Arizona Health Care Cost Containment System Administration (AHCCCS) RFP #YH19-0001

January 25, 2018

CARE 1ST
HEALTH PLAN ARIZONA
A WellCare Company

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**
Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	**15**
Executive Summary and Disclosure		
Executive Summary	RFP Section H, Instructions to Offerors	**33**
Moral or Religious Objections	RFP Section H, Instructions to Offerors	**36**
Narrative Submission Requirements		
1.	RFP Section I, Exhibit C	**37**
2.	RFP Section I, Exhibit C	**39**
3.	RFP Section I, Exhibit C	**46**
4.	RFP Section I, Exhibit C	**51**
5.	RFP Section I, Exhibit C	**58**
6.	RFP Section I, Exhibit C	**63**
7.	RFP Section I, Exhibit C	**68**
8.	RFP Section I, Exhibit C	**75**
9.	RFP Section I, Exhibit C	**80**
10.	RFP Section I, Exhibit C	**85**
11.	RFP Section I, Exhibit C	**90**
12.	RFP Section I, Exhibit C	**95**
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	**100**
14.	RFP Section I, Exhibit C	**105**
15.	RFP Section I, Exhibit C	**110**
16. A (North) *If applicable*	RFP Section I, Exhibit C	**115**
16. B (South) *If applicable*	RFP Section I, Exhibit C	**118**
17.	RFP Section I, Exhibit C	**121**
18.	RFP Section I, Exhibit C	**126**
Oral Presentations		
Names and Titles of Participating Individuals	RFP Section H, Instructions to Offerors	**127**
Resumes of Participating Individuals	RFP Section H, Instructions to Offerors	**128**
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit D Refer to Bidders' Library	**139**
Affiliated Organization Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	**140**
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	**141**

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

BID CHOICE FORM - PART 1

Care1st Health Plan Arizona, Inc. **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	1
☑	**North**: Mohave, Coconino, Apache, Navajo and Yavapai Counties	3
☑	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties	2

Authorized Signature — January 22, 2018 (Date)

Scott Cummings (Print Name) — President (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.**

Care1st Health Plan Arizona, Inc. **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 22, 2018 (Date)

Scott Cummings (Print Name) — President (Title)

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*)

57-1165217

Federal Employer Identification No.:

137133927

Dun and Bradstreet (DUN) No.

E-Mail Address: scummings@care1staz.com

Care1st Health Plan Arizona, Inc.

Company Name

2355 E Camelback Rd #300

Address

Phoenix, AZ 85016

City State Zip

For clarification of this offer, contact:

Name: Scott Cummings

Title: President

Phone: 602-778-1860

Signature of Person Authorized to Sign Offer

Scott Cummings

Printed Name

President

Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

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: Scott Cummings	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President	TITLE: Chief Procurement Officer
DATE: January 22, 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: Scott Cummings	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President	TITLE: Chief Procurement Officer
DATE: January 22, 2018	DATE:

Capitation Non-Benefit Costs Bid Submission pages 8-32.
Please see the Capitation Submission Folder

Executive Summary and Disclosure

CARE 1ST HEALTH PLAN ARIZONA
A WellCare Company

Executive Summary

CARE1ST: A COMMITTED PARTNER IN TRANSFORMATION, CLINICAL, AND OPERATIONAL EXCELLENCE

Care1st Health Plan Arizona, Inc. (Care1st) is proud to have served Arizona Medicaid members for nearly 15 years and looks forward to continuing our record of innovation and clinical and operational excellence through the AHCCCS Complete Care (ACC) Transformation. Our Care 1st leadership team President Scott Cummings, our COO Susan Cordier, and our CFO Deena Sigel, each have more than 11 years together leading a highly successful AHCCCS Health Plan. They have a deep understanding of what it takes to be successful in transforming to a new framework.

Care1st is backed by our new parent company, WellCare Healths Plan, Inc.which adds a breadth of capability to our programming through their deep experience in administering integrated contracts across a variety of geographies and diverse populations – from the remote Appalachian Mountains of Kentucky to the minority urban communities of Miami and across the country to the Hawiian Islands. With WellCare, we remain focused exclusively on government-funded health care programs – with every element of our operation having been designed specifically to serve members in programs like ACC. Today, WellCare operates in all 50 states serving 4.3 million Medicaid, Medicare and PDP members, including 2.7 million Medicaid members across 11 states.

WellCare offers a uniquely integrated model with all behavioral and physical health clinical activities and operations taking place under one company with no separate division or subcontractor. We also maintain clinical responsibillity for pharmacy services in our PBM relationship and offer a uniquely integrated approach to addressing social determinants with the award-winning CommUnity Impact Model. WellCare was recently named a Fortune Most Admired company, and recognized by Points of Light Foundation with "**The Civic 50**" award for being a leader in the healthcare industry and engaging in outstanding community service.

WellCare's 8,900 associates across the country, including 300 Care1st associates in Arizona, are guided by a simple mission: "***Our Members are our Reason for Being***."

Care1st brings a strong history in Arizona of partnership, innovation and operational and clinical success. ***Since 2012, Care1st's membership more than doubled, our provider network almost tripled, yet we have maintained top operational and quality outcomes, including a 15 percent decline in provider complaints and quality ratings within the top third of health plans over the past eight years.***

We have been on the cutting edge of addressing member social determinants of health with our investment in the Avondale Resource Center to provide a one-stop shop for members to access social service resources and other critical partnerships with organizations like Arizona Agency on Aging to help us locate difficult to find members and provide intensive coordination for those most in need. We have also implemented provider-facing tools and processes that keep us as a favored payer among providers with top rankings in provider satisfaction. Our hands-on, in-person provider engagement model with dedicated teams and workgroups designed to address provider issues in real-time and our approach to value-based payment strategies that drive provider innovation, quality and accountability, are just two key areas of experience that are particularly critical as we move toward the ACC implementation.

OUR HIGH-LEVEL APPROACH TO MEETING CONTRACT REQUIREMENTS

As a current contractor, we have consistently demonstrated our ability to meet and exceed contract requirements, and we are ready to do the same for new requirements of the ACC. At Care1st, we understand the vision of "putting the head back on the body." For the past 18 months, we have been preparing for integration, expanding our network, meeting with stakeholders, enhancing our already-integrated care model, recruiting and hiring staff, restructuring our organization and building key partnerships to innovate and enhance capabilities.

Preparing for the Transformation: We are ready to begin day 1 with a focused understanding of what needs to happen to support the goals of the ACC program, both internally and throughout the care delivery system. We have already established protocols for transition activities taken from successful transitions we've undertaken over the past several years transitioning some 63,000 member lives through a variety of plan changes. And we are further

supported by WellCare project management and leadership resources which have experience with broad changes and implementations like ACC across Medicaid health plans.

Staffing and Organization: We are deepening our leadership and management bench with new behavioral health expertise and have organized our teams to make sure member advocates, those with lived experience and those representing special populations have a strong voice in our organization.

Expanding the Network: We have held more than 1,200 provider meetings and have increased our network by 14% percent over the past year alone. We consistently look for ways not to just add volume to our network but to enhance the standard of care, demonstrated through our experience here and the experience of our affiliated health plans in facilitating access to integrated benefits. We have also designed value-based payment strategies to support integration aligned with AHCCCS' Targeted Investment Program, as well as approaches to support behavioral health and integrated providers as they move off block funding – a critical priority for the agency.

Enhancing the Care Model: We already operate a fully integrated care model, which includes in-person care management processes and high-touch activity to ensure members get intensive interventions timely. We have also been working toward greater accountability for providers in care coordination activities through the use of shared actionable data, value-based payment strategies and enhanced provider support tools.

Building Partnerships: Throughout our 18 months of preparation, we have been looking for unique partners who can help us innovate and develop best practices within the ACC framework. We have designed special alliances with providers like Dr. Luke Pederson at Banner who is working to develop a center of excellence for babies with neonatal abstinence syndrome and their mothers and Connections AZ to enhance access to post-crisis services so members have a better chance of avoiding a second behavioral health crisis. We are also continuing to expand on our work in the community, investing in renovations for a new integrated clinic in Avondale, as one example.

COMMITMENT TO BRINGING VALUE TO THE ACC PROGRAM

Care1st adds value to the ACC through our commitment to excellence and service to our members, providers and the communities we serve. Specifically, we are committed to adding value through innovation across the program.

Integrated delivery system for physical and behavioral health services: As one of the few truly integrated health plans serving Medicaid members through a single-purpose built platform, we offer AHCCCS a unique solution to ensure members and providers have a one-stop system of services. Our integrated care model ensures members are provided an assigned ongoing source of care and a primary person designated to help coordinate services. We offer providers a single, local point of contact who can assist with their clinical, quality and administrative needs. And we bring value by offering innovative payment solutions and support tools to encourage integration at the provider level to build out a fully integrated care delivery system, as well as by building innovative partnerships, such as our work with Southwest Behavioral Health and Valley Pain Consultants to promote collaboration on an integrated care delivery system for those suffering from chronic pain and at higher risk for opioid use.

Care coordination: Our organizational design and operational processes were built to add value by enhancing care coordination and management with integrated staffing, system and tools; leveraging of care coordination best practices around identification and stratification of the membership and effective interventions such as our high touch Care1st at Home program for members with most complex needs; and a network able to take accountability for integrated care coordination activities across all levels of member need.

Assistance navigating the service delivery system: Our member-facing staff continuously help members and families navigate the service delivery system. Our EPSDT staff helps connect families to providers to address development delays, disorders, or disabilities. Our maternal and child health staff contact pregnant women to make sure they are getting prenatal care they need and help families connect with AzEIP to get care for a child diagnosed with developmental delays. Our CommUnity Impact Model liaisons help connect members to community based organizations for social services needs such as housing, food, and utilities assistance. Our staff regularly takes special effort to help members, even assisting in scheduling appointments and arranging for non-emergent medical

transportation. These are just a few examples of how we help to ensure members access needed services.

Enhanced care coordination and support for members with special health needs: We are committed to ongoing collaboration with AHCCCS to improve outcomes, experience of care, and quality of life for all our members, including those with special health needs. Programs like our Justice System Care Coordination Program, High Needs and High Cost program, pediatric care management programs and others provides individualized care coordination for members and families with the most complex physical health, behavioral health and psychosocial needs.

Providers as essential partners: Care1st recognizes that partnering with providers is essential to transforming to an integrated healthcare model. We offer a variety of resources to help providers become more fully integrated, including: practice transformation support; communication support through clinical and provider engagement technology, Joint Operating Committees, a state of the art provider portal that provides member level information, care planning for all physical and behavioral health services, gaps in care and facilitates communication across all providers on a member's Integrated Care Team. WellCare's support of provider-led change has driven the creation of a comprehensive VBP program for Medicaid and Medicare providers in more than 20 states over the past 20 years, putting us in a unique position to support the goal to pay for value, quality and outcomes.

Clinical and operational performance improvement and self-monitoring: Our proprietary tools and technologies are built specifically to support government programs, allowing us to monitor quality and performance system-wide. We produce, analyze and share dozens of data feeds and reports with internal and external stakeholders including providers and AHCCCS; all with the objective of understanding and improving performance. For example, we have a broad set of reports that allow us to monitor claims denial rates, prior authorizations, grievances and appeals and dedicated workgroups that find and address trends timely. Our quality infrastructure supports consistent self-monitoring of key metrics to drive intervention such as new outreach and education activities to enhance member adherence to preventive care.

Promote cost containment: Our knowledge, experience and active engagement in Arizona has allowed us to operate in a manner that promotes cost containment and efficiency, as evidenced by our per member per month (PMPM) medical costs that are nearly $15 PMPM lower than peers in our current service areas. Our success "bending the cost curve" is attributed to our focused efforts over the past nearly 15 years including provider payment, drug utilization, emergency department use, and care management and care coordination strategies. We are considering additional strategies, many of which are identified as best practices by our Medicaid affiliates, to support integration and transformation, like our Comprehensive Opioid Management Program and our Field-based Care Management Program, both of which have delivered improvements in utilization and cost of care.

Conforms to system values and guiding principles: Care1st recognizes the importance of AHCCCS' System Values and Guiding Principles, and has incorporated these into our integrated clinical model of care.

MEETING MEDICARE D-SNP REQUIREMENTS

Care1st's legacy of providing and managing benefits and care coordination for Medicaid beneficiaries, including those who are dually eligible for Medicare and Medicaid, dates back to 2005 when we introduced our Medicare Dual Eligible Special Needs Plan (D-SNP). Over the last decade, our affiliate, ONECare by Care1st Health Plan Arizona, Inc. (ONECare), has grown and evolved together with the D-SNP program including the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Under ONECare's current MIPPA agreement with AHCCCS and CMS, beneficiaries who are dually eligible for Medicare and Medicaid may enroll in Care1st+ (HMO-SNP). As of January 1, 2018, more than 2,100 members have selected Care1st+ as their plan of choice, in part, because of our unparalleled support and care coordination.

Our current MIPPA agreement is approved through December 31, 2018. Our Medicare product development staff are already underway preparing our D-SNP application for 2019, which will be submitted by the CMS deadline. All Notices of Intent to Apply for every county we are bidding on were submitted by the deadline. We acknowledge the requirements of the ACC contract and will abide by Paragraph 9 of the Contract, RFP Section D, Paragraph 70, and the D-SNP Health Plan Agreement with AHCCCS, including but not limited to licensure and certification, affiliation, branding, Medicare structure including integration of Medicare and Medicaid services, care coordination, conversion enrollment, transition activity, and information and data reporting requirements.

MORAL OR RELIGIOUS OBJECTIONS

CARE1ST RESPONSE TO MORAL OR RELIGIOUS OBJECTIONS

Care1st has no objections, on the basis of moral or religious grounds, to provide or reimburse for a covered service [42 CFR 438.102(a)(2)].

Narrative Submission Requirements

CARE 1ST HEALTH PLAN ARIZONA
A WellCare Company

EXPERIENCE IN ARIZONA AND WITH OTHER CONTRACTS

Care1st Health Plan Arizona, Inc. (Care1st), a wholly-owned subsidiary of WellCare Health Plans, Inc., and our affiliates participate exclusively in government-sponsored programs with a focus on serving the most complex members served by those programs. Because of our dedication to serving members enrolled in government programs, we have designed every aspect of our business to serve those members, including our care model, policies, information technology systems, processes, and company culture. We understand the flexibility needed to serve these members and adapt to evolutions in population health and regulatory frameworks, like that which is expected with the implementation of the AHCCCS Complete Care (ACC) Contract and transformation.

Care1st Experience with Arizona Medicaid Contracts We have operated as a contractor in the AHCCCS program for nearly 15 years and have grown and evolved with the program, consistently demonstrating excellence, including:

- Care1st was rated the No. 1 plan by members for getting care quickly for children, and the number two plan overall among adults.
- Care 1st has been consistently ranked in the top 3 health plans across all questions in the provider claims satisfaction survey.
- Care1st has been a top third plan in QM/PI performance over the past eight years.
- In a 2016 AHCCCS report to the governor on childhood immunization rates, Care1st exceeded the statewide average across 11 reporting plans on ten out of ten measures.
- Care1st stands out among AHCCCS plans in that we have received no encounter sanctions dating back to 2009.
- No plan has outperformed Care1st in AHCCCS' operational reviews over the past six years.
- In 2017, Care1st acquired 43,000 members of another AHCCCS plan that relinquished its program contract. We collaborated with AHCCCS and the terming health plan and met all transition milestones.

Our Medicaid experience in Arizona includes the following:

Geographic Coverage Care1st's current geographic service area is Maricopa and Pima Counties.

Population Served and Enrollment Under our AHCCCS Acute Care contract, Care1st serves Title XIX members, TANF members, eligible members receiving Supplemental Security Income (SSI), and eligible members under the Affordable Care Act expansion, as well as Title XXI (CHIP) members. Additionally, we are contracted with the Department of Economic Security/Division of Development Disabilities (DES/DDD) to serve Medicaid eligible individuals with developmental and intellectual disabilities. Under our MIPPA agreement with AHCCCS, we serve members who are dually eligible for Medicare and Medicaid. As of June 30, 2017, approximately 161,700 Medicaid-eligible members were enrolled in our plans, including nearly 158,300 in our Acute Care plan, 1,400 in our DDD plan, and 2,000 in the ONECare MAP dual eligible special needs plan (DSNP).

Integration Status Care1st coordinates benefits for the TANF, ABD/SSI, CHIP, expansion and dual eligible populations, including integrated behavioral and physical health benefits for the GMH/SU duals. We also deliver managed care services for persons with developmental disabilities who are clients of DDD and coordinate care for these members.

Years in Program and Current Contract Status Care1st has been contracted with AHCCCS since 2003 and with the DES/DDD since May 2011. Both current contracts expire September 30, 2018.

EXPERIENCE MANAGING HEALTHCARE SYSTEMS SIMILAR TO THE AHCCCS COMPLETE CARE PROGRAM

Our affiliates have managed healthcare delivery systems similar to the ACC program since 1994. Today, WellCare plans serve Medicaid programs in 11 states covering approximately 2.6 million members – managing integrated benefits in 9 of those states. We selected our Florida and Kentucky plans to serve as benchmark programs for this response as they are representative of our ability to serve ACC members. In both states, we manage a fully integrated set of benefits, including coverage for general mental health and substance use disorder services across the membership. In both states, we serve a broad range of populations, including complex members such as adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), medically fragile children and others with special health care needs such as children in the child welfare system and justice involved individuals. These states also demonstrate our ability to develop programming tailored for different communities and challenges, such as the rural challenges of the Appalachian Mountains in Kentucky and the diversity of cultures served throughout Florida's urban and rural communities. In both Florida and Kentucky, WellCare has the largest memberships,

becoming the plan of choice in Kentucky in recent years with No. 1 rankings in member satisfaction. Our Florida affiliate, known as Staywell, is the only plan in Florida to have ever served in all 67 counties, and even with the largest membership, consistently outpaces other plans on key quality and utilization metrics as described throughout our response.

WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida (Staywell) Staywell is WellCare's most established plan having served Medicaid since 1994. Staywell's Florida footprint demonstrates that, as an organization, we have the resources and scalability to operate statewide in Arizona. Staywell is a representative benchmark for other reasons, including similar populations, local care management teams, provider engagement and value-based contracting, and cultural and linguistic considerations. Further description of our Florida Medicaid affiliate is provided below:

- ***Geographic Coverage*** Under the contract with Agency for Health Care Administration (AHCA), Staywell operates in 65 of 67 Florida counties.
- ***Population Served and Enrollment*** Under the Florida Medicaid contract, Staywell serves TANF, ABD/SSI, and DE members while under its contract with Florida Healthy Kids, Staywell serves CHIP members. By membership, Staywell is the largest Medicaid plan in Florida. As of June 30, 2017, Staywell had 670,852 Medicaid members (including 26,608 dual eligibles, 64,077 Florida Healthy Kids members, and 100,348 MAP members (including 33,388 DSNP).
- ***Integration Status*** Staywell is fully integrated coordinating physical health, behavioral health and social services for the TANF, ABD/SSI and DE populations under the MMA Contract. Covered services include: inpatient and outpatient services; physician services; prescription drugs; dental services; vision services; hospice services; laboratory services; EPSDT; family planning; mental health and substance use disorder services; emergency services; hearing services; durable medical equipment; physical, occupational, respiratory and speech therapy services; transportation; pet and equine therapy; and radiology services.
- ***Years in Program and Current Contract Status*** Staywell has been contracted with AHCA to provide Medicaid managed care services since 1994. The term of the current MMA Contract expires on December 31, 2018.

WellCare of Kentucky, Inc. (WellCare) WellCare provides managed care to recipients of state-based government healthcare programs in Kentucky through a single contract for Medicaid and CHIP under the Kentucky Plan for Medical Assistance. Our Kentucky affiliate represents our organization's ability to quickly implement a managed care program. The lessons we learned there will help us ensure successful integration and expansion in Arizona. Our Kentucky Medicaid affiliate is a representative benchmark for ACC for other reasons, including populations served, population health challenges, community engagement, and the geographical remoteness of some areas together with lagging community infrastructures. The following is a further description of our Kentucky Medicaid affiliate:

- ***Geographic Coverage*** Under their contract with the Department for Medicaid Services (DMS), WellCare operates statewide in all 120 Kentucky counties. Additionally, WellCare of Kentucky operates MAPs, including SNPs there.
- ***Population Served and Enrollment*** Under their contract with DMS, WellCare serves TANF, ABD/SSI, DE, and CHIP members. As of June 30, 2017, WellCare served 446,471 members under the Kentucky Medicaid Contract, making them the largest Medicaid plan in Kentucky by membership.
- ***Integration Status*** WellCare is fully integrated coordinating physical health, behavioral health and social services for the TANF, ABD/SSI, CHIP, dual eligible and Affordable Care Act Medicaid expansion populations, including children in foster care and adult guardianship. Covered services include: inpatient and outpatient services; physician services; prescription drugs; dental services; vision services; hospice services; laboratory services; EPSDT; family planning; mental health and substance use disorder services; emergency services; hearing services; durable medical equipment; physical, occupational and speech therapy services; and radiology services.
- ***Years in Program and Current Contract Status*** WellCare has provided Medicaid managed care services to Kentucky members since November 2011. The term of the current KY Medicaid Contract expires on December 31, 2018. It has a one-year renewal option remaining and one six-month renewal option potentially extending it through June 30, 2020.

IMPLEMENTING CRITICAL COMPONENTS AND PRINCIPLES OF INTEGRATED SERVICE DELIVERY

Care1st is excited for the opportunity to continue as a trusted partner for AHCCCS as the state takes this next major step towards a truly integrated system of care with AHCCCS Complete Care (ACC). ***Care1st is uniquely qualified to help with this transformation. Our local leadership is empowered to make rapid-cycle decisions and we do not delegate key clinical functions, including behavioral health and pharmacy, enabling us to operate a truly integrated system. Part of our integrated appraoch includes addressing social determinants of our members and have been on the leading edge both in Arizona and around the country.*** Care1st has been honored to work closely with AHCCCS to provide high quality care to our members with transformative activities throughout the life of our contracts. Whether it was leading to address the social needs of our members and our communities through work like the launch of the Avondale Resource Center, or partnering with providers like Catalytic Health to meet members where they are: holistically, we have been working toward this transformation alongside AHCCCS for nearly 15 years. Building on our successes in Arizona, we have added the experience of our affiliated health plans across the country and our new parent company, WellCare, to effectively implement the vision of ACC and to help build healthier communities across our state. Our approach to implementing a comprehensive behavioral and physical health benefit package is grounded in our approach to whole-person care shown in **Figure 2-1.** Our Complete Care System (CCS) is member and family centered with a focus on the role we can play as an ACC plan to collaborate with and empower a modernized and integrated delivery system designed specifically to provide a comprehensive package of behavioral health (BH) and physical health (PH) benefits for our members.

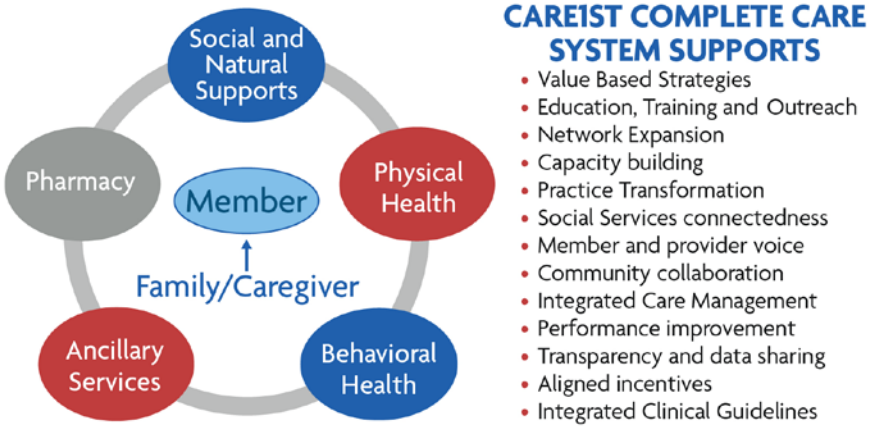


Figure 2-1: Care1st Complete Care System Supports

Our Integrated Clinical Leadership Team includes experts in BH and PH, including specialists in addiction and other high-risk needs as well as peers and advocates. They work together side-by-side, are cross-trained to manage co-morbid conditions of our members, work on the same fully integrated care management system – CareCentral – and leverage one set of integrated policies, procedures and clinical guidelines. Implementing the critical components and principles of BH and PH service delivery is a complex and multidimensional effort. Our member-centered tactics to implementing and managing the ACC principles fall into the following four categories, described in more detail below:

- Facilitating access to high quality care
- Enhancing overall population health through integrated care coordination and timely linkages to services
- Engaging members to simplify their healthcare experience
- Continuously monitoring and improving the service delivery system

Facilitating Access to High Quality Care

Ensuring members have access to the comprehensive PH, BH and specialty benefits package afforded through ACC is a critical part of implementing and managing the program. Care1st has been working for more than a year across the state to expand our comprehensive network of providers. ***We have held more than 1,200 provider meetings and have increased our network by 14% percent over the past year.*** We consistently look for ways not to just add volume to our network but to enhance the standard of care, demonstrated through our experience here and the experience of our affiliated health plans in facilitating access to integrated benefits. Key to this strategy are the following tactics:

Expanding Our Network to Facilitate Access to the Integrated Benefit Package: In addition to integrated, BH, and PH providers, our network expansion over the past year includes: Specialty and BH providers such as the Multi-Specialty Interdisciplinary Clinics (MSICs) like Yuma Regional Medical Center's Children's Rehabilitative Services; Phoenix Children's specialty network; Touchstone Health Services; S.E.E.K; and IASIS facilities including St. Lukes Behavioral Health Center. We have also expanded geographically adding providers across the South and North GSAs.

"Touchstone Health Services began its journey to embrace the health home model of integrated care by adding pediatric medicine to complement existing behavioral health offerings to our 7,000 plus members in 2017. Care1st was eager to better comprehend our care coordination, evidence-based programs, and our commitment to both medical and behavioral health needs of our members… this genuine interest, support and desire to understand current behavioral health and integrated care practices that makes Care1st an excellent partner as we navigate the ever-changing infrastructure of health care." Bryan Davey, CEO, Touchstone Health Services.

Ensuring the Availability of Culturally and Linguistically Appropriate Recovery-Focused Care: Member and family voice is critical to the successful design, implementation, and monitoring of a modernized integrated care delivery system. Care1st has created and elevated an Advocacy Department that reports directly to the CEO and has access to other executive and senior level positions supporting the voice of members and families. We know that peer, family, and advocacy organizations can make significant contributions to the design, implementation, and monitoring of the Whole Person Integrated Service Delivery Vision that we will be unfolding under the ACC. We will engage with them to listen and most importantly ***understand*** the needs, barriers, and solutions for system transformation that is whole person-centered. Additionally, Care1st will collaborate with providers to advance how they gather, understand and act upon member and family voice as they progress through the system transformation process.

All Care1st associates are trained in cultural competency and how it relates to members during New Hire Orientation and annually thereafter. Staff working in our call center, CM teams or similar roles with higher member interaction receive further training on cultural competency issues that positively influences the interactions our members. Customer Service Representatives (CSRs) must meet a more stringent cultural competency requirement. Quality program auditors and supervisors review six to eight CSR calls each month for cultural competence and other key issues related to customer service. Each CSR receives a scorecard that is reviewed monthly with his or her supervisor. We will also have specific training focused on supporting our American Indian members.

Supporting Providers in Maintaining a High Standard of Care and in Transforming to an Integrated Delivery System: Care1st will use a developmental model to support providers adopting and operating within an Integrated Health Home (IHH). We will follow and enrich the path that AHCCCS has laid out through its Targeted Investments (TI) approach for enhancing the system to acquire capabilities that advance integrated care. We "Meet Providers Where They Are", conducting outreach and engagement to explore with a provider their desire and current capabilities to advance integrated practices and value-based purchasing (VBP) approaches. We have engaged providers who are already on the path for integrating care and are actively participating in the TI, many of whom are already part of our existing contracted network. We are actively engaging other providers not yet on this transformation journey, and have received positive interest from providers in collaborating to improve integration capabilities.

As we have done with success in our affiliate health plans in Florida and Kentucky, we will collaborate with providers to conduct a Provider Integration Self-Assessment and develop a Provider Transformation Plan. The Transformation Plan is intended to move the provider through a series of development steps to support their ability to become more integrated. As part of the Transformation Plan, members will be assigned an IHH of their choice that will be accountable for the complete care of the member. As the system evolves and there are more Centers of Excellence (COE) that are Integrated Clinics, members will be encouraged to seek services from an IHH with a COE status. We have already begun assigning members to integrated clinics through preferred PCP auto-assigment within the past 6 months. Initially, we will start with supporting members with the highest need levels to have health homes that are COE and eventually encourage all members to seek health homes that are COE. By year end of the first year of the contract, our goal is to have all providers engaged in their integration journey. By year five, we will have members assigned to IHHs that are operating at a Category 4 of the Alternative Payment Model (APM) Framework published by the Health Care Payment Learning and Action Network (HCP-LAN) including having fully developed care coordination, care management, utilization management and quality management capabilities to effectively manage care and achieve health outcomes with positive member experience while effecting the overall healthcare cost curve.

FACILITATING ACCESS WITH INTEGRATED HEALTH HOMES (IHH): Our Florida affiliate (Staywell) has been working with providers to become health homes in order to improve access for members with PH and BH needs. Their approach is to support providers in choosing an IHH model. Options were to choose to be accredited by one of the national accreditation bodies for BHH, PMCH, or be certified under Staywell IHH options.

Through collaborative approaches, Care1st will enable providers and IHHs to increase their integration capabilities by providing technical assistance though **Practice Coaches,** who provide support based on the information learned from the provider's self-assessment as well as additional information and data available to Care1st. Practice Coaches will support providers in many ways including the use of: integrated Clinical Practice Guidelines (CPGs); evidence-based engagement tools and strategies; motivational engagement interviewing strategies; identifying social factors impacting health; the HIE; quality improvement and measurement activities.

Working in tandem with Practice Coaches, **Quality Practice Advisors (QPAs)** will support providers including IHHs in advancing their capabilities to positively effect health outcomes and member experience. QPAs collaborate with providers to improve quality related measures such as HEDIS, EPSDT wellness services, chronic disease management, and fidelity measures targeted to practices such as Child System of Care and address whole person care.

Offering Payment Arrangements to Incent Providers to Transform and Operate at the Highest Standard of Care: Care1st rewards providers that deliver and coordinate quality services resulting in improved outcomes, improved experience and operatational efficiently by using **VBP strategies**. Through the course of this contract we will move reimbursement from a fee-for-service approach to using advanced alternative payment models using the nationally recognized Health Care Payment Learning and Action Network (HCP-LAN) Framework. By year five of this contract, we aim to have the majority of contracts integrate behavioral and physical health and be full risk in accordance with Category 4 of the APM Framework. Practice Coaches play a critical role to support a provider in developing and organizing their operational and clinical practices that are in alignment with alternative payment methodologies. A Practice Coach will assist in sharing knowledge and understanding of VBP, assisting the practice in identifying the operational practices that need changes to support VBP success (e.g. outcome measurement), and providing information on optional processes that achieved success for similar operations.

Facilitate Access to Non-Benefited Social Service Resources: Key to providing truly integrated care is addressing the social determinants that impact member health. Care1st facilitates access to social service resources to address these social determinants through our industry-leading CommUnity Impact Model and our system partners relationships.

Through the WellCare family of health plans' social determinants program, **CommUnity Impact**, we analyze census and health ranking data to determine where to invest local community grants and create necessary supports. We hire local community liaisons to develop the necessary relationships with our community partners. We staff a community assistance line (available to members, nonmembers, providers) with peers who have similar lived experience to our members, to help identify available resources like housing, food, etc. We track, and refer, as necessary, to minimize the social and geographic challenges and facilitate the needed care for our members. The CommUnity Impact program will be adapted and implemented to address the needs of members and families in Arizona and will support, leverage and grow the available infrastructure (e.g. peer and family support lines). The Arizona CommUnity Impact project is led by our newly formed Advocacy Department comprised of: Member Advocacy Administrator; Individual and Family Affairs Administrator; Adult, Child, CRS, and Veteran Advocates; Justice Liaison; Court Coordinator; and Employment/Vocational Administrator. The project will also be supported by other leadership across the organization. Care1st has many established relationships with system partners and will engage additional **system partners** to create effective care coordination protocols with representatives including: Justice Representatives: Problem-Solving Courts, Probation, and Parole; Department of Child Safety (DCS) representatives to address the needs of children at risk of being taken into or returning from the care/custody of the state; Children's Rehabilitative Services representatives: and Department of Economic Services – Rehabilitation services for those needing vocational rehabilitation services. Our work in developing protocols will address the integrated behavioral and physical health member benefit.

ADDRESSING SOCIAL DETERMINANTS WITH UNIQUE PARTNERSHIPS: Care1st's partnership with the **Crisis Response Center (CRC)** in Tucson focuses on a continuous improvement process to assist members who have gone into their facility because of a BH crisis. CRC provides integrated services such as Assessment and Consultation, Medication Services, Individual, Group and Family Crisis Counseling, Crisis Services – level I acute, level I sub-acute, 23-hour observation, Court-Ordered Evaluation and Treatment Services, Peer Support and Co-morbid treatment for select medical conditions. CRC often identifies eminent medical conditions that need referral and attention and works with our care manager to assure the proper provider referrals are made.

Enhancing Overall Population Health through Integrated Care Coordination and Timely Linkages to Services

Care1st is committed to improving overall population health for both adults and children at the population and individual level. Our integrated clinical model of care employs the Principles of Adult and Children Behavioral

Healthcare, and is supported by the use of: Technology and data; Clinical Practice Guidelines (CPGs) and evidence-based practices; identification of members with complex needs; and providing prevention and wellness through mining and sharing of care gaps.

Leverage Integrated Technology, Data and Processes to Manage Population Health: Care1st will use the foundational technology investments WellCare has been developing and utilizing for many years. All technologies have been designed and deployed to support managing integrated BH and PH benefits including members' social determinants of health. **Our integrated care management platform, Care Central,** directly incorporates all aspects of care management, quality and clinical outcomes to support the physical (including dental, pharmacy, vision, and others), behavioral and social needs of our members and incorporates provider-focused tools for viewing all aspects of member care. Our enhanced secure **Provider Portal** offers providers easy access to member specific information (e.g. integrated claims, integrated behavioral and physical health information, integrated care gaps, etc.), informational resources (e.g. CPGs and claims educational material), and provider performance information (e.g. **provider report cards** conveying provider performance—displayed in ways for a provider to compare their performance to other similar providers, incentive amounts earned, additional incentives available if they moved to the next level of VBP arrangement.)

Care1st incorporates pharmacy practices from other WellCare health plans that have accelerated its use of **pharmacy management practices** to fully address the integrated behavioral and physical health pharmacy services. Further, through this approach, we address nationally and locally known challenges in which pharmacy management can play a critical role in changing practices. Some examples of this are: 1) provide access to real time information about dispensed medications for both behavioral and physical health needs, 2) provide data alerts for contraindicated dispending of psychotropic and physical health care medications to prescribers, 3) ***enhancing our opioid pharmacy "lock-in" program in which WellCare has demonstrated a 50% reduction in dispensing of opioids in Kentucky***, or 4) use predictive analytics and modeling to identify potential of prescription fill and non-use waste.

IMPLEMENTING BEST PRACTICES IN INTEGRATED CPGS: Our Florida affiliate, Staywell, held quarterly "Strategic Integration Sessions" attended by behavioral and physical health providers; introducing key providers to each other, and facilitating professional collaborations regarding potential models. From one of the Strategic Integration Sessions, a surgeon recommended addressing the BH needs of amputees in Clinical Practice Guidelines (CPG). Since that time, we have amended our CPGs to be fully integrated and the project was completed in 2017. The fully integrated CPGs will be used within our Care1st operations and within the Arizona service delivery network.

Implement Best Practices in Integrated Clinical Practice Guidelines (CPGs) and Evidence-Based Practices: Our integrated Clinical Practice Guidelines (CPGs) address the BH and PH condition from a whole person perspective. For example, a CPG addressing prenatal care will address physical health interventions as well as BH and social determinants considerations. Designed to create uniformity among the application of best practices for providers, CPGs are a valuable tool in ensuring quality care for members.

Using evidence-based interventions, our team of BH specialists works with BH providers and organizations like Northern Arizona Consumers Advancing Recovery by Empowerment and Wellness Connections, to connect members and their families to beneficial services. Care1st will also incorporate and contribute to AHCCCS best practice guidelines such as Psychiatric Best Practice Guidelines for Children: Birth to five years of age, and Unique Behavioral Health Services for Children, Youth and Families involved with Department of Child Safety.

Identify Members with Complex Needs to Ensure Alignment to the Right Services: Care1st understands the importance of identifying members with complex needs in order to provide the appropriate services for these members, whether that is assigning the member toa provider to facilitate Child Family Team, a specialty health home to address a specific complex need (i.e. Banner Sickle Cell program); or our own short-term care management services.

Care1st uses integrated data to understand member needs and to ensure that members receive care coordination and services at the intensity required to meet their needs. A Care Management need level is assigned to a member based on an algorithm of many factors derived from information about the behavioral and physical health of an individual as well as social determinants information (e.g. standardized screening and assessment scores, utilization data, predictive risk scores, medication adherence history and data system flags such as justice involved, special health care needs, state agency involvement, extreme psycho social factors, etc.). Levels may also be manually assigned to an alternative level based on a request to review level of need. Assignment to the most intense need levels will also influence assignment to additional coordination and oversight supports, such as assignment to a High

Needs Case Management Program at the provider level for children or assignment to the Care Management Program at the health plan level.

APPROPRIATELY ALIGNING MEMBERS WITH COMPLEX NEEDS: Care1st is collaborating with Connections Health Solutions (Connections), which focuses on treating members who are experiencing BH crisis, to develop and implement an integrated behavioral and physical health post crisis program to support transitions. The model will focus on short-term, high touch interventions by an interdisciplinary team that includes peers, nurses, physicians, and social workers. Post-Crisis individuals who are recuperating and need extra time and attention may need to 1) be connected to the next level of care through warm handoffs and troubleshoot care coordination issues, and 2) receive support while they are still recovering from the crisis episode (e.g. helping the member access prescribed medications, get to their appointments, and make sure they have access to essential needs such as food and housing).

Provide Prevention and Wellness through Mining and Sharing of Care Gaps: We work at continuous quality improvement in order to enhance the quality of care and experience for those we serve. This is evidenced in the multi-channel strategy we have in place to close gaps in care. Our integrated PH and BH leadership team meets with providers to discuss open care gaps and determine innovative methods of closing these care gaps. Our **heat maps** allow us to identify providers by zip code that have the greatest numbers of open member care gaps needing improvement. These tools provide access to datamarts (HEDIS care gaps, EPSDT care gaps, and others) generated from our quality programs to provide alerts to members and providers on our secure portal and to members via our mobile application. Our **monthly provider scorecards**, delivered by our clinical team, educates providers on non-adherent members and helps them develop strategies to close care gaps. Our **Quality Practice Advisors** will work with providers to identify and close care gaps related to preventive care, and our **Provider Care Advocates** will be co-located in select provider offices with a focus on scheduling appointments for targeted members with identified care gaps. Our **provider portal** also provides a listing of our PCP patient panel and care gaps.

Engaging Members to Simplify the Healthcare Experience

Care1st encourages members and families to take an active role in managing their healthcare, both at a system level and at an individual level. We also undestand that the complexity of the currently fragmented healthcare system can be overwhelming for members and families. When members and families are given a voice in their healthcare and are guided through the intricacies of this system, there is a deeper understanding of the underlying issues that affect a person's health and wellbeing and a greater opportunity for improved health outcomes. Care1st has a variety of tactics to improve member experience and help them navigate the currently fragmented healthcare system, including:

Outreach and Education: Care1st offers an array of resources to address the whole health needs of members and families, providing support to engage in their treatment and provide the best resources to enhance their self-care. Mobile and stationary **Welcome Rooms** will offer a location to host a wide variety of events, including children's reading and literacy classes, nutrition and wellness classes, AA/NA meetings, one-on-one contact with a Care1st representative, and provide special needs resource navigation. Our Welcome Room strategy in Arizona includes engagement efforts through Promotoras and CHWs, peer and family support specialists and care coordinator staff. Members will have access to a **Member Portal** that will offer self-service tools and links to service supports such as a pharmacy and provider search. **Mobile phone notifications and apps** will provide health education and health engagement approaches such as appointment reminders. **Newsletters** provide information on member benefits and preventive care, and are mailed or available on our website. Members also have access to the **24/7 Nurse Advice Line** to engage with live clinical staff and manage their circumstance.

Maternal and Child Programs: Our **Hugs** program provides education, guidance and support for all our pregnant members and provides layered interventions based on the member's risk. The program provides helpful tips, tools and information for pregnant members to make healthy choices during pregnancy to achieve the healthiest birth outcome. Hugs identifies pregnant members through state files, claims, care coordination referral, and by direct notification from the member or provider. Upon confirmation of the pregnancy, we make multi-modal outreach (e.g., loaner phone calls, texts, social media, our mobile application) to all pregnant members to assess her current health status using the Prenatal Comprehensive Assessment of risk for preterm birth or pregnancy complications.

Unable to Contact (UTC) Program: Care1st continually looks for ways to enhance member engagement, especially for those members who most need care management. For those who are difficult to reach, we make multiple phone attempts over several days and times of day. We also send mailed communications and engage the member's providers and pharmacy to find alternative contact information. Additionally, we collaborate with the RBHAs,

Maricopa County Area Agency on Aging, and Pima Council on Aging to find members. One significant challenge to engagement is reaching members who struggle with social determinants of health such as homelessness, language barriers, transportation, or financial concerns that may limit access to a regular phone or the Internet. To engage members that we are unable to contact (UTC), Staywell implemented the "Boots on the Street" program in February 2017, which used existing Community Health Worker staff to provide aggressive outreach to those members we have been unable to contact. Over the 5-month program, the ***CHWs made in-person contact with 42% of members identified as "Unable to Contact" during the initial 90 days of enrollment. Thirty-six of the members consented to a health risk assessment at the time of contact and over 600 were referred to and engaged in care management.***

ENGAGING MEMBERS WITH TELEMEDICINE: Catalytic Health Partners leverages a telehealth ready technology platform (PHR) to support scaling member engagements and preventing care fragmentation. Members have access through a provided internet-connected tablet. The entire care team, including the PCP and specialists, has access to PHR, enabling the seamless sharing of clinical information to ensure safe transitions and continuity of care. ***Over a one-year period of engaging in this care model, 61% of diabetic members improved AIC by 1 point, 91% of hypertensive members experienced lower BP and 47% saw declines in their PHQ-9 score which screens for depression. 17% of members were able to improve their overall health and participate in some level of employment.***

Care1st at Home Care Management Program: Our fully integrated care model, Care1st at Home, factors in a member's PH, BH, pharmacy and social support needs and is grounded in our organizational mission to help members live better, healthier lives. Person-centered care, delivered by single point cross-trained care managers, is tailored to reflect the choice and voice of each member and their caregiver, as applicable, and to address the member's unique personal goals. Our approach focuses on a clinically robust data analysis and risk stratification process, identifies and addresses potential barriers to member engagement, and emphasizes field-based care management for high risk members. In addition, it offers evidence-based medical and behavioral clinical guidelines and utilizes a comprehensive medical management platform that houses all care coordination documentation, social service referrals, claims, authorizations, assessments, person-centered plans of care, interdisciplinary care team meetings, and demographic data. ***The Care1st at Home program has nationally shown a reduction in avoidable hospitalizations by 26% and inappropriate emergency room visits by 8% while increasing the use of outpatient and pharmacy services.***

Continuously Monitor and Improve the Service Delivery System

Care1st has proven strategies to monitor and improve the operations and effectiveness of integrated care delivery systems affecting health outcomes, member experience and impacting the cost curve. Our approach is to positively impact the whole health of our members to live productively and as independently as possible in the community. Some aspects of the multi-faceted comprehensive approach to continuously monitor and improve the system include:

Using Feedback from Members, Families, System Partners and Providers: Care1st uses formal surveys, internal and external committees and one-on-one interactions to obtain information and feedback from various stakeholders about the effectiveness of the service delivery system. Examples include, but are not limited to: CAHPS surveys; the Member, Family and Stakeholder Council; and community advocacy committees such as the Child and Family Advisory Partnership. Information and feedback obtained flows through our quality processes for opportunities for improvement. Based on the nature of the opportunities presented, actions for improvement will be assigned to a department to lead those efforts. The progress of improvements are formally tracked through the Quality Department and reported back to all applicable committees and up to Executive Leadership. Care1st will also incorporate AHCCCS best practices such as the Youth Involvement in the Childrens Behavioral Health System Practice Tool. This gives youths equal power and voice in their recovery, provides for formal and informal peer supports, and allows for continuous feedback from youths through leadership development programs and committee participation.

Performing Data Analysis and Performance Improvement Activity: Our parent company WellCare constantly invests in the enhancement of our formal Enterprise Information Management (EIM) Solution that supports all of our data needs, including application processing, regulatory reporting, and ad hoc reporting. Specifically, this includes providing the data analytics and data informatics capabilities needed to drive performance improvement and quality management activities. This comprehensive EIM solution ensures that all data sources (e.g., HEDIS®, CAHPS, Claims, Appeals, Grievances, Rx data, Social, AMRR, Surveys) are captured and catalogued, integrated to enable robust reporting capabilities, and provide the analytic tools needed to identify care gaps and opportunities. With this information, we build programs and initiatives that improve health outcomes for our members, such as the Hugs

program described above.

Care1st and our affiliate health plans possess broad and rich experience conducting **performance improvement projects (PIPs)** that achieve significant progress across clinical and non-clinical areas through our adoption and integration of the Continuous Quality Improvement (CQI) Rapid Cycle Plan-Do-Study-Act (PDSA) methodology. Our PIP guidelines include: Activities related to external quality review; Mandatory activities; and the CMS guidelines as outlined in the most recent publication EQR Protocol 7 Implementation of PIPs and include:

- Specifications of clinical or health services delivery areas to be monitored including objective quality indicators
- A system to achieve improvement in quality
- Methods to evaluate effectiveness of the interventions
- A system to institute planning and initiation of activities for increasing or sustaining improvement

Providing Transparency and Data Sharing: We offer providers an array of resources to assist them in improving member health outcomes. Our enhanced **Provider Portal** includes functionality to view all services received by a member, including physical and BH utilization, lab, Medical Loss Ratio (MLR), claims and quality performance. Our **Heat Maps**, which are available through the Provider Portal or through printed reports from Quality staff, allow us to identify member care gaps by zip code drilled down to the provider group, physician or member level. Our **UM scorecard** compares provider groups against Care1st Key Performance Indicators including admission and readmission rates, medical loss ratio, pharmacy costs per member, generic dispensing rates and prescription PMPM, allowing providers to better manage medical costs and address member care gaps. Our **Appointment Agendas** show member care gaps and potentially missed diagnoses that providers can reference during patient visits and allows providers and Care1st a comprehensive view of our member's health status to confirm they receive the right level of support for their condition. Our **P4Q Portal** will give Care1st PCPs a snapshot of the care gaps tied to performance payments, allowing them to prioritize based on those measures that will result in the most improved member health outcomes. Our proprietary **AccuReports** system allows providers who have entered into VBP shared savings/shared risk arrangement with quality incentive payments to view data on readmissions, members incurring high costs, and pharmacy utilization via a secure site. Large practices participating in shared savings arrangements receive and use detailed **claims data feeds** to better understand their performance and improvement opportunities.

MONITORING THE SYSTEM AND IMPROVING OUTCOMES: In an effort to improve health outcomes for mothers and babies and encourage members to establish a medical home, Staywell initiated the Timeliness of Prenatal Visits and Well-Child Visits in the First 15 Months of Life PIP. The measures applied through this PIP resulted in a statistically significant improvement in the number of prenatal care visits and well-child visits in the first 15 months of life.

Building Capacity of Existing Providers: In order to improve service delivery, we have a number of methods to build capacity among our existing providers, including:

- Execute VBP agreements tailored to incent providers like North Country HealthCare FQHC to expand access.
- Subject to licensure requirements, contracts with licensed independent social workers, clinical nurse specialists, and nurse practitioners who practice in remote locations.
- Offer incentives to providers to participate in the adoption and use of health information technology and implement technological solutions to share health information through VBP and Care1st technology solutions.
- Advance Health Home model through practice transformation.
- Support practices participating in Targeted Investment and the Transforming Clinical Practices Initiative programs through robust data sharing, dissemination of population health best practices, care coordination and support for members' social needs, and VBP models.

Incenting Behavior Change with Providers and Members: Through our **P4Q provider incentive program**, which has proven successful in our affiliates including Staywell, Care1st PCPs will have the opportunity to earn bonus payments for completing necessary treatment for their patients that are above and beyond their normal contractual payment. Payments provide tangible feedback that can influence behavior for the provider and ultimately impact the healthcare outcomes for the member, further aligning and promoting quality. ***In 2016, 83% of Staywell's targeted P4Q measures showed year-over-year improvement.***

Care1st's member incentive program, **Healthy Rewards**, is designed to improve health outcomes by rewarding members with cash-value incentives for practicing good health behaviors including visiting their PCP, completing well-child visits and receiving mammograms.

CAREFULLY IMPLEMENTING AND SELF-MONITORING THE COMPLETE CARE TRANSFORMATION

Through our experience adding populations, geographies and services to our plan, Care1st recognizes the importance of a smooth transition that ensures members access and receive services with no interruption in their care. With every implementation and transition we have completed, we prioritized preserving existing relationships between providers and members, minimizing disturbance. Even as we nearly tripled membership and our network over the past five years, provider complaints and member grievances have both declined. ***Since 2013, we have effectively managed transitions for more than 63,000 lives***, as well as added another 40,000 expansion members to our membership. Through this activity, ***we have remained a top ranked AHCCCS plan for provider satisfaction, quality outcomes and operational excellence, all critical to members and their families experiencing a positive transition***.

A HISTORY OF GROWTH AND TRANSITION

- 2013: Expanded into Pima County and transitioned 15,000 lives representing a 30% increase in members.
- 2014: Added over 40,000 lives through ACA expansion
- 2014: Transitioned physical health services for SMI members to integrated RBHAs
- 2015: Transitioned in GMH/SA benefits for 5,000 duals
- 2017: Transitioned 43,000 PHP members, a nearly 40% increase

The complexity of the AHCCCS Complete Care (ACC) transition to fully integrate care and transition children's rehabilitative services (CRS) is the most challenging change AHCCCS and its plan partners have undertaken since the program's inception. From payment modernization within the behavioral health (BH) system to helping the system support provider-led care coordination and addressing social determinants of health, this transformation requires unparalleled levels of engagement and close monitoring to ensure success. We will leverage our proven strategies used during successful transitions in Arizona combined with the broad experience of WellCare and our affiliated health plans across the country, several of whom have been on the cutting edge of integrating BH services. In Kentucky, we have led the state in transitioning vulnerable children with complex cases into managed care and back into stable homes; in Florida, we were among the first plans to manage BH needs and have recently led the state in introducing an Integrated Health Home (IHH) framework. ***The key to an ACC effective transition is strong preparation on the front-end along with detailed self-monitoring at each phase.***

Pre-Implementation		Post-Implementation
• Understanding the Transition	• Building out Self-Monitoring Tools	• Oversight and Governance
• Tactical Preparations	• Staffing	• Continuity of Care
		• Ongoing Self-Monitoring Activities

Pre-Implementation: Understanding the Transition

Care1st has been preparing for the ACC transition for more than 18 months, structuring the necessary elements to support system transformation. We have traveled the state meeting with providers, advocates, and stakeholders to understand each element of the current program, the impact of the ACC transformation and the tactical steps necessary to ensure a smooth transition for members and providers. Our Plan CEO Scott Cummings personally led this activity by conducting listening tours with BH providers, tribal nations, health care systems and other key stakeholders. His work is supplemented by efforts from several Care1st and WellCare team members including WellCare's Vice-President of BH Operations Carole Matyas; Care1st's Provider Services Team led by Director Jessica Sedita-Igneri and Manager Tim Tejada; and Advocacy representatives who met with social service resources across the state, as we believe it is critical to address social determinants as a key element of integrated whole-person care. We have engaged directly with the Arizona Council of Human Service Providers, and through events coordinated by the Arizona Association of Health Plans (AzAHP), we have developed key relationships and broadened our knowledge of the Arizona BH and CRS systems. We are closely engaged with the state's work leading to the ACC transformation, including participating in state meetings, following state initiatives (i.e., the Targeted Investment program) and working closely with our acute care and RBHA partners across the state. This activity and early engagement has led to a more informed and complete implementation and transition plan and guides our tactical preparations, including our network expansion build – a critical component to ensure continued access to services; our staffing and hiring activities; our monitoring plans and various elements of implementation described in further detail below.

Pre-Implementation: Tactical Preparations

Pre-implementation activities help us to operationally be ready to help members through the continuity of care period and are critical to setting-up and benchmarking self-monitoring tools and processes we deploy throughout the process. ***Self-monitoring begins with accountability and is activated with a single point of leadership for transition activities.*** Susan Cordier, Chief Operating Officer, will be the Transition Coordinator for this transformative contract, as she has extensive experience leading transitions throughout the life of our AHCCCS contract. With more than 10 years of experience with Care1st and over 15 years in the AHCCCS program, Susan assumes accountability for the full array of transition activities and along with Kathy Hoffman, Sr. Director Health Services, is the primary point of contact for AHCCCS, the relinquishing health plans and the RBHAs throughout the transition period. Susan and Kathy are supported by a Transition Coordination Team, including our Senior Medical Director Dr. Satya Sarma; Behavioral Health Medical Director Dr. Marketa Wills; and other key local staff including representatives from prior authorization, inpatient concurrent review staff, CM, and leadership from Provider Services, IT, claims, and customer service. Under Susan's leadership, the team developed a series of strategies, processes and tools (described below) that we begin leveraging long before go-live to ensure smooth transitions, monitoring member care and provider continuity throughout the process. This local Care1st activity is supported by WellCare's expert transition teams including our enterprise Project Management Office (ePMO) and Integrated Solutions Team (IST), with direct accountability to executive leadership, who facilitate successful operational transitions across the organization.

Relinquishing Plan Meetings: We use a hands-on approach to each element of transition and will meet with the relinquishing health plan(s) and RBHA(s) early in the transition process to understand the data they are providing, including each field and data element, and work toward alignment. We will also identify specific network similiarities and differences so we can help members adjust to the change. For instance, if the relinquishing plan is using a different non-emergency medical transportation (NEMT) provider, and the member has pre-scheduled weekly transports to a therapy appointment, we will ensure those services are transitioned smoothly to our NEMT provider. ***Communications Schedule:*** Within the Implementation Plan and Transition Log, we maintain a detailed Communications Schedule that establishes specific plans and timelines for each communication to members and providers. Time is allowed to obtain AHCCCS approval for items per ACOM Policy 404. We will make sure members and providers understand the transition, have a single point of contact for questions and concerns and know how to reach us throughout the process. ***Staff Training:*** We update all training materials and conduct specialized training for both existing and new staff to cover each key element and nuance of the ACC program for day 1 execution.

Pre-Implementation: Building Out Self-Monitoring Tools

Detailed Implementation Plan and Timeline: We develop a detailed Implementation Plan and timeline outlining each new contract element and operational activity necessary to facilitate member transition. The Implementation Plan is managed by the ePMO, with each activity assigned an owner and a due date. The ePMO, which has successfully managed more than 120 projects, systems conversions and new implementations since 2014, holds regular (as often as daily or twice-daily) meetings through implementaiton to monitor and ensure ach step of the plan is on schedule. The plan is our central tool for self-monitoring each step of the implementation process. ***Transition of Care Database:*** The Transition of Care Database is a critical tool that allows us to monitor early identification of members with complex needs, as well as any remaining network gaps for incoming members so we can address those during the readiness period. ***We developed this database tool for the 2013 AHCCCS RFP transition and used it again for the 2017 PHP member transition.*** We populate the database with clinical information from the DEF files, blind spot data, and suppplemental data from relinquishing health plan(s) and RBHA(s). The database allows our team to drill down by member and provider and easily identify members aligned with PCPs or specialists not yet in our network, allowing Jessica and her team to quickly target additional providers for contracting, or complete a Letter of Agreement (LOA) and prior authorization overrides. It also allows us to run members through our proprietary Identification and Stratification (ID/Strat) Engine and identify members at greatest risk and intervene early as identified below in **Table 3-1**, where we detail out transition activities for members with various special needs. After go-live we continue to revisit the data, along with new data from our internal risk profile and health risk screening, to monitor variances to our intial analysis with individual members so we can quickly intervene if our monitoring finds a member needing additional services. It also helps us identify members in critical care settings or those who have complex or urgent needs, such as oxygen-dependency. ***Transition Log:*** A key part of our monitoring process is documenting each activity in our Transition Log, such as identifying PCP assignments and members with critical care needs. This tool works

alongside the Implementation Plan to specifically document operational transition activities, which helps us self-monitor that tasks remain on track. We also use it to document each activity for AHCCCS and internal audit review, which we conduct post-implementation as another monitoring checkpoint.

Pre-Implementation: Staffing

In addition to the Tribal Coordinator and the Member Advocacy Administrator (MAA) and given the delicate nature of the BH and CSR transitions as well as geographic changes, we will over-staff clinical and support teams, particularly in the BH area, as a contingency against staff vacancy, to be ready for the challenge of a large onboarding of membership. As we develop new leadership positions, they will plug into transition activities, playing a key role in representing the member voice and assisting with communications and engagement activities with specialized stakeholders, such as the justice system and courts and DCS . ***These positions will also play a critical role in the ongoing self-monitoring activities*** described below.

During the critical implementation period around go-live, we designate staff members to a ***Clinical Rapid Response Team, which has access to our Transition of Care database and monitor complex member transitions in real time.*** Staff members, both locally and from WellCare are placed in our ***Clinical Command Center*** and are empowered to handle escalated member clinical issues that could potentially place a member at-risk, in real time (e.g. continuity of care, care transitions, provider gaps and medication and DME monitoring). Specifically, if a member facing a lack of refills on an antipsychotic medication gets pushback from their pharmacy because of the change in health plans, the Clinical Rapid Response Team will urgently reach out to the pharmacy to get an immediate supply to the member while the pharmacy team works out any over-arching concerns of that pharmacy.

Post-Implementation: Governance and Oversight

Monitoring activities are overseen by our Executive Leadership Team (ELT) who are engaged in every implementation, including WellCare's CEO Ken Burdick, who reviews regular reports on transition milestones. Our lines of accountability are found 1) in our **local Arizona-based organization and leadership** through our local Board of Directors (BOD) and 2) in the **WellCare corporate infrastructure** to include regional oversight from our West Division President Stephanie Davis, the WellCare Executive Leadership Team (ELT) and up to our national BOD whose members set vision and expectations for the entire enterprise. We have an intense focus on compliance and maintain an independent compliance infrastructure with direct accountability to our BOD. This focus helps us define ongoing self-monitoring approaches through our internal audit and risk management teams. We will conduct a comprehensive audit of all pre- and post-implementation activities that include review of the Implementation Plan and Transition Log and current reports. Identified improvement opportunities will be quickly addressed by operational leaders. In addition, we established a number of unique approaches for ongoing self-monitoring of the ACC transition leveraging our high-touch member and provider engagement approaches throughout the process.

Post-Implementation: Continuity of Care

Our priority during any transition is member care and we understand the importance of preserving existing relationships between providers and members. We accomplish this by first understanding individual Transition Requirements, as outlined in Exhibit G, for both adults and children under age 21 by each provider type. For ACC, we will configure our systems, update policies and procedures and train staff across the organization on key details of continuity of care requirements, such as allowing CRS members to remain with their MSIC indefinitely, or ensuring pregnant members in the third trimester can receive services from their current OB provider and deliver at their planned hospital regardless of those providers' status within our network. In addition to the formal requirements laid out in Exhibit G, we will review individual cases to identify needs that extend past the requirements and err on the side of continuity while we work with members and their individual providers on a case-by-case basis. We load existing prior authorizations identified through the data sources noted above into our system. We also review pharmacy information, aligning with our pharmacy transition protocols, allowing new members continuation of drug therapy for non-formulary drugs and formulary drugs with UM edits. During the transition period, we will not apply quantity limits, step therapy, prior authorization or age limits. As noted in our implementation plan, beyond capturing existing service authorizations, we will pay claims, without regard for prior authorization or contract status of the provider for periods of time outlined in Exhibit G based on member and provider type.

Continuity of Care for Members with Complex Needs: We first identify members with complex transition needs, such as a transplant patient, through the data sources described above and through our own ID/Strat algorithm specifically built to predict member risk even before they become complex. This is helpful to identify members with specialized BH and social service needs that may not present in traditional identification tools: based only on cost and not overall need. We align each member with complex needs with the right CM and care coordination resources so coordination activities continue without interruption. For children already engaged in a Child Family Team (CFT), we'll engage early with the existing CFT members and care manager to ensure they have a Care1st contact available to facilitate services and assist with removal of barriers.

Members individually identified as complex will be enrolled in CM and welcomed into the program through telephonic outreach. These include members that have an active transplant case, are undergoing dialysis, high risk OB, have an open BH admission or who are working with the RBHA. Targeted members with the most complex health needs will be served through our field-based Care1st at Home complex CM program. For those members already in an established CM or care coordination program, we will transition the care plan from the relinquishing health plan or RBHA. Ideally, this effort will take place prior to go-live as we use our Transition of Care Database to find members early and engage in a warm handoff from the existing care manager or coordinator. Our monitoring policies specify continuity of care protocols and procedures for members identified as at-risk by AHCCCS as shown in **Table 3-1**.

Table 3-1: Transition Policies for Vulnerable Member Populations

Special Need	Transition Monitoring
High Risk Pregnancy or pregnancy within the last trimester	Monitored and assigned to High Risk OB care managers with a joint CM transition (one to one CM discussions on each member). Members in the last trimester: automatically authorized for OB care with current provider.
Transplant	Monitored and assigned to a transplant care manager, with joint individual member transition conferences and creation of authorizations as needed.
Hospitalization or nursing facility placement	Monitoring of supplemental data and transition with facility care coordinator to new plan inpatient review nurse on an individual member level with discharge plan discussion and outpatient authorizations as needed.
Special Needs Children under age 19; CRS condition, or those in out of home placement, foster care or adoption assistance	Monitoring of incoming ETI and supplemental data with transition calls between care managers on an individual member level with care plan discussion and outpatient authorizations. Members in and/or transitioning into an out-of-home placement with an IN or OON provider will continue to receive treatment through the duration of their prescribed treatment plan.
HN/HC integrated members	Group interdisciplinary transition conference monitors and discusses each HN/HC member, then member warm transfers to new care manager.
Ongoing treatment: dialysis, chemotherapy, radiation, end of life care hospice	Monitoring of members in active treatment with an IN or OON provider continue to receive treatment through the duration of their prescribed treatment plan with auth over that extended treatment timeframe as needed.
NICU infants with ongoing conditions (Complex Peds)	Monitored and assigned to a Pediatric care manager with joint CM transition and creation of authorization as needed (HHS, DME, etc.).
Elevated Lead Levels	EPSDT Coordinator identifies and monitors members with elevated blood lead on ETI forms and contacts member and PCP to confirm ongoing blood testing.
Members with prior authorizations	All prior authorizations monitored and loaded in core system so existing authorizations are honored and claims adjudicated.
Significant medical and BH risk (e.g. COE/COT, SMI Opt out)	ID/Strat of members with high risk factors are monitored for CM services with priority given to those in CM, newly designated and/or going through the COE/COT process. A joint care management transition (one to one care manager discussions on care plans) will occur.
Vendors: DME, pharmacy, medically necessary transportation	Joint transition discussions and monitoring plans at member level, with telephonic outreach to impacted members. We'll ensure that MTBA, our transportation partner, designates a Transition Coordinator to set-up existing blanket authorizations and orders regardless plan of origin.

Special Need	Transition Monitoring
American Indian Members	Tribal Coordinator will consult with the relinquishing providers' tribal coordinators and/or AIHP or TRBHA, as well as existing providers.
Other Special Needs Cases	For members that may contact AHCCCS, state and local officials, the media or the Governor's office regularly, we assign a Care1st at Home care manager to meet with the member and ensure they have direct contact with us, and we will make our Clinical Rapid Response Team aware of those members so escalation of any concerns can be immediately brought to leadership's attention.

Post-Implementation: On-Going Self-Monitoring Activities

Each day, throughout the go-live implementation period, we ***conduct daily cross-functional huddles*** to review urgent and critical needs identified by AHCCCS or our internal teams and milestones and daily operational reports to ensure we are on track. We have an array of reports and monitoring tools we use in those immediate days to monitor transition activity including, but not limited to: member and provider complaints and grievances, claims denials, progress of network gap closures, member and provider call center statistics, and authorization load status reports. For example, when Care1st membership doubled from 2012 to 2017, we **reduced grievances per 1,000 members by 53%** because we closely monitored grievances, and took action to minimize activities creating member abrasion. We also utilize "listening posts" that allow us to monitor members' experience and satisfaction real-time through phone and web-based survey tools to ensure early identification of emerging issues.

We continue self-monitoring transition activities for at least one year with specialized monitoring and reporting processes and tools that merge into our Quality Management and Performance Improvement (QM/PI) governance and committee structure. We will leverage common self-monitoring activities, including:

- Internal and External Audits
- Association feedback
- Member and Provider Satisfaction Surveys
- Call Center Service Levels
- Provider Relations feedback and JOCs
- Member Grievance and Appeals Reports
- Over and Under Utilization Review
- Feedback from our Member, Family and Stakeholder Advocacy Council (MAC)
- Claim Denials and Disputes Reports
- Ongoing Network and Access to Care Monitoring, including appointment availability

Additionally, we want to hear directly from those most impacted by the transformation so we can continue to strengthen and tailor our program to their needs. Some strategies for monitoring through engagement include:

Specialized JOCs: We will identify the largest BH and multi-specialty clinics and have our leadership meet in-person with their leadership at monthly Joint Operating Committee (JOC) meetings to discuss what-is and what-is-not working improvement strategies. We'll use the JOCs to discuss specific measures such as claims adjudication and denial rates as well as specific member issues, such as coordination of care for high-needs members. ***Follow-up Meetings with Key Partners:*** We will outreach to the same providers, stakeholders and advocates we met with during the past 18 months to assess issues they are facing with us or the transformation in general and report this through our internal interdisciplinary workgroup structure and with AHCCCS and other ACC plans. ***Member Advocacy Council :*** Our MMA team will lead dedicated Council meetings through the transition specifically aimed at transition challenges so we can tailor our ongoing activity to meet those needs. ***Quality Committees:*** We seek feedback from providers through quality committees with provider participation. ***Integration Summits:*** Modeled after the successful strategy employed by our Florida affiliate, we will conduct targeted integration summits. These events bring together key physical and BH providers in a designated geography to discuss barriers to integration and the ACC Transformation, while brainstorming solutions. ***CommUnity Assistance Line (CAL) Reports:*** Our proprietary CAL is staffed by individuals with lived experiences similar to our members. As members call-in for assistance with social needs like food and housing, CAL representatives assess any additional concerns members have. We will report on these interactions and identify common issues our members are facing through the transition to develop solutions to address them.

4. CARE COORDINATION INTEGRATION

ADMINISTERING INTEGRATED HEALTHCARE BENEFITS

As providers assume greater responsibility for care coordination in an increasingly integrated healthcare delivery system, Care1st envisions our role as the **single point of accountability responsible for care management (CM) and coordination activities** to ensure our members receive comprehensive, integrated care when and where they need it. Care1st has long recognized the importance of administering AHCCCS benefits in a way that drives value: optimizing quality and cost. Integration will further drive the transformation from volume to value by empowering the healthcare delivery system's coordinated impact on the entire care continuum. We partner with providers to innovate advanced care delivery models underpinned by value-based payment (VBP) arrangements, collaborate to solve problems and identify opportunities to improve our members' health outcomes and develop and share resources to actuate these outcomes and ensure member satisfaction in the new integrated healthcare system. From healthy members whose focus is to stay well, to members with complex co-morbidities, our model is to support, supplement or establish the elements that help members succeed in achieving optimal health. Our core principles at the organizational level to administer integrated benefits include the following:

- Utilizing a collaborative organizational structure and supporting operational systems that promote the delivery of integrated physical and behavioral health (BH) care;
- Expanding care coordination and CM best practices for integrated care; and,
- Considering the physical and BH needs of our members during network development and management activities to ensure co-morbid needs are addressed within an integrated setting.

Core Principle 1: Organization and Operational Systems Supporting Integrated Service Delivery

All aspects of Care1st's leadership and staff fall under the same umbrella, within one system, using integrated tools. Rather than dividing care coordination activities among separate companies or divisions like other contractors, Care1st is **foundationally** integrated to deliver a comprehensive physical and BH service delivery system. All of our practices and approaches at the organizational level are integrated and member-focused to tailor to each member's individual needs, which is particularly critical when administering integrated benefits because being under one system allows us to ensure continuity of care as the member's heirarchy of needs ebb and flow with their care, condition and life circumstances. And because we focus exclusively on members served through a government-sponsored program, all of our organizational structure and operational systems are specifically designed to serve members like those in the AHCCCS Complete Care (ACC) program.

Improving Outcomes Through In-Sourced, Fully Integrated Care Management

A recent study of our Florida affiliate, Staywell, showed that after they in-sourced behavioral health management from a vendor in late 2014, they saw significant gains over two years in health outcomes including a 4% decrease in medical surgical inpatient readmissions, a 17% drop in behavioral health inpatient admissions and a 14% drop in BH readmissions, while increasing outpatient and pharmacy services.

Integrated Staff: Our integrated Arizona-based clinical leadership represents physical, BH and social services expertise and plays an integral role in designing and implementing integrated population health strategies and programs that are focused on improving health outcomes, enhancing care coordination and member satisfaction. Since the announcement of the ACC transformation, Care1st has investigated the nuances of integrated service delivery, soliciting perspectives from an array of providers, tribal councils and community advocates. With each new insight, we have transformed our staffing infrastructure to model the ACC plan of 2018, including the designation of a Tribal Coordinator, Practice Transformation Team, creating additional clinical leadership and lived experience roles, and hiring a BH team to complement our transitional efforts. These staff members operate under a single set of fully integrated policies aimed at whole-member care and operational integration across departments. This is particularly important under parity rules and to align with AHCCCS integrated AMPM and ACOM policies.

Integrated Systems: Care1st and our parent company WellCare have invested in integrated data-driven system solutions and tools designed to facilitate convenience for our providers, members and associates by integrating physical and BH and social determinants into member records, member identification and stratification, and our population health management activities. As a result, provider directories, claims history, care gaps, care planning and coordination, and our provider portal directly incorporate behavioral and physical health into the same applications and resources. Additionally, our member-facing staff are trained and consistently demonstrate a "whole person" view of the member they are guiding, whether through a call to help a member find the appropriate provider, or in the field with our care managers who have whole-person care accountabilities.

Integrated Clinical Practice Guidelines: Care1st's clinical practice guidelines (CPGs) are a valuable resource for our staff our providers and support uniform application of clinical best practices. They identify and document diagnostic, treatment and preventive services associated with best outcomes in various clinical circumstances. Our guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals with specific clinical expertise and on the recommendation of world-class and highly trusted sources such as American Academic of Pediatrics, American Heart Association and American Psychiatric Association. We have adopted fully integrated CPGs based on the specific needs of our members including maternal and child health (MCH) needs and conditions of concern in our local populations such as hemophilia and sickle cell disease. In total, we offer more than 50 fully integrated CPGs: **Asthma:** Screening for anxiety and depression and initiate treatment or continued surveillance when discovered. **Diabetes in Adults:** Assess for risk of depression and share with appropriate provider(s) if risks are identified. **Opioid Use:** Members with chronic pain should be connected to a pain management specialist and a BH provider who can prescribe non-opioid medications and non-pharmacological approaches to managing chronic pain. **Depression:** Individuals with depression are four times as likely to develop a heart attack and are at a significantly increased risk of death or a second heart attack.

Core Principle 2: Expand on Integrated Care Coordination and Care Management Best Practices

Our organizational approach to care coordination and CM is rooted in best practices of population health and flexes to members' needs - from ongoing care coordination led by our providers for more stable members, to acute intensive CM supported by Care1st care managers. ***We envision our role in care coordination and*** CM ***as a facilitator to empower members to reach their personal health and recovery goals and to support providers to meet their responsibilities to ensure members get the coordinated, integrated care they need.*** We ensure that every member has a designated person or entitity with responsibillity for coordinating services for the member and stratify coordination interventions based on member acuity at any given time. Each step in our CM/care coordination practices, described below and designed in adherence with AMPM Policies 500 and 1000, is geared to improving overall population health outcomes by aligning integrated resources and ensuring access and referral to the comprehensive set of benefits we will administer under ACC.

Care1st's high touch approach has led to **87%** of pregnant members receiving timely prenatal care.

Proactive identification of members for engagement in care management. All care coordination and CM begins with an evaluation of each member's care history to understand members' physical, behavioral, pharmaceutical and social needs. This begins with an initial screening of each member's needs as outlined in AMPM Policy 920, conducted via phone, mailing or in person at a resource center or Care1st Welcome Room, to allow members to self-identify their health status and critical needs. Next, using Care1st's proprietary Identification & Stratification (ID/Strat) Tool (**Figure 4-1**), we score each member's risk based on a variety of inputs including: the HRA, enrollment file, claims, diagnoses and comorbidities, and cost and medication adherence/risk scores. ***In an emerging feature of our ID/Strat tool, we are including social service risk determined through our unique approach to cataloging and tracking utilization of social service resources***, such as non-benefited housing supports or access to healthy food. We use the combination of these data to stratify members based on the severity and complexity of their health needs, and coordinate care that addresses their physical and BH needs as well as their social determinants of health. Our identification tool was specifically designed to pick up on BH risk often overlooked through traditional models. ***After first launching the tool,WellCare identified 20 percent more members previously masked by claims-only based identification tools and half of those had a BH diagnosis.*** One example of the strength of our assessement, identification and stratification processes is in our HUGS program, where we reach out to make personal contact with every pregnant member – a high touch approach that has led to 87% of pregnant members receiving timely prenatal care.

Providing the appropriate level of care management/coordination of services to members with comorbid physical health and behavioral health conditions. The risk score outlined by our ID/Strat Engine is one way we determine the intensity of CM intervention and how member care is coordinated for each stratification level: High-cost/high needs members (Level 3); low-cost/low needs members (Level 1); and those members with a varying degree of costs and needs (Level 2). We also identify members with certain special needs such as justice-involved members or children already engaged with a Child and Family Team, to identify the right kind of CM involvement by our team. For example, we will not be duplicating efforts of the CFT, so our role in those cases flexes to one of participation, data sharing and coordination/referral assistance to empower the team to meet the child's needs. For members identified for some level of short-term Care1st Intensive Care Management, ***we use the smart assignment engine within our ID/Strat model that recognizes member hierarchy of needs and assigns members to care managers that are best equipped to manage their conditions.*** For example, if we have a high needs/high cost member identified because of multiple psychiatric ED and inpatient admissions, that member may be assigned a Care1st at Home Care Manager who is a licensed clinical social worker. All care managers have access to our integrated CPGs as well as are **cross-trained to address co-morbid conditions**. They also have real-time and direct access to an internal multi-disciplinary team to consult on cases, including such roles as registered nurses, a housing coordinator, community advocates, tribal coordinator, child and adult system administrators, pharmacists and our integrated clinical leadership team of physical and BH physicians and psychiatrists should they need assistance on any aspect of member care.

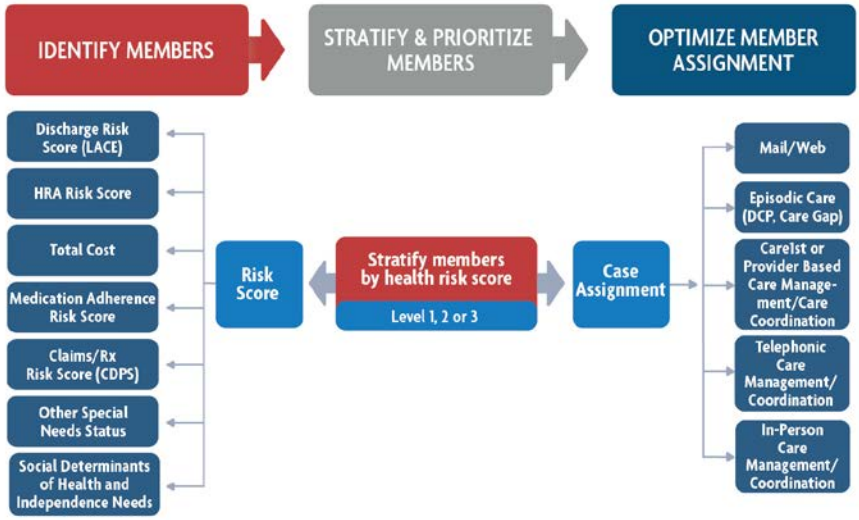


Figure 4-1: Care1st's Proprietary ID/Strat Engine

A key feature of our integrated Care Management system is Care1st at Home. We provide field-based, in-home and telephonic CM and coordination solutions to meet members and caregivers where they are. Field care managers live and work in the same communities where the members they serve reside. We hire committed, caring professionals who are familiar with the strengths and challenges within their service communities, with the cultural diversity of the membership and with the barriers many members face when striving for optimal health. A key element of our approach is that we leverage licensed personnel to work in people's homes rather than just outreach workers used by many Medicaid managed care plans. Having licensed nurses or social workers in member homes allows us to more accurately understand the needs of the member and tailor the right interventions. Our Care1st at Home Care Managers provide person-centered support and guidance in a fully integrated manner to address a member's medical, social, behavioral and environmental needs. Every aspect of our CM is integrated—identification and stratification, assessments, care planning, follow-up and monitoring—and we pay special attention to the social determinants of health that can influence whether members can follow through on their treatment. In other state affiliates, like Florida, ***the model has shown a 26% decrease reduction in avoidable inpatient admissions and 8% reduction in unnecessary ED visits for those engaged.***

Best Practice: Empowering Provider-Led Care Coordination

While we value our role to provide direct intensive short-term care management for ACC members who face urgent and complex needs, our priority remains aligning members with providers equipped to offer comprehensive care coordination. We offer providers a variety of tools to support their care coordination activities including the provider portal with detailed clinical and utilization data on their patients, panel care gap reports, Quality Practice Advisors to review, payment flexibility, appointment scheduling assistance, social services resource referral and coordination and, as needed, embedded Patient Care Advocates and/or Discharge Planners to support critical short-term needs.

Collaborating on an ongoing basis with both the member and other individuals involved in the member's care: Care Managers and Coordinators work closely with members and their caregivers throughout the CM process. An integral part of our care planning is the identification of each member's interdisciplinary care team (ICT), which generally includes the member, caregiver or guardian (if appropriate), the care manager, the member's PCP and other critical speciality providers. Care1st makes it easy for ICT members to collaborate in and stay informed about the member's care. We meet providers where they are—in offices, schools, hospitals and nursing facilities—and use technology where available and appropriate to facilitate "face-to-face" meetings to discuss the member's case. Care Plans are made available to all ICT members, a critical step in ensuring collaboration on an ongoing basis. Care managers stay in touch with members and their ICT based on a frequency prescribed and approved by supervisors based on member need. ICT engagement is then consistently monitored and assessed by the supervisors to ensure consistent and effective engagement.

Ensuring continuity and coordination of physical and behavioral health services and collaboration/communication among physical and behavioral healthcare providers. As providers move along the integration continuum, we expect to see increasing collaboration, co-location and eventually integration among physical and behavioral healthcare providers. Until integration is achieved, we take a very active role in connecting providers and sharing integrated data to encourage collaboration and communication to enhance care coordination for physical and BH.

- **Interdisciplinary Care Team:** As mentioned above, we use the ICT approach to encourage coordination regardless of member primary need at any given time.
- **Integrated Data Sharing**: Our data is available to all providers through our provider portal providing transparency into both physical and BH conditions and utilization including reasons for ED use or inpatient admission
- **PCP-Behavioral Health Toolkit:** We offer a toolkit to PCPs to help them navigate BH conditions including assessments and how to manage basic BH needs and how to collaborate on more complex conditions.
- **Value Based Strategies:** Our flexible approaches to VBP encourages, supports, and trains providers to advance towards more integrated approaches for care delivery. Our provider engagement model includes on-site assistance with providers, focused on closing care gaps and creates virtual integrated care.
- **Member Assignment and Alignment:** We seek natural opportunities to build "virtual health homes," a particularly strong technique to care coordination in rural areas where large concentrations of membership may be seeing the same PCP and BH provider.

Operating a single integrated member services toll-free phone line and a single nurse triage line available for all members for physical health and behavioral health services. One key approach to enhancing care coordination is making it easy for members and providers to reach us for information. We operate fully integrated single member service and nurse advice toll-free lines. This allows members to self-navigate the system – which enhances their experience and empowers them to take control of their health and care coordination.

95% of Care1st members would recommend our after-hours nurse and triage line to friends and family.

Core Principle 3: Considering members' co-morbid needs in network development and management and encouraging members to use integrated service settings

Building on the critical components and milestones outlined in AHCCCS' Targeted Investment (TI) approach to support integration, we engage key providers and offer administrative support as they seek special designations and offer a continuum of VBP strategies to incent and support an integrated service delivery model at the provider level, which is key to improving whole member care and outcomes. We also align members with integrated and high quality providers through our auto-assignment algorithm to prioritize high quality integrated providers to matches specific member needs with provider capability to treat and coordinate care.

Considering integration and co-morbidity in network development and contracting: As we have expanded our network to ensure access to the comprehensive set of benefits, we have taken specific steps to prioritize contracting with integrated providers, centers of excellence and specialized providers to enhance care coordination activities at the provider level. A key to our long-term network development plan is enhancing the number of members with access to a fully Integrated Health Home. We provide support through our dedicated ***Practice Transformation Team*** to build capacity among providers interested in obtaining IHH designation. We will work with existing providers such as CODAC, La Frontera/Empact and Valle De Sol to provide general BH and substance use services currently carved out. With the inclusion of these services under the acute care plan, we have a high volume of providers joining our

network, including FQHCs, ICs and outpatient BH clinics. We use AHCCCS' guidelines as well as our experience with IHHs in our Florida market to build a robust IHH network throughout Arizona.

Innovative Partnerships with Key Providers: To enhance care coordination and improve the member experience, we have been a leader in the state in designing payment strategies that drive whole-member care at the provider level. We support providers to define level 3 and level 4 VBP arrangements for comprehensive, integrated care through aligned incentives. We seek partners who are interested in innovating in areas of integrated care coordination and CM and look for ways to fund and support those innovations through VBPs, member assignment to ensure volume for new services or levels of care coordination, data sharing and transparency and a broad range of supports. Just two examples of several partnerships we are engaging in for the ACC contract include the following:

- **Integrated Treatment for Pain Management (PM) with Valley Pain Consultants**: Care1st's partnership with Southwest Behavioral Health (SWBH), a BH provider and Valley Pain Consultants, a pain management clinic, pushes collaboration on an integrated care delivery system for those suffering from chronic pain and at a higher risk for opioid use. The program embeds a BH practitioner one day per week in the PM office to provide care for members. Care1st provides integrated data, care coordination and support in addressing social determinants of health, such as homelessness, joblessness, social supports, financial resources, transportation needs and justice system involvement. Previous studies of similar models in our KY and/or FL affiliates have been shown to significantly improve care compliance, ***decrease prescription opiate use, better manage behavioral health, decrease utilization of ED and inpatient care, and increase member and provider satisfaction***.
- **Crisis Response Center (CRC) in Tucson:** Care1st's partnership with the Crisis Response Center (CRC) in Tucson focuses on a continuous improvement process to assist members seeking care due to a BH crisis. CRC provides an array of integrated assessment, counseling, crisis, peer and other BH services. When working with clients, CRC often identifies complex medical conditions needing referral and attention. Care1st and CRC's partnership focuses on the identification and referral of these members to resolve barriers to access. For members enrolled in BH services, Care1st takes the information gathered from the CRC collaboration, along with information obtained through our own data, and further partners with community BH providers such as La Frontera, CODAC and COPE who operate integrated clinics (ICs) and IHHs. For members with greater medical needs, the Care1st care manager works to facilitate coordination between the medical and BH providers. The care manager may provide ongoing support to the BH provider to assist with support and resolve any remaining barriers.

Strategies to Encourage Members to Utilize Integrated Service Settings: Using our provider assignment algorithm, we align Care1st members with the right provider, in the right setting, to coordinate whole-person care. Our strategy is to partner with local integrated health homes that fit our member needs for care and coordination. For example, we recently partnered with a Phoenix area VB integrated practice, Bayless Health Care, and aligned their care and coordination services to more than 4,000 local members over an 18 month period– a concentration in volume that supports integrated care delivery and improved health outcomes. We will use this approach to align members to appropriate local integrated health homes across the state. Other strategies we use to encourage members to use integrated service settings to improve outcomes:

- ***Education and outreach activities*** to introduce integrated care to members through health fairs, welcome packets and newsletters, MCH coordination for pregnant members and community advocacy engagement.
- ***Creating local partnerships*** like the one with Avondale Elementary School District's Community Health Initiative and Bayless Health Care to support building a new multi-specialty integrated health clinic across the street from our Avondale Resource Center to help treat members where they are.
- ***Care management/care coordination referral*** so when a member need is identified, care managers or coordinators can quickly align to the most integrated setting to meet the member need, including assignment to centers of excellence for highly specialized needs such as pregnant women with substance use disorder

PAST EXPERIENCE ADMINISTRATING INTEGRATED CONTRACTS

Care1st has been an AHCCCS health plan for more than 14 years, and has taken accountability and ownership of "whole person" care, regardless of what services we are covering, which means collaborating across other health plans and RBHAs to ensure member needs are met regardless of need. For the ACC transformation, we also draw on the past experience of our affiliates across the country, the vast majority of whom operate integrate contracts, to design an approach to administer integrated benefits under ACC, enhance care coordination and improve outcomes.

Florida's Evolving Models of Integration: Our Florida affiliate, Staywell, was among the first in the state to administer BH benefits and has been doing so for about 20 years. In 2014, Staywell fully integrated BH management into its core operations, operating under a single umbrella. Unlike other Medicaid managed care plans that operate carved out versions of BH care, their holistic approach ensures that BH benefits are fully integrated into the program and included seamlessly into member materials and customer service scripts. Network and CM teams work together to support members with both physical and BH needs to ensure access to services through a contracted network, coordination across the continuum of care and assistance in accessing the benefits needed to provide quality outcomes for its members. A recent Staywell study analyzed utilization for members who had one or more BH conditions and at least one chronic physical health coverage before and after integration. A few results include ***a 9% decrease in PMPM cost***, driven largely by decreases in inpatient stays for both physical and BH conditions. They also saw a ***16% increase in use of outpatient mental health services and pharmacy services by 19%,*** providing a strong indication of enhanced care coordination activities to get members the right care in the most appropriate settings.

WellCare of Kentucky's Innovations for Integrated Care: WellCare of Kentucky piloted an initiative to improve health outcomes and quality of care for adult members with a Severe Mental Illness (SMI) and five additional chronic medical conditions, including asthma, COPD, diabetes, hypertension/heart disease and AIDS. The goal of the program was to make a positive impact on members' utilization of the emergency department, hospital admissions and readmissions, frequency of PCP/psychiatrist visits and medication adherence by implementing face-to-face integrated case management using a clinical dyad consisting of a nurse case manager and a social worker case manager. The clinical dyads participating in the pilot received core case management training (motivational interviewing, case management safety and documentation) as well as condition specific training (schizophrenia, bipolar disorder, anxiety, depression, suicide assessment/prevention, substance use disorder, asthma, COPD, diabetes, hypertension/heart disease and obesity). The clinical dyad continued to work with members and their families, treating providers and identified social support systems via face-to-face visits to coordinate needed care and assist the member to remain stable in the community. ***The results of the program were significant with a 31% decline in total cost of care for members engaged driven largely by a 66% decrease in inpatient expenses and a 10% decrease in ED visits.***

With the AHCCCS Complete Care contract, we will borrow from our affiliates and use similar strategies of focused care coordination and CM for high needs members and provider empowerment to effectively coordinate integrated care to transform the current Arizona Medicaid plan by reducing admission rates and overall expenses and provide truly integrated care designed to reach all members.

USING TECHNOLOGY AND SOCIAL MEDIA CREATIVELY TO ENGAGE MEMBERS AND IMPROVE OUTCOMES

Care1st uses the power and reach of technology to increase access to information, promote health literacy and to empower members. With our integrated use of information and innovative tools, social media and our monitoring capabilities, we apply technologies in ways that will impove member satisfaction and health outcomes.

Table 4-5: Tools and Information

TOOLS	DESCRIPTION	IMPROVEMENT OBJECTIVE
MyWellCare App	Our mobile app provides members tools and information for self-management on-the-go. Some of the features include appointment reminders, secure messaging from Care1st, instant ID card view, as well as transparency into the members care plans, medication adherence and care gaps. Our mobile app is available in Spanish and English and also offers a "Find a Provider Tool" to allow members to find providers closest to their locations.	• **Member Satisfaction**: Ease of use, real-time access to key information, effective reminders • **Improved Outcomes:** Adherence to preventive care, care gaps & reminders
Care1st Website	Our integrated website was developed and is continuously enhanced based on feedback from members and caregivers. Our public website provides public access to benefit plan overviews, contract information, a searchable member handbook, a searchable provider directory, quick tips, BH information, new member FAQs and more. Our member Secure Member Portal highlights care gaps, helps make appointments and allows members to get their ID card.	• **Member Satisfaction:** Comprehensive access to key member/medical information, health education • **Improved Outcomes:** Clinical supports, care gap information • **Enhanced Care Coordination:** Connection to resources, ICT

Telepsychiatry	BH providers accommodate members who cannot travel and connect members to board-certified providers who have devoted a significant portion of their practice to telehealth.	• **Improved Outcomes:** Ease of access to critical services
Loaner Phone	Provides a pre-programmed smartphone to members who qualify. The phone gives these members the capability to connect to the app, Member Services and our 24-hour Nurse Advice line or contact their provider or care manager.	• **Improved Outcomes:** Adherence to care plan, preventable event avoidance
Online BH Therapy	Free, confidential online cognitive behavioral therapy for members and their families available on a smart phone and available as a URL website and portal.	• **Improved Outcomes**: Ease of use, enhanced accessibility to health plan
EPSDT Text Messaging Program	Designed to increase child and adolescent well-visits and annual dental visits by using short message service (SMS) or text messaging to engaging health plan members. Parents of all members ages 3-20 receive a message reminding them to schedule well visits. Follow-up reminders are sent for members who continue to be noncompliant with a well visit or dental visit.	• **Member Satisfaction:** Ease of use, critical reminders • **Improved Outcomes:** Enhanced member engagement, adherence to preventive care,
Prenatal Messaging Program	For expectant and postpartum moms. Prenatal texts include a brief statement tailored for the members' week of pregnancy with a link to a microsite that provides education on the specific topic. Members are also given a direct number to contact a maternal and child health specialist if they need help.	• **Member Satisfaction:** Ease of use; enhanced accessibility to health plan • **Improved Outcomes:** Adherence to preventive care
Live Lactation/ First Year of Life Support for New Moms	A free app-based service, known as Pacify, for pregnant women and new moms that provides education through text messaging and 24-hour access to live clinicians and lactation consultants.	• **Member Satisfaction:** Ease of use; enhanced accessibility to health plan • **Improved Outcomes:** Adherence to preventive care

Engagement & Social Media

Care1st's social media strategy has expanded through our parent company's industry-leading approach to member engagement through several social media platforms. A key advantage in being part of WellCare, we now have the resources of a team solely dedicated to providing member service through social media. The CARES team actively monitors and responds to specific inquiries received within two hours of posting for all social media outlets, during business hours. If necessary to resolve the member's issue, the customer service team will reach out to the member, providers and/or other team members through the most appropriate channel. ***The CARES team responds to all incoming inquiries, beating the industry average response rate of 40%.***

Members can visit our Facebook page at **https://www.facebook.com/WellCareHealthPlans**, which has passed the 10,000 threshold for followers/likes, representing an 82% increase since January 1, 2017. Our social media presence also includes a Twitter page, company blog, e-newsletter called WellCare Connections, and videos on YouTube to ensure we can properly address all member-centered inquiries and provide content in a timely manner. WellCare is found on Twitter **@WellCare_Health**.

Our company blog and YouTube channels provide information or the location of information quickly and in an audio/visual format. Member stories are particularly powerful on this social media outlet and give members insight into what WellCare can do for them. Videos are also available as resources for using WellCare's benefits and services. There is a video with instructions for navigating our Web site; stories about WellCare's work with charitable organizations are found on YouTube as well. Specific Care1st presence on social media will be linked to the WellCare offerings on YouTube and Facebook at the go live date of 10/1/2018.

5. 54 YEAR OLD FEMALE AND HOW OFFEROR WILL MANAGE CARE

SUPPORT FOR A MEMBER WITH BEHAVIORAL AND PHYSICAL HEALTH CONDITIONS

Care1st's intensely local and in-person approach to care coordination was designed to meet the needs of complex members like Flora who have co-occuring conditions. Our combination of interventions specific to SUD coincide with the National Principles of Care's core concepts of quality addiction treatment. These include a personal plan for Flora with frequent monitoring, reassessments and adjustments, routine screenings for SUD and BH concerns, seizing the moment when Flora seeks treatment through fast access to inpatient facilities, use of medication as a legitimate treatment for SUD, viewing Flora's management of her heroin dependence through the lens of disease management, coordinated care of all of her conditions (schizophrenia, diabetes, neuropathy, etc.), access to accredited and licensed behavioral health professionals, and support for Flora's recovery by natural supports, community and peer groups.

Enrollment and Integrated Care Staffing

During the ACC readiness period leading up to October 1, 2018, Care1st uses our Transition of Care Database, populated by data from AHCCCS and relinquishing plans, to identify Flora as a high-needs member. With this advanced notice, Care1st begins several activities concurrently to ensure Flora's continuity of care as she moves from the previous plan to Care1st. We immediately (within the same business day) coordinate with the relinquishing plan to gather information about Flora's psychosocial and medical history and past treatment. The Transition Team flags Flora on the potential transiton list (PTL) as special needs due to history of ED use and co-morbid complex conditions. The Transition Team gleans all information about current services Flora receives and ensures continuity of care by honoring existing prior authoriziations until Flora has a safe transition, whether or not her physicians are participating Care1st-contracted providers. All transition activities for Flora are completed per AMPM Policy 520, ACOM Policy 402 and 440, as well as other relevant policies related to Flora as a high-needs member transitioning.

Like all members' information, Flora's data is analyzed with Care1st's Identification & Stratification Engine (ID/Strat), which uses historical records and inputs to score Flora's risk based on her predicted future behavior. Flora's case is concurrently and redundantly flagged as high-risk based on her enrollment information due to several factors: frequent prescriptions in the past for specialty narcotics; Flora's non-adherence to medications and diabetic supplies; her diagnosis of schizophrenia with co-occurring substance use and diabetes; and her high ED utilization; and her multiple inpatient psychiatric admissions for acutely psychotic behavioral disturbances. Care Manager (CM) David, is assigned as Flora's field-based care manager. He is matched with Flora because of his specialized expertise in managing members with SUD. When he feels he needs additional input or expert advice, he has the assistance and support of co-located clinicians, RN care managers, LCSW care managers, a pharmacist, medical and behavioral health physicians, who have different skill sets and program expertise, as well as care coordinators that handle more administative tasks. This internal multidisciplinary team allows David to be a single point of contact for Flora with Care1st, which is important for members like Flora with complex conditions who may have difficulty interacting with multiple parties due to underlying paranoia and difficulty forming interpersonal attachments.

David reviews her enrollment history in the AHCCCS eligility system and confirms Flora had been assigned to a RBHA in the past. In collaboration with her previous plan's CM, David begins working on a personal transition plan. He reviews Flora's treatment history including previous RBHA services, her PCP, her pharmacy and medication history, claims and HIE data. Through these records and her pharmacy claims for Percocet, David discovers that she has a confirmed diagnoses of schizophrenia, opioid dependence and diabetes, and is not coping well with chronic pain from peripheral neuropathy. Her records also show sporadic housing and food insecurity as well as inconsistent behavioral health management and physical health services. Due to the complexity of her conditions, Flora benefits from the *Care1st at Home* program, which includes medication management, direct communication and collaboration with *all* treating providers, applied strategies to engage her in self-management and improve adherence to long- and short-term goals, evidence-based interventions that address her behavioral health needs, management of chronic conditions, pain management to decrease her reliance on opioids, and improve her social determinents of health, all through our integrated model of care.

As David is reviewing available information on Flora and preparing to reach out to her, the provider reconcilation team identifies Flora's PCP as noncontracted. To ensure continuity of care, a Tucson-based Provider Services Rep

contacts the PCP about contracting with Care1st, or at minimum, develop a single case agreement to ensure continuity while Flora's most immediate needs are met and she can be aligned with an Integrated Health Home (IHH) or Center of Excellence better equipped to meet her complex needs.

David immediately identifies Flora as someone who may be difficult to reach. Her records show a history of unstable housing and she has no telephone number in her records, nor is David able to find a number for her in our member data management (MDM) database. Since she is high-risk, David forwards her information immediately to our Unable to Contact (UTC) team who mine for additional contact information for Flora using advanced search tools, like Lexus Nexus. They also look at any utilization history, including medication fills, and contact providers or the pharmacy to obtain any available updated contact information. When those members are not successful in finding Flora, we use our partnerships with community groups, such as Catalytic Health Partners in Tuscon, to find Flora through in-person contact with homeless shelters, churches and community groups. Since Flora's information does not provide many leads, David notifies additional community partners, like La Frontera's Readily Accessible People (RAPP) program. Just when he gets a lead that she may be living in a homeless camp on Congress Avenue, he receives information that Flora is in St. Mary's ED.

UNABLE TO CONTACT PROGRAM

We help locate members like Flora, who have a history of unstable housing, using multiple methods, like skip trace technology, community partner collaboration and "feet on the street." Partners in the community inform us when a UTC member uses the ER, or become involved with the justice system. Community Health Workers visit shelters, community centers and homeless encampments to track members in person. So far, our program has resulted in a 46% success rate in finding difficult to reach members nationwide.

The staff at St. Mary's identify Flora as a Care1st member, and when they are unable to discharge Flora from the ED timely because of her housing barriers and complex co-morbid needs, they contact Care1st. David is subsequently notified because the UM nurse coordinator sees in our single management platform, CareCentral, that Flora has been flagged for High-Risk Care Management, is identified as UTC and is assigned to David. She contacts David to let him know that Flora is at St. Mary's ED ready for discharge. His review of Flora's file, along with the additional information provided by St. Mary's, identifies several priorities for his first encounter with Flora:

- Ensure Flora is medically stable and safe
- Identify a dual diagnosis residential treatment program that can provide stable living and treatment immediately upon ED discharge and support for Flora to participate in a Medication Assisted Treatment (MAT) program
- Contact the prescribing behavioral health provider and previous RBHA to write psychotropic medications for the next 30 days to cover Flora's medications through the end of October
- Ensure medication reconciliation post-discharge from the ED
- Engage with the current PCP to ultimately find Flora an IHH of her choice better able to manager her care long-term

Initial Assessment and Person-Centered Planning

Within one day of receiving notification, David visits Flora face-to-face at St. Mary's. Through spending time with Flora, David employs a systematic approach to assessing Flora's needs and strengths as they relate to her physical and behavioral health and any need for special supports, her social, environmental and cultural factors and natural supports. He knows that building a relationship with Flora will take time, and he employs motivational interviewing to engage her. She is argumentative and suspicious of David and accuses him of spying on her because he seems to know too much about her. She also appears to be distracted and, at times, is responding to internal stimuli so it is difficult for David to elicit information from her. Ultimately, David is able to complete the initial assessments but a great deal of the information is gleaned from records through CareCentral. He records her limited responses and the collateral information collected in his hand-held tablet.The assessment reveals several signifant factors related to Flora's medical, behavioral and social/cultural history and current status, strengths and preferences.

Medical	Behavioral	Social/Cultural
• Has diabetes, but does not take her medication (Glyburide XL) or tests blood sugars • Adverse reactions to her medications prevent her from taking them regularly • She describes her pain related to her peripheral neuropathy as "pins and needles" and takes Percocet when she can obtain a prescription • She uses heroin as a form of pain control	• Uses IV Heroin several times a week • She scores a 10 (moderate depression) on the PHQ9 but has no thoughts of self-harm • Distrustful of her behavioral health providers and previously opted-out of receiving physical health services from the RBHA. • Not currently controlling her schizophrenia with medication resulting in a high degree of paranoia as well as some hallucinations	• Distrustful of authority • Panhandles frequently • Rarely eats a "good meal" • Significant ambivalence to MAT • Estranged from her family with few natural supports • Has a few friends in the homeless encampment where she frequently sleeps • Currently has no stable housing • Currently has no job, though has two years of college education and technical skills • Expresses that she is tired of being hungry, tired, and in pain

With Flora's permission, David calls La Frontera to arrange for an intake worker for their residential treatment program, La Casa de Vida, to meet with Flora in the ED. Although Flora is not fully on-board with residential treatment at present, in alignment with National Principles of Care, David looks for ways to speed Flora's access to treatment as soon as she is ready. David collaborates immediately with Flora's former PCP, ED physician and the hospital social work staff to identify strategies with Flora for post-discharge, emphasizing the purpose of integrated care and reestablishing relationships with a licensed BH provider. David also proposes connecting Flora with a peer support specialist, someone with lived experience, who can provide support and offer experience on recovery.

Meeting Flora's Needs and Assisting Him to Achieve His Goals

David meets with members of the internal team (such as Pharmacist Ronald Erkens, Behavioral Health Medical Director Dr. Maketa Wills and advocacy team like housing coordinator) to strategize around Flora's complex care coordination. He also meets with her former care manager and providers. He discovers additional information about Flora important to the care planning process. Using the totality of Flora's physical and behavioral health, social history and current strengths and preferences and the inputs from the multidisciplinary team, David works with Flora to create a care plan of mutually agreed upon short and long term goals that are realistic and measurable, including taking her medication to manage her schizophrenia. Flora's care plan includes interventions that address each of her diagnoses and conditions with specific, evidence-based steps that tie to Care1st's integrated Clinical Practice Guidelines (CPGs). As Flora's immediate needs may change over the course of care, the care plan reflects these contigencies to give Flora clear guidance when facing various challenges, such as access to food, identifying and managing symptoms of psychosis and taking her medications, feeling the need to use, when she experiences pain, feels depressed or, in general, is not managing well. Her providers can access her care plan and 360-degree member dashboard on the Care1st Provider Portal

Issue #1: Substance Use. Goal: Get help to stop IV heroin use. **Plan:** Flora's most pressing immediate risk is her IV heroin use coupled with management of schizophrenia symptoms. Opioid use puts her in danger of overdose. Her schizophrenia symptoms, including paranoia, auditory hallucinations and thought-disordered psychosis, combined with herion addiction prevents her from managing her other conditions, making good choices about her diabetes, nutrition and overall health, and from finding and maintaining stable housing. David understands the importance of meeting Flora where she is. After some "false starts" where Flora agreed to go to treatment and then changed her mind, after remembering a friend who died of a heroin overdose, Flora ultimately decides to enter a dual diagnosis residential program offered by La Frontera with the expectation that she would discharge to the outpatient MAT program. David updates her care plan in CareCentral to reflect new goals based on her treatment plan. David has already made sure Flora is pre-approved for the program and it is authorized. During her residential stay, she is treated with methadone, which is continued on an outpatient basis once Flora moves to Milagro transitional housing. She is also started on the oral antipsychotic medication Haldol (see below) while at La Frontera which helps to quiet the voices and makes her thinking more organized and linear. Her co-occuring conditions can be treated onsite

through El Rio.

Flora agrees that it is more convenient for her to receive care through La Frontera's IHH. While at Milagro and beyond, when she finds long-term housing, her team of providers will continue to provide seamless continuity during the time when she is most needing support. David facilitates a multidisciplinary team meeting with Flora's exiting PCP and Flora's assigned Case Manager at La Frontera and the new PCP and BH provider to ensure all Flora's treating providers are updated and aligned on her treatment goals. Care1st's BH coordinator contacts the RBHA to ensure they are also aligned with the treatment plan to avoid a duplication of services as the team assesses Flora's current SMI eligibility and needs. David educates Flora on how to advocate for her needs and to seek care with a consistent provider team and ensures there is no duplication of services.

Issue #2: Schizophrenia. Goal: Re-establish a relationship with a BH provider and adhere to her medication regimen. **Plan:** Flora's behavioral health history shows she was diagnosed with paranoid schizophrenia in college and began taking psychotropic medications. She has experienced intermittent psychiatric crises marked by paranoid delusions, auditory hallucinations and behavioral outbursts. She was most recently prescribed Clozapine, which worked well to manage her hallucinations but caused a drop in her white blood cell count so it had to be discontinued. To assist Flora in achieving optimal health, David emphasizes the importance of re-engaging with a behavioral health provider and starting back on antipsychotic medication. David also arranges for reevaluation to see if Flora qualifies for SMI services through the RBHA.

During her ED stay, Flora's pressured speech and agitation were alleviated with Haldol. David consulted with Dr. Wills our behavioral health medical director and pharmacist, Mr. Erkens for options. In working with her provider at LaFrontera, it was decided that Flora would continue on Haldol since she responded well to it in the acute setting. Furthermore, given her history of non-adherence with psychiatric medication, Haldol was thought to be a good choice given its long-acting preparation. While at Casa de Vida, she was started on oral Haldol and it was ultimately converted to the long-acting injection (LAI) preparation. She will be able to receive the LAI on an outpatient basis as well, through La Frontera's IHH.

Issue #3: Brittle Diabetes. Goal: Check her blood sugar regularly and be adherent to medication. **Plan:** Flora's homelessness prevents her from getting regular meals and she experienced hypoglycemia after taking the Glyburide XL when the sugar lows made her feel terrible. She subsequently stopped checking her blood sugars. Flora's A1c, taken while she was in the ED, was 9.5%.

David uses our Diabetes in Adults Clinical Practice Guidelines (CPG) to discuss how Flora can self-manage her diabetes by minimizing her risk factors. Flora agrees to manage her blood sugars with a combination of nutrition and medication. She agrees to add a 20 minute walk while she is in treatment. David coordinates approval of a glucometer that actively provides feedback to Flora on her dietary choices allows the Care1st Care Management team to monitor her condition, and supply her providers actionable data to adjust her medications. She tests her blood sugars levels twice a day and records her glucose level in her log book. Her care team agrees that a more modest A1C goal and a long-acting antipsychotic with less adverse impact on her blood sugars is best suited for Flora. It is less likely to give Flora hypoglycemic episodes that seem to make her feel worse, especially when her intake fluctuates. Her PCP approves Metformin, which Flora has never tried and for which she has no contraindications. Because of the potential side effects, she will need to be educated to report any GI symptoms and to have her labs followed. When Flora is in residential treatment, she transitions to the new PCP, who coordinates specialty referrals as Flora has not had an Opthalmology or Podiatry visit.

Issue #4: Neuropathy. Goal: Avoid ED use due to incidence of pain through alternate pain management techniques and medication. **Plan:** Flora's describes her neuropathy pain as "pins and needles," and it is important to find a pain remedy that helps her stay off heroin. The Care1st Pharmacist works with the La Frontera pain clinic to prescribe topical Lidocaine for immediate relief of Flora's neuropathy pain while reintroducing low dose Gabapentin. Flora's care team recognizes the need to educate Flora that Gabapentin is a better choice for her pain management, but takes time to control symptoms. In the meantime, the topical medication will give relief to her pain. The focus is to start low and go slow to counter potential side effects. Knowing that she has reacted unfavorably to Gabapentin before, David is proactive in discussing the effects of the drug with Flora. If she has side effects from the medication

she agrees to inform her provider and to keep an open dialog to find what works for her to control her pain.

Once she has settled into supportive housing, she will continue her regular visits with La Frontera's pain clinic to reduce her likeihood of using heroin as a pain management tool. The pain clinic provider offers Flora additional non-pharmacological pain management techniques such as guided imagery and meditation to help her control her pain and reduce stress. David uses Teach Back to reinforce these techiques and includes them on her crisis plan.

Issue #5: Unstable Housing. Goal: Find suitable, safe housing using the assistance for which Flora qualifies. **Plan:** Flora has been homeless for several years but desires stable housing for herself. She understands that the streets are not safe, but her drug addiction prevents her from staying in the safer homeless shelters in the neighborhood. When Flora decides to enter Casa de Vida, she has access to stable, safe housing during the initial MAT and later at Milagro, La Frontera's transitional housing. While Flora is inpatient, David continues working with Flora, the CommUnity Assistance Line team and La Frontera to identify longer term stable housing options for Flora. David assists Flora with applying for Social Security Disability Insurance (SSDI) (if not already achieved), and a plan to assess enrolling in an employment program (to be decided at the completion of her residence at Milagro).

Our Housing Coordinator and the support specialists with LaFrontera assist Flora by completing a VI-SPDAT, an assessment that prioritizes housing based on housing status, history, vulnerability and services needs. Based on her high score on this assessment she is eligible for the housing assistance (identification and placement) coordinated entry system. Additionally, Care1st's CommUnity Advocacy associate introduces Flora to Care1st's network of community partnerships that will help her with food and nutrition, low-cost housing or temporary shelters, peer supports in the community to help her continue recovery from substance use, speciality programs for women and other resources to back her whole-person health goals. Since Flora is interested in looking for employment, David engages WellCare Works, our program that provides members job training and connections through added benefits and engagement with community employment programs.

Continued Monitoring and Assessment

When Flora leaves Casa de Vida and after successful residential treatment, she moves to La Frontera's Milagro transitional housing, and her care plan is modified to reflect her changing needs. While Flora was in the residential program, David visited her weekly to monitor her progress and build trust. During the initial days of Flora's transition to the new facility, David increases the frequency of in-person visits to daily until he is sure that Flora is coping well in the new environment. He assists in helping her schedule her follow-up appointments and arrange for transportation. As Flora's mental health symptoms stabilize, she is more and more trusting of David and becomes appreciative of the help that David is providing.

David continues to use his skills in motivational interviewing to keep Flora engaged in her health and recovery. Flora talks about how in the past, she tried to quit heroin "cold turkey," but she was frustrated and unsuccessful. She says she now feels she has the tools she needs to continue to recovery. She is doing well on methadone and enjoys the peer support she receives through La Frontera. She is managing her schizoprenia well through medication therapy. Flora relies on her crisis plan when she is in pain or feels she has the desire to use heroin. The crisis plan is part of her care plan and provides instructions for the various obstacles Flora may face as well as contact information for members of her care team, David, her housing specialist, and the CommUnity Assistance Line, as well as her supports through LaFrontera. She continues her outpatient methadone therapy through her IHH and remains in contact with her provider team. As Flora thrives, David transitions the role of care manager to her IHH and PCP. Even so, David continues to periodically contact Flora to ensure that she is continuing on her successful path to recovery.

HELPING A MEMBER WITH SPECIAL HEALTH CARE NEEDS MEET THE CHALLENGES OF PREGNANCY

Care1st is uniquely qualified to meet the needs of this member, Valerie, who is dealing with the painful symptoms of sickle cell anemia and a history of opioid use during her pregnancy. Her circumstances are complicated by a recent incarceration. Our approach to helping Valerie achieve optimal outcomes for her and her baby involves integrated behavioral, community, pharmaceutical and physical health care management (CM) services and provider partnerships through our innovative High Risk OB CM services, Hugs. Our integrated strategies deliver intensive prenatal and postpartum interventions that address her pregnancy and her condition-specific management using clinically sound practices.

87% of Care1st members receive prenatal care within the 1st trimester

Our approach to Valerie's care coodination aligns with AHCCCS' Values and Guiding Principles in providing Valerie timely, culturally appropriate, integrated care coordination. Using evidence-based practices will improve her likelihood of a healthy birth as she engages in effective and self-management strategies to control her sickle cell anemia. Our justice-involved CM program is designed with these principles in mind to assist members like Valerie who face incarceration with respect and cultural competence.

Early Identification and Integrated Case Staffing

Valerie is known to the Care1st CM team due to her sickle cell anemia, intermittent opioid prescription fullfillment and ED use related to sickle cell crisis management. When Valerie discovers she is pregnant through a home pregnancy test, she contacts her care manager, Cathy, to share her results. Cathy knows Valerie's history and knowing Valerie's complex needs and her high risks associated with sickle cell anemia during pregnancy, immediately refers her case to the Hugs High Risk OB program. The Hugs care manager, Susan, will be Valerie's primary point of contact for her pregnancy and will oversee Valerie's care through the postpartum period. Susan is chosen for Valerie's CM for several reasons. She has expertise in helping members like Valerie who deal with pain and opioid use in pregnancy, she lives and works in Valerie's own neighborhood and she is familiar with sickle cell anemia and how it affects pregnancy. Finally, Susan is trained specifically in providing care coordination to teen moms, fostering trust, building the teen's strengths and skills, while meeting these young women where they are on their journey. Susan is part of a local Hugs team that is supported by specialized RNs, LCSWs and clinical leadership supplementing and enhance Susan's own knowledge around Valerie's complex medical issues. In addition, the team comprises CommUnity Advocates with deep knowledge of local community resources available.

CARE1ST HUGS PROGRAM

Valerie and other pregnant members benefit from our high-touch Hugs OB care management program designed to identify members with potential risk factors (behavioral, social, medical, and SUD) that may adversely affect the outcome of the pregnancy. Hugs supports and guides high risk pregnant women like Valerie to practice good prenatal care through face-to-face, in-home visits with Hugs' care managers, direct mailings of educational materials, availability of a care manager for questions and concerns, advocating for consistent follow-up with their providers. Hugs participants enjoy incentives once they complete prenatal visits such as a portable play yard or stroller.

Susan reviews Valerie's medical history from Care1st's CareCentral medical management platform and sees that Valerie was under a hematologist's care at Phoenix Children's Hospital prior to turning 18-years-old; most recently, Valerie visited a hemotologist at Banner University. Because Care1st has access to the Banner EMR system, Susan reviews Valerie's initial hematology visit which included a crisis plan. A high priority for Valerie's sickle cell disease management plan is that she is at risk of using opioids, including illicit opioids if her pain worsens during pregnancy—a risk for both her and the fetus. She is also at higher risk of depression, which can also precipitate substance use and poorer self care. Susan also accesses the Care1st data warehouse system which includes blind spot data and reflects Valerie has not had historical engagement with behavioral health providers. Susan pulls-up Valerie's CSPMP and sees she has filled a prescription for opioids intermittently prescribed by her hemotologist and one was filled as recently as two months ago. Susan accesses Care1st's PBM online and medication fills shows she is currently on hydroxyurea for her sickle cell anemia, but Valerie's medication adherence is sporadic with the last fill over 60 days ago.

Susan immediately (within one day of pregnancy notification) attempts to connect with Valerie to administer a Comprehensive Assessment; however, she has no success reaching her at the number listed in Valerie's medical record. The line is answered by Valerie's mother, who informs Susan that Valerie is incarcerated.

Engagement with Valerie within the Justice System

Susan contacts Lisa, the Justice Liaison, Care1st's single point of contact for the justice system.

The Justice Report flags Valerie, who is already active in CM services, and Lisa uses this report to confirm that Valerie has been incarcerated in the Maricopa County Jail system. Lisa, in collaboration with Susan, reviews all aspects of Valerie's care. They discuss Valerie's current medications, diagnoses, natural supports, and available treatment details. As an experienced high-risk OB care manager, Susan knows Valerie has several risk factors with Sickle Cell Anemia along with her age, education and lifestyle choices. She also knows that crises like anemia and vasoocclusive occur more often in pregnancy and are the most common maternal complications associated with sickle cell disease in pregnancy. Painful crises are more common with advancing pregnancy and in the postpartum period. Susan and Lisa also consult the internal Care1st multidisciplinary team to discuss a plan of action for Valerie around Valerie's complex medical needs and a sickle cell anemia crisis plan prior to Lisa conducting Justice Reach-In Activities and talking with Correctional Health Services. Because Valerie has not had time to establish care with an OB, Susan works with Banner's Sickle Cell Clinic to identify a Banner OB provider who can work hand-in-hand with her hemotologist to provide comprehensive OB care and advise while Valerie is incarcerated. She also confers with a perinatologist (Maternal Fetal Medicine Specialist). The perinatologist will work with Valerie's obstetrician and hematologist to provide prompt evaluation for precipitating factors such as dehydration, hypoxia or infection.

Through Care1st's partnership with county jails including the Maricopa County Jail where Valerie is incarcerated and Correctional Health Services, our Justice Liaison, Lisa Judd, is able to connect with our high-risk members who become justice-involved with the goal of a seamless transition back into the community. Lisa consults the Justice Report based on the AHCCCS 834 enrollment file to identify members who are incarcerated with suspended AHCCCS eligibility, chronic/complex medical care needs, and medication-assisted-treatment-eligible that may benefit from Reach-In coordination activities. In Valerie's case, Lisa would have been alerted to Valerie's incarceration without the proactive step from the care manager.

Due to Valerie's complex circumstances, Lisa and Susan expedite their comprehensive assessment of Valerie. They arrange for an in-person visit at the jail.

Integrated, Person-Centered Assessments

Valerie's comprehensive assessment evaluates her health status and clinical history. It is also condition specific to understanding her sickle cell anemia symptoms and her pregnancy risks. As per the pregnancy clinical practice guideline (CPG), Valerie is assessed for depression (PHQ9) and given a lifestyle assessment to define her use and exposure to cigarettes, alcohol and controlled substances. She is also assessed for psychosocial factors and her social determinants of health; ethnic, cultural, spiritual, linguistic, literacy for beliefs, barriers, needs and preferences; and family resources and involvement as well as natural supports.

The assessment reveals several significant factors related to Valerie's medical, behavioral and social/cultural history and current status.

Medical	Behavioral	Social/Cultural
• Has not had a sickle cell crisis in the last 6 months • Not currently experiencing any pain • Pain managed thus she has not taken opioids in the last 6 months • Denies contractions, bleeding, and leaking of any fluids • Afraid of having a sickle cell crisis and being treated poorly in jail	• Recently quit smoking • She scores a 10 (moderate depression) on the PHQ9and has no thoughts of self-harm • Expresses that her depression is affecting her pregnancy, her ability to be a good mom and making better choices for herself and for her baby	• English speaking • Has Christian beliefs but non-practicing • Was living at home with her parents but was "kicked out" • Wants to complete her high school education, is frustrated but determined to complete her education to "be a better mom"

Medical	Behavioral	Social/Cultural
	• SOAPP-R and the ORT to assess for possible opioid abuse • Scored <2 on the CAGE: no concerns of alcohol use • Would not be a candidate for medication assisted treatment (MAT) since she is not misusing opioids, but she does require adequate pain control	• Does not have a job • Valerie's mom is "coming to grips" with her pregnancy • Estranged relationship with her family • The baby's father has no knowledge of her pregnancy • Would like to keep her baby • This is her first incarceration

Meeting Valerie's Needs and Assisting Her in Meeting Her Goals

As Valerie gets to know and trust Lisa and Susan, she opens up about what she envisions for herself and her unborn baby. With agreement from Valerie, Lisa and Susan invite a caseworker from Correctional Health Services to be part of her person-centered planning. Through the team's planning process, Valerie and her mother work together to develop a mutually agreed upon, appropriate care plan that meets Valerie's medical, behavioral, social and medication needs in the most integrated manner, pre- and post-incarceration. The team puts Valerie's goals and desires into meaningful and measurable long-and short-term goals based on Valerie's wishes, talents, and strengths. Valerie signs and receives a copy of her care plan, which is updated with each reassessment Lisa and Susan perform. After the initial face-to-face visit, Lisa and Susan conduct biweekly conference calls with Valerie to continue monitoring her progress, keep Valerie focused on her post-release goals, and communicate coordination activities. Closer to Valerie's release date, Lisa arranges for an appointment with her providers to occur immediately upon her release.

Issue #1: Young and Pregnant with sickle cell anemia. Goal: Deliver a Healthy Baby through prenatal care, education and self-care methods. **The Plan During Incarceration**: The obstetrical team resumes primary responsibility for coordinating her services, so that Valerie has ongoing access to high-risk obstetric care, member education including the potential for neonatal abstinance syndrom (NAS) with opiates, and coordinates follow-up care to minimize maternal morbidity and mortality. The obstetrical team outreaches to the hematologist about her use of hydroxyurea during her pregnancy. The hematologist advises Valerie discontinue the hydroxyurea, which is contraindicated in pregnancy. **Once Valerie is released from jail**, the plan focuses on collaboration with the specialists treating Valerie and helping her navigate her numerous benefits and services that can support her through her delivery and beyond. The hemotologist refers Valerie to Banner Sickle Cell clinic for prevention of sickle cell crisis, especially during the pregnancy and postpartum period. The hematologist coordinates with her OB to discuss Valerie's care. Susan assists in navigating, resolving barriers in accessing care, reinforcing the provider's treatment plan and education, and confirms that Valerie understands the modifications to her plan as she transitions out of jail. Susan collaborates with the OB/Perinatologist to ensure no barriers to prior authorizations for medically necessary services and diagnostic testing exist (i.e. additional ultrasounds). She reviews the pain crisis plan for up-to-date contact information and appropriate strategies for coping and pain management guidance. Through frequent, in-person home visits, she assists Valerie with scheduling additional appointments, arranging transportation, and assessing her for complications. Susan ensures Valerie has all contact numbers she may need to answer her questions including the Care Manager's number, the number for Member Services, the 24-hour Nurse Advice Line. Susan educates Valerie about pregnancy complications related to sickle cell disease including risk of miscarriage, premature birth and low-birth weight, the importance of hydration and the importance of taking folic acid to support red blood cells necessary to supporting a healthy pregnancy. Susan ensures Valerie's providers have knowledge of our health plan's clinical practice guidelines (CPGs), which are based on validated, nationally recognized sources for both her pregnancy and her sickle cell disease. **Third Trimester**: When Valerie enters her third trimester, Susan helps her treatment team prepare Valerie for delivery. Susan collaborates with the OB, Nurse Partnership and TOPS to ensure that Valerie gets a tour of the Banner Medical Center facility, where she will deliver and the hospital's neonatal intensive care unit (NICU). Banner Medical Center has experience managing high risk pregnancy and NAS. She assists Valerie in packing appropriately for the hospital stay and coordinates with TOPS for Valerie to attend child-birth classes. Susan reinforces the OB's education regarding family planning, birth spacing and the use of long-acting reversible

contraception (LARC). She helps Valerie identify a pediatrician, register with Pacify for valuable educational information through text and have 24-hour access to clinical consultation and lactation specialists after the baby is born. Susan collaborates with the TOPS program to enroll Valerie in parenting classes and teenage pregnancy/parenting support groups. Valerie obtains a car seat, crib and other baby supplies (i.e. baby clothing, toys and books) through Jensen's Corner, a boutique affiliated with TOPS. With Valerie's permission, this information is also shared with Valerie's mother.

Issue #2: Depression **Goal:** Improve Her Mood. **The Plan during Incarceration**: Lisa and Susan further utilize the Behavioral Health Conditions in High Risk Pregnancy CPG to discuss with Valerie how to best self-manage her symptoms of depression, minimizing her risks of postpartum depression. Lisa educates Valerie about behavioral health services available through Correctional Health Services, such as one-on-one, group counseling and psychiatry. Susan discusses with Valerie the risks versus benefits of antidepressants use in pregnancy and how poorly controlled depression can negatively impact Valerie's baby and her ability to deal with pain. Valerie opts for anti-depressants with one-on-one counseling. Susan coordinates with Valerie's BH provider, who prescribes a medication that is considered safe in pregnancy. Susan will continue to monitor Valerie's depression to ensure that the antidepressant is working. Lisa connects with Correctional Health Services staff to establish individual counseling for Valerie and submits a formal referral to a behavioral health provider, Family Services Agency (FSA), as they have experience with working with individuals re-entering the community following incarceration, and counsel on life choices to avoid future incarceration. Lisa sets-up an initial intake appointment with FSA **6 days after Valerie's expected release date** and arranges for transportation to the appointment, and having her mother be present for the appointment at Valerie's request. Once she delivers, she is reassessed and monitored closely for signs of post-partum depression. Her team assesses her periodically using the Edinburgh Postpartum Depression Screening Tool. Because she showed signs of depression during her pregnancy, she is at an increased risk for post-partum depression and psychosis. Her obstetrical team advises her on the use of anti-depressant medications, which can help to significantly improve mood in combination with counselling and group support.

Issue #3: Possible crises and associated pain **Goal:** Manage her pain and medical conditions**.** Per the Sickle Cell Anemia clinical practice guideline (CPG), Susan instructs Valerie, using Teach Back specific methods, that she can self-manage her sickle cell disease. These include drinking enough water each day, washing hands frequently, proper food preparation and cleaning, getting her flu vaccine, avoiding second-hand smoke, avoiding exposure to cold, high altitudes and other situtuations that cause low blood oxygen. Valerie agrees to call the physician if she feels symptoms indicative of sickle cell crisis, such as a fever, irritability, tiredness, dizziness, increased heart rate, and trouble breathing, among others. **During a Sickle Cell Crisis:** With the stress of transitioning from the jail system to Maggie's Place, Valerie has a sickle cell crisis. Valerie considers calling her street contacts for some opioids, but because of the strength of her support from our CM team (Susan), she calls Susan first who advises her to enact her sickle cell crisis plan. Valerie follow the plan and calls her mother for a ride to the Banner Sickle Cell clinic. Banner Sickle Cell clinic monitors Valerie and her unborn baby for hydration, transfusion, pain management, OB evaluation and treatment. Banner's licensed BH staff outreaches to the obstetrical team, Susan, and Family Services Agency (FSA) advising of this recent sickle cell crisis. They participate in discharge planning and also scheduling a follow-up medical and behavioral health appointment. Due to the nature of the crisis being stressed induced, FSA will focus on helping Valerie develop coping skills to manage stress.

Issue #4: Homelessness **Goal:** Find housing that can accommodate Valerie during her pregnancy and after delivery**. During incarceration,** Lisa and Susan explore suitable housing options with Valerie since Valerie's mother does not feel she can support Valerie and her baby at her home. The criteria is to find housing that provides stable housing for women who are pregnant, who need assistance with parenting and education. Prior to her release, Valerie requests assistance connecting to Maggie's Place. Lisa works with Maggie's Place to provide safe, transitional housing, parenting support and life skills training for Valerie and her baby. Maggie's Place will allow Valerie to stay nine months after giving birth. **Two weeks prior to Valerie's release from jail,** Lisa and Susan facilitate a Skype teleconference for her obstetrical team and Correctional Health Services provider to ensure smooth transition of her physical, behavioral health, social, and pharmacutical care plan post-release. The Skype meeting includes Valerie,Valerie's mom, Susan, Lisa, the probation officer, Nurse Family Partnership, and a Maggie's Place representive. The probation officer

discusses probation directives and assists in determining required resources. The team reviews her housing plan and available peer support services. They also schedule and arrange for transportation for follow-up provider appointments after her release, including her appointment with FSA. **Once released from jail,** Valerie moves into Maggie's Place and Susan assists her in obtaining a free, government phone so that they can maintain regular contact. Valerie is also referred to WIC. For items related to the justice system, Lisa remains the primary point of contact and ensures Valerie is following all probation directives and communicates regularly with the probation officer about Valerie's progress. Valerie receives peer support for women who are justice-involved to help her transition and to prevent recidivism.

Issue #5: Valerie feels unprepared to become a parent **Goal:** Develop her skills through education and training to be a Better Parent. **During Valerie's incarceration,** Lisa shares with Valerie available community resources that could help her meet her educational and behavioral health goals once she is released, such as AWEE (Arizona Women's Education and Employment, Inc); Fresh Start Women's Foundation and a list of behavioral health providers (Terros, Empact, JFCS). Maggie's Place that can also assist with career, education and lifeskills support. **When Valerie is released from jail**, she benefits from FSA's assistance on reestablishing Valerie with TOPS services. To start Valerie on the path to earn her GED, FSA finds an online school where Valerie can continue her education. For additional support, they also refer her to Maricopa Center for Adolescent Parents for childcare while she takes classes. As part of the treatment plan, Valerie attends weekly individual counseling to manage her symptoms of depression and family counseling to work on improving her family relationships.

Continued Monitoring for Valerie

As a teen mother with several risk factors, Susan will monitor Valerie for opioid use during and after the pregnancy to ensure that her occassional use to manage her pain does not grow into misuse. Her baby, though only occassionally exposed to opioids, is monitored for NAS, and should the baby require NICU or intensive services, will be referred to our Comprehensive Infant Care Management program to assist Valerie and her baby with special health needs. Susan assists her during the postpartum period to ensure that the baby receives the necessary follow-up appointments, well-baby checks and vaccinations as per the EPSDT periodicity schedule. Susan and Lisa also ensure that Valerie complies with all probation requirements and continues to build on her talents and strengths to prevent recidivism.

Care1st's Comprehensive Infant Care Management program serves medically complex or fragile infants and their families. Babies born with NAS are wrapped in services and intensive care management that includes home visits by a specially trained nurse, and training and education for the family in caring for NAS babies. Our program is managed by a pediatrician and promotes the use of breastfeeding, bonding of the family unit, and co-rooming.

Summary

With the targeted programs designed to support teen moms who are justice-involved and with the collaboration and guidance of the high risk OB program, Valerie delivers an infant with a minimal hospital stay, obtains safe housing, is able to attend and benefit from an individualized counseling, family counseling, and support group for teens. She is able to reconnect with her family with plans to transition her back into the family home; her mom agrees to help with childcare. The OB transitions Valerie's care after 60 days to her established PCP who will continue to manage her primary care needs. Her hematologist continues to manage her sickle cell disease with weekly evaluation and treatment at Banner Sickle Cell Clinic. Valerie is successfully breastfeeding and using Pacify for lactation support and plans to breastfeed for one year. When Valerie is done breastfeeding, she will be reevaluated for appropriate medications to treat her sickle cell disease. Valerie has not had a sickle cell crisis since prior to delivery. Valerie continues to work towards completing her GED and being the best mom she can be.

IMPROVING MEMBER ENGAGEMENT, DEVELOPING BEST PRACTICES, AND TRACKING OUTCOMES

Care1st is committed to ongoing collaboration with AHCCCS to improve outcomes, experience of care, and quality of life for all our members. Under the oversight of the Adult and Children's Healthcare Administrator's and the coordination of care with system partners, we will focus on implementing best practices for the integration of physical health (PH) and behavioral health (BH) care as a strategy to engage members and provide broader access to BH care, as well as measure the outcomes of best practices.

Justice-Involved (JI) Care1st has coordinated care for nearly 100 JI members with complex health needs annually. These activities are part of our Justice System Care Coordination Program (JSCCP) in which our PH and BH care managers, advocacy staff, and justice liaison help members achieve positive outcomes, including reducing their risk of recidivism. The impact of our care coordination is shown in *A Case of Caring* below.

A CASE OF CARING: A Care1st member was released following an 8-year prison stay. Recently diagnosed with HIV, the member lacked PH, BH, and social service resources. Through our JSCCP, we connected him to the Shanti Group, a local organization serving those with HIV, which provided him with housing, HIV education, individual therapy, and vocational rehab. Our JSCCP helped him connect with providers, get medications, and adopt lifestyle changes. He remains engaged with Shanti House and our JSCCP, and is compliant with treatment. He has stayed out of jail and has not had a hospital admission. He recently reported he is feeling well and working a night job he likes. We continue to outreach and give support to prevent recidivism because of the complexity of his health and social issues.

Improving Engagement Our goal in engaging JI members is to help them access services, comply with treatment, and improve self-management skills. Our approach to engagement includes:

- **Justice system collaboration:** Our Justice Liaison engages with the justice system, including the jails, sheriff's office, correctional health staff, Arizona Department of Corrections (ADOC), including Community Supervision and Probation Courts, and others as part of our "reach-in" and care coordination activities.
- **Technology:** We use video visitation technology to meet virtually with JI members throughout Maricopa and Pima, including those in the 4th Avenue, Durango, Estrella, and Lower Buckeye jails.
- **Peer support:** Given the research showing the benefits of peer support for reentry and recovery, we collaborate with organizations like Hope Lives – Vive La Esperanza to connect JI members to peer support for help accessing services for basic needs, complying with courts, probation, and pre-trial services, and sustaining recovery.
- **Facilitate information exchange:** With member consent, we share information with justice system stakeholders and providers to develop treatment plans incorporating community release conditions and aid members in getting care and services. Furthering coordination, we will establish MOUs with the Arizona Administrative Office of the Courts for Juvenile/Adult Probation, the ADOC for Juveniles and Adults, and county jails.
- **Fully-integrated care:** We connect JI members to fully integrated providers like Terros and La Frontera to address their complete physical, behavioral, and social service needs.
- **Tribal communities:** We will collaborate with tribal communities, courts, and providers for care coordination and data sharing to ensure successful member transition back into tribal communities.
- **Evidence-based practices (EBP):** Given the trajectory of the school-to-prison pipeline with zero tolerance school policies leading to expulsion and drop-outs, we will work with our providers to adopt EBPs through value-based purchasing (VBP) arrangements, and use Centers of Excellence (COEs) and targeted interventions such as Functional Family Therapy (FFT) and Multisystemic Therapy designed for children and youth who are acting out.

Developing Best Practices Our quality improvement framework features a multifaceted approach to develop best practices to help JI members access services, comply with treatment and improve self-management skills. Our approach strengthens our staff's and providers' ability to care for members. Our approach includes:

- **Collaborations:** Our Justice Liaison will collaborate with the AOCs, Juvenile and Adult Probation to address strategies to optimize the use of services relating to Mental Health and Drug Courts. Furthermore, we collaborate between plans and with tribes to build and advance initiatives. In 2017, we organized an inter-plan meeting so Arizona Medicaid plans could share "lessons learned" and discuss best practices for working with JI members.
- **Stakeholder meetings:** Our leadership routinely takes part in criminal justice stakeholder meetings and workgroups where they identify and discuss best practices, and develop innovative partnerships. Our partnership with HOPE, Inc. and Stand Together and Recover (S.T.A.R.) began through an in-service hosted by S.T.A.R.

- **Staff:** Our Justice Liaison has more than 11 years of experience as an SUD clinician and RBHA SMI care manager, and in adult corrections and holds certifications in addiction and aggression management. Her advanced understanding of incarceration and reentry dynamics allows her to continuously improve the support we provide.

Tracking Outcomes We track operational, quality, and cost metrics to monitor program effectiveness, including:

- Return to work or school
- Cases unable to contact
- TI providers serving JI
- ED rates
- Outpatient visit rates
- Total cost
- Cases with goals met
- Recidivism rate
- Eligibility redetermination date
- 7-day appointments
- Admissions rates

In addition, we will track enhanced information for American Indian members who are justice-involved, including the status of MOUs, tribal consultations, trainings, are sharing of resources.

Court Ordered Evaluation/Treatment (COE/T) Our **Integrated Care Management Program** helps coordinate PH, BH, SUD, and social services and data sharing for members with COE/T. We help ensure timely access to pre-petition screening, court ordered evaluation, and court order treatment.

Improving Engagement Our goal is to maximize members' dignity, independence, and self-management capabilities. Our approach reflects the importance of protecting members' rights and includes:

- **Care management:** Members are referred to our BH CM team who collaborate with treating providers and others involved in the members' care. Our care managers help wrap intensive and timely services around the member and family to maximize engagement and strengthen support systems. We align treatment plan strategies and interventions with member needs, values, and beliefs, and ensure the member's and family's voice is honored.
- **Integrated Health Homes (IHHs) and COEs:** Our care managers partner with evaluating providers to connect members with IHHs and COEs such as Spectrum Healthcare and Southwest Behavioral Health who can help them achieve their treatment and recovery goals.
- **Tribal courts and providers:** We respect the sovereignty of tribal courts. When tribal providers are involved in COT, we will collaborate to ensure member coordination and continuity of care for the duration of COT and when transitioned to services on the reservation, as applicable.
- **EBPs:** Our BH care managers work with BH providers/ organizations like Northern Arizona Consumers Advancing Recovery by Empowerment and Wellness Connections to connect members and families to valuable EB services.
- **Crisis planning :** We collaborate with local crisis providers to develop treatment plans and coordinate highly customized follow-up services. We will offer access to our 24/7 Nurse Line to help the Crisis Network (CRN) and work with hospital EDs to evaluate, treat and refer members presenting with BH and SUD issues.
- **Post-crisis intervention:** Given the importance of post-crisis care, we are collaborating with Connections Health Solutions to offer their innovative *Comprehensive Transitional Care Program for the Post-Crisis Episode*, connecting members to the next level of care and ensure beneficial recovery support, (i.e. peer support services through Recovery Empowerment Network (REN) or S.T.A.R.).
- **Provider support:** Given our extensive clinical and socioeconomic data, we help providers in preparing for testimony, so they can give the courts a full clinical picture. Additionally, providers' can access our CommUnity Impact Model social services database to assist members in connecting to basic social services.

Developing and Implementing Best Practices Our multifaceted approach to develop best practices to help COE/T members access services, includes the following:

- **Advisory board:** Care1st will initiate the creation of a COE/T Advisory Board with representatives from local hospitals, mental health courts, tribal courts and providers, screening agencies, crisis providers, peer and family-run organizations, and BH providers, and members and families with lived experience to identify, discuss, and address opportunities related to COE/T. Our court coordinator, adult and child BH advocates, veterans advocate, tribal coordinator and member advocacy and individual and family affairs administrators will also participate.
- **Staff:** Building on our success with our justice liaison, we will hire a court coordinator who has prior experience with drug, mental health, criminal or tribal court proceedings, as well as BH and SUD work experience. As the single point-of-contact for information specific to the court's disposition for eligible members.

Tracking Outcomes Our COE/T measure set includes the following operational, quality, and cost metrics:

- Status of court orders
- Total cost
- Medication adherence
- Out-of-state placement for COE/T
- Judicial reviews
- Level of goal attainment

- Adherence to COT
- Adherence to COEs
- Access and availability of COE services

High Needs and High Costs (HN/HC) Care1st provides intensive CM to members with HN/HC who have PH and BH needs, based on the utilization and total health care costs. Our **HN/HC Care Management Program** staff includes care managers and advocacy staff who monitor and implement interventions for appropriate and timely care. The April 2016 reporting period showed **Care1st's reductions over baseline outperformed the statewide average for all but one measure** and showed a reduction of ED use our targeted Care1st ED Diversion for high and moderate utilizers by 41% and 56%, respectively.

Improving Engagement Our success in improving utilization and outcomes is attibuted to our engagement approach, which includes provider partnerships and specialized CM, as summarized below:

- **Field-based care management:** Our *Care1st at Home* field-based program delivers in-person CM services. This personalized support fosters engagement while allowing staff to see the member and family in their environment. The frequency of in-person contact is based on individual needs and preferences.
- **Impact social determinants:** We routinely collaborate with the Area Agency on Aging (AAA) in Maricopa and the Pima Council on Aging (PCOA) to complete home assessments to identify members' social and environmental needs and connect them to funding sources. In addition, we will use our CommUnity Impact Model to address social barriers through: 1) our extensive web-enabled database of 6,000 organizations serving Arizonans, 2) our peer-driven community telephonic support through our CommUnity Impact Model liaisons, housing and education staff, and Individual & Family Affairs Administrator, and 3) closing social service gaps through community investment as part of our commitment to invest $1 million into local communities over three years.
- **Integrated care team (ICTs) meetings:** Our monthly ICTs shares information about members' histories, status, goals, and treatment plans with treating providers. In addition, we collaborate with community providers who deliver intensive navigation services that focus on care coordination, crisis intervention, connections to housing, and collaboration with law enforcement such as Community Bridges' Comprehensive Community Health Program, La Frontera/EMPACT's crisis navigators and the CRN.

Developing and Implementing Best Practices We develop best practices to help HC/HN access appropriate and timely care through:

- **Stakeholder meetings:** Our leadership routinely takes part in AHCCCS stakeholder meetings and workgroups where they identify and discuss best practices, including the health plan HN/HC meetings.
- **Provider collaboration:** We develop best practices through collaborations with providers and organizations who serve members with HN/HC. For example, we meet with CRN to discuss trends amongst members with complex needs and ways to collaborate to support them.
- **Internal committees:** Our quality committees such as PMC and national Medical Policy Committee (MPC) are a critical element of our approach to developing best practices. MPC develops and maintains evidence-based CPGs which represent the best available scientific and clinical research and expertise from leading professional organizations including United States Preventive Services Task Force, American Academy of Child and Adolescent Psychiatry, the Agency for Healthcare Research and Quality. Our suite of more than 50 PH and BH guidelines will be adopted in Arizona and serves to elevate and optimize member care, including diabetes, high-risk pregnancies, heart disease, Autism Spectrum Disorder and other complex yet manageable conditions. PMC identify strategies for helping providers adopt best practices including alternative payment and value-based arrangements.

Tracking Outcomes We track an array of operational, quality and cost metrics for members with HN/HC, including:

- Member satisfaction and quality of life
- PH/BH admits
- Length of stay
- PCP and BH provider visits
- ED visits/total cost PMPM
- Readmissions PMPM
- Return to work
- Stabilized housing
- Adherence to CPGs

Substance Use Disorders (SUD) Care1st and our family of Medicaid health plans coordinate care for nearly 2.8 million Medicaid members. **BH conditions, including SUD, account for 5 of our top 10 diagnoses**. Given the prevalence and significance, we have developed numerous strategies for care coordination outreach and engagement specifically for those with SUDs, the results of which are signficant. In one year, **we reduced the percent of members with oxycodone prescriptions by nearly 25% and the percent of members with co-prescriptions of benzodiazipines and a Schedule II substance by 20%**.

Improving Engagement Underlying conditions, including those related to pain management, coupled with co-occuring socioeconomic issues and associated stigmas create challenges for those needing help with SUD. Members are sometimes transient or homeless and difficult to reach. Our approach to engaging members and families includes:

- **Care management:** Our BH care managers use motivational interviewing (MI) techniques and principles for all CM activities including assessment, care plan development, and monitoring. MI helps care managers build rapport and trust, which is especially important for understanding where members are in the stages of change. Our care managers then apply interventions like our *Members Empowered to Succeed (METS) Program,* an integrated, holistic recovery-oriented program for members in care for an extended period with high use of services. Our METS program has delivered meaningful results including **a 6% reduction in ED use**.
- **Pain management:** For members whose SUD is associated with pain management, we have a unique pain management program. Among the interventions available to help increase engagement and improve outcomes are our partnerships with Valley Pain Consultants and Southwest Behavioral Health, prescriber and pharmacy lock-in protocols, and care plan development and management.
- **Peer support:** We collaborate with peer and family-run organizations like REN, Wellness Connections, and S.T.A.R. to help members access community support for basic needs, support adherence to their treatment plans, and develop a plan for sustaining recovery.
- **COEs:** Care1st will contract with COEs to implement EBPs and track outcomes for adolescents with SUDs, including Adolescent Community Reinforcement Approach (A-CRA), Assertive Community Care (ACC), and Global Appraisal of Individual Needs (GAIN).

Developing and Implementing Best Practices In addition to leveraging our internal committees and staff experience, our team identifies and develops best practices using a variety of methods including:

- **Participation in stakeholder meetings:** Our staff takes part in SUD stakeholder meetings and workgroups such as the Arizona Substance Abuse Task Force's Neonatal Abstinence Syndrome Work Group where they discuss the development and implementation of best practices.
- **Collaboration with providers:** We develop best practices through collaborations on program enhancements with providers including for example E-Prescribing of controlled substances and review of State and Federal Guidelines. Recently we met with Valle Del Sol to discuss trends, challenges, and how we can support them to screen and treat members with SUD. In Kentucky, as a result of an ongoing collaboration, we are enhancing our opiate medication management program, **which has delivered significant results, including 50% reduction in opioid dispensing, a 35% decrease in cyclobenzaprine dispensing, and a 30% reduction in benzodiazepine dispensing.**
- **Staff Education:** Staff attend conferences and seminars to learn about the latest in clinical developments and approaches to care from leading professionals in the field of BH and SUD. Two such conferences are ASU's Center for Applied Behavioral Health's Annual Summer Institute and the Southwestern School for Behavioral Health Studies Annual Conference.

Tracking Outcomes We track an array of operational, quality and cost metrics for members with SUD, including:

- Controlled substance use
- Medication Assisted Treatment (MAT)
- Outpatient/ED visit rates
- Cases with goals met
- Links to pain management resources
- Member satisfaction
- Length of stay
- Total Cost
- Admission/Readmissions

At Risk of Removal by DCS Care1st and our Medicaid affiliates have a combined 44 years of experience improving care for children involved in our country's child welfare systems. Each day, our care managers use this model to plan, coordinate and monitor care for nearly 24,000 child welfare-involved members nationwide, many of whom experience neglect, family dysfunction, and physical, sexual, and emotional abuse, and who often have complex physical, behavioral, and developmental conditions. We share in DCS' goal of ensuring safety and stability for children and collaborate with child welfare agencies and organizations to coordinate services to strengthen the family.

Improving Engagement We identify children at risk of removal by DCS through a number of channels including CM evaluation and monitoring, specialized programs (i.e., enhanced opioid management), ID&Strat, provider referral and information, schools, and data reporting from the crisis network. Each child is referred to our pediatric CM team for a review of the child's and family's physical, behavioral, social, and environmental needs and strengths, including an assessment of adverse events and trauma. Many families facing the possible removal of a child are transient, live in abject poverty, have BH and SUD conditions, and are in a constant "hyper state" based on their collective

circumstances. Because of these factors, our engagement strategies include:

- **Collaboration with DCS:** We will collaborate closely with DCS staff providing a designated contact within our pediatric CM team that can immediately assist with referrals, information needs, and intervention. We will also collaborate with DCS and Care1st families to connect members to DCS programs, like Building Resilient Families.
- **Field-based care management:** Our care managers will work with the child's treating provider, Child & Family Team (CFT) facilitator, and DCS worker, if applicable, to ensure there is clear documentation and understanding of safety or health threats such as domestic violence, drug use, unsafe living conditions or neglect. Care managers will collaborate to help find services that are intensive, comprehensive and quickly delivered to maximize family engagement and strengthen natural supports, including social services. Our staff help ensure the strategies and interventions align with the family's needs, values, and beliefs, and reflective of their voice and choice.
- **Mitigate wait lists:** In Arizona, due to demand for specialized services, families are at risk of being "wait listed" and face delays which can increase risk to the child. Our care managers will work with the CFT staff the care team to expedite finding alternative providers and services.
- **Home-based services for adults:** Many child-serving providers and agencies meet members where they are, whether at home, school, or the provider's office. The same is not true in the system of care. To support the child and family's plans, we will build provider partnerships for therapies and interventions in non-traditions settings.
- **Motivational interviewing (MI):** We apply MI to all CM activities including assessment, care plan development, and monitoring. MI helps care managers build rapport and trust, which is especially important for understanding family history, challenges, and concerns that may contribute to the potential removal of a child from the home. Using MI, care managers empower the family by helping them express behavior change in their own voice, explore and select options, and identify strengths and achievements.
- **Family run-organizations:** We will collaborate with Mentally Ill Kids in Distress (MIKID) and Family Involvement Center (FIC) to engage and support parents and caregivers. Care1st will work with treating providers to connect families to a parent partner who was once involved in the child welfare system. We will also partner to implement Family Forums, which allow families to discuss how to find the right care, break down barriers, and get support from other families in a similar situation. Our Individual and Family Affairs Administrator will gather information to present to providers to help improve service delivery for this population.
- **EBPs:** EBPs such as trauma-focused cognitive behavioral therapy (TF-CBT), parent-child interactional therapy, Eye Movement Desensitization and Reprocessing are important methods of treating the complex and comprehensive needs of this population. Our provider services team ensures sufficient specialty providers who deliver services to children, adolescents and adults with developmental or cognitive disabilities; sexual offenders; sexual abuse victims; individuals with SUDs; individuals in need of dialectical behavior therapy; and transition-aged youth.
- **Grand round with judges:** Given the role of family courts, we propose to coordinate grand rounds with the family court judiciary to ensure the full team, including the presiding judge, has a complete clinical and psychosocial history and there is alignment with court ordered treatment.
- **Alternative modes of treatment:** Because of the statewide shortage of providers, including child and adolescent psychiatrists, we use alternative modes of treatment such as telemedicine to ensure members are engaged in care. By collaborating with telemedicine providers like Banner Health, we enable children and families to have video conference sessions with psychiatrists and therapists via a secure, compliant video connection.

Developing Best Practices Our approach to identifying and developing best practices includes:

- **Collaboration with affiliate health plans:** As an organization who manages care for more than 24,000 members in the child welfare system nationwide, including Florida and Kentucky, our parent company created an internal child welfare advisory group. Medical directors along with representatives from CM, advocacy, network, prior authorization, product development and others meet to discuss best practices, share knowledge and experience within states and local communities, and collaborate on program development and enhancements.
- **Collaboration with providers, organizations, and the school systems:** Meeting with providers, school system leaders and organizations who serve the child welfare population is an excellent way to identify and develop care coordination best practices. Our Care1st leadership team recently met with CRN on their data reporting capabilities, and with Devereux to better understand their challenges in caring for those at risk of removal from their home, and how we can collaborate and support them.
- **Collaboration with DCS:** We are appointing a DCS liaison on our CM team. The liaison will be our single point-of-

contact with DCS for program matters, and monitor DCS communications for information about conferences, education, training, resources, workgroups, and councils, and communicate with staff as needed.

- **Integrated clinical rounds:** Our pediatric care managers use rounds to identify and implement best practices at a member level. Complex or challenging cases are presented at rounds, which integrate all aspects of healthcare and include Care1st's PH medical director and BH medical director.
- **Internal committees:** Our CASQIC quality committee, subcommittees, and councils such as PMC, MPC, and P&T are a rich source of information about best practices. For example, P&T routinely monitors and evaluates the use of psychotropic medications in children and adolescents while MPC monitors clinical developments and standards of care. Our MAC will enhance our ability to define and implement best practices for this complex population.

Tracking Outcomes We use a comprehensive set of measures to track the effectiveness of our pediatric CM program and our child-focused interventions, including:

- **Effectiveness of care:** Our effectiveness of care measures include: out-of-home placements; incidence of maltreatment or maltreatment reoccurrence; CASII and ESCII levels; admissions; ED use; success in school, based on age; connections to social services; readmission rates; use of psychotropic medications; and delinquency.
- **Adherence to EBPs:** Our staff work to ensure appropriate and timely preventive screenings, immunizations, counseling, and treatment. We monitor and address adherence to an array of HEDIS and HEDIS-like measures such as immunizations, well-child visits, and chronic CM.
- **Access to care:** We use access to care measures like children's access to PCPs and annual dental visits to ensure our members and their families can readily access care from our providers.
- **Experience of care:** Given the correlation between experience, adherence, and outcomes, we examine the degree to which our members are receiving care and services that are child and family-centered and culturally relevant. We use traditional grievance information, CM satisfaction surveys and CAHPS indicators.

Transitioning from CMDP Annually, Care1st coordinates care for nearly 300 children transitioning for CMDP as part of our Pediatric Care Management Program. Our team of pediatric PH and BH care managers, advocacy staff, and child BH member advocate help children and their families seamlessly transition as they switch funding streams. In order to ensure children transitioning from CMDP have safety and permanency, we focus on maintaining continuity of care and service, addressing lingering and unmet needs, and building stability throughout the reunification.

Improving Engagement Those transitioning from CMDP include children being reunified with parent(s) and, increasingly, children reunified with family members like grandparents as part of their longer-term reunification plan. More than 30% of members transitioning to Care1st from CMDP are 15 years of ago or older – adolescents likely preparing for adulthood. Each of these groups face their own set of challenges. Emancipating youth are often unprepared for managing their healthcare, perceiving their personal health as a lesser priority than employment, education, and housing. Youth also tend to be unaware of the array of benefits and services available. Reunified families are frequently overwhelmed by childcare needs and demands. At times, caregivers need additional skills or resources to be confident and successful. We foster and build member and family engagement through the following:

- **Collaboration with CMDP:** Children transitioning from CMDP for whom we receive an Enrollment Transition Information (ETI) are referred to our pediatric CM team. Working with CMDP, families, and DCS, if applicable, our care managers ensure children are current with recommended screenings and services, compliant with treatment plans, and connected to community-based services including Arizona Early Intervention Program (AzEIP).
- **Supportive Networks:** Working with providers and provider case managers, we ensure families have reunification support through peer and family-run organizations like FIC and MIKID which help connect families to community resources and help them navigate the children's BH and other child-serving systems.
- **Training for foster families:** Building on the experience of our Kentucky affiliate, we welcome the opportunity to collaborate with DCS, CMDP, Arizona Medicaid health plans, foster families, and other child and family-serving organizations to develop foster family training under the ACC contract. Training would address the fundamentals of Medicaid managed care under the ACC contract including EPSDT coverage, roles and responsibilities throughout the various child-serving systems, information that may be needed from foster families, and more.
- **Youth-in-Transition:** For emancipating youth, we will review the status of their transition training and readiness across a variety of factors such as education, employment, housing, transportation, financial skills, resiliency, and others, connecting them to resources including COEs that use the Transition to Independence (TIP) Model.
- **EBPs:** For those previously engaged in foster care, EB services such as TF-CBT, PCIT, and EMDR can be important

components of treating a child's complex and comprehensive needs. Our team of specialists works with providers and organizations to connect children to these beneficial services.

- **AzEIP:** Care1st has a long-standing history collaborating with the AzEIP to help infants and toddlers with developmental delays or disabilities. We work with families in AzEIP to ensure they are fully engaged in early intervention services.
- **Child-serving organizations:** We pride ourselves on the relationships we have built with child-serving organizations and those who serve as key influencers. Our local Head Start agencies routinely invite us to attend meetings to discuss childcare-related topics such as immunizations and EPSDT well visits. The trust and credibility we built with these organizations and members has been a critical factor in optimizing engagement.
- **Self-management**: Our care managers connect members and caregivers to community resources for self-management education, training, and support so they can build skills and confidence in self-care. For example, a care manager working with a child with epilepsy and his or her caregiver focuses on education and training about seizure triggers, warning signs, improved seizure control, safety issues, and lifestyle and behavior modification.

Developing Best Practices Our approach to identifying and developing best practices for children transitioning from CMDP includes participating in our national child welfare advisory group, collaborating with DCS, and collaborating with providers and organizations who specialize in caring for foster children and former foster youth.

Tracking Outcomes We use a set of child and adolescent metrics to track the effectiveness of our program and child-focused interventions including:

- **Effectiveness of care:** Our effectiveness of care measure set includes: inpatient admissions; ED use; success in school, based on age; connections to social services; readmission rates; and use of psychotropic medications.
- **Adherence to EBPs:** Our staff ensure children receive EBPs like preventive screenings, immunizations, counseling, and treatment by monitoring and addressing adherence to an array of HEDIS and HEDIS-like measures such as immunizations, well-child checks, chronic CM, and others.
- **Access to care:** We use access to care measures like children's access to PCPs and annual dental visits to ensure our members and their families can readily access care from our providers.
- **Experience of care:** Given the correlation between experience, adherence, and outcomes, we track and monitor the degree to which our members are receiving care and services that are child and family-centered and culturally relevant using traditional grievance information, CM satisfaction surveys, and CAHPS indicators.

IMPLEMENTING BEST PRACTICES

We examine implementation of best practices in consultation with our Senior Medical Director, Dr. Satya Sarma, our leadership team, and contracted providers. For example, our internal SUD workgroup evaluates implementation of SUD best practices including those related to the growing opioid epidemic. When implementing best practices and program changes, planning and execution are paramount. Our implementation plans consider: staffing and supervision, financial resources including provider reimbursement, systems, program procedures, tools for standardized processes, medical and pharmacy prior authorization rules, medical and claims payment policy, staff education and training, educational resources, stakeholder communications, provider peer-to-peer meetings, provider and member portals, and more. We document implementation plans with clearly defined owners and target dates which are managed through workgroups and internal committees.

MONITORING AND EVALUATING OUTCOMES

Our special needs care coordination and CM programs are an integral part of our Quality Management and Performance Improvement (QM/PI) program, governed by our QM/PI governance committee known as CASQIC. Dr. Sarma is accountable for our robust programs while our Sr. Director of Field Health Services Kathy Hoffman, our Adult and Child Healthcare Administrators and Member Advocacy Administrator are responsible for daily operations, including member engagement, program interventions, tracking and monitoring, and CQI activites. Dr. Sarma and Kathy are responsible for aggregating, analyzing, and sharing the results of our tracking and monitoring in order to positively impact outcomes. Results of program-level tracking and monitoring are reviewed quarterly and annually at relevant workgroups like our SUD workgroup. Results are also presented to our PMC and CASQIC committees focused on performance, interventions and collaborations, successes and barriers, and improvement opportunities with health plan leadership and our providers. Tracking and monitoring results are also reported to AHCCCS, as required.

8. IMPROVING OUTCOMES, ADDING VALUE AND IMPROVING THE EXPERIENCE OF AHCCCS MEMBERS

HOLISTIC, PERSON-CENTERED MATERNAL AND CHILD PROGRAMS

Under the AHCCCS Complete Care (ACC) Program, Care1st's focused strategies for pregnant women reflect our care philosophy that a positive birth outcome continues past delivery through the postpartum period and extends through baby's first years and beyond. Our high-touch, coordinated approach addresses physical and behavioral health, as well as environmental and social factors, to support optimal birth and child health outcomes. Our **pregnancy and high risk OB program, Care1st Hugs**, and our comprehensive neonatal and EPSDT programs provide appropriate intensity of care coordination for each member, using a layered approach that includes telephonic and home visits and multiple channels of communication to fit each member's need and circumstance. In addition to the requirements set forth in AMPM Policy 400 and other MCH policies, Care1st integrates multiple strategies to; (1) advance member timeliness and frequency of maternal care directly improving birth outcomes, including a significant decrease in NICU admissions, (2) add value for all stakeholders, by removing barriers and improving results, and (3) improve the pregnancy and post-partum experience, for our moms, babies and families. Touchpoints throughout a woman's pregnancy are opportunities for Care1st to leverage our stategies including, but not limited to, the following:

- Identification of Pregnancy Early and Immediate Outreach to Members
- Personalized and Accessible Resources Helping Navigate the Health Care System
- OB Care Management with Early Identification of High-Risk Populations
- Obstetrical Partnerships and Maternal Medical Homes with Value Based Arrangements

To support these strategies, our data-driven processes (such as early member identification, reviewing barriers and challenges and implementation of new strategies to drive improved results) and individual metrics (such as Total OB Authorization Requests, Health Assessment Surveys, and pregnant member welcome calls) are used to develop effective approaches that improve birth and child health outcomes and members' experiences. Member-level data (readmissions; Neonatal Abstinence Syndrome (NAS) incidences; adherence to prenatal schedule) are used to improve overall clinical and operational performance. Our process aligns with the U.S. Public Health Service's five "A's" of promoting healthy behaviors: Assess, Advise, Agree, Assist and Arrange.

Care1st Uses Program-Level Data to Improve Operational Performance

Through ongoing data monitoring, low rates of postpartum visits were identified. Through data analysis and member contact we learned often members completed postpartum visits outside the optimal timeframe of 21 to 56 days, particularly if they had a C-section and visited their doctor for a post-delivery check prior to 21 days, but did not return for another visit. In 2017, we added another MCH staff member dedicated to engaging postpartum moms through telephonic outreach, assisting in scheduling appointments during the appropriate time period, and with addressing no-shows for postpartum appointments. **Efforts resulted in a 59.4% increase in the postpartum visit rate since 2015.**

Care1st's Hugs Program Improves Outcomes and Member Experience

The Hugs program provides education, guidance and support for all pregnant members and provides layered interventions based on the member's risk. Hugs identifies pregnant members through state files, claims, referral, and by direct notification from the member or provider. Upon confirmation of the pregnancy, we make multi-modal outreach to assess each pregnant member's current health status and risk for preterm birth or pregnancy complications using the Prenatal Comprehensive Assessment.

In 2017, we launched an innovative mobile app called Pacify, with text messaging scripted specifically for expecting and postpartum members. Care1st is the first organization in Arizona to offer Pacify, providing 24/7 video calls with registered dieticians and lactation consultants for help and advice through baby's first year of life. Pacify also includes health education and reminders tailored to the member's week of pregnancy or delivery date via push notifications.

Identification of Pregnant Members

Because of the importance of early identification, and the barriers to timely identification, we established several supportive sources to identify a pregnancy and send a "new mom" alert to our Hugs Coordinator. Our sources include:

- PCP referrals
- Active Care Roster (ACR) received from AHCCCS

Care1st's high-touch approach has led to an **87%** rate of timely prenatal care (in the first trimester or within 42 days of enrollment).

- Member notification from Health Assessment Surveys or through direct contact with members services or Hugs
- Enrollment Transition Information (ETI) received from relinquishing health plans
- Total OB authorization requests from providers
- Providers authorization or claims payment related to a pregnancy diagnosis
- EPSDT outbound telephone calls for teens with no reported annual well visits
- Pharmacy reports for pregnancy related prescriptions, i.e. prenatal vitamins
- Hospitalizations with pregnancy diagnosis

When a pregnant member is identified, Care1st mails a "New Mom" packet including a ***"Preparing for a Healthy Baby"*** book, educational links on our website and a refrigerator magnet with the toll-free number of their Hugs Coordinator. Additionally, our telephonic outreach includes text messaging support and member engagement by Pacify and member-focused counseling.

Best Practice: One barrier we have found in serving pregnant members is those who are difficult to reach. To address this barrier, we use multiple channels of communication to reach our members. We mine claims information, pharmacy records and conduct provider outreach for emergency and alternate contact phone numbers in AHCCCS' PMMIS and our mobile device management (MDM) database. We check recent prior authorization requests to investigate recent utilization and contact that provider for updated information. If we are unable to find a valid number or mailing address, we look for email addresses and send an email asking the member to call their Hugs Coordinator via a direct number. We can also engage our boots on the ground Unable to Contact partners, such as the local AAAs or Catalytic Health Partners, who help us find at-risk members difficult to engage through in-person contact.

73% of our newly identified pregnant members receive one-on-one **assistance in navigating the health care system.**

Assessments and Care Assistance for Lower and Moderate Risk Members

Upon initial contact, our Hugs Coordinator uses a Care1st proprietary questionnaire to assess health risks and identify factors impacting the member's goals and outcomes. The survey tool is designed to advance into additional information gathering in response to affirmative answers by the member, identifying needs such as transportation, food assistance, and more. Assessments also evaluate the member for behavioral health (BH) conditions. During the initial phone call, the Hugs Coordinator asks questions to detect potential depression, which can trigger a referral to other Care1st staff for BH and substance use disorder (SUD) interventions. ***We ensure each pregnant member has a dedicated Coordinator to contact for questions or needs that arise during the pregnancy.*** After the assessment, if the member is identified as high-risk, she is connected to our high-risk OB program described below. Otherwise, the Hugs Coordinator provides easy to understand person-specific advice to the member. Together, the coordinator and the member select appropriate goals, and based on the member's interest in making lifestyle changes, the coordinator will help her with methods to change the behavior, such as to quit smoking during her pregancy. Assistance may include educating the member, helping her acquire needed skills, addressing social/environmental factors, or simply coordinating provider appointments and transportation. Regular follow-up calls are arranged by the coordinator for continued assistance and support during and following the pregnancy. The coordinator works with the member to adjust the goals and/or assistance, including referring the member to a high-risk CM, BH program, or other needed resources. ***Throughout the process, our strong relationships with our OB provider community allow us to work closely with them as they manage member care. We provide OBs tools such as data on member utilization, medication adherence and risk, to empower them to better help their patients.***

Care1st will implement additional programs over the next year to strategically address barriers we have identified through our experience in Arizona. For example, we identified certain populations (eg. American Indian) that lack early identification due to social circumstances or the complexity of co-occurring conditions in the mother. Our effective strategies involve using our Community Impact Model for social service support and referral to connect members to resources outside the delivery system, partnering with key community stakeholders and taking an active in-person approach.

Throughout our coordination activity, MCH coordinators also address needs of family members. By reviewing our centralized eligibility and claims system we can identify family members' gaps in care, such as child or adult immunizations, well-child visits, dental visits, and diabetic screenings, if applicable, and updating PCP or dental home

information if members see a different provider than the one assigned. We also refer to community resources such as food and diaper banks, housing assistance, and GED or literacy classes.

OB CARE MANAGEMENT OF HIGH-RISK POPULATIONS

Members identified as high-risk for early delivery, miscarriage, pregnancy complications, or who have co-occuring conditions are referred to our Hugs High-Risk OB Care Management program, where dedicated OB care managers conduct intensive care planning and intervention with the member to help encourage a healthy birth outcome. For example, those at risk for early delivery may be eligible for coverage of 17P (hydroxyprogesterone) injections, which the care manager will arrange for, even in member homes if needed. Enhanced and targeted programs for certain at-risk member populations provide additional assistance and support members, such as those who are justice-involved, teen mothers-to-be and those with co-occuring SUD and pregnancy.

Co-occurring SUD and Pregnancy Program. In addition to intentive short-term care management, we promote the use *of Substance Use Disorders (SUDs) in High Risk Pregnancy* Clinical Practice Guidelines (CPGs) to address common SUDs and educate providers in assessing social determinants to understand the family's specific barriers to optimal outcomes. Additionally, Care1st recognizes the Controlled Substance Prescription Monitoring Program (CSPMP) as a critical tool in dealing with substance abuse across all populations, including pregnant members. Care1st recommends the provider review the pregnant member's CSPMP record at least each trimester.

To accelerate efforts to better treat SUD during pregnancy, Care1st is partnering with Dr. Luke Peterson, a family practice physician and fellowship trained addictionologist at Banner in ***developing a Center of Excellence model for treating Opioid Use Disorder (OUD) in Pregnancy and NAS.*** The model, which we will support through our Value-Based Payment (VBP) and data sharing mechanisms, aligns with key strategies identified by ACOG in its White Paper of November 2017 on OUD in pregnancy: change perceptions of opioid use disorder through the use of a common language; develop and offer multifaceted education and implementation tools to better assist women's health care providers in caring for pregnant women with opioid use disorder; create better engagement and communication among providers within the continuum of care and across service areas, including the justice system; and enhance patient and family engagement. Key features include:

- Integrating the care continuum of OUD in pregnancy through close collaboration between Banner's Family Practice clinic (where Dr. Peterson's practice integrates primary care, behavioral health and addiction treatment) and Banner Obstetricians.
- Banner's Family Practice Residents and an inaugural addiction fellow will train through the clinic, allowing the practice to scale up services, while simultaneously growing a much needed competent clinical workforce.
- Incorporating MAT for opioid dependent pregnant members
- Promoting evidence based practices such as co-rooming and breastfeeding that encourage bonding, while improving outcomes for NAS babies
- Integrating BH services and peer support, with plans to offer group as well as individual counseling
- Engaging key stakeholders in the community, including policymakers and the Justice System
- Developing meaningful metrics and outcomes tracking
- Supporting the preservation of the mother-child dyad as well as broader family/kinship/community ties

Special Approach for Pregnant Teens

Any member under 18 years of age, who is pregnant, is automatically referred for high-risk OB CM. Through CM, we leverage community resources designed specifically for pregnant teens or that provide wrap-around services to support their needs, including: Teenage Outreach & Pregnancy Service (TOPS), providing support, education and a boutique for maternity and baby gear; ADHS Healthy Start, offering culturally competent home visits and care management services through the baby's second year of life; Maricopa County Public Health Department Healthy Start Program, offering home visits and education; Maricopa County Public Health Nurse-Family, a home-visit program for first time moms; and, Teenage Parent Program (TAPP), an alternative education program for pregnant and parenting teens who want to continue their education and obtain their high school diploma while remaining close to their babies.

Care Coordination Post Delivery

During the baby's first two years, EPSDT Specialists outreach based on the AHCCCS EPSDT Periodicity Schedule.

Through tailored telephone outreach, other needs may be identified with direct assistance or by connecting her to important community resources and value-added benefits that enhance the family's health and wellness. Mom is encouraged to enroll in WIC, if not already, and may be connected with programs such as the Family Nurse Partnership home visiting program, the Maricopa Integrated Health System (MIHS) Internatal clinic for women who had high-risk pregnancies and the Arizona Postpartum Wellness Coalition Warmline.

Best Practice: If baby is suspected or diagnosed as having a potential CRS condition prior to birth, an alert is placed on the case rather than waiting until the diagnosis presents itself at childbirth. This ensures the Concurrent Review Nurse (CRN) who will see the mom before post-delivery discharge is engaged and the CRS Coordinator and OB CM are prepared to proactively assist the family. Barrier addressed: Timely access to the right care.

Care Management for Medically Complex Newborns

NEONATAL CARE MANAGEMENT DELIVERS IMPROVED OUTCOMES

- **73-80%** member engagement in care management
- Members consistently rate our CM program at the highest levels of satisfaction
- Babies go home on average 2-3 days sooner

A key part of our MCH program is making sure babies with complex needs at birth receive care they need to have healthier overall lives. Our Comprehensive Infant Care Program (CIC) is customized to meet the individual needs of medically complex or premature infants and their families.Our program centers on the NICU stay, as well as the first year of life for at-risk infants, and uses trained nurses and neonatologists to conduct NICU-specific UM reviews to ensure infants are receiving appropriate care, in the right setting. Nurses help families navigate their healthcare resources such as appropriate ER and PCP use and coordination with social supports. CIC neonatologists, pediatricians and NICU nurses work collaboratively across the continuum of care with providers to understand care plans and ensure appropriate lengths of stay in the hospital. Our team of NICU Nurse CMs and Social Work CMs begin working with families from the infant's admission to a NICU or Special Care Nursery, through discharge planning and post-hospitalization care. Key features include:

- **Integrated Care** –We ensure families are prepared for the transition home and continue to support them throughout the continuum of care, providing education, coordinating healthcare services, and encouraging wellness and safety. Our CMs are available 24/7 to answer health care questions and give direction to appropriate resources whenever the need arises.
- **Quality** – Our program integrates performance measures and impacts many key factors including the reduction of readmissions, improved number of well-child checks and immunizations.
- **Access** – CIC works with families to ensure they have identified providers and can overcome social limitations such as transportation or language barriers to access PCPs and specialists.
- **Cost-Savings** – CIC has demonstrated over the past decade that proactive conversations with providers and the families of medically complex newborns improves quality, naturally reducing overall costs.
- **Family Education** – We heavily involve parents and families in NICU and at-risk infant care planning. CMs train and educate families on the care of medically complex babies regarding growth, social and development milestones, caring for the small, frail newborn, feeding schedules and supplementation, use of medical equipment, problem solving and education for CPR, suctioning, apnea monitoring alarms, rest and support of caregivers, and emergency planning for minor and severe illnesses. Care plans for infants include guidance for caregivers and parents, and are comprehensive to cover physical, behavioral, social and pharmaceutical interventions.

Addressing Additional Barriers to Optimal Birth Outcomes

To help our members remove barriers to a healthy birth, we reach out proactively, as described above in the Hugs Coordinator outreach process, and:

- ***Provide 24/7 access to resources.*** Care1st maintains a round-the-clock nurse advice line, for members who have questions which may not rise to the level of seeing a doctor or visiting a hospital.
- ***Distribute educational materials in written and video formats.*** Topics covered include planning delivery, choosing a pediatrician, tips for packing for the hospital, monitoring early signs of labor and family planning (e.g. birth spacing and the availability of long-acting reversible contraceptives).
- ***Offer incentives to encourage health literacy.*** Care1st supports free community baby showers, prenatal

education events where members participate in a raffle, receive refreshments and a gift basket while learning about prenatal care and organizations in the community, such as WIC. The Maternity Education and Reward Program (MERP) provides basic prenatal, postpartum and newborn care educational materials for all its pregnant and newly delivered members, and rewards them for compliance with doctor and wellness visits.

- ***Communicate in the member's preferred language and preferred method.*** All written member materials are translated into the required languages. Care1st employs bilingual staff and also, uses a translation service.
- ***Connect members to social services.*** We connect members to community resources through our proprietary CommUnity Impact Model, designed to sustain and grow a network of social safety net organizations within the communities we serve. MCH Coordinators and OB CMs use the Care1st CommUnity Impact Model Referral Tracker to link pregnant members to a multitude of programs and services. Referrals are tracked in the electronic member record with referrals and the delivery of services confirmed electronically through data sharing agreements with targeted social service providers.

OBSTETRICAL PARTNERSHIPS AND MATERNAL MEDICAL HOMES WITH VALUE-BASED ARRANGEMENTS

We facilitate datasharing and collaboration based on clinical best practices, frequently providing both formal and informal feedback to our providers. High-volume OB/Gyn providers are identified for onsite visits by their Network Management representative and a Quality Improvement team member. The Care1st team provides a Maternal and Child Health toolkit with articles and evidence-based tools such as Care1st's CPGs, also available on Care1st's Provider website. Our Monthly "Practice Pointers" include MCH-specific topics sent to our OB/Gyn providers. SUD, NAS, teen pregnancy, and postpartum depression are topics included in mailings and faxes.

Providers are encouraged to use current CPGs and evidence-based tools, such as the Screening, Brief Intervention, and Referral to Treatment tool to identify, reduce, and prevent problematic use, abuse, and substance dependence. Maternity-focused CPGs, updated annually, align with the US Preventive Services Task Force and ACOG guidelines. ***Enhanced Value-Based Payments.*** Providers will be eligible for bonuses for specified outcomes. For example, our OB Enhanced Payment Program will allow an OB provider to earn up to a $1,200 bonus per delivery upon fulfillment of four specific criteria aligned with improved birth outcomes: (1) ensuring the pregnant mother has six or more prenatal visits, (2) completing a postpartum visit within six weeks of delivery; (3) evidence of predelivery pertussis vaccination; and (4) submission of the SBIRT tool by the end of the second trimester. This program supplements Care1st's partnership with Access to Healthcare's OB Care Coordination program. In its first year, Access to Healthcare's OB Care Coordination program had 99% compliance for prenatal care appointment attendance and 94% compliance for postpartum visit attendance. Additionally, 100% of members completed their new baby pediatric visit.
As an example of a value-based purchasing strategy and clinical collaboration in an integrated care model, we refer our Hugs partipants in Maricopa County to the Valley Perinatology Center of Excellence (COE) and our CIC NICU CM program. We incorporate performance measures that impact the reduction of readmissions and improve health outcomes for the mother and child. Through data analysis, we chose Valley Perinatology as a preferred provider who drives improved outcomes with lower utilization. Our Value-Based Arrangement focuses on reduction in NICU deliveries, reduction in ultrasounds, and increased prenatal utilization via partnerships with maternity groups.

Care1st's rate of NICU admissions (2017) is **45% lower** than the most recent rate for all AHCCCS births

POSITIVE TRENDS IN IMPROVING OUTCOMES

Strategies currently in use to engage members and partner with providers have helped improve birth outcomes. ***From 2014 – 2017, Care1st decreased its C-Section rates by 14.8% and NICU admissions by 19.0%.*** With a focus on improved outcomes beyond the immediate postpartum period, Care1st has consistently performed well in measures related to the completion of well-child visits in the first 15 months of life and immunizations completed by 24 months of age. ***Our provider education efforts have also resulted in strong performance for PCP preventive screenings such as oral health and developmental surveillance, with these rates greater than 99.0%.***

A LEADER IN ADDRESSING THE DEVELOPMENTAL NEEDS OF YOUNG CHILDREN

Care1st's rate of PCP and member adherence to surveillance was more than 97% in 2017, an increase of 7% over 2016. Additionally, we have consistently exceeded the state Medicaid average for well-child and adolescent checkups since contract year (CY) 2013. For CY2015, ***our well-child checkup rate for children birth to 15 months of age and 3 to 6-years of age, and our adolescent well-care visits exceeded AHCCCS' aggregate rate by 7%, 9%, and 8%***, respectively. Our success ensuring adherence to checkups and suveillance is due to our investments in our children's model of care, including our EPSDT and well-visit programs. Our results are evidence that, together with providers and child and family-serving organizations, ***we address the developmental needs of nearly 77,000 children in Arizona.***

A COMPREHENSIVE APPROACH TO ADDRESSING DEVELOPMENTAL NEEDS OF YOUNG CHILDREN

Children's early years are of critical importance to their lifelong development, well-being, health, and healthcare cost, which is why it is imperative that children's development be assessed at the earliest age possible. Engaging our members in routine developmental and behavioral screening at American Academy of Pediatrics (AAP) and Bright Futures recommended well-child visits, as well as providing surveillance at every office visit allows for the prompt identification of issues or delays related to cognition, social or emotional development, communication, activities of daily living (ADLs), and physical development including fine, gross, or perceptual motor skills. With early identification, our providers can appropriately diagnose and treat members which may prevent or mitigate long-term issues, as may be the case with a child with speech delays due to chronic ear infections possibly resulting in hearing loss, a child with correctable vision problems, or a child with or at risk for Autism Spectrum Disorder (ASD).

Our pediatric model of care is an integral part of our Care Management and Quality Management and Performance Improvement (QM/PI) programs, governed by our QM/PI governance committee known as the Clinical and Service Quality Improvement Committee (CASQIC). Our Senior Medical Director, Dr. Satya Sarma, is accountable for our pediatric care model and related programs, all of which align to the Arizona Vision-Twelve Principles for Children's Behavioral Health Service Delivery as outlined in AMPM Policy 430. Our children's healthcare administrator and behavioral health (BH) medical director will further advance our children and adolescent care coordination efforts. Reporting to Dr. Sarma, our children's healthcare administrator will oversee our fully integrated physical and behavioral health and social services programs for members birth through 20 years of age, including our children's physical and behavioral health service delivery system. Our Manager of Quality Improvement, EPSDT, MCH, and Division of Developmental Disabilities (DDD), Maritza Jimenez, is responsible for day-to-day activities along with her 15 dedicated, full-time EPSDT staff.

Processes to Monitor the Identification of Members with Developmental Delay and the Provision of Services The goal of our pediatric model of care is to *enable children to achieve their full potential* and our strategy is fourfold:

- Identify and diagnose early
- Enable easy access to necessary care and services, and beneficial information and support to caregivers
- Facilitate access to an integrated network of quality providers specializing in children with developmental delays, disabilities, and behavioral disorders
- Support evidence-based treatment

We coordinate activities with providers, schools, community organizations, families and caregivers, workgroups, and committees to ensure the greatest impact. In the following sections, we explore our strategies and processes to monitor the identification of members with developmental delays, disabilities and behavioral disorders and ensure the provision of services, including intensive behavioral intervention (IBI) benefits for those with a behavioral or developmental condition.

Identify and Diagnose Early Our first strategy for addressing children's developmental needs is to identify and diagnose early through routine surveillance, screening, and referrals, as young as possible - ideally before 2 years of age. For members less than 21 years of age, ***Care1st trains and incents PCPs to conduct routine health screenings, including vision, hearing, developmental, and BH screenings, using standardized, validated instruments.*** For children less than 16-months of age, this approach includes the Parent's Evaluation of Developmental Status (PEDS) and Ages & Stages Questionnaire (ASQ) tools. For children 16 to 30-months of age, this approach includes PEDS, ASQ

and Modified Checklist for Autism in Toddlers (revised) (M-CHAT-R). Providers must conduct screenings per the timeframes specified in the AHCCCS Periodicity Schedule, as well as inter-periodic screenings as appropriate for each member or when a parent or PCP has a concern. Dr. Sarma and her team communicate expectations for PCP screening through a variety of channels including our Care1st provider agreement, provider manual, routine verbal and written communications, provider orientation, provider portal and care gap reports, newsletters, joint operating committee (JOC) meetings, and semi-annual provider forums. Our team also communicates with members about the importance of screenings and recommended timeframes using a mix of media such as the member handbook, newsletters, mailed notices, telephonic outreach, and text messages.

We train our PCPs to complete the AHCCCS EPSDT tracking form for well-visits, documenting the services provided. PCPs send completed copies to Care1st where our EPSDT staff enters the information provided, including specialist referrals to Arizona Early Intervention Program (AzEIP) or behavioral or developmental specialists, into our proprietary database. ***All specialist referrals trigger follow-up by our EPSDT or BH staff*** consisting of a review of authorization and claim data and outreach. Our staff outreach to the child's parent or guardian. As part of our ***whole health, family-centered approach***, we confirm the referral, assess the status of appointment scheduling, and identify needs such as transportation. We also assess if the family has adequate supports in place and coordinate intervention, as appropriate. Care1st closely coordinates with AzEIP to ensure our young members with developmental or other concerns who are referred to them for evaluation get close follow-up and coordination of their individualized service needs irrespective of whether or not they qualify for AzEIP services. Our Maternal Child Health department monitors AzEIP referrals and coordinates with AzEIP and the PCP to ensure member-specific needs are assessed and addressed, even in cases where the child's delay is not severe enough to qualify the child for AzEIP services. In this way, children at every level of developmental need are ensured the early intervention they need to achieve optimal outcomes.

To get a complete picture of the health services children receive, ***we routinely measure adherence to screenings***. Our QM/PI team uses this information, along with HEDIS data and others, to monitor use of services preventive and chronic care coordination measures, and to identify gaps in care and opportunities for improvement. Information about care gaps is used to conduct telephonic outreach and for mailing reminder letters to members. ***We have completed nearly 163,000 preventive outreach, referral and therapy follow-up calls, and mailed nearly 350,000 EPSDT preventive outreach letters reminding parents and caregivers of the need for well visits since October 2014.*** We also supply data to our care management and customer service staff, as well as providers for outreach and follow up. Additionally, we monitor provider compliance with screening tools. The outcome of our monitoring triggers provider outreach and education. Quarterly and annually, our comprehensive outreach and surveillance results are reported to PMC and CASQIC committees and to AHCCCS using the national CMS-416 methodology.

Enable Access to Proven, Necessary Care and Services as well as Information Our second strategy for addressing children's developmental and behavioral needs is to enable access to proven, necessary care and services through our ***fully-integrated Pediatric Care Coordination Program***. We identify children for our Pediatric Care Coordination Program through the previously mentioned EPSDT tracking forms as well as our identification and stratification (ID/Strat) algorithm, prior authorization (PA) requests for therapies, NICU discharges, or school, provider or caregiver referrals.

Once we identify a child with special needs, he or she is referred to our pediatric care coordination team, comprising licensed nurses and BH staff, for assessment. During the assessment, our care manager verifies if the child is current with recommended services, treatments and referrals based on his or her age and needs. This assessment includes ensuring the BH provider has completed the Early Childhood Service Intensity Instrument (ECSII), for those birth through five years of age, or the Child and Adolescent Service Intensity Instrument (CASII), for those 6 through 17 years of age. Those needing care coordination are enrolled in our Pediatric Care Coordination Program, with parental consent, so we can work with the child and family to ensure all needs are met. Our pediatric care managers help parents and caregivers of children with developmental and behavioral needs navigate the healthcare and social service delivery system. They engage families in child and family-centered planning to assist in addressing their unique needs and produce a care plan that emphasizes community participation, meaningful social relationships, enhanced opportunities for choice, and continued personal development. If a caregiver needs help scheduling appointments or arranging transportation, our care manager assists. During scheduled care plan reviews, our care managers follow up to ensure appointments have been kept, services delivered, and, if necessary, referrals provided. ***As one of three***

health plans serving AHCCCS' Acute Care and DDD populations, we are uniquely positioned to help families with children with developmental and behavioral needs determine if they qualify for DDD and, if so, help them in completing their application, as shown in the following *Case of Caring*.

A CASE OF CARING: During a visit with a 2-year old Care1st member, the provider conducted a developmental screening and noted issues with expressive language and auditory comprehension. The provider referred the child and his family to AzEIP. Per our EPSDT protocols, we began routine outreach with the member's family to ensure they were engaged with AzEIP. During our follow up, we identified the child had been diagnosed with ASD, ADHD and global delays qualifying him for AHCCCS' DDD program. When it came time to apply for DDD, the parents hesitated. Their hesitation was due to a language barrier and their misunderstanding about the DDD plan and their son's eligibility (the parent's primary language is Spanish). We engaged our bilingual Care1st DDD Liaison to provide the family with information about the DDD program in their native language. She also helped them complete the DDD application. Because of his level of ASD the child was approved, and the family chose to enroll in our Care1st DDD program. The child and his family now have the support of his Care1st DDD care manager and a DDD Support Coordinator. ***Because of our diligent follow up and support, the member and his family are DDD-qualified for life and can receive needed benefits and services like habilitative speech, respite care and incontinence supplies.***

Our pediatric model of care recognizes that ***a child in need is a family in need.*** As part of our family-centered approach, our care managers extend support to parents and other children in the household. This may include connecting the family to community resources like peer and family support offered through Family Involvement Center or support for homelessness provided by United Methodist Outreach Ministries (UMOM). For many communities, especially those in the North and South GSA, infrastructures are lacking and many face significant social service gaps related to affordable housing, employment and access to healthy food. Because our model of care features an integrated, in-house social service component, *CommUnity Impact Model,* we are uniquely positioned to address member and community needs. Our care managers work with our CommUnity Impact team, housing and education staff, and member advocacy team, to address family needs and close gaps through community investment. ***We have committed to investing $1M in local communities across the state over three years***.

In addition to ensuring timely delivery of services through our care coordination and CommUnity Impact programs, our systems and processes enable unfettered access for members with developmental needs and the providers who care for them. For example, our referral policies support provider collaboration and integration as specialists may directly refer to other specialists. Policies like this positively affect clinical outcomes by creating timely access while also enhancing the member, family, and provider experience. We also enable access and care coordination through technology. Our recently deployed enhanced provider portal allows providers and their office staff to easily access actionable data regarding care gaps, needed screenings, and tools and resources like our evidence-based child and adolescent preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) for physical and behavioral health conditions like ASD, epilepsy, and others. Our website includes links to information needed by families of children with developmental and behavioral disorders, primary and specialty care providers, and state agencies. Because not all families have Internet access, printed resources are also conveniently available.

Facilitate Access to an Integrated Network of Quality Behavioral, Physical and Social Service Providers Our third strategy for addressing children's developmental and behavioral needs is to ensure access to an integrated network of quality providers across a range of specialties and subspecialties. As an existing contractor, we have met with advocacy groups, community organizations, and providers throughout the state, including the Arizona Chapter of the American Academy of Pediatrics, Touchstone, the Association for Supportive Childcare, Southwest Human Development, Good Neighbor Alliance, Avondale Elementary School District, and Pinal/Gila Community Child Services, to prepare for integration and expansion. We know the importance of providing access to quality BH, physical health, therapy, and social service providers who can screen for, diagnose, and treat members with developmental and behavioral disorders. We also know many communities throughout the state face significant challenges due to high rates of chronic health conditions, provider shortages, limited access to care and community services, and cultural and geographic factors.

To help communities overcome challenges and provide the needed support for children with or at-risk for developmental delays, disabilities, and behavioral disorders and their families, our Provider Services Director, Jessica

Sedita-Igneri, and Vice President of the Center for CommUnity Impact, Pamme Taylor, and their teams are expanding and enhancing our network of physical health, developmental, BH, and social service providers throughout the state. ***Our community-based social services network includes more than 6,000 organizations that address social determinants of health like homelessness, food insecurity, employment, peer and family supports, respite care, and more, for Arizonans. Our network of nearly 13,000 providers, including nearly 450 pediatricians, is also growing.*** To support children and families, we formed an ASD Workgroup to inform our network efforts and prior authorization criteria. Acting upon feedback received from child and family-serving organizations such as United Cerebral Palsy, Highland Behavioral, Southwest Autism Research & Resource Center (SARRC), and Hope Group, ***we have written agreements with Touchstone and Southwest Behavioral Health, both of whom are ASD Centers of Excellence***, as well as S.E.E.K. Arizona. Our network development efforts continue as we negotiate with Child and Family Support Services, Encompass Health Services, Southeastern Arizona Behavioral Health Services, and the Guidance Center.

To address the statewide provider shortages, we are using a variety of strategies to enhance access to care for children diagnosed with developmental delays, disabilities, and behavioral disorders and their families, including:

- Executing VBP agreements to incent providers like North Country HealthCare FQHC to expand access
- Supporting Project ECHO's (Extension for Community Healthcare Outcomes) telemedicine initiative and their efforts related to rural specialty care
- Collaborating with telemedicine and telepsychiatry providers like Banner Health to expand service delivery.
- Expanding the use of Community Health Workers and Promotoras
- Implementing and promoting peer and family support programs

To address time to diagnose, which is often delayed due to scarcity of qualified clinicians, we are collaborating with SARRC, a national leader in ASD, and AHCCCS' ASD Committee for Telehealth Policy to explore resources like telemedicine platforms that allow diagnostic evaluation of a child where a parent has a developmental concern.

In addition to ensuring the adequacy of our provider and social service network, we are focused on provider education including requirements for routine screening, diagnosis, treatment and referral, and reporting. We are also training providers on the Care1st tools and services available to support their treatment plans such as our pediatric care coordination program, pay-for-quality incentives, enhanced provider portal, PHGs and CPGS, practice support tools like our HEDIS Toolkit and pharmacy reports, and CommUnity Impact Model social services database. Care1st's commitment to coordinating care for this special needs population goes well beyond traditional billable services and provider education. We are pursuing innovative solutions that leverage partnerships in new and creative ways, just as our Kentucky affiliate did for members with ASD in foster care, as shown in the *Innovative Partnerships* below.

INNOVATIVE PARTNERSHIPS: Prior to Medicaid managed care in Kentucky, many children diagnosed with ASD or developmental disabilities ended up in foster care and many, in turn, ended up in inpatient facilities – some for as many as three to four years. Placement changes were also commonplace, averaging more than three per year. Determined to change the paradigm and enhance the care provided to these children, our Kentucky affiliate implemented an *ASD and Developmental Disability Special Care Coordination Service.* The goal of the program was to keep children diagnosed with ASD out of institutional care by finding suitable alternatives in the lowest level of care that matched their individual needs. The team collaborated with the Kentucky Department of Community-Based Services and a therapeutic foster care provider with the right funding flexibility from the state to increase options for these children. Applying trauma-informed care models, care managers connected children with providers who understood their needs. Because of this program, ***many of the children transitioned to the community where some stayed for more than a year, where they developed supportive relationships with foster parents, service providers, schools, places of worship, and social groups. Some even reconnected with family they had not seen for years***.

Support Evidence-Based Treatment Our fourth strategy for addressing children's developmental and behavioral needs is to support evidence-based treatment. Under Dr. Sarma's leadership, our pediatric care coordination program facilitates access to comprehensive, proven services needed to correct and ameliorate children's health conditions. Our evidence-based guidelines represent the best available scientific and clinical research and expertise from leading professional organizations including The American Academy of Pediatrics, United States Preventive Services Task Force, American Academy of Child and Adolescent Psychiatry, the Agency for Healthcare Research and Quality and American Academy of Family Physicians, among others. Our guidelines include:

- Child and adolescent PHGs, modeled after The American Academy of Pediatrics' *Bright Futures Guidelines*
- More than 50 physical and behavioral health CPGs for a range of conditions including ASD, Child and Adolescent Behavioral Health, and Epilepsy
- More than 215 coverage guidelines including Developmental Screening and Testing, Pediatric Skilled Therapy Services for Developmental Delay, Therapy Services for ASD, and Applied Behavioral Analysis (ABA)

Our guidelines optimize the care our members receive, including those with or at risk for developing ASD and those with other developmental and behavioral delays or disabilities. Our guidelines address symptomatology, treatment including pharmacotherapy, member and family engagement, utilization, and recommended care management goals and objectives. We will align our criteria with any guidelines AHCCCS issues for ABA therapy or other evidence-based treatment, while ensuring that intensity of treatment is tailored to members' individual levels of need. For example, where targeted behavior change can impact outcomes, a more focused approach may be beneficial.

To ensure evidence-based recommendations are factored into providers' decision-making, members' child and family-centered care plans, discharge plans, member and caregiver education, and provider education, we incorporate guideline recommendations into care manager training, provider education resources, and care manager tools, such as ***our condition-specific QuickCard reference cards which summarize critical elements of the CPGs including case goals, interventions to promote self-management and build parent and caregiver capacity, and more***.

Managing Intensive Behavioral Intervention Benefits for Members with Behavioral or Developmental Conditions

Consistent with AHCCCS benefit guidelines, we will provide Intensive Behavioral Therapy (IBT) treatment modalities, including ABA and early Intensive Behavioral Intervention (IBI) - a form of ABA specifically for very young children, typically less than five years of age and often younger than three - based on individual medical necessity determinations. Given the complexity of service needs, comorbidities and multiple providers, our pediatric care managers will manage the IBI benefit. Experienced care managers with specialized training will ensure access to all necessary services including trauma-informed care, if necessary, and the full spectrum of services offered within the community. They will assist in the coordination of PAs as well as ongoing evaluation of the effectiveness of services. The IBI benefit will be available for children with a diagnosis of ASD when the consultation for ABA services is conducted by an ABA-certified provider. We will ensure completion of the proper language, preference, and functional behavior assessments, along with direct observation and measurement of behavior, file review, administration of behavior scales or other assessments as appropriate, interviews with the member, caregivers, and other professionals, and, when age appropriate, IQ or similar standardized test scores. Care1st will authorize IBI services provided in members' homes and providers' offices. As part of our review, we will ensure the member does not require 24-hour monitoring by a healthcare provider and is considered medically stable; there is a complete biopsychosocial summary including those living with the member, environmental factors of note, and any medical issues; there is a treatment plan for each area of concern that defines the frequency of baseline behaviors and the plan to address the behaviors; the member has a transition plan; and treatment components are taken from cognitive functioning, pre-academic skills, safety skills, social skills, play and leisure skills, community integration, vocational skills, coping and tolerance skills, and adaptive and self-help skills.

Because of the statewide shortage of developmental pediatricians, there is a long wait time to diagnose developmental delays and ASD. Additionally, a shortage of therapy providers adversely affects timely treatment. To mitigate these issues, our Medicaid affiliates in states with similar provider shortages have established ABA reporting specifications and protocols to proactively identify children who may be candidates for IBI. Care managers proactively share information with providers so they can evaluate the child. With AHCCCS' approval, we will implement similar protocols to ensure the provision of services in Arizona. Our protocols will include coordination with AzEIP for early intervention for children from birth to three-years old since AzEIP has their contracted providers of therapy services paid separately. Additionally, we will continue to explore technologies to scale scarce resources, like the diagnostic platform SARRC demonstrated. We will also maximize resource availability by matching resources to prioritized needs, as in the case of a child demonstrating disruptive behaviors. In this instance, we will connect the child and family to focused behavioral therapies needed to rapidly address the disruptive behaviors and stabilize the child's integration into school or family, while more comprehensive behavioral planning occurs.

FOCUSED APPROACH TO REDUCING PREVENTABLE EVENTS FOR BEHAVIORAL HEALTH

Using our experience with integration in Arizona and other states, and our proven care coordination model and sophisticated data analytic techniques, we will ***implement a fully integrated healthcare continuum that minimizes Emergency Department (ED) holds for behavioral health (BH) conditions, reduces the number of psychiatric hospital admissions in- and out-of-state, increases alternative community-based services, and ensures follow-up care***. We deploy specific member and provider strategies, as well as system-level approaches that focus on prevention, intervention and effective follow-up to align members to the right level of timely care. Key to managing utilization of appropriate BH services is monitoring and analysis through our Performance and Monitoring Committee (PMC). Under the leadership of our Chief Executive Officer Scott Cummings, the Care1st PMC meets at least monthly to review utilization, cost, and quality data and design interventions to promote appropriate use of services. The team analyzes data and trends across counties, practices, hospital systems, ancillary providers, and clinical conditions. Through the implementation of ACC, we are adding specific analysis and reports of ED Holds, psychiatric admissions and readmissions, medication adherence (which plays a critical role in BH utilization) and 7-day and 30-day follow-up and utilization of outpatient services. Our data warehouse allows us to drill down into those reports to pinpoint specific cost drivers and contributing factors. This level of precision allows us to develop or deploy targeted interventions to drive appropriate and efficient use of services. For example, we know that AHCCCS has had success in reducing ED holds over the past 12 months from nearly 70 hours to 14 hours. Still, there are specific outlier issues for members with co-morbid complex medical and psychiatric needs, as well as for certain children showing signs of violence or a history of sex offense. This knowledge is driving one of several of our proposed solutions for mitigating ED holds – capacity building within the delivery system. In capacity building to address co-morbidity driving ED Holds, ***we partner with providers interested and able to expand access to services for members with a complex behavioral health need and a complex medical issue.*** We will offer payment mechanisms and support that makes it meaningful for a provider to invest-in adding or expanding this level of care. This is just one of several strategies we are adoping to minimize ED Holds as outlined in **Table 10-1** below. We describe several of these strategies below the table.

SUCCESS IN MANAGING ED

Care1st implemented special high-touch interventions resulting in a reduction of ED use for high and moderate utilizers by **41% and 56%**, respectively.

SUCCESS IN REDUCED PSYCHIATRIC ADMISSIONS

Our Florida affiliate, Staywell, consistently performs better than the state average on readmission rates for members with BH diagnoses. For example, Staywell readmission rate for persons with major depression was 10.3% outperforming the state overall rate of 17.4%. After fully integrating Staywell in 2014, we saw a 17% decrease in inpatient BH admissions for members with co-morbid conditions.

System Strategies	Member Strategies	Provider Strategies
• Invest in and support capacity building for key service • Expand Peer Supports and other outpatient services • Enhance immediate access to care • Invest in and support community/social service resources • Collaborate with community for, invest in and expand access to Crisis Intervention Team (CIT) training • Rapid Cycle Improvement	• Care1st at Home intensive CM intervention for most complex needs • Real-Time UM Available 24/7 • Align members with integrated health homes incented to provide preventive care • Screening/early identification • Crisis Planning and adherence • Education and outreach	• Value-Based Purchasing • Provider benchmarking on access and availability • Accountability for key prevention and utilization metrics • Joint Operating Committees • Training and education

Table 10-1: Strategies to Minimize ED Holds

System Strategy: Ensuring Capacity of the Right Services to Minimize ED Holds

Our experience in Arizona, and our integrated settings of Florida and Kentucky, tells us that ED holds often occur when members have no where else to go, either pre- or post ED admission. Below are a few of our tactics around building capacity and access to divert members to other settings.

Investing and Partnering to Enhance Capacity in Critical Services: We identify services within the system that are lacking capacity growth, such as services for children showing signs of violence, peer supports and intensive outpatient (IOP) programs for the GM/SA population, and we are reaching out to partners to help expand that capacity. This is a strategy we are accustomed to in Arizona where we are partnering with Bayless Health Care and the Avondale Elementary School District to open an integrated clinic on their campus. We are funding renovations to support the new clinic because we recognized the need to reach children and families where they are. As ACC launches, we will look specifically at drivers of ED holds and other preventable events to expand partnerships like this.

Best Practice: Care1st is ***partnering with Connections Health Solutions*** to expand access to a new service they are launching for post-crisis transitional care, designed specifically for the GMH/SU population. Connections AZ has recently developed its ***Comprehensive Transitional Care Program for the Post-Crisis Episode*** for members who present in crisis at a Connections' psychiatric emergency care center. Their model focuses on short-term, high-touch interventions by an interdisciplinary team that includes peers, nurses, physicians and social workers. Post-crisis, members are still recovering and need extra time and attention to ensure that they get connected to the next level of care and support them while they recover from the crisis episode, such as helping them get their medications or make their next appointment. Care1st will not only pay for these services but works with Connections AZ to share data and coordinate post-crisis care for our members jointly. This will help to further reduce unnecessary ED holds.

Expansion of use of peers in crisis response settings and programs: Care1st plans to support the inclusion of a full array of peer supports within existing and newly developed crisis programs, including mobile outreach. Additionally, we use peers to promote early intervention (pre-crisis warm line), crisis response, and post crisis system navigation. Our staff with lived experience will support the development of peer supports in collaboration with the state's BH delivery system and the emerging integrated system of providers. Our Florida affiliate partnered with local NAMI chapters to expand peer training, supporting our long company-wide history of hiring staff with lived experiences.

System Strategy: Collaborating and Enhancing Access to Resources

Enhance Immediate Access to Care and Dedicated Outpatient Services: A particular issue in the current Arizona crisis system is post-crisis support, especially for the GMH/SU population and children. With the SMI population dominating services within the RBHA systems, many BH and integrated providers don't have bandwidth to participate in crisis discharge services and supports. We will incent providers to offer dedicated times for specialized Child Family Team (CFT) meetings for children emerging from crisis and to offer special post-crisis appointments for adults emerging from an emergency situation.

Bolster Access to Housing and other Social Supports: Our CommUnity Impact Model is specifically designed to build capacity for and create linkages to necessary social service resources such as housing, employment and healthy food. Through the CommUnity Impact Model, we analyze health data to determine where to invest local community grants to create necessary supports that address our members' needs. We hire local community liaisons to develop the necessary relationships with our community partners, and we staff a CommUnity Assistance Line (available to members, nonmembers and providers) with peers who have lived experience to help them connect to community resources through our proprietary database of available services. We track access to those services and whether or not they were effective in meeting member needs. That tracking then cycles back through our analysis to target funding and investment to the most effective programs. ***A study by the Robert Wood Johnson Foundation of our model in Kentucky found total medical spending was reduced by $450 for each social service accessed. Reductions were attributed in part to a 17% reduction in ED use.***

Member Strategy: Predicting Risk, Identifying Member Need and Intervening Appropriately

The best approach to minimizing ED Holds is preventing the ED visit in the first place. Critical to addressing crises is being able to quickly identify the root cause of the problem and implement member-centered interventions to address the underlying issue. Our approaches to managing member crisis include prevention, prediction, identification and intensive intervention as seen in tactics outlined below.

Predictive Analytics to identify high-risk profiles for eventual crisis presentations: Screening and identification is informed by our capacity to use predictive analytics to generate the pre-crisis profiles of individuals who later present for severe BH ED interventions, as we do for high-risk medical patients. These predictive analytic profiles are a result

of our fully integrated data and care management (CM) solution within CareCentral, and they allowing our Integrated Clinical team to, with community providers, develop an appropriate early intervention plan. An obvious high-risk profile is the member that repeatedly use the ED for psychiatric purposes. We will work with our crisis providers to create a data driven QI process to identify the small number of multiple users and initiate extensive CM intervention to align them with the right resources, including an integrated health home incented to ensure they have the right services to prevent unnecessary ED use. Our ID/Strat model was specifically designed to tease out BH risk. After implementing the new model, WellCare identified 20% more individuals at risk who were previously masked by traditional identification tools used in managed care. Half of those new members identified for intervention had a BH diagnosis. Once identified, members with specialized needs receive targeted CM interventions.

Best Practice: Application of Zero Suicide as a system wide quality improvement framework: Care1st has borrowed from the comprehensive Zero Suicide approach piloted by Henry Ford Health System and others to apply what has been learned to reduce or eliminate suicide throughout our network. We will coordinate our efforts with existing Zero Suicide efforts in other systems across the state. By making identification of suicide risk – and response to that risk with proactive intervention – one of our care coordination data points for QI tracking and registry, we hope to intervene and direct people to help sooner without presenting at an ED with suicidal thoughts or intentions.

Coordinate with state and local efforts to facilitate access to civil commitment (COT) without using ED: Individuals who might need involuntary care can be successfully connected to services by using the civil commitment process via the courts rather than going unnecessarily to an ED. Care1st will ensure that our provider network, members, and particularly our BH Care Coordination and UM Team are fully versed on how to leverage these processes in each region. This is done through modules within our provider training, information available on the provider portal and in provider newsletters.

Locating and engaging difficult to reach members: Ensuring members get services before a crisis drives them to the ED is the impetus behind our investments in our Unable to Contact (UTC) program, designed to find and engage members who are difficult to locate. Through the ACC contract, we are expanding on community partnerships we have with programs like AAA and PCOA to help find and engage UTC members. Our UTC program begins with a deep search of all available records for a member including previous claims for a medication fill or doctor visit. We track down previous phone numbers and addresses and take steps at multiple times of the day to reach out to known contacts for members. If those efforts don't succeed, we engage partners through incentivized payments to locate and engage members at risk so we can help align them with a health home and CM resources.

WellCare of Kentucky Keep-In-Touch for Rural Communities

Kentucky's Eastern Region boasts the Central Appalachian Mountains, which can create a barrier to access in itself. The Keep-In-Touch Kentucky initiative deploys a dedicated team of three associates to travel to these remote areas where they visited homeless shelters, churches, strip malls and shopping areas, neighborhood markets, and community centers to locate 447 of the 1247 members targeted for the program. ***The program resulted in a 19.6% reduction in ER care; 21.4% reeducation in inpatient care; and a 16.6% reduction in overall medical expenses.***

Provider Strategy: Value-Based Purchasing to Optimize Right Care at the Right Time

A significant element of minimizing time spent in the ED is building accountability within our network for ensuring members receive care at the right time, in the right place. As an integrated payer, we are aliging our metrics, incentives and payment models toward moving providers along the conitnuum of greater responsibility for total cost of member care. By doing this, providers are incented to look at whole-person care regardless if it's a BH or physical health condition driving unnecessary over-utilization of higher cost services. Some of the tactics specifically related to ED Holds and ED diversion within our greater VBP strategy include the following:

Incentives for network BH providers to respond to crisis with same day access, afterhours, or weekend visits: In alignment with AHCCCS' appointment standards, Care1st will incentivize providers of all types to provide same day and afterhours access for new or existing clients in crisis. The incentives may include prioritization for referrals, as well as a significant rate enhancement for crisis visits.

Support of and investment in statewide and community efforts, including encouraging CIT team development in law enforcement: Care1st will coordinate with all system initiatives to address avoidance of ED holds, including collaborating with Arizona Association of Health Plans, Arizona Hospital and Healthcare Association, Arizona Council of Human Service Providers and RBHAs. We will work to support system efforts to develop CIT teams for BH response by local law enforcement, including offering training and resources, as well as working to develop system wide protocols between the crisis system and the Complete Care Contracts Uniform approach to ensure system partners and providers have defined responsibilities that result in improved member health outcomes.

REDUCING THE NUMBER OF PSYCHIATRIC HOSPITAL ADMISSIONS

Because ED visits and ED holds often result in a psychiatric hospital admission, many of the strategies outlined above for minimizing ED holds cross over to reducing inpatient admissions for BH diagnoses. In addition to these strategies and tactics, some of our appoaches specific to managing admission rates include:

Proactive utilization management for individuals in psychiatric crisis provided through our crisis care coordination team with psychiatric consultation: Care1st applies nationally recognized utilization management criteria (e.g. MCG, LOCUS and CALOCUS), and will train our providers to use these as well for a common language. Our CM Team proactively reviews criteria at the beginning of service and concurrently to facilitate seamless transition from inpatient to lower cost stepdown care. This allows for a longer stay when needed and coupled with strong discharge planning, results in decreased inpatient readmissions. For complex cases where families are **requesting out-of-state placement**, we will leverage a high level of expert consultation and our CM Team will work with the family to develop a comprehensive community-based plan that is focused on successful and intensive community services over time while ensuring physical health needs are met. Additionally, we will comply with AMPM Policy 450: Out-of-State Placements, ensuring agreement of the family, provision of non-emergent care is available and all in-state options are thoroughly exhausted.

Development of access to a full continuum of step down programs for children and adults with acute risk, including those with active SUD: We do not want people admitted to higher levels of care only because diversion programs that might otherwise be appropriate refuse to accept a person with current or recent substance use. Nor do we want people spending hours in the ED waiting to "sober up" before appropriate assessment, intervention, engagement, and disposition to occur. Care1st's approach to co-occurring MH and SUD is consistent with our overall whole health approach: All services must be capable of providing integrated interventions as needed to individuals with co-occurring MH/SUD. This is termed "universal co-occurring capability", and has been implemented in other systems nationally, as well as being connected to historic efforts to improve co-occurring services in Arizona. Care1st intends to will provide technical assistance and consultation to help all crisis providers welcome and engage individuals with co-occurring conditions, and to coordinate with statewide efforts to address this issue.

Meeting members where they are: We offer Care1st at Home, our field-based CM model that serves members identified as highest risk in their communities. We engage an integrated team of cross-trained nurses, social workers and member advocates who work together to support members. Members are aligned with the type of licensed professional that best meets their hierarchy of needs. The care manager conducts a comprehensive assessment, guides the member through the goal setting process and develops with the member their care plan, including a crisis plan. We incorporate discharge planning, disease management and medication reconcilliation as a core part of Care1st at Home CM. ***Through this fully-integrated field-based care model, our Florida affiliate reduced avoidable hospital admissions for those managed by 11% in it's first year in operation.***

A Case of Caring: Getting a Member the Care they Need
A 37 year-old member at our Kentucky affiliate plan had a heroin addiction with several rapid readmissions to an acute medical unit. The member also had a disability which required coordination with her family and the BH providers used by the member. The plan helped her find a facility to accommodate the her disability and substance abuse issue, set-up the resources to ensure the member would be able to fully participate in a treatment program and followed-up to confirm she was receiving and engaged in treatment. The member ultimately spent about 90 days in treatment and was referred to wrap-around outpatient services upon discharge. ***Since this member completed residential treatment there have been no further BH inpatient admissions for over a year.***

INCREASING ALTERNATIVE COMMUNITY BASED SERVICES

We encourage development and utilization of community-based services aimed at stabilizing high-risk individuals over time and reducing recidivism and rapid readmission, which has historically been high in the Arizona Title 19 population. The GM/SA population specifically needs targeted and innovative approaches to increase access to community-based services that serve as alternatives to higher levels of care. Many of the system strategies outlined above to reduce preventable events such as ***enhancing the use of peer support services*** and ***support for dedicated post-crisis outpatient services*** are aimed at increasing access to and utilization of community-based services.

Developing Integrated Health Home and VBP Strategies: Providers who have accountability and responsibility for member total cost of care are naturally incented to expand options for community based outpatient services and steer members to those services more timely. Our VBP strategies support development of integrated health homes, and aligning members to those homes through our assignment algorithm. Those Health Homes are incented to help members get appropriate outpatient care and are measured on their ability to ensure members receive preventive screening and necessary treatment in the most appropriate settings.

Enhanced Management of Outpatient Services: In 2016, WellCare developed our *METS program, Members Empowered to Succeed*. Based on SAMHSA's *10 Fundamental Components of Recovery*, this integrated, holistic recovery-oriented program is designed for members in care for an extended period with high utilization associated with their services (more than 30 outpatient sessions). Targeted members are assigned a dedicated, specially-trained METS care manager who develops a current clinical picture, including medication history, using information in CareCentral. After a clear clinical profile is established the care manager presents the member in a Treatment Team Review (TTR) meeting. During the multidisciplinary TTR meeting barriers, strengths, and other factors are identified to develop the care manager's next steps to follow-up on the member's case and develop a tailored Roadmap to Recovery. ***Results for those enrolled in the program include a 54.7% PMPM reduction in total visits, a 6.1% reduction in ED use, and an increase in pharmacy use – suggesting improved medication adherence. For these members, the total cost for professional BH visits dropped by 35.7%.*** By ensuring members are in the right levels of outpatient care, we are able to free-up the system to manage new members or members immediately after crisis in the community.

Develop Provider Capacity for Evidence-Based Services: Care1st will work to develop provider capacity to offer a variety of high fidelity wraparound services, including Evidence Based Practices (EBP) such as Multisystemic Therapy and Functional Family Therapy for selected families and children who are high-risk for recidivism, decompensation and/or at risk of out of home placement in hospitals, residential treatment facilities or foster care. We will coordinate our efforts with the RBHAs, the DCS, and other stakeholders who are working to improve dissemination of EBPs for youth to help children safely stay with their families. We are using a similar approach for adults who may not be eligible for First Episode of Psychosis (FEP) services or RBHA services but who display a high degree of instability.

ENSURING FOLLOW-UP CARE IS PROVIDED

Follow-up care is a critical element of each of the strategies described above. The period immediately following discharge from an ED hold or psychiatric hospital admission is a time of increased vulnerability. Our follow-up activities include:

Our Florida affiliate, Staywell, saw a nearly **4% increase** in 7-day follow-up from 2015 to 2016 after introducing tactics such as bridge appointments, bonus payments and embedded discharge planners.

Bonus on 7-day follow-up: Our pay for performance program includes measurement of 7-day and 30-day follow-up; providers can be bonused on their ability provide members timely follow-up care.

Hands-on Discharge Planning: Dedicated discharge planners work with providers to ensure discharge plans not only refer members to services, but they are also connected, appointments are made and there is a detailed plan for each step of the discharge process.

Provider Benchmarking and Peer Review: We review follow-up data by member and provider and when a provider doesn't meet benchmark standards for follow-up care, our BH Medical Director will reach out and work directly with the provider to strategize how to help members achieve their follow-up goals.

Other tactics include: **Member education** regarding the importance of follow-up care; and **Assistance with scheduling** follow-up appointments and arranging transportation, if necessary.

BUILDING A COMPREHENSIVE NETWORK OF SPECIALTY AND BEHAVIORAL HEALTH PROVIDERS

In preparation for the complex transition to AHCCCS Complete Care (ACC), we began our network expansion in November 2016, a year before the ACC RFP was released. At the time, we had an existing network of more than 11,000 unique providers including behavioral health (BH) only providers, physical health (PH) only providers, specialty providers and integrated providers in our current service areas in Maricopa and Pima Counties, which we've expanded by more than 2,000 providers over the year. In addition to integrated, BH, and PH providers, this expansion included: Specialty and BH providers such as the Multi-Specialty Interdisciplinary Clinics (MSICs) like Yuma Regional Medical Center's Children's Rehabilitative Services; Phoenix Children's specialty network; Touchstone Health Services; S.E.E.K; and IASIS facilities including St. Lukes Behavioral Health Center. We have also expanded geographically adding providers across the South and North GSAs. We used what we learned about practice patterns ***from our more than 1,200 discussions with primary care physicians (PCPs), specialty providers and BH providers and organizations*** like The Arizona Council of Human Service Providers over the past year to expedite the network build. These meetings included providers such as: Terros, Banner, Touchstone, La Frontera, COPE, Arizona Children's Association, CODAC, Community Bridges, Community Health Associates, Arizona Counseling and Treatment, SEABHS, and ConnectionsAZ, Sun Life Family Health Center, Canyonlands Healthcare, Chiricahua Community Health Centers, Sunset Community Health Center, Yuma Regional Medical Center, La Paz Regional Medical Center, Northern Arizona Healthcare, many of which provide services in multiple counties.

COMPREHENSIVE PROVIDER NETWORK

Our network includes more than 2,000 adult and pediatric PCPs, 1,000 adult and pediatric BH providers, and 10,000 adult and pediatric specialists

Using a Proven Network Development Strategy

Our Provider Services team, led by Director Jessica Sedita-Igneri and Manager Tim Tejada and assisted by WellCare BH Vice President Carole Matyas, is made up of knowledgeable and experienced staff who support our existing network and are responsible for developing the comprehensive provider network.

While the Provider Services team recruited providers for Maricopa and Pima Counties to supplement our existing comprehensive network, we supplemented the team with local experienced health care consultants Kelly Laffey and Elaine Teune. They helped us with our successful Pima County build in 2012/2013 and are assisting us in building our network throughout Arizona. Both have outstanding relationships with the Arizona provider community including integrated providers, BH providers, PH providers and specialty providers.

Using our high-touch approach to network development outlined in our Network Development Plan, our Provider Services team performed early analysis of the market and membership needs followed by targeted recruitment, contracting, training and retention, – continuously assessing and monitoring the build throughout the process.

Analyze: We estimate membership by population type and condition, run geo-access based on time and distance standards outlined in the draft version of ACOM Policy 436 Network Standards for all required provider types, and compare this to our existing contracted network within the GSA to determine incremental needs. Recognizing that time and distance standards are only one measure of access adequacy, we talk to providers, community stakeholders, internal staff and members to determine components needed beyond standards to ensure true adequacy of adult and pediatric BH and specialty providers. We also use competitor analysis, the Arizona Council of Human Services' member list, AHCCCS' Targeted Investment list and reference files, ADHS license lists, CMS.gov Find a Provider Tool, Blind Spot data and other health plan and RBHA directories. We use this additional information to supplement and determine the true volume of needed providers. This exercise also informs us about potential lack of availability of providers in a given geography and prepares us to look for alternative solutions like telemedicine, mobile docs and virtual clinics.

Based on the input received, estimated membership levels by GSA, and the analysis performed by county, we produce a target list by zip code with the number and types of providers needed/desired to ensure member access to services.

Target: Armed with our target list of adult and pediatric BH and specialty providers needed to ensure member access, we determine which providers to pursue to meet these "adequacy" volumes. We base this target list on data, coupled with recommendations from trusted provider and advocate experts, including Arizona Children's Association, Arizona Behavioral Health Services, Arizona Center for Rural Health and Navajo Nation Department of Health, as well as our own expert leaders including WellCare BH Vice President Carole Matyas and Licensed Professional Counselor Suzanne Rabideau. When determining which providers to pursue, we also consider evidence-based practices for Autism Spectrum Disorders; early childhood best practice services; inclusion of RHBA services; full array of crisis services; Centers of Excellence; positive behavioral supports/intensive in-home/family-based services such as multi-systematic therapy and functional family therapy; DCS Home Care Training to Home Care Client (HCTC) Treatment providers (foster care treatment); and Opioid treatment. We also look at regional issues such as lack of transportation in rural areas to determine which providers to target. Based on this feedback and information, we create a list of specific organizations and providers to outreach for contracting sufficient to meet adequacy for our adult and pediatric BH and specialty providers, including: Southwest Behavioral Health (SWBH), Community Health Associates, La Frontera, COPE, CHEERS, RIAS, CODAC, Cenpatico, Touchstone, Arizona Cooperative Therapies, Sunrise Therapy Services, Rise Services, Child and Family Resources, Hummingbird Early Intervention Services, Northland Therapy Services and Northern Arizona Healthcare Children's Health Center, among others.

Contract: We initiate contracting through a number of mechanisms to ensure timely and sufficient provider engagement including direct face-to-face, telephonic outreach and mailings. Jessica and Tim lead the team of staff and consultants making the initial contact to introduce Care1st and assess the provider's interest in joining our network. Additionally, members of our Executive Team engage key medical, behavioral and tribal providers and facilities in existing and targeted service areas to have meaningful discussions on topics such as integrated care models and alternative payment models that drive quality, cost-efficiency, and member outcomes. As contracting activity begins to occur, our Provider Services team reviews redlines and rate requests, collects any missing information required to process practitioners, facilities and ancillary providers through the credentialing, contract execution and system loading process. This high-touch approach minimizes provider frustration and creates a seamless end-to-end contracting process. It also allows us to continuously assess the provider network and make any necessary adjustments throughout the process.

Train: Experience has taught us that training is the key to effectiveness and ultimately satisfaction for providers. As a result, we invest heavily in training at initial on-boarding and throughout a provider's engagement with us. This training begins with the Welcome Packet which is mailed to all newly contracted groups and includes tools needed to collaborate with Care1st. The assigned Provider Services Representative schedules a face-to-face orientation with new groups/providers within 60 days of their effective date. They review AHCCCS and Care1st guidelines, processes, policies and procedures. The most current reference tools, forms, referral directories, etc., are reviewed with office staff via our website or hard copy, with follow up in-services performed as needed. We continue this initial training, through whatever mode is desired by the provider, until the provider and staff are comfortable in working with Care1st. Additionally, we constantly monitor for potential training needs, particularly for new providers, by reviewing provider call volumes, complaints, feedback from Provider Services staff, etc. When a need is identified, whether with an individual provider or systemically throughout the network, we quickly respond. Further, and on an on-going basis, Care1st conducts provider forums focused on AHCCCS and Care1st updates semi-annually in each GSA and does in-services for providers on new and emerging policies and procedures. We will increase the frequency of provider forums during implementation for BH and the additional geographies. In preparation for the AHCCCS transformation, we have provided BH-specific provider training including presenting "A Day in the Life of a Claim" at the 2016 AzAHP Claims 101 for the Council of Human Service Providers.

Retain: The best way to recruit and retain providers is to fully support them and satisfy their needs and expectations. Our Provider Engagement Model extends well beyond traditional provider services activities and is highly responsive to provider needs, continually seeking to reduce administrative burden for providers and office staff. The key to our success in retaining high-quality providers is the excellent service we deliver, as evidenced by our ***consistent top 3 health plan ranking in the most recent provider claim satisfaction surveys***. *Our retention rate for 2017 was 99.42%.*

In order to ensure continuous quality improvement and maintain adequacy, we constantly monitor and assess our provider network through quarterly Geoaccess reports that evaluate if time/distance standards as stated in the draft

version of ACOM Policy 436 Network Standards are being met by current and potential providers. Geo-access reports, which are run through Quest Analytics and processed through our Provider Recruitment Tool, help us track our progress against new requirements and identify areas for improvement.

IDENTIFYING AREAS OF CONCERN AND OVERCOMING CONTRACTING CHALLENGES

Throughout more than 1,200 discussions with providers since November 2016, we have found providers engaged and willing to be part of the ACC Transformation. We have been able to contract with more than 2,000 new providers through this process, but we also know that providers still have concerns with the transformation. Most notable areas of concern and challenges we have identified to ensuring accessibility include:

Payment Transformation Challenges:

The primary payment transformation challenge stems from the requirement for BH providers to move away from block payments. Many BH providers are worried about their financial viability as they adopt fee-for-service payments, and need assistance making this transition. Similarly, many BH providers are hesitant to contract with us pre-award.

Integration Challenges:

Because PH and BH have historically been managed separately, another challenge lies in provider ability to become truly integrated under AHCCCS' vision. This deficit has resulted in the inability of many providers to view the whole person when providing care. For example, many BH and substance use providers do not always consider that PCPs and pain management providers like SWBH can provide Medication-Assisted Treatment services, and are not getting members in front of medical communities to address their serious medical conditions. Likewise, PCPs may underdiagnose and subsequently fail to treat more common BH conditions. Many BH and specialty providers are not accustomed to working with data, which creates integration challenges. Similarly, gaps in "co-occurring capability," provider proficiency with integrated MH and SUD treatment rather than sequential treatment, create a challenge.

Solutions to Payment Transformation and Integration Challenges:

Data Sharing: Care1st uses a variety of tools to securely share data with providers to provide transparency and advance clinical integration. For example, in CYE19 Care1st will implement WellCare's enhanced Provider Portal that allows a member's entire provider care team to view if the member has had an emergency department (ED) visit, medications they are taking, and open care gaps. Heat maps are data views generated from our quality programs that allow Provider Service Representatives to identify care gaps and barriers to access based on zip code and develop strategies to address these barriers. Appointment agendas show care gaps integrated with missed diagnosis for a single member at the time of visit, ensuring continuity of care between providers. Provider forums and Joint Operating Committee discussions will review and share guidance on how data can drive practice transformation.

Innovative BH Partnerships: We'll complete implementation of a pilot with SWBH and Valley Pain Specialists to address the high rates of opioid use. We are partnering with the Crisis Response Center in Tucson on a continuous improvement process to address members with high utilization of the crisis system, and with ConnectionsAZ to implement their Comprehensive Transitional Care Program for the post crisis episode for members who present in crisis at their psychiatric emergency care center.

The Care1st provider network currently includes 103 PCMH locations, 57 Integrated Clinic locations, 19 colocated PH and BH clinics, 42 FQHCs, 26 FQHC look-alike locations and 4 Centers of Excellence.

Provider Readiness Assessments: Care1st uses a formal readiness assessment to determine a provider's ability to become fully integrated and enter into value-based payment (VBP) arrangements. The information from the assessments helps us to "meet providers where they are" and design the appropriate phased approach in supporting providers throughout the payment transformation.

Support for Integrated Health Homes (IHHs): We have been working with PCMHs including Cigna, FQHCs including Adelante and FQHC look-alike MIHS to ensure we have providers credentialed as IHHs, providing support through robust data sharing, access to tools to reduce administrative burden, and support for care coordination functions. We also provide support to build capacity among providers interested in obtaining the designation. For example, we work with providers to adopt single-source EHR systems allowing visibility into member care plans across provider sites and authorized services and care gaps with our care management platform,

CareCentral. We also help prepare providers to join AHCCCS' HIE to further reduce administrative burden. We support integrated health systems and provider organizations such as Banner and Catalytic that demonstrate their ability to effectively manage members with complex co-morbid conditions like bipolar disorder and diabetes through level 3 VBP arrangements that help ensure comprehensive, integrated care through aligned incentives. We use AHCCCS guideliness and our experience with IHHs in our Florida market to build a robust IHH network throughout Arizona.

OVERCOMING INTEGRATION CHALLENGES WITH IHHs: Peace River Wellness Center, our Florida plan's first IHH, addresses a broad range of PH needs and provides an onsite therapist. Peace River receives a PMPM, a portion of which includes a performance bonus payment based on how well they meet quality targets on our IHH performance measures. Preliminary data shows: 100% of members qualifying for BH screens and referral received screens, exceeding the 95% goal; 100% of members qualifying for depression screens received screens, exceeding the 70% goal; 62% of members with hypertension were adequately controlled during the year, exceeding their goal of 60%; 78% of members had documented Body Mass Index scores and when necessary follow-up plans, exceeding the 70% goal. We will apply this experience to IHHs in Arizona.

Centers of Excellence (COE) Partnerships: We have contracted with COEs including CODAC, SWBH and Touchstone and are recruiting others including Casa de Los Niños and EasterSeals Blake Foundation in order to achieve higher value for children and adults with specialized needs through greater focus on appropriateness of care, clinical excellence, and member satisfaction.

Training: Provider coaches work onsite within provider practices to deliver practice transformation support. This includes comprehensive training targeted for PH providers (e.g. Managing SUD), BH providers (e.g. Managed Care Overview), and combined (e.g. Person-Centered Care and Caring for Members with Co-Morbidities). Provider Claims Educators will provide further training and technical support, with the ability to adjust claims on-site when needed.

Rural Challenges:

Care1st recognizes there are limited specialists and BH providers, particularly for children, in rural areas compared to urban areas. Our provider partnership strategy is anchored by a core commitment to offer local and accessible support staff who live in the communities we serve. These associates bring an understanding of the local health care systems and the unique challenges within each GSA. Our staff also participate in local partnerships aimed at enhancing access to care. In-person connection is always important, so our clinical team routinely meets with high-volume providers in rural communities to discuss utilization, quality and integration, in order to further enhance relationships. In rural communities, we rely on our well-formed relationships with safety-net providers such as FQHCs, RHCs, CMHCs and critical access hospitals to identify providers new to the area.

Tribal Challenges:

Care1st recognizes the unique challenges in contracting with tribal providers and the importance of care coordination and data sharing regardless of contract status. We also recognize the challenge in coordinating with IHS with their unique credentialing and payment requirements as a federal agency. We must respect each tribe's sovereignty and unique cultural nuances while addressing the transportation challenges, lack of providers in rural areas and language barriers that make access difficult for tribal communities.

EXPERIENCE OVERCOMING CHALLENGES: In 2011, WellCare was selected to serve Kentucky Medicaid in seven regions, and began serving the entire state in 2013. Upon being awarded a Medicaid managed care contract, we had roughly 90 days to build a fully accessible provider network. Our local leadership actively engaged in relationship building with key health systems and we immediately addressed and resolved barriers to contract negotiation. Our success in launching a strong provider network contributed to a significant surge in member choice rates. The tremendous effort required to build and expand our coverage within this highly diverse state, which was new to managed care, is testament to our ability to overcome similar barriers in Arizona and exceed AHCCCS' expectations.

Solutions to Rural and Tribal Challenges:

HealthyNations Program: With a focus on supporting providers to deliver innovative and integrated care, our HealthyNations program will promote cultural sensitivity and interconnectedness, cultivating tribal provider participation and community-based partnerships. Overseen by Tribal Coordinator Jearlyn Tsosie, who reports to State President Scott Cummings, the HealthyNations program will include a dedicated Tribal Provider Relations

Representative, a Tribal Behavioral Health Coordinator, a Tribal Care Coordinator and a dedicated Quality Practice Advisor who will work directly with tribes to address access challenges.

Community Advocacy: We will leverage our CommUnity Impact Model to identify, fund and expand services, including housing and employment initiatives provided by organizations like Chicanos Por La Causa, JFCS and La Frontera. In addition, providers in Pima County, including Intermountain Centers, are co-locating on reservations to address the lack of access to tribal providers. We will supplement our Community Advocacy Line database with these and other tribal resources.

REMOVING BARRIERS THROUGH COMMUNITY PARTNERSHIP: In 2009, Care1st collaborated with the City of Avondale and First Things First to create the Care1st Avondale Resource Center in the heart of Avondale. Since then, more than 400,000 people have benefited from the Center, which is a one-stop hub of human and social services such as health care enrollment assistance, early childhood development programs, literacy classes, WIC, employment assistance, and more. The Center was a finalist for the 2016 All American City Award.

Cross-Border Providers: We recognize Arizona patterns of care and have a defined strategy to partner with providers to meet members where they are, such as contacting providers like Colorado River Medical Center, Rehoboth McKinley Christian Health Care Services, and Dixie Regional Medical Center in contiguous states including California, Nevada, New Mexico and Utah to initiate contracting.

Hub and Spoke Model: We will work with prominent provider groups and nurse practitioners in rural areas to establish "clinic" days. This strategy can be combined with VBP, as we do in other markets, where we use a higher reimbursement rate to encourage providers to offer "clinic" days in areas with limited access.

Non-Emergency Transportation: Last year, Care1st's non-emergency transportation (NEMT) provider, MTBA, provided more than 138,000 trips to our members. Recognizing the importance of NEMT for members with complex needs, we'll work closely with MTBA so that members, regardless of disability or medical complexity, utilize their NEMT benefit to access healthcare services. For example, we will transport a member to the closest county if there is no provider available in theirs. MTBA also has a comprehensive network of transportation options for tribal members on and off reservation, including the "friends and family" program which reimburses participants for mileage.

Pop-up Welcome Rooms: Pop-up Welcome Rooms leverage the strength of Chapter Houses and Community Centers as a community gathering spot to support and enhance health education and community activities for members in rural communities including American Indian members. Regional pop-ups travel from location to location within each GSA delivering preventive care including dental care, hearing tests and inoculations. Pop-ups may include computers, Internet connectivity and serve as "hot spots" where Internet connectivity may not be strong otherwise. We will initiate conversations with Frontier, HughesNet Internet, CenturyLink, and Cricket Wireless to fund and support the best broadband, phone and HD video conference calls from offsite locations with members and providers for follow-up appointments, particularly for those members with chronic health conditions. Expanding connectivity with members living in rural areas will allow us to take advantage of our robust telemonitoring services to stay connected with members with complex needs at all times.

Telemedicine: Telemedicine offers the benefit of expanding access to care for all members, including those who live in rural areas, have complex conditions or schedules that can make travel difficult, or simply prefer the convenience and/or privacy it offers. By meeting members where they are, telemedicine serves to reduce avoidable ED visits, reduce administrative costs and improve health outcomes. We will leverage partnerships with current providers offering telemedicine including Catalytic, Terros and Banner, to expand our telemedicine network. We will also create virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the state. In addition, we will use our experience in other markets to enhance our capabilities. Our Florida plan was an early supporter of telemedicine solutions, contracting with IMPOWER, a non-profit BH and child well-being organization, to provide BH treatment. Members engage in treatment with IMPOWER clinicians from home using a laptop or tablet. IMPOWER is able to e-prescribe medications and was the first provider in Florida to receive a license to prescribe controlled substances to patients served via telemedicine. IMPOWER has reported up to a 30% reduction in appointment no-show rates, increasing Medicaid reimbursement for psychiatrists. We will implement a similar program in Arizona.

MANAGING PROVIDER RELATIONS AND COMMUNICATIONS

Care1st has a system to effectively manage provider relations and communications built on repeatable, scalable and measurable processes. We apply rapid-cycle resolution to provider complaints, contracting issues, prior authorization and claims concerns with our dedicated staff, our communication process and our workgroups and reports. This high-touch approach is aimed at reducing administrative burden and improving provider satisfaction.

Our commitment to improving provider satisfaction is evident in the continued decreases in provider claim disputes and complaints, and our performance in AHCCCS' ***provider claim satisfaction surveys where we have consistently ranked in the top 3 health plans across all questions.***

IMPROVING PROVIDER SATISFACTION: "As a provider, my every interaction with Care1st has been handled with the personal attention and efficiency of a small, local business rather than the cold, bureaucratic, scripted responses I'm used to from other insurers. From credentialing to claims, personal attention to detail and a friendly, professional demeanor has been the norm. I know that when I pick up the phone and call Care1st, I'm going to get a friendly person *right down the road,* who will *just...get...things...done!"* – Dr. Heather McCoy, Integrative Headache Care, LLC in Scottsdale, Arizona.

Minimizing Complaints, Contracting Issues, Prior Authorization and Claims Concerns

Dedicated Staff

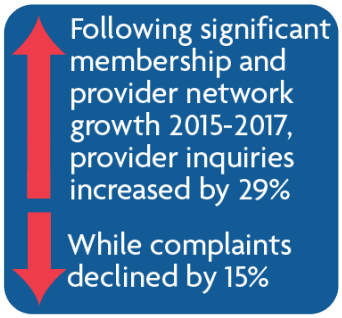
We have dedicated local staff to help providers successfully navigate claims and prior authorization requirements and minimize complaints, contracting issues and prior authorization and payment concerns. Our local staff, supported by a Corporate team, is familiar with each GSA and includes:

Figure 12- 1: Provider Engagement Model

Provider Engagement Team: Led by Director Jessica Sedita-Igneri and Manager Tim Tejada, the Provider Engagement team is made up of experienced Internal and External Provider Service Representatives (PSRs), Contracting Specialists, and Configuration Data Specialists (CDS). The Provider Engagement team engages providers contracted with Care1st, arranging support, training and communication. Our Provider Engagement team works collaboratively within their assigned regions and includes PSRs who manage the provider relationships and are supported by representatives from Claims and Provider Services who educate, listen, and address inquiries to resolve problems quickly. Since taking on BH responsibilities for the dual GMH/SU population in 2015, each team member has been immersed in BH and is knowledgeable in and has responsibility for integrated providers, BH only providers, physical health only providers and providers serving our special needs populations including DDD, D-SNP, foster care and Title XIX children.

Our Internal PSRs manage incoming provider inquiries and complaints from all provider types. When providers contact Provider Services by phone, they reach a live person without maneuvering through layers of Interactive Voice Response (IVR). All inquiries are acknowledged within 3 business days and resolved within 30 business days as required by AHCCCS contract Section D 28. ***Since 2012, Care1st membership more than doubled, the provider network almost tripled, and 95% of inquiries and complaints have been acknowledged and resolved the same day***.

External PSRs are consistently in the field meeting with providers and staff in-person, fostering strong relationships and partnerships. Field work includes new provider orientations, follow-up visits, sessions to educate new staff, problem resolution, and reinforcing information sent to the network by mail, fax, email, and website posting regarding AHCCCS and Care1st policies, guidelines and processes. These activities include prior authorization, claims, quality, credentialing, and program changes, to name a few. Data collected during a visit that requires a system update is documented and provided to the CDS staff who updates the system within required turnaround times (TATs). We are analyzing the need to increase our staff to service additional GSAs and BH and specialty providers following contract award, and based on membership assumptions have established target hiring numbers, developed detailed recruiting plans and initiated interviews.



Together the PSRs and Contracting Specialists are responsible for expediently and accurately moving providers through credentialing, contracting, system loading and notification. They work closely with our Arizona credentialing team using a streamlined process built around the Provider Services Contracting Database that includes TAT tracking and monitoring mechanisms. ***The enhancements made to this process over the past 5 years have resulted in continual improvement of accuracy and TATs.*** Current credentialing TAT is 19 days, and TAT to notify providers and load all required information into our system is 13 days from the Credentialing Committee approval date. AHCCCS standards allow 90 and 30 days respectively. Each PSR and Contracting Specialist works with a designated CDS to maintain accurate provider data in our core system, adhering to strict TATs and high quality standards. They load new providers and complete updates to existing provider records within 7 days. Automated weekly and monthly reporting identifies errors, which are corrected by CDSs within 5 days of receipt. In addition, 10% of all work is audited for accuracy and timeliness. The 2017 TAT is 5 days with 99.82% accuracy. Trends are monitored and employee feedback and training occurs immediately after identification.

Provider Claims Educators (PCEs) serve as liaisons focused on educating contracted and non-contracted providers on claims submissions, billing questions, and available resources to minimize complaints and claims concerns. They research and resolve claims issues, proactively outreach on billing trends, and provide real time claims review and adjustment during provider discussions. Provider Claims Educators attend all provider claim Joint Operating Committee (JOC) meetings and review claim utilization, denial rates, questions, upcoming policy changes, and resolve provider questions and concerns. Provider Claims Educators use post-adjudication/prepayment reporting and high volume denial reporting to proactively outreach to providers and staff to educate and assist with resolving claim and billing issues before they may be aware an issue exists. This close working relationship with providers allows for early identification and resolution prior to escalation. Provider Claims Educators are the single greatest resource for the provider to dig deep and resolve any underlying claim issue, including billing and prior authorization education.

Our **Claims Customer Service (CCS*)*** team is dedicated to answering provider claims questions and resolving claims issues. Experienced Claims Customer Service Representatives are trained to process claims, giving them in-depth understanding of claims submission and handling requirements. Training allows them to achieve a first call resolution of 87%. Huddles with the CCS team occur at least three times weekly to discuss call trends to identify outreach and educational opportunities to assist providers with future claims submissions. Internal staff training occurs when an educational opportunity is identified.

Claim Disputes and Appeals (CD&A) uses a number of strategies that complement our provider relations and communications mission. Examples include "pay and educate," which includes coordinated provider education by the PSRs and PCEs to resolve one-off claim disputes. Claims, Disputes and Appeals also executes alternative payment strategies with contracted and non-contracted providers, settling disputes at a mutually agreed upon, medically appropriate level of care. This team also manages our highly successful alternative JOC dispute process with contracted hospitals, who account for 70% of our inpatient utilization. JOCs occur monthly or as needed with hospital staff, and both sides are empowered to make decisions during these meetings***. Since December 2014, all 1,260 JOC cases (100%) have been successfully resolved***. This means Care1st and the hospital reached an amicable resolution and avoided the formal dispute process on 1,260 preliminarily disputed bed days or admissions.

The **Prior Authorization (PA) Team** participates in provider JOCs and provides feedback to improve accuracy and thoroughness of prior authorization submissions to shorten TAT and minimize denials. Leadership presentations at the provider forums discuss clinical criteria, top reasons for denials and requests for additional information and how to reduce PAs. The PA Guidelines are reviewed at least annually as required in AHCCCS Medical Policy Manual (AMPM) Policy 1010. However, we hold monthly discussions to review provider feedback and analyze requests and approval and denial rates, using this data to identify opportunities for provider outreach and decreasing prior authorization requirements.

Communication, Education and Outreach

Consistent, frequent communication with our providers has proven effective in minimizing provider abrasion and establishing trusted partnerships for better member care. Our communication, education and outreach approach includes regular in-person visits, a newly redesigned provider portal, provider forums, provider committees, a provider manual, newsletters, letters and frequent telephonic follow-ups that allow us to get to know our providers well and understand their needs in the context of their practice. Communication and contact is both formal and informal, scheduled and ad hoc and tailored for what best suits the provider.

Immediately upon completion of credentialing, contracting and system loading, all new providers receive a Welcome Packet outlining their effective date with Care1st. The packet also includes other key reference material like our Quick Reference Guide, Electronic Funds Transfer/Electronic Data Interchange/Electronic Remittance Advice Instructions; and required information such as the Care1st Member Grievances and Appeals and Provider Claim Disputes and Requests for Hearing Policies, the name and contact information of their assigned External PSR, key phone/fax/email information, alerting them to forthcoming outreach by their External PSR to schedule an in-person orientation visit.

Care1st completed nearly 5,000 visits/outreach over the last 12 months

Biannual provider forums offer an integrated agenda, are open to all providers and offer an opportunity to ask questions and offer suggestions. Our leaders and subject matter experts review our provider reference tools and give detailed explanation of updates to guidelines, prior auth requirements, benefit changes, and claim processing rules. Attendees complete a survey after each forum and we use the results to make modifications in how/what we present and when we schedule. Providers and staff unable to attend in person are able to schedule an in-person visit to review the forum materials. In addition to these, we have monthly and quarterly JOC discussions with key providers including Durable Medical Equipment/infusion, enteral, home health, hospitals, non-emergency medical transportation, vision, dental, PCMH and VBP partners to address issues in a collaborative setting.

In addition to the education and outreach discussed above, Care1st employs a broad range of tools to communicate with and educate providers on all aspects of the AHCCCS Program and Care1st processes, including billing and prior authorization requirements such as:

Table 12-1: Additional Care1st Provider Education Tools

Provider Website and Portal	In addition to the requirements outlined in AHCCCS Contractor Operations Manual (ACOM) policy 416, it provides a broad array of information including member care gaps, payment status, a prior authorization lookup tool, Provider Service Rep contacts, reference materials, forms, blast fax communications, e-prescribing reminder and resources, and compliance resources.
Website Reference Guide	Summarizes everything available on the website and secure provider portal
Provider Manual	Updated and distributed throughout the year. Available hard copy and on the Care1st website. Adheres to all requirements outlined in ACOM policy 416.
Provider Bulletins	Ad hoc communications that address current issues such as updates/changes and resource links and include a wealth of general and AHCCCS-specific information.
Quick Reference Guide	Detailed, easy to use A-Z “how to” guide continually improved and updated no less than 2x each year.
Biller’s Corner	Distributed at least quarterly and highlights billing reminders based on denial trends; used to provide education to reduce future denials.

We understand different providers have different needs and at times, some needs are more pressing than others and must be addressed in a more focused manner. We give this due consideration and act accordingly. For example, as part of our provider relations and communication efforts to engage, train, educate and assist BH providers during our geographic expansion and BH rollout, we have completed high-touch outreach based on trends identified through inquiries and claim submissions including: duplicate claim submissions; modifier billing; rendering provider (individual

vs. clinic); NPI; eligibility; contract status and authorization; transportation and secondary billing. We also understand that some BH providers may not understand how to bill Medicaid. During our recruitment and engagement process, we work with these providers to help them understand the basics about claims, and provide ongoing support to educate them about the claim submission process.

We share our processes with the BH provider community in different ways, such as:

- Participating in and presenting at the 2016 AzAHP Claims 101 for the Council of Human Service Providers where Anthony Crooks, Provider Claims Educator and Tim Tejada PS Manager presented "A Day in the Life of a Claim" which detailed our claims process from start to finish, including training, internal workgroups focused on BH, and ongoing internal education. We were the only Acute plan to present at this event.
- Participating in unique one on one meetings such as the event we were invited to in August 2017 by Emily Jenkins, President/CEO The Arizona Council of Human Service Providers with several of its members including representatives from RI international, S.T.A.R, JFCS, Terros and Topaz.
- Gathering feedback during rural and urban stakeholder meetings with groups including: Community Bridges, Pinal County Sheriff's Office, Arizona Children's Association, Southeastern Arizona Behavioral Health Services, Horizon Human Services, ConnectionsAZ, Community Health Associates and La Frontera.

Workgroups and Reports

Care1st uses internal workgroups and reports to provide additional support and minimize complaints, contracting issues, prior authorization and claims concerns.

Care1st uses a matrixed internal ***workgroup structure*** to drive interdepartmental coordination and communication, critical to our provider relations mission and helping Care1st minimize complaints, contracting issues, prior authorization and claims concerns through regular monitoring and review of our processes. Examples of our workgroups include System Implementation, Utilization and Billing, Prior Authorization, Fee Schedule, Claim Disputes and Appeals Trending, and Behavioral Health Claims Monitoring. Workgroups ensure optimal system setup when operationalizing and implementing AHCCCS requirements, policy and benefit changes, and provider contracts. This approach allows us to discuss and act on provider feedback, identify actionable opportunities for internal staff and provider education and continual operational improvements. Truly cross-functional, they include leadership and representatives from operations, claims, provider services, CD&A, prior authorization, clinical operations, customer service, finance, compliance, quality, configuration, IT and pharmacy.

Care1st continually develops and uses ***reports*** to monitor trends, confirm processes and systems are working optimally, proactively identify opportunities for improvement and education, and prevent issues from escalating and increasing in volume. Prevention is a major catalyst in reducing administrative burden on providers such as resubmissions, rework and prior authorization denials which lead to complaints, concerns and claim disputes. Care1st has implemented approximately 200 post-adjudication/prepayment reports to identify, correct, and/or provide education prior to finalization of the claim, including:

- **High Volume Claim Denial Report:** A weekly high volume denial report captures all providers with a denial rate greater than 25%, regardless of claim volume. Provider Claims Educators outreach immediately to educate impacted providers on coding and coverage, as well as identify potential provider system issues resulting in high volume duplicate submissions.
- **Claim Denial Report:** Monthly report provided prior to each JOC meeting that captures all denials from the previous calendar month to assist in easily identifying trends.
- **Membership Transition Claim & Prior Authorization Reports:** To ensure a smooth transition for providers and members following onboarding of new membership and/or benefit responsibility these reports to identify claims for transitioning members that may have been erroneously adjudicated to deny for prior auth, to correct pre-payment and eliminate administrative burden on providers.
- **Dual Eligible GMH/SU Reports:** Upon implementation of GMH/SU coverage for dual eligible members, we implemented reports to ensure BH claims for dual-eligible members were not erroneously denied. This allows us to correct the claims pre-payment and identify internal education opportunities to prevent future denials.
- **Provider Network Management Data Reports:** Reporting is used to capture and correct common data entry errors including provider and specialty type, fee schedule, panel discrepancies, prior authorization requirements

and tax identification number to name a few. These reports allow proactive identification and resolution to ensure accurate directories, application of prior authorization requirements, and claims adjudication.

- **Appeals Report:** Care1st will implement enhancements to the monthly appeals report capturing all prior authorizations approved, denied and partially denied, along with review of claims denials which also include corresponding appeals and their resolution of overturned, upheld, or partially upheld.

REDUCING ADMINISTRATIVE BURDEN WITH CLAIM DENIAL REPORTS: Initially piloted with hospital partner Honor Health, our Claim Denial Report allows providers to quickly drill down to trending issues, better manage Accounts Receivable, and educate staff. Its value was immediately apparent, prompting Care1st to provide it to all JOC partners and other high volume submitters, and on-demand for any other provider.

PREPARING FOR THE COMPLETE CARE TRANSFORMATION

To further support AHCCCS' transformative change, Care1st will do more than just minimize provider complaints, contracting, prior authorization and claims concerns. We have been on the ground meeting with physical and BH providers all over the state for more than 18 months preparing for the transfomation, and discussing the challenges of moving to a fully integrated healthcare system. We will use our proven high-touch approach to:

- Extend our platform and coordinate additional broad spectrum BH provider meetings (quarterly beginning in CYE19; semi-annually thereafter) and collaborate with other plans on semiannual discussions and forums with IHS and 638 tribal facilities to gather input; discuss issues; identify challenges and barriers; problem solve; share information and strategize ways to improve and strengthen the delivery system for all members
- Expand our JOCs to include Quality leadership as well as BH providers and IHS and 638 tribal facilities in each awarded GSA
- Rollout an enhanced provider portal that includes functionality allowing providers to view all services received by a member, including physical, BH, lab, etc., and enabling providers to access relevant information with the fewest amount of "click throughs" possible
- Establish a command center supported by our Transformation Team that will supplement our local team, ensuring new providers are supported with one-on-one training and technical support
- Embed staff including Provider Claims Educators in provider offices for further training and technical support, with the ability to adjust claims on-site when needed
- Add Care1st staff, including but not limited to PSRs and PCEs, to serve BH and specialty providers, with support from existing staff, including 450 BH professionals, across the enterprise
- Enhance our Provider Engagement Model with proven experience from WellCare, which includes quality and clinical components to expand beyond operational support for providers. These include Care Managers, Quality Practice Advisors (QPAs) and Patient Care Advocates (PCAs) who are a critical part of the approach, supporting PSRs in their efforts to improve provider satisfaction. Our PCA program is both a service enhancement for providers and a best practice. PCAs will be co-located in select provider offices with a focus on scheduling appointments for targeted members with identified care gaps. Our QPAs will work with PSRs to collaborate with providers on activities to meet quality goals related to HEDIS, EPSDT wellness services and member access to care
- Establish a Clinical Command Center, where a Clinical Rapid Response Team of Care1st and WellCare member services and clinical staff are empowered to handle escalated member clinical issues such as a member getting pushback on antipsychotic medication refills that could potentially place a member at risk in real time
- Implement an annual comprehensive provider satisfaction survey

Care1st will continue to employ our structured, formal processes to minimize provider complaints, contracting issues, prior authorization and claims concerns to build upon our successful provider claim satisfaction ranking and ensure similar results in additional GSAs and with additional providers.

CARE1ST'S APPROACH TO OBTAINING AND USING FEEDBACK TO IMPROVE MEMBER AND PROVIDER EXPERIENCE

Care1st ranks among the top Arizona Medicaid plans in several key indicators of satisfaction. We meet stakeholders' needs and expectations, and continue to improve, by collecting specific information from ***more than 20 unique touch points*** in the member life cycle and during provider interactions. These activities are part of our ***Member and Provider Experience Measurement Program*** which aggregates feedback, allowing us to understand factors driving satisfaction and opportunities to add value, improve outcomes and enhance the health plan experience. Care1st was ranked among the top Arizona Medicaid plans in the areas of claims processing and resolution, to name a few.

Our data-driven Measurement Program is an integral part of our Quality Management and Performance Improvement (QM/PI) program which is governed by our QM/PI governance committee known as the Clinical and Service Quality Improvement Committee (CASQIC). Our Chief Operating Officer Susan Cordier is accountable for our robust Measurement Program, which includes essential components of provider, member and family experience. These functions are managed directly by our Provider Services Director, Jessica Sedita-Igneri, and Customer Service Director, Mike Ferguson. Going forward, member and family experience will be the joint responsibility of our Member Advocacy Administrator (MAA), currently being recruited, and Mike.

We apply four distinct yet complementary strategies to obtain and use member, family and provider feedback including:

- Engage stakeholders in ***Governance and Oversight***
- Monitor key ***"listening posts"***
- ***Measure experience and satisfaction*** with Care1st
- Measure experience during ***"moments that matter"***

These strategies are aligned to our QM/PI program, as well as member and provider engagement. Data and insights are aggregated, analyzed, and shared across strategies to enhance our ability to affect outcomes. We coordinate activities with committees such as the Performance Measurement Committee (PMC) and CASQIC to maximize impact. In the sections that follow, we further describe each of these strategies, the methods used to collect feedback, and how the feedback obtained has been used to improve stakeholder experience.

PROCESSES TO OBTAIN AND USE MEMBER FEEDBACK TO IMPROVE MEMBER EXPERIENCE

We use focused strategies and approaches to obtain member and family feedback. While many are in use today, we are evolving our Measurement Program to reflect the needs of the ACC contract and best practices. Specifically, our Measurement Program is being enhanced to include the Governance and Oversight strategy and corresponding methods, as illustrated in **Figure 13-1** and summarized below. We are also enhancing our Measurement Program to include other methods, many of which are best practices from other WellCare Medicaid plans (affiliates).

Figure 13-1: Member and family feedback strategies and approaches

Engaging Members and Families in Care1st Governance and Oversight We will use three means of obtaining feedback through member engagement in governance and oversight. First, we are implementing an Arizona ***Member, Family and Stakeholder Advocacy Council (MAC)***. Operational in our affiliates, including Florida and Kentucky, MACs consist of members, parents or guardians of children, professional and advocacy group representatives, and representatives from our management teams. Our Care1st model will feature a centralized MAC in Phoenix, which will be led by our MAA and meet quarterly, as well as a regional MAC in each of the other GSAs in which we operate. Through our MACs, we will solicit member and family input and feedback on a range of topics, including, but not limited to:

- Experiences and needs, including physical and behavioral health (BH) service coordination, care management, provider network and technology
- Member experience data like CAHPS survey results and grievances
- Design, development, and interpretation of our QM/PI program results
- Communications (i.e., handbooks, newsletters, educational materials) cultural relevance, usability, and readability

- Outreach efforts and other health and social services that affect physical and behavioral health and well-being

Second, we are inviting ***members and families to join quality committees, including CASQIC***, so they can provide input and feedback for decision-making. Our Senior Medical Director Dr. Satya Sarma, our Quality Improvement Director Nancy DeRosa and committee chairs are selecting peer and family member representatives for these committees. Third, and lastly, our ***member advocacy organization will represent the "voice of the member"***. Led by our MAA, our advocacy staff is being recruited with "lived experience" and will include our Individual and Family Affairs Administrator, CRS Member Advocate, Adult BH Advocate, Child BH Advocate and Veteran Advocate. The team will increase member and family voice in areas of leadership, service delivery and decision-making; advocate for programs and services supportive of members and families, especially those with special needs, BH or physical conditions; collaborate with members and families to identify concerns and remove barriers that affect service delivery and member satisfaction; and promote development and use of member and family support programs. Our member advocacy organization will also participate in local meetings and workgroups that provide member and family voice through advocacy organizations (e.g., Maricopa Child and Family Advisory Partnership meetings at the Family Involvement Center).

Measure Overall Experience and Satisfaction with Care1st The AHCCCS-administered ***CAHPS Survey is a key component of our member experience improvement efforts***. Nancy DeRosa leads our team in analysis and development of action plans to address barriers and contributing factors using the Plan, Do, Study, Act (PDSA) model. Results, analysis, barriers and action plans are submitted to PMC and CASQIC for review, recommendations, and approval. Action plans and updates are also submitted to AHCCCS for feedback and direction. Beginning in 2018, as part of our Measurement Program evolution and as a standard approach for all health plans, ***we will administer the CAHPS survey annually for Care1st members as part of the more than 75,000 surveys sent to our affiliates' members throughout the country***. ***Our CAHPS survey will include the item set for children with chronic conditions including BH and developmental conditions.*** Implementation of the annual survey will supplement the AHCCCS-administered survey results and provide us with data that will be analyzed against affiliate plans and national benchmarks. This will allow us to measure the effects of improvement activities and identify additional improvement opportunities. As with the AHCCCS-administered survey, Nancy will lead analysis and action plan development, in collaboration with our MAA, MAC, PMC, and CASQIC.

In addition, we ***conduct targeted surveys*** of members and families with special needs, similar to the Title XIX/XXI special needs populations that will be served under the ACC contract. Results are incorporated into our model of care.

- **Persons with Developmental Disabilities (DDD) who receive non-CRS related physical health services:** Results consistently show ***satisfaction levels greater than 90% for customer service, being treated with respect and dignity, PCPs and provider office staff***. Using the PDSA model, we use results to make improvements in communicating with members, parents, and guardians on how to obtain help with medically necessary transportation, BH services, and filing a complaint.
- **D-SNP:** We use an NCQA-certified vendor to administer a CAHPS survey for our D-SNP members. Over the past three years, ***results for all five overall ratings increased significantly and five of six composite measures improved***. Like the 2016 AHCCCS survey, our D-SNP plan achieved 4-stars for rating of health plan, drug plan and customer service.

Obtaining Member and Caregiver Feedback Through Monitoring of Key "Listening Posts" ***Inquiry, grievance, and call survey data serve as critical "listening posts"*** that allow us to monitor member and caregiver experience and satisfaction in "real time" long before issues may be detected in CAHPS surveys. These listening posts shed light into member and caregiver questions and concerns, points of abrasion, the quality of service we are providing and the quality of care delivered by our providers. Our Customer Service Director, Mike is responsible for the monitoring and reporting of call and web inquiries, grievance and call survey data.

As phone and web inquiries are received, they are logged in our customer contact system by inquiry type. Mike produces an operational dashboard for inquiry activity, including volume and type. As trends are identified, they are escalated to the appropriate area, which may include a Joint Operating Committee (JOC), provider services, or functional workgroup, for further analysis and action. Mike provides trend reporting and action plans updates to the PMC.

While membership more than doubled from 2012 to 2017, ***we reduced grievances per 1,000 members by 53%***, from .50 to .23. We attribute the steady reduction of grievances to our comprehensive oversight and management of activities

used to minimize abrasion. Grievances are captured in our customer contact system using AHCCCS-defined grievance categories, allowing our interdisciplinary Grievance Workgroup to easily monitor and analyze grievance trends. The workgroup, comprised of customer service, prior authorization (PA), and provider services leadership as well as representatives from compliance, quality improvement, and claim disputes and appeals, meets weekly to examine grievance issues, root causes and contributing factors, and resolutions. The workgroup evaluates trends by volume, category, provider, practice, location and more. Data is shared with providers through JOCs and our provider services staff. Action plans are developed and monitored at subsequent workgroup meetings and reported to PMC and CASQIC.

HOW FEEDBACK RESULTED IN IMPROVEMENT: In 2015, after identifying a grievance trend among Care1st members receiving pre-scheduled trips for recurring visits, our non-emergent medical transportation (NEMT) partner implemented a procedural change to assign only employed drivers with special training to these transports. The change improved members' experience with NEMT and ***reduced related grievances by 33% over two-years***.

In addition to gathering feedback through inquiries and grievances, we routinely ***assess satisfaction with telephonic support***. For example, we invite members who call our nurse triage line to share feedback about their experience including overall satisfaction, answer timeliness, and satisfaction with the representative. As part of the ACC contract implementation, we are enhancing our Measurement Program with customer service post-call surveys. These surveys, operational in our affiliates including our Kentucky and Florida Medicaid plans, allow us to assess experience with Customer Service. Members are invited to complete a voluntary, quick, easy-to-use, IVR-based post-call survey at each customer service encounter. IVR provides a secure, comfortable mechanism to provide honest feedback about the experience, including satisfaction with the customer service representative (CSR) who assisted, if they were treated with respect and courtesy, and the likelihood of recommending the plan. Branching logic allows us to drill down to understand the issues resulting in dissatisfaction. Our MAC, PMC and CASQIC will review nurse triage and customer service post call surveys results and identify opportunities for improvement.

Measuring Member and Family Experience During "Moments that Matter" In addition to other feedback mechanisms, we ***measure experience with specific programs and services during "moments that matter"***, such as upon engagement or at the conclusion of specific programs. For example, in 2017, ***we implemented Pacify in response to member feedback*** – specifically new moms who expressed challenges breastfeeding following hospital discharge. As the first organization in Arizona to offer Pacify, we use the mobile application to connect new moms to a lactation consultant or dietician through video chat for real-time 24/7 assistance. At the end of each interaction, members are asked to provide feedback about their experience. ***Overall satisfaction with the program is extremely high, 4.9 out of 5.***

As part of the evolution of our Measurement Program, we are introducing additional approaches beginning this year. For example, under the leadership of our Senior Director Field Health Services, Kathy Hoffman, ***members and caregivers will be surveyed 90 days after their initial enrollment in care management*** and again when the need for care management concludes. Indicators of program satisfaction will include health education materials received, care management staff, meeting cultural needs and preferences, helpfulness in adhering to a care plan, likelihood of recommending the program to others, and interpretation or translation services, if applicable. As we do in our affiliates, survey results will be compiled and analyzed, and action plans developed so we can continuously provide excellent member and caregiver experience for those enrolled in care management. For example, the most recent Care Management Survey Annual Report for our Kentucky affiliate indicates ***100% of those surveyed are satisfied working with their care manager***.

PROCESSES TO OBTAIN AND USE PROVIDER FEEDBACK TO IMPROVE PROVIDER EXPERIENCE

Providers are essential partners in the delivery of physical and BH services. Our goal is to facilitate members getting needed care in a manner that is efficient and effective for providers. Understanding how we are performing relative to that goal is critical. Therefore, we use an array of focused strategies and approaches to

Figure 13-2: Provider feedback collection strategies and approaches

obtain and use provider feedback. These approaches are illustrated in **Figure 13-2** and discussed below. While many are operational, we are evolving our Measurement Program to reflect the needs of the ACC contract and practices from our affiliate plans.

Engaging Providers in Care1st Governance and Oversight We have three primary means of obtaining feedback through provider engagement in governance and oversight. First, ***providers serve on CASQIC and quality subcommittees*** where we routinely obtain input and feedback on process improvement and member and family engagement to impact health outcomes, and member and provider experience. CASQIC currently includes six Arizona-licensed providers representing physical and BH services with experience caring for our members. Participants include Family Physician, Dr. Abraham Kuruvilla; Psychiatrist, Dr. James McLoone; Clinical Informatics Fellow, Dr. J. Edward Bernardo Maddela; Pediatrician and Neonatalogist, Dr. Mark Shwer; Pediatrician, Dr. Duane Wooten; and Family Practice Nurse Practitioner, Nona Siegel. Under the ACC contract, the committee composition is being expanded to represent additional specialties, such as Developmental Behavioral Pediatricians and Obstetrics and Gynecology, tribal providers, and GSAs.

HOW FEEDBACK RESULTED IN IMPROVEMENT: During a recent CASQIC meeting, providers discussed barriers to HPV vaccinations, including parental attitudes and beliefs. ***We used their feedback to develop enhanced education to help providers address concerns and objections.*** Our October *Practice Pointer* focused on HPV vaccination, offering strategies for talking with parents, CDC talking points and HPV resources and we will continue to make it a focus of provider and member education in 2018.

Second, to support Arizona's transformation to fully integrated care, in 2018, Care1st will ***conduct integration summits*** in the GSAs in which we are awarded a contract. Modeled after successful integration summits conducted by our Florida affiliate, we will use the summits to better understand the integrated physical, behavioral and social models that are working in each GSA, the challenges providers face in developing and sustaining integrated models of care and what we can do to help foster integration. Care1st also will hold quarterly strategic integration sessions to promote a shared understanding of integrated practice across disciplines; refine delivery models; identify challenges in developing and sustaining integrated models; and seek input on actionable solutions to overcome barriers.

Third, our ***provider services organization represents the "voice of the provider"***. Led by Jessica, the provider services team will coordinate with the BH team and our Tribal Coordinator, to continue to increase providers' voice in areas of leadership, service delivery and Care1st decision-making committees and workgroups; advocate for services beneficial and supportive to providers; and communicate and collaborate with providers and office staff to identify concerns and remove barriers that affect care delivery and provider satisfaction.

Measure Overall Experience and Satisfaction with Care1st Our commitment to improving provider experience is evident in our performance in ***AHCCCS' provider claim satisfaction surveys where we consistently rank in the top 3 across all questions and have been the top ranking plan for initial claims processing and resolution of claims issues.*** We are awaiting the 2017 results and, upon receipt, will analyze findings and implement actions to improve performance.

As part of our Measurement Program evolution, in 2018, ***we are implementing a best practice from our affiliate plans, an annual comprehensive provider satisfaction survey***, which is sent to more than 300,000 providers nationwide. Administered by SPH Analytics, the survey allows us to measure and benchmark how well we are meeting our providers' expectations and needs across key areas including:

- Provider Service staff
- Health plan and competitors' plans
- Administration and claims payment
- Pharmacy
- Network and coordination of care
- PA and quality management

Based on the data collected, a report is produced summarizing the results, and identifying strengths and opportunities. As we do currently with the AHCCCS-administered survey, the results of the annual survey will be presented to relevant workgroups and committees to continuously improve provider experience.

Obtaining Provider Feedback Through Monitoring of Key "Listening Posts" ***Provider call inquiries, complaints, and claim disputes, together with information gathered during in-person meetings, serve as critical "listening posts".*** As with member listening posts, this feedback allows us to monitor provider experience and satisfaction in "real time".

Listenings posts provide valuable insights into provider questions, points of abrasions, and perceptions of our service and support. As with member call and grievance data, we collect provider inquiries and complaint trends and analyze the data to identify issues or opportunities to improve care and service delivery. Using a dedicated provider inquiry and complaint tracking database, we track, trend, analyze and evaluate strategy effectiveness and improve operations as well as provider service, communications and education.

To monitor service and ensure provider satisfaction, ***we conduct routine JOCs with hospital partners, PCMH and VBP partners, and other key providers*** (e.g., vision, dental, home health, durable medical equipment, NEMT). Provider services, claims, PA, finance, and operations representatives attend each JOC. During JOCs, we engage providers, listen to their concerns, discuss policy changes, review member grievances, monitor timeliness and accuracy of claims payment, identify and resolve billing issues, and discuss other improvement opportunities. JOCs also assist in effective accounts receivable management, promote network stability and timely access to services by increasing provider satisfaction. Given their importance, we are expanding our JOCs under the ACC contract to include BH providers and Indian Health Service (IHS) and 638 Tribal Facilities that serve American Indian members in each awarded GSA.

HOW FEEDBACK RESULTED IN IMPROVEMENT: In May 2017, using feedback from JOC partner HonorHealth, we created a monthly claim denial dashboard for their use in reviewing trends and ensuring claims needing correction were resubmitted promptly. The value of this report was immediately clear, prompting us to offer it to all JOC partners and other high-volume claim submitters, as well as upon request. In the six months since implementation, ***our JOC partners have lauded the report as an extremely helpful tool that allows them to quickly drill down on issues and trends, better manage accounts receivable, and educate staff***.

Provider Claims Educators (PCE) are an integral part of our Measurement Program and high-touch approach as they communicate daily with contracted and non-contracted providers via phone, email and in-person meetings to ensure the effective exchange of information and gain feedback about claims submission practices. PCEs track each provider encounter and data is routinely analyzed and reported in our monthly operational dashboard. As improvement opportunities are identified, they are directed to the appropriate department or workgroup for action.

HOW FEEDBACK RESULTED IN IMPROVEMENT: In 2017, we received a nurse practitioner (NP) complaint from AHCCCS. The NP expressed concern about denial of procedure 64615. We confirmed code 64615 was not included in the NP provider type table. Sr. PCE, Anthony Crooks, outreached to the NP who explained 64615 was both integral to and within the NP scope of practice, as defined by CMS. Advocating on her behalf, we submitted a request to AHCCCS' coding committee. AHCCCS approved coverage of 64615 for NPs and updated the reference files. The day following AHCCCS' notification, we reprocessed the claims. ***The NP expressed her appreciation and desire to see more Care1st members based on our service and responsiveness to her needs.***

Measuring Provider Experience During "Moments that Matter" In addition to the above feedback collection strategies and approaches, Care1st ***monitors provider experience through specific programs and services during "moments that matter"***. Examples include Provider Forums, focused engagements and more.

- **Provider Forums:** Semi-annual Provider Forums, held in contracted GSAs, allow us to share information with providers and serve as an opportunity for them to give feedback. Content is derived from benefit and policy changes as well as provider interests and needs identified through workgroups and activities. With ACC contract implementation, we are expanding our forums to include quarterly meetings with BH providers, IHS and 638 Tribal Facilities serving American Indian members. Feedback will be used to improve member and provider experience.
- **Focused Feedback Engagements:** Periodically, we engage providers in focused projects where input is of utmost importance. Methods like ad hoc surveys and focus groups allow us to better understand provider needs and expectations.

HOW FEEDBACK RESULTED IN IMPROVEMENT: Our parent organization solicited provider and office staff feedback to redesign the provider portal. Ease of use was found to be a top need. As a result, the portal redesign allows providers to access physical health and BH data with the fewest "clicks" possible. ***The redesign enhanced provider experience and helps providers deliver timely, quality care to our members.*** In 2018, we will deploy the enhanced provider portal to Care1st providers.

ACCELERATING INTEGRATION THROUGH KEY VALUE-BASED STRATEGIES

Care1st has a long history of advancing AHCCCS goals as the program has evolved over nearly 15 years of serving Arizona members. Care1st, along with WellCare and our 10 affiliated health plans around the country, have unique experience regarding integration and payment modernization, leading the state in addressing social determinants of health (i.e. access to housing or food) and driving provider accountability through innovative partnerships and payment arrangements. ***In the past 3 years alone, Care1st increased the number of providers participating in our value-based strategies by 41%***. We continue to expand this effort through behavioral health (BH) and specialty provider contracting in advance of the AHCCCS Complete Care (ACC) program.

For ACC, we have further enhanced our value-based integration strategies as described below. Our program to support integration and payment modernization comes together through our ACC value-based strategies:

- ***Fostering integration*** through the alignment of metrics, incentives and payment
- ***Promoting accountability*** and ownership through sharing meaningful, integrated and actionable data
- ***Supporting provider evolution*** through practice transformation tools, support and investment

Aligning Metrics, Incentives and Payment

We recognize the power we have to promote greater integration through the way we structure payment arrangements with providers. For instance, our unique shared savings arrangement with Catalytic Health Partners has improved outcomes for members engaged in integrated care on metrics involving employment, ED visits, hypertension and depression. We have adopted the nationally recognized Health Care Payment Learning and Action Network ***(HCP-LAN)*** Framework in our effort to advance value-based strategies. For the ACC program, we have overlaid the Framework with the ***Substance Abuse and Mental Health Services Administration's (SAMSHA) six-levels of integration continuum*** as we work to move providers to true integrated care as shown in **Figure 14-1**. We know from our experience here, and in other states, that the best way to encourage providers to integrate care is to make them responsible for integrated metrics and total cost of member care. But we also recognize that many providers need significant support to transform their payment structure – an issue magnified in Arizona where behavioral health and many integrated providers will be moving from block funding. Recognizing this challenge, we have additional options for value-based payment (VBP) arrangments based on provider type, level of integration and sophistication, and have established a ***dedicated Practice Transformation Team***, which we discuss below. In addition to our broad experience in Arizona with alternative payment methodologies (APMs), our Kentucky plan has helped BH providers shift payment sources for behavioral health services, and our Florida plan, Staywell, is leading efforts to promote Integrated Health Homes (IHH).

Integrated Health Home Model in Florida

Launched last year with Peace River Center, Staywell offers a VBP approach to qualifying Community Mental Health Centers (CMHCs) that deliver integrated medical/behavioral care and meet specific quality targets. ***Staywell pays Peace River Center an additional PMPM bonus based on their meeting defined quality measures***, such as percentage of members that have LDL Cholesterol Testing (Medical), follow-up within 7 Days after Mental Health Hospitalization (Behavioral), and Diabetes screening for members using anti-psychotics (Medical and Behavioral).

Diverse Portfolio of Payment Arrangements and Assistance Moving off Block Funding

To move providers along the continuum set forth in the HCP-LAN Framework shown in **Figure 14-1,** we have designed a diverse portfolio of VBP arrangements and requisite support models to meet providers where they are today and set them up for success as they take on greater financial risk and become more integrated. Specifically, for ACC, ***we have expanded our current portfolio of FFS provider payments linked to quality, shared savings and global risk payments*** to add nuanced options that target two significant challenges unique to the new program.

First, we specifically designed these additional options to promote integration by ensuring value payments reward providers for administrative activity that demonstrates integration (i.e. using an integration toolkit, implementing integrated screenings, etc.) and for achieving goals on integrated measures (i.e., measuring a BH provider on physical health HEDIS measures). Second, we designed our ACC APMs with the distinct understanding of the significant challenge it will be for BH and integrated providers to move off of block funding. We have been in close discussions with several large community mental health centers (CMHCs) who have been contemplating this change but are worried about financial viability, and we understand that a phased process with significant levels of support will be necessary to protect member access while providers adjust. We also align our APM structure with the AHCCCS' Targeted Investment (TI) program, using our ACC Practice Transformation Team to support TI providers in meeting their milestones for each core component of the program. As providers become more experienced, comfortable and sophisticated, we expect them to move to greater levels of risk. In the table below, we describe the provider types and value-based integration strategies we designed.

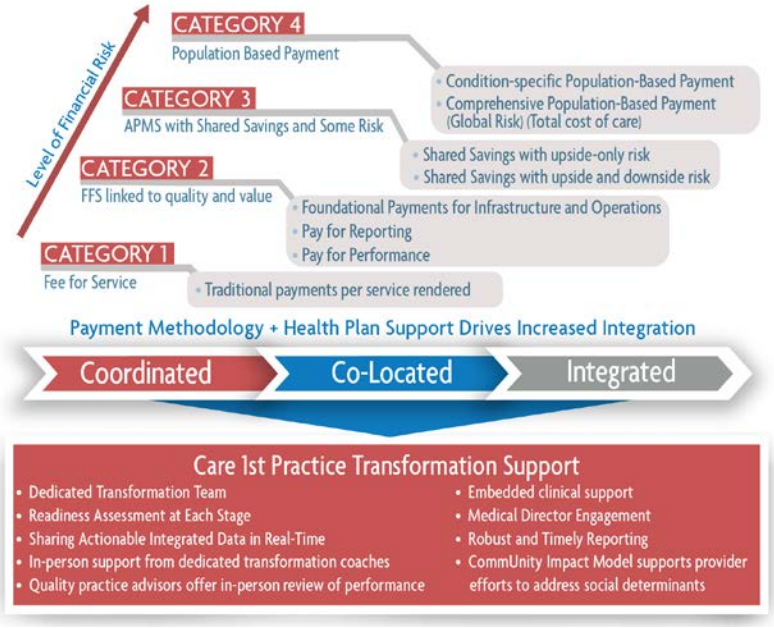


Figure 14-1: We leverage the HCP-LAN Framework to help providers move along the integration continuum

Provider Type	Specific Value-Based Integration Strategies
Integrated CMHC/ Behavioral Health Home	Capitated payment for BH services and FFS for physical health services, moving to comprehensive capitation and risk over time once members become attributable to the Integrated Health Home (IHH) for full care and funding becomes stable. Moderated by stop loss and risk corridors if warranted.
Integrated FQHC/ Integrated Health Home	Capitated payment for physical health coverage plus FFS for BH services, moving to comprehensive capitation over time once members become attributable to the IHH for full care and funding becomes stable. (FQHCs remain whole through funding equivalent to PPS rate regardless of VBP arrangement. VBP allows more flexibility for the IHH.)
Integrated Health Systems (i.e. Banner)	Full risk for total cost of care/population health including BH and physical health services. Moderated by stop loss and risk corridors if warranted.
Behavioral Health Only	• Option A: Contact Capitation Rate (flat PMPM fee for a specific set of members on the provider's panel) for care coordination and management for all services • Option B: Initial move to FFS for General Mental Health/Substance Use (GMH/SU) services with a monthly loan upfront (reconciled later) as the provider transforms and is able to adjust to varying payment mechanisms • Both options are layered with bonus payments for achieving key quality and administrative goals (e.g., HEDIS, 7-day follow-up, reduction in ED visits, data sharing, EMR connectivity, screening, enrollment with HIE, etc.) • The providers can also have access to a shared savings bonus option depending on their ability to contain costs through better coordinated care for members on their roster list, dependent on achievement of quality minimum performance levels at a population level (i.e., savings cannot be attained through decreased access to needed care).

Physical Health Only	In the initial phases of the ACC contract, we maintain our current portfolio of arrangements for PH only providers including pay for performance bonus, shared savings (upside only) and some shared risk. ***We will have 100% of our PCPs in a pay for performance or P4Q bonus program,*** and the P4Q programs will include metrics that reflect member engagement in BH services, such as drug and alcohol rehab.
Certain Specialty Providers (i.e. OB, Oncology)	• Bonus payments for completing key measures, such as prenatal visits • Shared Savings for reducing cost of care, such as reduced ED visits

For each of these strategies, we have varying levels of expectations for providers. Our ACC Transformation Team will assess provider readiness for each expectation and ***design an individualized Transformation Plan that Practice Coaches will use to help providers meet expectations for integration and taking on more risk.*** Some of these expectations mirror or are very similar to the milestones and core components of the TI program.

- EMR Connectivity for enhanced data sharing
- Providing and consuming data with the HIE
- Use of Integrated Screening Tools
- Co-Located or Integrated Practices
- Care Coordination/Management Activity (varying levels based on capabilities), including options to embed Care1st clinical support within the practice
- Participating in Interdisciplinary Care Teams
- Participating in Joint Operating Committees
- Participate in comprehensive cross-training targeted person-centered care, caring for members with co-morbid conditions as well as targeted training for physical and behavioral health providers.

Best Practice – Facilitating Virtual Health Home Integration: We recognize the challenge for providers to move toward co-location or integration, especially in rural areas of Arizona. In the North GSA, particularly, we anticipate the scarcity of PCPs places a burden on existing providers to get patients in timely making it increasingly difficult to engage in collaborative efforts. We will serve as a "bridge" during initial phases of the transformation to create a ***Virtual Integrated Health Home*** in certain areas of the state. Through this process, we pick our highest volume BH provider and PCP in a given area and align members with co-morbid conditions to those providers (in accordance with member choice). We will offer similar payment structures as identified above for IHHs to incent coordination, and provide support in terms of joint data sharing as well as hands-on clinical and quality support as needed to facilitate collaboration. This unique approach affords members the benefits of an IHH while providers are able to move along the continuum in a more structured way.

Leveraging Integrated Metrics and Incentives

Key to successfully leveraging value-based strategies to accelerate integration efforts among providers is to align providers across the healthcare continuum with meaningful outcomes for ACC members. For example, holding PCPs accountable for traditional BH measures like 7-day follow-up after hospitalization better incents PCPs to collaborate on BH needs of their patients. We select performance measures for our VBP arrangements through careful consideration of measures important to AHCCCS, population health priorities for the members we serve and data analytics that identify prevalent conditions, areas of greatest need and potential impact. Led by our Value Based Purchasing Director Kathy Thurman, a team consisting of Medical Director Dr. Satya Sarma, Behavioral Health Medical Director Marketa Wills, Field Health Services Senior Director Kathy Hoffman, Quality Improvement Director Nancy DeRosa and Provider Services Director Jessica Sedita Igneri continuously look for ways to enhance value-based strategies with the right metrics and incentives. This may mean introducing a new incentive, such as payments for flu shot compliance or working with provider and member advisory groups to introduce measures such as ***"Initiation and Engagement in Treatment of Alcohol and Other Drug Dependence" to our PCP P4Q program***. When selecting performance measures, we look at member improvement opportunities such as:

- Integration of physical and behavioral health
- Prevention and screening
- Access to care for physical and mental health conditions
- Management of chronic conditions such as HbA1c control, blood pressure control, medication adherence

Sharing Meaningful, Integrated and Actionable Data

Another key to successfully leveraging value-based strategies to accelerate integration is sharing integrated, meaningful and actionable member, provider and system data. We know that because of the long history of BH providers receiving block payments, some are less experienced in trending and analyzing traditional managed care data such as utilization, HEDIS and other quality data. To address this challenge, we offer an array of processes and tools to share and analyze data with providers including in-office support. ***Because we operate on one Single Integrated Platform and do not delegate out behavioral health plan functions, we can offer providers a single, easy to use approach to access integrated patient data.***

Some of the data points we share with providers include:

- Medical, behavioral and pharmacy claims data
- Quality measures/graphs
- E-prescribing data
- Gaps in care across the continuum
- Readmission stats
- Cost of care/gain share
- ED use, inclusive of all diagnoses
- Newborn data
- Shared savings statistics

Using Staff to Share Data

Our ***Dedicated Value-Based Purchasing Director*** and ***ACC Transformation Team leader*** Kathy Thurman leads provider Joint Operating Committees (JOCs) to review clinical and quality data and resolve administrative issues. Additionally, we are adding ***Quality Practice Advisors*** (QPAs) to our Provider Engagement Model. Modeled after very successful efforts in our Florida and Kentucky plans, QPAs provide in-person quality improvement support at the practice level, meeting with providers and office staff to talk through care gap reports, quality data reports and utilization statistics, identify barriers and share best practices to improve outcomes. With the addition of integration as a key element of our value-based strategies, ***Practice Coaches,*** who are part of our dedicated ***ACC Transformation Team,*** will be used to share integration data points with providers working to hit key milestones and collaboration components outlined in their individualized Care1st Transformation Plan.

Using Technology to Share Data

We regularly share data and reports with providers today, and are further enhancing our data sharing capabilities through implementation of the ACC contract with best practices from our affiliated health plans as identified below:

Claims Data Feeds: Large practices participating in Shared Savings arrangements receive and use detailed claims data feeds to better understand their performance and improvement opportunities. For example, if summary reports show a spike in BH ED utilization, the claims data allows for "drill down" to zip code level to identify if there is an opportunity to promote mobile crisis in that area as an alternative. **AccuReports:** Our proprietary AccuReports system is specifically designed for providers who have entered into a VBP shared savings/shared risk arrangement with quality incentive payments. It is available to providers via a secure site and provides data on readmissions, members incurring high costs, and pharmacy utilization. **Partnership for Quality (P4Q) Portal:** Our new P4Q portal can drill down by practice, provider or member and has been specifically designed to align with our P4Q program. It will give Care1st PCPs a snapshot of the care gaps tied to performance payments, allowing them to prioritize based on those measures that will result in the most improved member health outcomes. Providers can view reports online or download reports to share with members. **Provider Portal:** Our enhanced provider portal includes functionality allowing providers to view all services received by a member, including physical and BH utilization, lab, Medical Loss Ratio (MLR), claims and quality performance. **Member Care Gap Heat Maps:** Heat maps allow us to identify health issues by zip code drilled down to the provider group, physician or member level which in turn allows members to work with our providers to identify localized strategies, taking into account barriers such as language and available transportation resources. For example, diabetic members in Tucson may have the same healthcare needs as those in a rural county but the opportunities to accessing quality healthcare may be different. Heat maps are available through the provider portal or through printouts shared by QPAs. **Care Gap Reports & Appointment Agendas:** ***Care gap reports*** show providers their status on key quality measures, and identify individual member care gaps and the assigned PCP based on year-over-year provider performance. We have continued to invest to improve the timeliness with which we deliver these reports so that the data is as current as possible and they are available via our provider portal. Our ***Appointment Agendas*** show member care gaps and potentially missed diagnoses that providers can reference during patient visits and allows providers and Care1st a comprehensive view of member health status to confirm they receive the right level of support for their condition. **Utilization Management (UM) Scorecard:** The UM scorecard compares provider groups against Care1st Key Performance Indicators including admission and readmission

rates, medical loss ratio, pharmacy costs per member, generic dispensing rates and prescriptions PMPM. This allows providers to better manage medical costs and address member care gaps.

Practice Transformation Tools, Support and Investment

Understanding Challenges within the System

AHCCCS began its integration efforts nearly 10 years ago, and progress has been made in building the foundation for a transformed, integrated system of care. This transformation represents the most significant shift in the system's history. To help prepare for and facilitate this transformation, we met with stakeholders across the state for the past 18 months and understand that there is significant variability from provider to provider in their capacity and willingness to integrate care. We also have identified communications challenges and hindrances to the providers' ability to even collaborate, much less integrate. Care1st fully understands the work necessary to move toward a common language among different provider types while maintaining a strong emphasis on member and family voice.

Care1st Approach to Addressing Challenges and Supporting Providers along the Continuum

We have made significant investments in staff, capabilities and infrastructure to support our providers' progression along the value-based and integration continuum. Examples of our commitment to supporting our providers (in addition to the value-added data described above) include the following:

Dedicated Value Based Purchasing Director: By investing in this dedicated role, which reports directly to Plan President Scott Cummings, we not only elevate the value-based discussion within Care1st, we give providers and our staff a dedicated expert to contact on our value-based strategy. Kathy Thurman serves in this role at Care1st. **ACC Transformation Team:** We are introducing our dedicated ACC Transformation Team to support efforts to move providers along the integration continuum. The Team is cross-functional and members will help providers design Transformation Plans and will bring best practices to providers as they move through key integration milestones. The Team also assists in facilitating collaboration between providers not yet integrated to help them reach person-centered hollistic care coordination. **Provider Engagement Model:** Driven by our locally-based Provider Services team, our Provider Engagement Model, is cross-functional and supported by a wide array of subject matter experts including Medical Directors, QPAs, and Claims experts. This model successfully brings the collective expertise of these resources together via regular direct contact with our providers to review their performance and progression along the continuum under our VBP programs. **Positioning our Providers for Success:** We perform an extensive upfront readiness assessment in advance of finalizing certain complex value-based agreements to ensure our providers are aligned to the right model on our VBP continuum. This assessment includes a review of the provider's operating model, size of their Care1st member panel (as well as their overall panel), and historical financial performance.

Helping Behavioral Health and Integrated Providers off Block Funding

Each of the supports described through this response were designed and introduced for ACC with the specific understanding of the unique challenges of moving integrated and BH providers off of block funding. A phased and supported approach is critical to ensuring financial viability while moving to a more balanced value-based payment. In addition to unique value-based alternative payment methodologies and various data sharing and support tools for providers through the transition, we offer the following unique added programs for providers:

Targeted Provider Education & Training: Care1st takes a customized approach to educating providers on how to work with us within VBP arrangements. Our training programs will be reviewed by impacted providers to solicit their feedback on how we can better meet their needs. Unique elements include orientation sessions at provider offices, web-based training, claims/billing training, and accessing secure portals. Our Provider Claims Educators ***will work in provider offices*** addressing payment and billing issues in real time. **"Risk Accelerator Program":** Our innovative "Risk Accelerator Program" offers a provider a "starter balance" of medical cost efficiency surplus at the outset of certain select agreements. It provides an immediate positive reinforcement of the tangible benefits and opportunities available under a new value-based arrangement and different payment mechanism. **Financial Stability Mechanisms:** Standard components of many of our value-based contracts are "Stop Loss" and Reinsurance provisions, which support provider success and progression along the VBP continuum as they help ensure unavoidable high cost cases, such as transplants or members with hemophilia, but do not unduly compromise what is otherwise solid medical cost efficiency performance.

CARE1ST'S APPROACH TO CONTROLLING HEALTHCARE COST TRENDS BENDS THE COST CURVE

Our knowledge, experience and active engagement in Arizona has allowed us to achieve per member per month (pmpm) medical costs that are nearly $15 pmpm lower than peers in our current service areas, a true "bending of the cost curve." We have monitored and controlled healthcare costs for Medicaid members for more than 14 years and share AHCCCS' goal of ensuring Medicaid enrollees receive necessary physical and behavioral health services in a timely manner and in the most appropriate setting, achieving the best possible quality and cost outcomes.

Our monitoring and control systems are an integral part of our Quality Management and Performance Improvement (QM/PI) program and governed by our QM/PI governance committee known as the Clinical and Service Quality Improvement Committee (CASQIC), which is chaired by our Senior Medical Director Dr. Satya Sarma. Our monitoring and control systems allow us to understand current healthcare delivery, including cost drivers and how to effectively control expenditures. For example, we understand how provider payment arrangements contribute to overall healthcare costs and offer robust, quality-focused VBP arrangements. We also understand how ED use and oncology services impact healthcare costs in Arizona and have successfully implemented strategies to control expenditures in these areas. Similarly, we understand pharmacy services cost drivers, including the increased use of biologics, costly new medications and indications, and the opioid epidemic, for which we offer innovative, highly effective solutions.

APPLYING STRATEGIES TO CONTROL EXPENDITURES: In partnership with one of our FQHCs, we are implementing an innovative bundled payment model for Hepatitis C that is focused on comprehensive care and treatment effectiveness. We project the model ***to improve clinical outcomes while saving nearly $72,000 per average member infected with Hepatitis C who needs antiviral treatment over Fiscal Year 2016, all while improving member and caregiver experience of care,*** which achieves the Institute for Healthcare Improvement's Triple Aim.

As we prepare for the AHCCCS Complete Care (ACC) contract, our deep knowledge and experience in Arizona coupled with the capabilities of our parent company and experience of our Medicaid affiliates in providing fully integrated physical and behavioral health services and social services, will be invaluable. Our analysis of the AHCCCS databook for contract year 2016 dates of service revealed:

- Care1st Maricopa County ED services: ***$6.10 pmpm favorable to our peers***
- Care1st Maricopa County physician services: ***$6.90 pmpm favorable to our peers***
- Care1st Pima County ED services: ***$6.88 pmpm favorable to our peers***
- Care1st Pima County physician services: ***$7.24 pmpm favorable to our peers***

In addition, ***Care1st has a favorable pharmacy pmpm of $16.01 and $12.32 for Maricopa and Pima Counties***, respectively. We expect additional improvement in pharmacy costs as we leverage the WellCare purchasing power with our move to CVS as our pharmacy benefits management (PBM) partner effective January 1, 2018.

Our utilization, quality and cost monitoring and control systems are aligned to our QM/PI program. Data and insights are aggregated, analyzed, and shared across strategies to enhance our ability to positively affect outcomes. We coordinate activities with committees and workgroups to ensure maximum impact. In the sections that follow, we further describe our monitoring and control systems currently used to address today's leading cost drivers in Arizona, including provider payment, drug utilization, and ED use. In addition, we examine methods currently in use in our affiliate plans. These strategies and tactics address anticipated needs under the ACC contract, including integrated care management, BH services utilization, and social determinants of health. For each of the cost containment strategies reviewed, we examine how they will control expenditures and the benefits under the ACC contract.

CARE1ST'S APPROACH TO MONITORING AND CONTROLLING HEALTHCARE COST TRENDS

The management of health outcomes and healthcare cost trends is a direct reflection of our Quality Management/ Performance Improvement (QM/PI) program, which permeates across our organization and directly into our monitoring and management approach. Our systems involve routine measurement, analysis, actions to optimize utilization and cost, and ongoing monitoring and oversight.

Approach to Monitoring Healthcare Cost Trends Under the leadership of our President Scott Cummings, the Care1st team meets at least monthly to review utilization, cost, and quality data as part of the Performance and Monitoring Committee (PMC). The team, consisting of Dr. Satya Sarma, our Chief Operating Officer Susan Cordier, Chief Financial

Officer Deena Sigel, and Director Quality Improvement Nancy DeRosa, and others, analyzes data and trends across counties, practices, hospital systems, ancillary providers, and clinical conditions. Our data warehouse enables further analysis allowing us to pinpoint cost drivers and contributing factors. This level of precision allows us to develop or deploy targeted interventions to drive appropriate and efficient use of services. The following are methods we use to monitor physical and BH utilization and costs, including pharmacy services:

- In partnership with Medical Economics, we **monitor clinical quality, utilization and cost trends** using a robust suite of utilization reports. These reports use physical and behavioral health claim and authorization data along with other data derived from sources such as the AHCCCS' Data Exchange File, commonly referred to as "blind spot data", to systematically identify and address trends and changes in utilization. Data analyzed include admits and days per thousand, average length of stay, as well as readmission rates for inpatient utilization, C-section rates, and emergency department (ED) usage. Inpatient data is tracked and trended by service type (i.e., maternity, NICU, SNF, psychiatric, etc.), diagnosis, provider, and service area. We evaluate utilization and cost trends against goals and benchmarks. As part of our analysis, we use statistical models to find patterns of inappropriate ED use, office visit up-coding and improper billing patterns and are continuously developing mechanisms to improve efficiency and reduce administrative costs.
- Our **retrospective drug utilization reviews (rDURs)** are executed with routine examination of claims data and other records, through electronic drug claims processing and information retrieval systems to assess the clinical quality of prescribing and dispensing of formulary medications. rDURs are designed to find patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and members associated with specific drugs or groups of drugs.
- In addition to rDURs, we routinely **monitor pharmacy utilization and cost trends** for compliance with evidence-based clinical standards (i.e., step therapy), high risk medication, and medication therapy management. Proprietary Pharmacy Toolbox reports are central to pharmacy monitoring throughout our WellCare affiliates. These reports display utilization, drug evaluation review, and physician data by state for each month as well as year-to-date. As of January 2018, Pharmacy Toolbox reports are deployed and in use to monitor and measure Care1st's providers' prescribing patterns and usage.
- Medical Economics conducts state-specific **Medical Cost Review meetings** where a multi-disciplinary team reviews state-specific trends against benchmarks related to financial performance, medical cost and utilization, ED utilization, contracting, utilization management, and pharmacy network improvement. The analysis includes insights and observations from affiliate plans, which often allows us to proactively identify potential trends. Once the data is analyzed, the team identifies areas for improving efficiency along with interventions to reduce administrative and medical costs, for example. Status of follow-ups and trends are monitored to ensure timely completion and effectiveness in driving change. This process is conducted annually, giving a retrospective review of the full year, which allows us to prepare for emerging or predicted trends and planned activities.
- Lastly, our Special Investigations Unit (SIU) uses the General Dynamics STARS® SOLUTIONS analytical tool and HMS' Fraud, Waste and Abuse Portal to analyze medical and pharmacy claims for **potential fraud, waste and abuse**. Outlier and trend reporting allows us to analyze provider-level utilization and cost relative to peer comparisons.

Approach to Controlling Healthcare Cost Trends As cost containment opportunities are identified, we apply technical expertise to make improvements in network development, administrative processing, utilization management, care management, and information technology to control cost trends and optimize health outcomes. In the following sections, we examine several member and provider-focused strategies currently used in Arizona and beyond.

Provider Payment Strategies Over the past five years, ***we've increased the number of providers participating in VBP in Arizona by 41%,*** a testament of our commitment to AHCCCS' VBP initiative and the Health Care Payment Learning and Action Network (The LAN). VBP allows us to bend the cost curve while improving health outcomes, and member, caregiver and provider experience. Our flexible model is built for providers who care for members in government-sponsored healthcare programs and the challenges they face. In Arizona, ***we have implemented various types of VBP arrangements or alternative payment models with many providers, including Banner Health, Arizona Oncology, Catalytic Health Partners, El Rio, and Equality Health***. We will continue to expand the use of VBP, as well as increase the use of more mature VBP models that share savings and risk. Our strategy includes:

- Executing provider VBP agreements tailored around the provider practice structure and size, Care1st membership,

VBP experience, information technology and staffing resources, and ability and willingness to accept financial risk.

- Offering all providers, including those not yet ready to enter VBP, opportunities to take part in other pay-for-quality initiatives such as stacked bonus pay for performance programs for meeting key quality indicators.
- Increasing providers' ability to be successful with APMs through access to data analytics; clinical practice support and training through our quality practice advisors, patient care advocates, and other key staff; industry best practices; and use of an assessment tool to gauge their ability to mature into assuming financial risk.
- Continuing to revisit and negotiate new agreements to move providers along the continuum of VBP opportunities to increasingly aligned, shared risk payment arrangements.

We pride ourselves on executing financially viable provider contracts. Our ability to negotiate favorable terms is a result of positive, long-term relationships and efforts to position providers for success. For example, where possible, we negotiate additional quick pay discounts based on claims processing turn-around time. For claims processed in 2017, ***we attained 99.9% of available quick pay discounts, equating to more than $1.4 million in savings.***

APPLYING STRATEGIES TO CONTROL EXPENDITURES: As part of our shared commitment to enhance the quality of cancer care, Care1st and Arizona Oncology partner in a VBP agreement modeled after the CMS Oncology Care Model. Under our agreement, Arizona Oncology provides enhanced patient navigation services, advanced care planning services, palliative care, 24/7 on-call services, access to urgent appointments, and survivorship and psychosocial services. Arizona Oncology is eligible for shared savings, including upside rewards for improved ED use. In the first year of the agreement, Arizona Oncology ***reduced ED use by 110 visits, which we estimate at $73,000 in cost avoidance***. As part of our commitment to build a financially sustainable and value-based healthcare delivery system, we will continue to develop APMs like that offered to Arizona Oncology.

Drug Utilization Strategies Our Drug Utilization Review program provides members with the highest quality prescription drug benefit at the lowest possible cost while ensuring members are given appropriate access to medically-necessary drugs in a timely manner. Our program featu res a comprehensive review of members' pharmacy data prospectively, concurrently, and retrospectively to dispensing to ensure appropriate medication decision-making and positive clinical outcomes. Our program includes the use of prescriber feedback and ongoing evaluation for continuous improvement. For instance, we track and monitor prescribing patterns and usage for a variety of pharmacy measures, including psychotropic medications. Reports display real-time use, drug evaluation review, and physician data by month and year-to-date. Our "Atypical Antipsychotics for Members Under 10" report provides detailed reporting for members under 10 years of age prescribed atypical antipsychotics (excluding those diagnosed with ASD). Our "Pediatric Prescribing of ADHD Medications" report provides reporting for members under 17 years of age using medications for the treatment of ADHD. Similarly, our "Polypharmacy of Behavioral Health Medications" report provides reporting of members who have two or more prescriptions for different antipsychotic medications.

APPLYING STRATEGIES TO CONTROL EXPENDITURES: A multi-disciplinary team, led by our Kentucky Medical Director and BH Medical Director, saw the need to analyze data secondary to the high death rate from opioids in Kentucky. An analysis of pharmacy claims data confirmed members were using multiple prescribers and pharmacies to obtain opioids. Analysis also revealed members using multiple EDs to seek different ways to obtain opioids. The team implemented a comprehensive opioid management program that connects at-risk members with one pharmacy, one healthcare provider and a care manager with specialized training and experience in substance use treatment. Care managers connect members to needed physical, behavioral, pharmacy and social services. The program also targets prescribers, providing written notifications, peer-to-peer meetings with physical and BH medical directors, in-person meetings with our pharmacists, continued monitoring, and more. Results for the first six months include a ***50% reduction in opioid dispensing, a 35% decrease in cyclobenzaprine dispensing, and a 30% reduction in benzodiazepine dispensing. Based on the program's overwhelming success, we are integrating it throughout our Medicaid affiliates.*** We estimate the ***12-month adjusted savings will be more than $4.8M*** for the nationwide implementation. The program will complement ADHS' opioid plans, especially in Kingman, Buckeye, and Metro Phoenix and Tucson where opioid misuse is highest.

ED Utilization Strategies Rapid access to ED care is essential for those with acute clinical needs but frequent and inappropriate ED use suggests underlying problems. Many factors contribute to inappropriate use, including difficulty navigating the system or finding services; lack of coordinated care; housing challenges and food insecurity; lack of providers; member and caregiver anxiety and depression; and transportation. Our approach to controlling healthcare

ED-related costs is anchored on our care model and focused on providers, facilities, and members. Our strategies include broadening access and availability to primary and specialty care; sharing data and communicating with facilities and providers; engaging members who frequently use the ED and their families or caregivers in care management and providing support and disease management for those with chronic physical and behavioral health conditions; and addressing social determinants of health, such as linking members to a food pantry or housing resources.

APPLYING STRATEGY TO CONTROL EXPENDITURES: During a review of utilization and cost trend reports in 2015, we identified an unfavorable ED trend in Maricopa and Pima. Further analysis revealed the spike was attributed to the Medicaid Expansion Adult risk group. The population had a lack of primary care visits and a high incidence of co-occurring medical and behavioral diagnoses, often with pain, and alcohol and substance use. Because these are lower acuity, non-emergent conditions, we implemented an ED diversion program to reduce inappropriate ED use targeting members with high ED use over a six-month period. Those with seven or eight visits within a six-month period were stratified as moderately high utilizers while those with more than eight were stratified as high utilizers. Member lists were created applying the identification and stratification (ID/Strat) criteria to ED claims. A BH care manager outreached and engaged members on the appropriate use of the ED and assessed the members and their families for ongoing needs to improve self-management skills or social determinants preventing positive health outcomes. The care manager enrolled consenting members into our focused ED Diversion Program. Fifty-five percent were in the moderate category of ED use while 44% were in the high use category. The care manager implemented provider and member-directed strategies and tactics, including utilization reduction plans with ED staff; coordination with PCPs, BH providers and ED physicians to develop a plan of care to assess and treat in the lowest level of care; implementation of HIE alerts; enhanced discharge planning inclusive of BH and social services and post-discharge follow-up care; provider outreach and communication; education and care management support; complex care management for our highest risk members. Results included a reduction of ED use ***for high and moderate utilizers by 41% and 56%*, respectively**, which equates to an estimated $200,000 in healthcare cost savings. *Based on the project's success,* ***we expanded our high ED Diversion care management team to include a dedicated Moderate ED Diversion Care Coordinator, and expanded the use of HIE alerts for early identification***. This high-touch care management will be especially beneficial in the North and South GSA where alcohol and substance use are highly prevalent.

Integrated Field-Based Care Model for Members with Complex Care Needs and Their Families Care1st will implement field-based care management in 2019. This care model provides uniquely integrated medical, behavioral, social, environmental and culturally sensitive care to serve members and their caregivers holistically. Our care managers partner with providers to identify urgent and prioritized needs while promoting health literacy, self-care and empowerment. For example, members with co-occurring BH/SUDs and chronic health conditions are at-risk for poor health outcomes which impact cost expenditures. Our approach is to facilitate timely access to care while engaging members and caregivers in the appropriate intensity level of care management, and addressing needs through medication management, peer support and other community-based services that promote recovery, employment or education, and housing stability.

APPLYING STRATEGIES TO CONTROL EXPENDITURES: Nationally, our integrated field-based care model has improved utilization for our highest need and highest cost members compared to historic controls, mostly due to reductions in admissions and readmissions. In 2016, the overall inpatient admission rate for members receiving field-based care management was 22% lower than like members not enrolled in the program. Data reviewed at the individual condition level proves our care model is particularly effective for members with complex chronic needs. ***We saw lower utilization for members with diabetes, COPD, and CHF including a 9% lower rate in readmissions for members with diabetes, a 21.5% lower rate of readmissions for members with CHF, and a 21.5% lower rate of admissions for members with COPD.*** Integrated, field-based care will improve outcomes and cost of care throughout Arizona, especially in the medically underserved areas of the North and South GSA where chronic physical and BH conditions are prevalent.

Utilization of Behavioral Health Outpatient Services Across our Medicaid affiliates, nearly 60% of all BH spend is for outpatient services. For the majority needing BH services, care can be completed within the first eight to ten visits. However, through the course of managing care for those with significant BH needs, we found many remained in

treatment for years without established discharge plans. This is due in part to providers' beliefs that keeping members in care prevents deterioration. To further the recovery model, promote member and caregiver independence, and bend the cost curve, we are enhancing provide access to data through the provider portal and member care gap alerts, fostering use of support servives as outlined in the BH Covered Service Guide, and engaging members in high-touch care management, while addressing needs through community-based services.

APPLYING STRATEGIES TO CONTROL EXPENDITURES: In 2016, we developed our *METS program, Members Empowered to Succeed*. Based on SAMHSA's *10 Fundamental Components of Recovery*, our integrated, holistic recovery-oriented program is for members in care for an extended period with high use of services. We assign members to a dedicated, specially-trained METS care manager, who develops a current clinical picture, including medication history, using information in our medical management system along with information supplied by the treating provider. First a clear clinical picture is established and then the care manager presents the member in a Treatment Team Review (TTR) meeting. During the multidisciplinary TTR meeting barriers, strengths, and other factors are reviewed to develop the next steps for the care manager to follow on the member's case. This information is used to develop a collaborative Roadmap for Recovery, tailored to meet the member's needs, resulting in improved outcomes. Results include a 54.7% pmpm reduction in total visits, a 6.1% reduction in ED use, and an increase in pharmacy use – suggesting improved medication adherence. ***Total cost for professional BH visits also dropped by 35.7%. Based on METS' overwhelming success, we are expanding the program to Arizona to promote resiliency and recovery by empowering members and community supports to address members' needs across multiple systemic contexts.*** This program will address the behavioral health needs identified by many communities through their county health assessment projects.

Address Social Determinants of Health Our CommUnity Impact Model features four unique elements including: a web-enabled rich database of more than 6,000 organizations serving Arizonans; peer-driven community telephonic support by individuals from the local service area with lived experience; data-driven investments in community organizations to receive, record and report on referrals for members' and families' social needs such as homelessness, food insecurity, employment and educational opportunities, and other resources; and, evaluation of community-based service use to identify and act on opportunities for improvement. We are implementing the CommUnity Impact Model in Arizona in early 2019.

APPLYING STRATEGIES TO CONTROL EXPENDITURES: The powerful impact of using a model like our CommUnity Impact Model is clear when reviewing results from the 2016 study conducted by the Robert Wood Johnson National Coordinating Center for Public Health Systems and Service Research. Analysis of 8,400 program participants revealed ***total medical spending was reduced by $450 for each social service accessed.*** Reductions were attribute to a 26% reduction in ED spending, and a 53% reduction in inpatient spending.

CARE1ST'S APPROACH TO ENSURING SERVICE DELIVERY IN THE NORTH GEOGRAPHIC SERVICE AREA

As an incumbent, we have met with advocacy groups, community leaders, and physical and behavioral health providers, including those operated by tribal nations, throughout the region in preparation for the integration and geographic expansion in the North. These meetings yielded insight into service delivery, including challenges and supportive factors. Arizona's five C's - cattle, citrus, climate, copper and cotton – remain significant assets to the community contributing to both local economies and the way of life. Yet, high rates of chronic physical and behavioral conditions, coupled with significant provider shortages, limited access to care and community services, economic issues, lagging infrastructure, large open landscapes between population centers, and rugged terrain, leave many communities vulnerable. Areas and populations like Holbrook, Kingman, Winslow, tribal communities, Hopi Nation, Havasupai Indian Community, Hualapai Tribe, and Navajo Nation are among the ***highest health risk communities in Arizona***. Despite challenges, communities understand their needs and are working diligently to address priorities. Through the dedication and hard work of state agencies, community leaders, providers and others, improvements have been made in youth prescription and OTC drug abuse, childhood immunizations, and smoking during pregnancy.

Employing Focused Strategies to Ensure Service Delivery in the North Our goal for expansion is to maintain continuity of care by supporting efforts underway and mitigate barriers that affect the delivery of physical health, BH, and social services. Our parent organization's first-hand experience serving Medicare beneficiaries in the North and our affiliates' experience serving vulnerable Medicaid communities, like the Appalachian region in Kentucky and frontier tribal areas and remote island communities in other states, have been instrumental in defining focused service delivery strategies in the North. The following sections examine the aspects of service delivery in the region along with strategies and tactics we will employ to ensure members receive needed physical, BH and social services. We will continue to refine these strategies and approaches leading up to and beyond contract implementation.

Cultural and Geographic Factors and Strategies Culture and geography are significant factors in the North. The ethnically and culturally diverse region has a signficant American Indian population. In Navajo, Apache and Coconino, American Indians account for 73%, 43%, and 27% of the population, respectively and for many, English is not their primary language. The North is also geographically vast with great distances between population centers and low population density, especially in Apache and Coconino Counties. The region also lacks safe, reliable public and private transportation, which compounds the geographical issue. Based on these factors, we will employ the following service delivery strategies:

- Protect trusted member-provider relationships and facilitate continuity of care.
  - Contract with existing AHCCCS providers, like Northern Arizona Healthcare and the Guidance Center.
  - Offer member and provider incentives to establish and maintain regular primary care relationships.
  - Reinforce member-provider relationships and health homes through targeted messaging with members and data sharing with providers through standardized and ad hoc reports and the State's Health Information Exchange (HIE) while encouraging providers to move through the Meaningful Use continuum and participate in planning to improve care coordination and healthcare delivery for members.
- Under the direction of our Plan President, implement our *HealthyNations* American Indian engagement program led by our Tribal Coordinator.
  - Recruit staff and providers from within local communities that represent the community served and languages prominent in the region.
  - Establish an American Indian *CommUnity Council* to provide community investments to close social service gaps within tribal communities.
  - Deliver enhanced cultural competency training to staff and contracted providers, initially and annually.
  - Provide in-person and telephonic interpreters to ensure culturally and linguistically appropriate access.
- Engage our Member Advocacy Council in conjunction with the Member Advocacy Team, including the Tribal Coordinator, to identify concerns and remove barriers that affect service delivery and member satisfaction.
- Deliver culturally and linguistically appropriate materials such as member newsletters, provider directories, educational materials, and others.
- Provide non-emergent medical transportation (NEMT) through our vendor, MTBA.
  - Collaborate with MTBA and tribal nations to ensure transportation is not a barrier to service delivery through existing network and expansion, where needed.

  - Recruit American Indian drivers to provide NEMT for tribal communities and provide reimbursement for friends and family who provide NEMT for members living in tribal communities.

Social Determinants of Health and Community Infrastructure Factors and Strategies With high rates of unemployment and poverty, social determinants of health and community infrastructure are major factors affecting service delivery in the North. In Apache and Navajo County, 19% and 15% of the population, respectively, is unemployed and in Coconino, Navajo, and Apache more than 21% of the population live in poverty. Community infrastructure is also lacking and many face social service gaps related to affordable housing, job opportunities, and access to healthy food. Many areas, including Valentine and Willow Beach in Mohave, Tolani Lake and Fort Valley in Coconino; and Many Farms and Steamboat in Apache, have little-to-no internet or cellular service, leading to further isolation and access issues. We will employ strategies and approaches to address these issues, including:

- Implement *CommUnity Impact Model* to address social barriers through available community resources.
  - Facilitate access to community-based services, including employment and housing, through our ***extensive web-enabled database of 6,000 organizations serving Arizonans***.
  - Provide peer-driven community telephonic support from *CommUnity Impact Model Liaisons* with local service area, Housing and Education staff, and Individual & Family Affairs Administrator.
  - Close social service gaps through community investment as part of our commitment to ***invest $1 million into local communities over three years***, including our $500,000 grant to expand the First Star Academy concept for youth in foster care through Arizona State University to two new locations in 2018 and 2019.
  - Anticipate prioritized social needs of the population by tracking unmet social needs members request, working with community partners to continually improve focused investment in services.
- Establish mobile and stationary Welcome Rooms to offer a location to host a wide variety of events, including children's reading and literacy classes, nutrition and wellness classes, AA/NA meetings, and provide special needs resource navigation. Our Welcome Room strategy in Arizona includes engagement efforts through Promotoras and CHWs, peer and family support specialists and care coordinator staff.
- Expand connectivity for members in rural areas through partnerships with telecommunications and internet service providers that fund and support the best broadband, satellite, phone and high-definition video conference calls, like Wi-Power, HughesNet and the major cellular carriers.

System of Care Factors and Strategies The North is home to many medically underserved areas and populations. Physician and non-physician provider shortages limit access to well-care and general health services, especially in Kingman and Winslow, and among low income populations and throughout tribal communities. As a result, pharmacies often play a significant role in service delivery. Our service delivery strategies are focused on expanding access to and availability of services through existing providers and new modes of delivery in the North, including:

- Fully leverage American Indian delivery systems.
  - Partner with willing tribal nations and American Indian provider organizations, like Winslow IHS, to expand services to members in tribal communities.
- Expand capacity and capability of existing providers.
  - Execute VBP agreements tailored to incent providers like North Country HealthCare FQHC to expand access and availability.
  - Subject to licensure requirements, contract with licensed independent social workers, clinical nurse specialists, and nurse practitioners who practice in remote locations.
  - Provide incentives for providers to participate in the adoption and use of health information technology and implement technological solutions to share health information through VBP and Care1st technology solutions
  - Advance Health Home model through practice transformation.
  - Support practices participating in Targeted Investment and the Transforming Clinical Practices Initiative programs through robust data sharing, dissemination of population health best practices, care coordination and support for members' social needs, and value-based payment models.
- Create new modes of service delivery.
  - Collaborate with providers like North Country HealthCare FQHC to bring routine well care to underserved populations through use of mobile services.
  - Support Project ECHO (Extension for Community Healthcare Outcomes) telemedicine initiative and their efforts related to rural specialty care.

  - Use community paramedicine to extend care delivery.
  - Collaborate with telemedicine and telepsychiatry providers, like Banner Health, to expand service delivery.
  - Partner with pharmacies to have pharmacists assist with education, medication reconciliation, and vaccines.
- Facilitate data sharing across providers through utilization reports, Pharmacy Toolbox reports, HIE, and others.
- Support cross-border patterns of care through contracts with providers like Rehoboth McKinley in New Mexico.

Morbidity Factors and Strategies Chronic conditions like diabetes, heart disease, asthma, COPD, and kidney disease are highly prevalent. Four of the five counties have diabetes rates that exceed the national average, including Apache County where more than 14% of the population has diabetes. In Mohave and Yavapai, more than 18% of the population live with a disability affecting cognition or independent living. Behavioral health and substance use disorders are also highly prevalent. In Coconino County, more than 17% of adults drink excessively and 13% report current prescription drug misuse. Mohave County prescribed opioids at more than twice the national average based on 2015 data. Our service delivery strategies and approaches include:

- Deploy our field-based, integrated complex care management program, *Care1st at Home*, including:
  - Conduct comprehensive physical and environmental assessments to maximize independence and ability for members to live safely in their homes.
  - Address physical, behavioral, substance use, cognitive, and socioeconomic needs in partnership with physical and behavioral health providers through care management.
  - Facilitate supported employment based on members' goals and desires.
  - Partner with physical and behavioral health providers to provide tailored education through joint care plans.
- Develop members' capacity for self-management through integrated disease management programs.
- Implement and promote peer and family support programs.
- Create access to chronic physical and BH care and substance use programs.
  - Assist tribal nations in building connections and capacity for integrated care.
  - Incent providers to offer "clinic" days, to expand access to specialty care in their community.
  - Implement Screening, Brief Intervention and Referral to Treatment (SBIRT) among providers.
- Offer Enhanced Opiate Medication Management Program for prescription opiates to prevent the misuse and abuse of opioids; intervene when members are at-risk; support members with innovative treatments; collaborate with providers and encourage appropriate prescribing; connect members to needed programs and social services to help them address social or economic barriers that go beyond healthcare.
  - Provide care management to those at-risk for opioid abuse, including locking in pharmacies and prescribers, as well as community education about Harm Reduction strategies (i.e., Narcan use, clean needles).
- Promote E-Prescribing for controlled substances and increase access to medication-assisted treatment.

Modifiable Risk Factors and Strategies Many Northern residents have lifestyle risk factors that contribute to the burden of disease and impact the well-being of the population. For many communities, obesity, tobacco use and teen pregnancy are major concerns. For example, three of the five counties have adult obesity rates over 29%, including Mohave County, where nearly 31% of adults are obese. Mohave has the highest rate of tobacco use in the state as more than 25% of adults smoke. Teen births well-exceed state and national averages and Navajo County has the highest teen birth rate in Arizona. Our approach to service delivery includes addressing modifiable risk factors through community-based education and targeted behavior modification programs, including:

- Provide comprehensive education and communication.
  - Partner with local radio stations, such as KMUR, KFLG, KVYL, schools, faith-based organizations and Tribes to convey healthy living information.
  - Provide community education on healthy behaviors and risk factors, such as early warning signs of suicide and drug addiction, through mobile welcome rooms, health fairs, and train-the-trainer events.
  - Expand use of Arizona Health Start to help parents with children birth to five and pregnant women be successful, healthy and strong, and other CHWs to serve as member liaisons.
- Engage members in targeted behavior modification programs.
  - Implement member incentives for weight management and tobacco use and encourage tobacco cessation support through ASHLine.
  - Promote good prenatal and post-partum care, and provide focused teen family planning through our maternity program which includes engaging members through social media and technology.

CARE1ST'S APPROACH TO ENSURING SERVICE DELIVERY IN THE SOUTH GEOGRAPHIC SERVICE AREA

As an incumbent, we have met with advocacy groups, community leaders, and physical and behavioral health providers, including those operated by tribal nations, throughout the region in preparation for the integration and geographic expansion in the South. These meetings yielded insight into service delivery, including challenges and supportive factors. Arizona's five C's - cattle, citrus, climate, copper and cotton – remain significant assets to the community contributing to both local economies and the way of life. Yet, high rates of chronic physical and behavioral conditions coupled with significant provider shortages, limited access to care and community services, economic issues, and lagging infrastructure leave communities vulnerable. Areas and populations like Ajo, Bisbee, Douglas, the Tohono O'odhma Nation, and the San Carlos Apache Tribe are among the ***highest health risk communities in Arizona***. Despite challenges, communities understand their needs and are working diligently to address priorities. Through the dedication and hard work of agencies, community leaders, providers and others, improvements have been made in childhood immunizations in Cochise and La Paz, obesity in Pima, and teen pregnancy in Santa Cruz.

Employing Focused Strategies to Ensure Service Delivery in the South Our goal for expansion is to maintain continuity of care by supporting efforts underway while mitigating barriers that affect the delivery of physical health, behavioral health, and social services. Our affiliates' experience serving vulnerable Medicaid communities, like the Appalachian region in Kentucky, and frontier tribal areas and remote island communities in other states, have been instrumental in defining focused service delivery strategies and approaches in the South. The following sections examine the unique aspects of service delivery in the South, as well as the strategies and tactics we will employ to ensure members receive needed physical, behavioral and social services. We will continue to refine these strategies and approaches leading up to and beyond contract implementation.

Cultural and Geographic Factors and Strategies Culture and geography are significant factors in the South. The ethnically and culturally diverse region has signficant Hispanic and American Indian populations. In Greenlee, Santa Cruz, and Yuma, Hispanics account for 47%, 83%, and 62% of the population, respectively, whereas in Graham and La Paz 15% of the population is American Indian. For many, English is not their primary language. Outside of Pima, the South is geographically vast with great distances between population centers and low population density. These parts of the region lack safe, reliable public and private transportation, which compounds the geographical issue. Based on these factors, we will employ the following service delivery strategies:

- Protect trusted member-provider relationships and facilitate continuity of care.
  - Contract with existing AHCCCS providers, like Canyonlands Health Center, Mariposa Community Health Centers and Chiricahua Community Health Centers, which are the prominent providers in their communities.
  - Offer member and provider incentives to establish and maintain regular primary care relationships.
  - Reinforce member-provider relationships and health homes through targeted messaging with members and data sharing with providers through standardized and ad hoc reports and the State's Health Information Exchange (HIE) while encouraging providers to move through the Meaningful Use continuum and participate in planning to improve care coordination and healthcare delivery for members.
- Provide services and coordinate care in a culturally and linguistically appropriate manner.
  - Recruit staff and providers from within local communities that represent the community served and languages prominent in the region.
  - Deliver enhanced cultural competency training to staff and contracted providers, initially and annually.
  - Promote the use of Promotoras, Community Health Workers (CHWs) and other community-based resources.
  - Offer in-person and telephonic interpreters to ensure culturally and linguistically appropriate access.
- Engage our Member Advocacy Council in conjunction with the Member Advocacy Team, including the Tribal Coordinator, to identify concerns and remove barriers that affect service delivery and member satisfaction.
- Deliver culturally and linguistically appropriate materials such as member newsletters, provider directories, educational materials, and others.
- Collaborate with our non-emergent medical transportation (NEMT), MTBA, and tribal nations to ensure transportation is not a barrier to service delivery through existing network and expansion, where needed.
  - Recruit American Indian drivers to provide NEMT for tribal communities and provide reimbursement for friends and family who provide NEMT for members living in tribal communities.
- Use mobile vans to deliver primary care to remote areas, as Chiricahua currently does and is looking to expand.

Social Determinants of Health and Community Infrastructure Factors and Strategies With high rates of

unemployment and poverty, social determinants of health are a major factor affecting service delivery in the South. In Yuma and Santa Cruz, nearly 30% and 17% of the population, respectively, is unemployed, and in Graham, La Paz, Santa Cruz, and Yuma, more than 21% of the population lives in poverty. The economic reality in Yuma has resulted in it being repeatedly ranked as one of the most economically stressed counties in the country. Many areas face social service gaps related to affordable housing, job opportunities, and access to healthy food. We will employ strategies and approaches to address these issues, including:

- Implement *CommUnity Impact Model* to address social barriers through available community resources.
  - Facilitate access to community-based services, including employment and housing, through our ***extensive web-enabled database of 6,000 organizations serving Arizonans***.
  - Provide peer-driven community telephonic support from *CommUnity Impact Model Liaisons* with local service area, Housing and Education staff, and Individual & Family Affairs Administrator.
  - Close social service gaps through community investment as part of our commitment to ***invest $1 million into local communities over three years***, including a $500,000 grant to expand the First Star Academy concept for youth in foster care through Arizona State University to two new locations in 2018 and 2019.
  - Anticipate prioritized social needs of the population by tracking unmet social needs working with community partners to continually improve focused investment in services.
- Establish mobile and stationary Welcome Rooms to offer a location to host a wide variety of events, including children's reading and literacy classes, nutrition and wellness classes, AA/NA meetings, and provide special needs resource navigation. Our Welcome Room strategy in Arizona includes engagement efforts through Promotoras and CHWs, peer and family support specialists, and care coordinator staff.

System of Care Factors and Strategies The South is home to many medically underserved areas and populations. Physician and non-physician provider shortages limit access to well-care and general health services, especially in Sierra Vista, Benson, Duncan, Quartzite, Salmone, Pima County (outside greater Tucson), Ajo, Santa Cruz, Yuma west and Yuma north, and among low income populations, including those in Parker. Our strategies will expand access to and availability of services through existing providers and new modes of service delivery in the South, including:

- Expand capacity and capability of existing providers.
  - Expand our Pima-based partnership with Catalytic Health Partners which provides individualized, in-home and in-person healthcare management addressing social, behavioral and physical health, for vulnerable members, resulting in dramatic improvements in outcomes.
  - Subject to licensure requirements, contract with licensed independent social workers, clinical nurse specialists, and nurse practitioners who practice in remote locations.
  - Execute value-based agreements tailored to incent providers and FQHCs to expand access and availability.
  - Provide incentives for providers to participate in the adoption and use of health information technology and implement technological solutions to share health information through VBP and Care1st technology solutions
  - Support practices participating in Targeted Investment and the Transforming Clinical Practices Initiative programs through robust data sharing, dissemination of population health best practices, care coordination and support for members' social needs, and value-based payment models.
- Create new modes of service delivery.
  - Collaborate with telemedicine and telepsychiatry providers, like Banner Health, to expand service delivery.
  - Use social media, text and other modes to disseminate health education and self-management tools.
  - Collaborate with providers like Chiricahua Community Health Centers to expand access to routine well-care to underserved populations through use of mobile services.
  - Support Project ECHO (Extension for Community Healthcare Outcomes) telemedicine initiative and their efforts related to rural specialty care and use community paramedicine to extend care delivery.
- Partner with pharmacies to have pharmacists assist with education, medication reconciliation, and vaccines.
- Facilitate data sharing across providers through utilization reports, Pharmacy Toolbox reports, HIE, and others.
- Support cross-county patterns of care through contracts with providers, like Banner Health, as well as out-of-state telemedicine providers who qualify through the interstate medical licensure compact.

Morbidity Factors and Strategies Chronic health conditions like diabetes and heart disease are highly prevalent. Two of the seven counties have diabetes rates that exceed the national average, including Yuma and La Paz where more than 12% of the population has diabetes. Behavioral health and substance use disorders are also highly prevalent. In

La Paz and Pima, nearly 8% of adults drink excessively. One set of measures for substance abuse for adults relates to the prevalence of cirrhosis and chronic liver disease deaths. Six of the seven counties had mortality rates for cirrhosis and chronic liver disease higher than the statewide average; only Santa Cruz, had rates lower. Nearly a quarter of adults living in the region report current prescription drug misuse and nearly 2.5 out of every 1,000 babies born in the southern region are diagnosed with Neonatal Abstinence Syndrome, primarily caused by maternal opiate use. Our service delivery strategies and approaches include:

- Create access to chronic physical and behavioral healthcare and substance use programs.
  - Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) among providers.
  - Assist tribal nations in building connections and capacity for integrated care.
  - Incent providers to offer "clinic" days, to expand access to specialty care in their community.
- Offer Enhanced Opiate Medication Management Program for prescription opiates to prevent the misuse and abuse of opioids; intervene when members are at-risk; support members with innovative treatments; collaborate with providers and encourage appropriate prescribing; connect members to needed programs and social services to help them address social or economic barriers that go beyond healthcare.
  - Provide care management to those at-risk for opioid abuse, including locking in pharmacies and prescribers, as well as community education about Harm Reduction strategies (i.e., Narcan use, clean needles).
- Promote E-Prescribing for controlled substances and increase access to medications-assisted treatment.
- Deploy our field-based, integrated complex care management program, *Care1st at Home*, including:
  - Conduct comprehensive physical and environmental assessments to maximize independence and ability for members to live safely in their homes.
  - Address physical, behavioral, substance use, cognitive, and socioeconomic needs in partnership with physical and behavioral health providers through care management. Facilitate supported employment based on members' goals and desires.
  - Partner with physical and behavioral health providers to provide tailored education through joint care plans.
- Coordinate with the Integrated Health Homes established by the RBHA to not duplicate services.
- Develop members' capacity for self-management through integrated disease management programs.
- Implement and promote peer and family support programs.

Modifiable Risk Factors and Strategies Many Southern residents have lifestyle risk factors that contribute to the burden of disease and impact the well-being of the population. For many communities, obesity, tobacco use, teen pregnancy, and exposure to violence are major concerns. Six of the seven counties have adult obesity rates exceeding the state average, including Greenelee, where nearly 35.5% of adults are obese. Obesity in children two to five years of age is also a growing problem, especially in Santa Cruz and Yuma where nearly 16% of children are obese. The rate of adults who smoke is at or above the state average in Cochise, Greenelee, La Paz, and Santa Cruz; while Graham, Pima, and Yuma Counties are among the five Arizona counties with tobacco rates below the state average, the lowest of which is Yuma County. Teen births well-exceed state and national averages. Only Pima County has a teen birth rate below the state average. La Paz has the highest overall teen birth rate at 38/1,000 births as well as the highest birth rate among 18 to 19-year olds, at 177.8 per 1,000 births. Exposure to violence, both domestic violence and homicide, is prevalent in the region. Cochise County had the highest rate of domestic violence, 18%, while Greenelee had the highest homicide rate at 23.9 per 100,000. Our service delivery strategies include addressing modifiable risk factors through targeted behavior modification programs and community education, including:

- Engage members in targeted behavior modification programs.
  - Offer incentives for weight management and tobacco use; promote tobacco cessation coaching via ASHLine.
  - Promote good prenatal and post-partum care, and focused teen family planning through our maternity program which includes engaging members through social media and technology.
- Provide comprehensive education and communication.
  - Partner with schools, faith-based organizations and tribes to convey healthy living information. Provide community education on healthy behaviors and risk factors, such as early warning signs of suicide, violence prevention, and drug addiction, through mobile welcome rooms, health fairs, train-the-trainer events.
- Expand use of Arizona Health Start to help parents with children birth to five and pregnant women be successful, healthy and strong, and other CHWs to serve as member liaisons.
- Provide staff training on domestic violence, suicide prevention, and safety.

CARE1ST'S APPROACH TO ENGAGING AND COLLABORATING WITH TRIBES

Care1st takes an intensely community-focused collaborative approach to serving Arizona's American Indian population, respecting the sovereignty and autonomy of each tribal nation, building on the innovative programs already finding success in these communities, and collaborating with Tribes to make a positive impact on the lives of tribal members, whether enrolled in the American Indian Health Plan (AIHP) or Care1st. Through our experience currently serving American Indians in Arizona, we know that each tribal nation is unique in their readiness and interest in MOUs, contracting, and collaborating with health plans, and we have designed our approach to embrace and allow for this uniqueness while bringing forth best practice approaches for each tribal partner to consider. Our commitment to the AHCCCS Complete Care Program (ACC) is to play an active role in building a system of care that supports the needs of tribal communites and assists with the transition to a fully integrated healthcare model in collaboration with tribal nations, IHS, AHCCCS and other AHCCCS contractors including: RBHAs; TRBHAs; ALTCS and ACC health plans. Through this collaboration, we will align with AHCCCS' quality areas of focus discussed during the January 11, 2018 Tribal Consultation meeting, including: Understanding why American Indian members switch between AIHP and managed care, integrating AIHP by October 1, 2018, ensuring clarity of AHCCCS policies for tribal members, increasing care coordination activities and facilitating participation in the American Indian Medical Home (AIMH) program and improving data sharing. Care1st is committed and believes that it is critical for ACC managed care organizations to embrace and collaborate with AHCCCS and Tribes on these important areas of focus. Care1st staff working with our Tribal members and providers will be as knowledgable of the AIHP and AIMH as they are about Care1st and the managed care delivery system so that we can provide navigation, education, problem identification and problem solving services to the American Indian population.

DELIVERING SERVICES TO AMERICAN INDIAN MEMBERS

To better engage and collaborate with tribal partners, Care1st adopted WellCare's ***HealthyNations program***, which provides the infrastructure to support service delivery to our American Indian members. As part of this program, Care1st embarked on a series of "listening tours," visiting 10 tribal facilities and entities throughout Arizona including Navajo Area IHS, Navajo Nation Department of Health, Inter Tribal Council, Winslow Indian Healthcare Center, YAHC, Sells Indian Hospital, San Carlos Apache Healthcare, Phoenix Area IHS, Arizona Advisory Council on Indian Health Care and Native American Connections to gain a solid understanding and formulate plans to work with the tribes in ways that work for them. Through this outreach, we learned that transportation, provider recruitment and retention, language and lack of access to Internet and cellular services are key barriers to service delivery, and teen suicide, substance use and diabetes are among the top health disparities. Armed with this knowledge, we have developed culturally-sensitive strategies to engage and collaborate with tribes to build tribal provider and community partnerships, on and off the reservations, through dedicated staff and care coordination initiatives.

Engaging and Collaborating with Tribes through Dedicated Local Staff

Focused on supporting providers to deliver innovative and integrated care, our HealthyNations program uses dedicated local staff to promote cultural sensitivity and interconnectedness, cultivating tribal provider participation and community-based partnerships. To facilitate culturally-appropriate care, we hire staff from the tribal communities. We hire a multilingual workforce for functional units that have direct contact with American Indian members. Our translation services expands to all of Arizona's 22 Tribes and their requisite languages.

Figure 17-1: HealthyNations Org Chart

The Care1st HealthyNations Program is overseen by our Arizona-based Tribal Coordinator, Jearlyn Tsosie. Jearlyn will report directly to State President Scott Cummings and will be supported by our integrated operational and clinical resources. A Licensed Master Social Worker and member of the Navajo Nation, Jearlyn brings a depth of tribal and program knowledge that will enhance our ability to serve this culturally diverse population. Jearlyn has worked directly with 17 tribes over the

past 8 years, and understands that face-to-face communication is vital to building strong relationships with these communities. In her role as Tribal Coordinator, Jearlyn will:

- Complete and submit the Tribal Coordinator report
- Collaborate with IHS, Tribes, Tribal Organizations, Urban Indian Organizations (I/T/U) serving tribes in Care1st GSA(s) for care coordination including face-to-face meetings with children in residential facilities located off tribal lands as well as coordination with IHS, 638 Tribal Facilities, tribal, county and state service delivery and legal systems coordinate the involuntary commitment process for American Indian members
- Attend and participate in all Tribal Consultation Meetings and collaborate with AHCCCS to implement changes recommended through these meetings
- Collaborate with AHCCCS, IHS and 638 Tribal Facilities on member data sharing, improving communication through the utilization of HIE and EHR, embedded care managers to improve care coordination and health outcomes for American Indian members
- Provide customized education and training courses for licensed and unlicensed PH and BH personnel on and off tribal lands, assisting with development and implementation of in-service trainings for Indian health facilities, IHS, Tribally operated facility/program, and I/T/Us on utilization of services and BH resources available to tribal Communities and unique payment and credentialing rules
- Assist in collaborating with tribes to build and/or utilize existing technological infrastructure for mobile PH and BH, and, so that both telemedicine and telepsychiatry can occur on tribal lands which may include partnership with University of Arizona, Northern Arizona University, Arizona State University or other educational entities with community investment dollars that provide telemedicine

Jearlyn will be supported by the HealthyNations team, which includes a designated Tribal Provider Services representative (PSR), a clinical Tribal BH Coordinator, a Tribal Care Coordinator and a Quality Practice Advisor (QPA) as illustrated in Figure 17-1. This team will develop and guide our overall strategy in how we partner and deliver exceptional service for our American Indian members. We have learned through our national HealthyNations program that designated resources are critical to supporting collaboration with tribal partners. Our PSR understands that American Indian members can enroll and disenroll between the AIHP and an ACC plan throughout the year and assists with claims and eligibility questions unique to American Indian members. Similarly, Jearlyn has detailed understanding of which services are more easily attained on or off reservation, is knowledgeable of available IHS and 638 tribal facilities, and can quickly coordinate referrals to the right providers. Also, our QPA knows which care gaps are most common among tribal members, and can provide care gap reports to help tribal providers close them.

Figure 17-2: Framework for building relationships in Tribal Nations

Supporting Jearlyn in her efforts to develop collaborative relationships with IHS, Tribes, Tribal Organizations and I/T/U is Care1st's Tribal Consultant, April Tinhorn (Hualapai/Navajo/Chinese). April has over 21 years' experience working with tribal communities, through cultural strategic planning, digital storytelling, web development, and training. Since 2009 April has connected the Hualapai Tribe, Tohono O'odham Nation, San Carlos Apache Tribe, and Gila River Indian Community with others by creating official websites and outreach strategies and is a winner of the American Indian Chamber of Commerce of Arizona American Indian Business of the Year for 2017.

A designated tribal Provider Claims Educator (PCE) will support the HealthyNations team by educating tribal providers on claims submissions, billing questions, and available resources specific to each Tribe.

Promoting Cultural Sensitivity and Awareness in our Teams

We understand the importance of maintaining the existing healthcare structure in tribal communities, and will employ a face-to-face outreach strategy that supports current services and programs for each Tribe and enhances services without replacing them.

Because there is an interconnectivity between Arizona tribes, as well as a strong value placed on treating body, mind and spirit, the Tribal Coordinator will take a holistic outreach approach, connecting on an individual, family, community and tribal nation level to partner with the American Indian community.

All Care1st associates are trained in cultural competency and how it relates to members during New Hire Orientation and annually thereafter. Staff working in our call center, care management teams or similar roles with higher member interaction receive further training on cultural competency issues that influence their work with our members. Customer Service Representatives (CSRs) must meet a more stringent cultural competency requirement. Quality program auditors and supervisors review six to eight CSR calls each month for cultural competence and other key issues related to customer service. Each CSR receives a scorecard that is reviewed monthly with his or her supervisor.

Cultivating Provider and Community-Based Partnerships

In addition to the Tribal Coordinator outreach efforts, we had face-to-face engagement with traditional and non-traditional providers as well as the Tribal Advisory Council to understand the needs of American Indian members. We have built partnerships with community-based organizations that have American Indian representation. These organizations include: Native American Connections, Inter Tribal Council of Arizona, Phoenix Indian Center and Notah Begay III Foundation. These organizations will be represented on the Member Advisory Committee, will have input into our Quality Improvement program and will serve as valuable resources to the Tribal Coordinator.

Our community-based partnerships through our national ***CommUnity Impact model*** consists of over 190,000 social supports across the US. Care1st will implement this model within the tribal areas we serve. This web-based platform catalogues available social support services and helps providers and care coordinators connect members to community and faith based services like food banks, job support, housing, financial assistance and more. We staff a call line with associates that have lived experience to promote greater use of social supports. Providers may use this call line for assistance with any member they care for, whether they are Care1st members or not.

Engaging and Collaborating with Tribes through Care Coordination

Care1st supports care coordination activities that are handled by Arizona's Tribal Nations. While we offer care coordination and care management services through internal staff, we also prioritize the use of local available resources, including American Indian care coordination resources. We are working with Tribal Nations to understand coordination services available, including their use of CHRs, and how we may partner to fill gaps in care coordination for American Indian members. We have policies in place to ensure continuity of care for American Indian members who transition to AIHP and/or a TRBHA or RBHA for ongoing treatment.

Our integrated care model is designed for scalability and expansion to quickly integrate with pre-existing providers and referral patterns within the sovereignty of Tribal networks. Our care model includes physical, behavioral, pharmacy and social services, improving the health of American Indians in urban and rural communities both on and off reservations, focusing on health disparities specific to tribes including diabetes, substance use and generally higher prevalence of disease. Our BH Coordinator and Court Coordinator support the communication with tribal facilities and members who are involuntarily placed for treatment through court-ordered evaluation and court-ordered treatment process or become SMI, to ensure members are transitioned to the nearest facility on or off tribal lands.

Supporting Tribal Providers through Integration Efforts

Another key approach to addressing care coordination with Tribal providers is our focus on assisting I/T/Us to build their capacity to offer integrated care coordination for their patients. AHCCCS has recently implemented the American Indian Medical Home (AIMH) Program which will reimburse IHS/ Tribal 638 facilities for primary care management, diabetic education and care coordination for AIHP members designating the facility as their medical home. Additional reimbursement is provided if the facility participates in the state HIE. Through our discussions with tribal facilities including co-located BH provider Intermountain in Tohono O'Odham Nation, we learned there is strong interest in the AIMH program and facilities have initiated efforts to achieve PCMH recognition and connect to the HIE. Although the AIMH program applies to American Indian members who elect the AIHP rather than an MCO, we are committed to working with Tribal providers to become medical homes. Our capacity-building is structured around helping IHS and tribal 638 facilities become PCMHs and IHHs in alignment with AHCCCS' vision of a fully integrated healthcare system. We will help drive the transformation through MOUs for enrollment and data exchange, VBP arrangements, care coordination assistance and support the adoption of HIE systems.

IDENTIFYING, ESCALATING AND RESOLVING SERVICE DELIVERY BARRIERS ON AND OFF TRIBAL LANDS

Care1st understands the challenges faced by our American Indian members and providers, and has used this knowledge to improve the HealthyNations program which includes processes to identify, escalate and resolve the unique barriers to service delivery experienced by our American Indian members.

Identification of Barriers to Service Delivery

Listening Tours: Key staff, including our Tribal Coordinator, will visit community centers, Chapter Houses and I/T/Us in urban and rural areas throughout the state for monthly scheduled, well-publicized in-person meetings with American Indian members and provider staff to communicate health information and important health plan updates. Active and engaged listening, direct and meaningful contact are the hallmarks of this strategy. We will present information in storytelling and listening circles, and other culturally relevant methods. American Indian health educators will communicate important information on specific disease states impacting the community. Topics may include diabetes screening, prevention and nutrition, mental health awareness and conversations related to BH and treatment for drug addiction, and include other topics unique to each community. Care1st will use the information from listening tours to develop programs designed to improve access and remove barriers, including expanding our telemedicine capabilities, collaborating with Chapter Houses and developing virtual clinics, as discussed below.

Committee Feedback: Our Care1st member advisory committee (MAC) will include American Indian members, giving us further insight into the unique barriers this population faces. Our Care1st model will feature a centralized MAC that meets quarterly, with a regional MAC in each GSA in which we operate. Feedback from providers will be obtained through participation in various advisory councils, including but not limited to: Arizona Advisory Council on Indian Health Care, Native Americans for Community Action, Southwest Indigenous Women's Coalition, Navajo-Hopi Health Foundation, and AHCCCS Tribal Consultation meetings. Committee feedback will be analyzed using our data analytics system and subsequently presented as reports that will help us identify additional service delivery barriers.

Care Coordinator Feedback: Care1st care coordinators and field care managers hired from and serving tribal areas work directly with members on a daily basis, giving them insight into individual frustrations in receiving services. We are constantly soliciting feedback from our care coordinators to learn what barriers exist on an individual level.

Collaboration with Court Coordinator: The Court Coordinator role serves as Care1st's single point of contact for information and follow-up communication specific to Drug Court dispositions, Mental Health Court dispositions and Criminal Proceedings for eligible American Indian members. The role will also collaborate with our Justice System Liaison, tribal providers and the Arizona justice system to provide continuity of care and reach-in care coordination to identify and resolve service barriers for American Indian members.

Data Analysis: Care1st has a comprehensive data analytics system that looks at grievance, complaint and appeal trends, member satisfaction data, care gaps, and member appointment wait times that affect service delivery. Heat Mapping technology allows us to identify care gaps related to access by zip code, and our enhanced provider portal allows providers to quickly view each care gap and act to eliminateaddress them with members. Geo-access reports help us identify service gaps so we can proactively recruit providers where there is an individual or systemic need.

These efforts have helped us identify both individual and system-wide service delivery barriers, including lack of provider payment for care coordination, transportation issues, access to specialty and behavioral health services, language barriers, lack of internet and cellular service, and socio-economic issues.

Escalation and Resolution of Unique Barriers to Service Delivery

Our HealthyNations team is empowered to make rapid-cycle decisions that quickly escalate and resolve individual and system-wide barriers using our proven continuous quality improvement and care management processes.

Resolving Individual Barriers

The HealthyNations team reviews and resolves any individual barriers to service delivery to American Indian members identified through care coordinators, telephonic care management, in-community care management, court coordinator and committee feedback such as the availability of support services within the member's current living situation or access to specialty and behavioral health providers using our person-centered care management process.

We also have the ability to help discharge planning in person and on the phone. Our care management process begins with a health risk screening and integrated comprehensive assessment to act quickly on urgent or prioritized needs, followed by our industry-leading Identification and Stratification model to determine the level of support needed. From there, the HealthyNations team develops a service plan that uses a combination of support services and clinical interventions that take advantage of the full extent of available covered services to resolve service delivery barriers.

Resolving System-Wide Barriers

The HealthyNations team also reviews and resolves system-wide barriers that affect the American Indian population. Historical identification of these barriers through listening tours, committee feedback or data analyis include transportation, language barriers, and high rates of health disparities. To address these delivery gaps, we are adopting tribal drivers for our transportation teams, pop-up Welcome Rooms and telemedicine services as well as Performance Improvement Projects (PIPs).

Meeting Members Where They Are: We "meet members where they are" by partnering with local faith-based centers, non-profits, American Indian Chapter Houses and provider sites, senior/community centers and at school and community fairs. We set up educational kiosks in these locations and local retail stores, making it easy for American Indian members to access health information. We offer telemedicine and a comprehensive network of transportation options for tribal members on and off reservation, including the "friends and family" program which reimburses participants for mileage.

Our **Pop-Up Welcome Rooms** seek to leverage the strength of Chapter Houses and Community Centers as locations to support and enhance health education and community activities and also act as mobile screening sites. Multilingual print materials covering health education and screening topics are also available. These regional pop-ups travel from location to location within each GSA delivering preventive care including dental care, hearing tests and inoculations. Pop-ups also include computers, Internet connectivity and serve as "hot spots" where Internet connectivity may not be strong otherwise. We will initiate conversations with Frontier FiOS, HughesNet Internet, Comcast, CenturyLink, Cricket Wireless and Plateau to fund and support the best broadband, phone and HD video conference calls from an offsite location with members and providers for regular healthcare follow-up appointments. Using our suite of telemonitoring services allows us to stay in closer contact with members.

Telemedicine offers the benefit of expanding access to care for all members, including American Indian members living on or off tribal lands. Care1st supports AHCCCS' objective to expand the use of telemedicine and has made investments to educate members on telemedicine opportunities, train providers on telemedicine access and reimbursement policies, and support the State's efforts to examine opportunities to expand telemedicine across Arizona for all members. We will leverage partnerships with current providers offering telemedicine including Catalytic, Terros and Banner University Medical Center, to expand our telemedicine network.

Our **CommUnity Impact model** described previously includes programs such as Steps2Success which provides education/literacy, job preparation and college readiness to further support and empower members to overcome socioeconomic barriers that impact health and wellbeing.

Performance Improvement Projects (PIPs): Based on our Continuous Quality Improvement (CQI) Rapid Cycle Plan-Do-Study-Act (PDSA) methodology, our PIPs aim to resolve service delivery barriers through targeted interventions. For example, our Florida affiliate developed a Timeliness of Prenatal Visits PIP aimed at improving birth outcomes for our Medicaid population based on data analysis that showed a low occurrence of prenatal visits. PIP interventions included a variety of member and provider outreach and education that resulted in significant improvement in the timeliness of prenatal visits.

Provider Assistance: Our Provider Engagement Model offers providers support and training both in-person and telephonically. The use of MOUs and VBPs, when possible, helps to ease complexities of formal contracting for tribal providers, and our VBP arrangements such as Pay-For-Quality can offer tribal providers bonus payments for closing care gaps. Our enhanced provider portal enables both contracted and non-contracted providers to submit claims, even if just for reimbursement of care coordination, provides insight into member care gaps and allows the provider to look up member information. Our provider website offers information including PSR contacts, reference materials, blast fax communications, and e-prescribing reminders and resources.

18. AHCCCS CATEGORY AND SUBMISSION OF INFORMATION

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

AHCCCS CONTRACTOR CATEGORY INFORMATION

Care1st is a current AHCCCS Contractor or Affiliated Organization of a current AHCCCS Contractor (**Category 1**).

Care1st acknowledges that AHCCCS will review the most recent Acute Care Operational Review (CYE16) and no submission is required.

Oral Presentation pages 127-138. Please see Oral Presentation folder.

A.R.S. §35-393.01 Attestation

CARE 1ST
HEALTH PLAN ARIZONA
A WellCare Company

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.

Care1st Health Plan Arizona, Inc.
Company Name

2355 E Camelback Rd #300
Address

Phoenix AZ 85016
City State Zip

Signature of Person Authorized to Sign

Scott Cummings
Printed Name

President
Title

Affiliated Organization Attestation

CARE 1ST
HEALTH PLAN ARIZONA
A WellCare Company

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: Care1st Health Plan Arizona, Inc.

Affiliated Organization Name: _____

All Offerors must select one of the following:

____ 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.

X The Offeror is not bidding as an Affiliated Organization.

Care1st Health Plan Arizona, Inc.
Company Name

2355 E Camelback Rd #300
Address

Phoenix, AZ 85016
City State Zip

Signature of Person Authorized to Sign

Scott Cummings
Printed Name

President
Title

State Only Pregnancy Termination Agreement

State Only Pregnancy Termination Agreement

CARE 1ST HEALTH PLAN ARIZONA
A WellCare Company

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 Care1st Health Plan, Arizona Inc.(Offeror).

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

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

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

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

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

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

      1.1.2 Seriously impairing a bodily function of the pregnant member,

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

      1.1.4 Exacerbating a health problem of the pregnant member, or

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

   1.2 Conditions, Limitations and Exclusions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Care1st Health Plan Arizona, Inc.	
Offeror Name	Signature of Person Authorized to Sign
2355 E Camelback Rd #300	Scott Cummings
Address	Printed Name
Phoenix, AZ 85016	President
City State Zip	Title