information systems for utilization and case management. Directed multidisciplinary teams through workflow process redesign in a manner that improved efficiency by 30%.
- Directed strategic priorities including Value-based Purchasing initiatives such as Patient-Centered Medical Home contracting and development of Accountable Care Organization shared-savings models.
- Contributed to tactical and strategic network development as well as individual contracting initiatives.
- Contributed critical leadership that resulted in winning and implementing a new affiliated business (Maricopa Integrated Regional Behavioral Health Authority) and created an integrated behavioral-physical health plan for people with serious mental illness
- Accountable to both the Mercy Care Board of Directors as well as to national Aetna Medicaid Administrators corporate leadership. Supported all aspects of management and committees which required a sound understanding of both not-for-profit and for-profit business practices and regulations
- Full responsibility for compliance with all utilization and quality management standards achieving near perfect scores in operational reviews by the State and achieved highly successful outcomes of the CMS

audits of Advantage programs.
- Full responsibility for internal (corporate) and external (community practices and physicians) communication regarding all aspects of plan performance

U.S. Public Health Service (USPHS), Indian Health Service (IHS)
Commissioned Officer, 1990 – 2010

- As a ***Commissioned Officer***, provided service and leadership in this $4 Billion public Agency that delivers acute/chronic healthcare services for over 2 Million beneficiaries.
- Awarded USPHS Medals for excellence in clinical care and research efforts and over a 20 year career, continued clinical practice as a highly regarded primary care clinician with expertise in diabetes, HIV and other chronic diseases
- Attained rank of Captain (0-6) with an exceptional capability promotion
- As a national IHS consultant, travelled throughout the United States to develop and strengthen disease management and performance measurement programs which were recognized for improving quality and reducing costs. Designed, implemented, and improved specialty services for people affected by HIV, diabetes and cancer in a manner that resulted in sustained clinical improvements
- Held senior leadership positions at the Phoenix Indian Medical Center, the largest and "most visible" IHS facility. As Chief Executive Officer (interim), and Chief Operating Officer, was fully responsible for Joint Commission accreditation, a $140 Million annual operating budget, and direction for 1,000 employees. Programs delivered over 300,000 visits annually. Inpatient and outpatient services ranged from obstetrical to intensive care units and prevention outreach through oncology services
- Fully accountable to Federal and State regulatory agencies, such as DHHS, IHS, CMS and AHCCCS, for operational and financial compliance and outcomes
- Delivered comprehensive rural health as a physician and Clinical Director of the Mescalero Indian Hospital, Mescalero, New Mexico. This is a small acute care hospital and ambulatory facility serving people in remote southern New Mexico
- Recognized by peers for expertise in Hospital Incident Command management and for support of the emergency preparedness activities of the USPHS
- Authored over 40 peer-reviewed journal articles and book chapters, and delivered numerous lectures, newspaper, radio and television media segments. Collaborated with the National Institutes of Health on major research programs including the landmark Diabetes Prevention Program
- Managed public health monitoring and coordination with States and Counties

The John Hopkins Hospital, The John Hopkins University
Chief Resident and Faculty Member, 1989 – 1990

- Selected for a highly competitive, one-year position as ***Chief Resident and faculty member*** at this world-renowned major academic medical center in Baltimore, Maryland.
- Assistant Chief of Service, Attending Physician, and Instructor of Medicine

ACADEMIC BACKGROUND AND PROFESSIONAL CERTIFICATIONS

M.D.
University of Texas Health Science Center, Houston, Texas

B.A., History
Texas Agricultural and Mechanical University, College Station, Texas, *cum laude*

mercy care

Charlton Wilson

Medical Director/CMO

Licenses

- Active Licenses in Arizona and New Mexico

Certifications

- Board Certified, American Board of Internal Medicine
- Board Certified, Board of Governors, American College of Healthcare Executives
- Certified Health Insurance Executive, America's Health Insurance Plans

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.

Mercy Care	
Company Name	Signature of Person Authorized to Sign
4350 E. Cotton Center Blvd., Bldg. D	Mark Fisher
Address	Printed Name
Phoenix AZ 85040	President and CEO
City State Zip	Title

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: Mercy Care

Affiliated Organization Name: Mercy Maricopa Integrated Care

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.

Mercy Care	
Company Name	Signature of Person Authorized to Sign
4350 E. Cotton Center Blvd., Bldg D	Mark Fisher
Address	Printed Name
Phoenix AZ 85040	President and CEO
City State Zip	Title

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 Mercy Care (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.

Mercy Care	
Offeror Name	Signature of Person Authorized to Sign
4350 E. Cotton Center Blvd., Bldg D	Mark Fisher
Address	Printed Name
Phoenix AZ 85040	President and CEO
City State Zip	Title