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	4-5
Offeror's Signed Signature Page(s) for **each** Solicitation Amendment	Refer to Bidders' Library	6-7
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	9-11
Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	12-17
Executive Summary and Disclosure		
Executive Summary	RFP Section H, Instructions to Offerors	18-20
Moral or Religious Objections	RFP Section H, Instructions to Offerors	21
Narrative Submission Requirements		
1.	RFP Section I, Exhibit C	22-23
2.	RFP Section I, Exhibit C	24-30
3.	RFP Section I, Exhibit C	31-35
4.	RFP Section I, Exhibit C	36-42
5.	RFP Section I, Exhibit C	43-47
6.	RFP Section I, Exhibit C	48-52
7.	RFP Section I, Exhibit C	53-59
8.	RFP Section I, Exhibit C	60-64
9.	RFP Section I, Exhibit C	65-69
10.	RFP Section I, Exhibit C	70-74
11.	RFP Section I, Exhibit C	75-79
12.	RFP Section I, Exhibit C	80-84
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	85-89
14.	RFP Section I, Exhibit C	90-94
15.	RFP Section I, Exhibit C	95-99
16. A (North) *If applicable*	RFP Section I, Exhibit C	N/A
16. B (South) *If applicable*	RFP Section I, Exhibit C	100-102
17.	RFP Section I, Exhibit C	103-107
18.	RFP Section I, Exhibit C	108
Oral Presentations		
Names and Titles of Participating Individuals	RFP Section H, Instructions to Offerors	109
Resumes of Participating Individuals	RFP Section H, Instructions to Offerors	110-127
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit D Refer to Bidders' Library	128
Affiliated Organization Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	129
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	130-132

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

BID CHOICE FORM - PART 1

Banner – University Family Care Plan
OFFEROR'S NAME

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

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

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

Kathleen Oestreich
Authorized Signature

January 24, 2018
Date

Kathleen Oestreich
Print Name

Chief Executive Officer
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.**

Banner – University Family Care Plan
OFFEROR'S NAME

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

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

Kathleen Oestreich
Authorized Signature

January 24, 2018
Date

Kathleen Oestreich
Print Name

Chief Executive Officer
Title

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

SECTION A: SOLICITATION AND OFFER PAGE

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

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

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

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

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

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

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

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

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

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

Late Proposals shall not be considered.

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

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

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

OFFER

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

NPI No. (*optional*) 46-3766901	For clarification of this offer, contact: Kathleen Oestreich
Federal Employer Identification No.: N/A	Name: Chief Executive Officer
Dun and Bradstreet (DUN) No. Kathleen.Oestreich@bannerhealth.com	Title: 520-874-5531
Email Address: Banner - University Family Care Plan	Phone: Kathleen Oestreich
Company Name: 2701 E. Elvira Road	Signature of Person Authorized to Sign Offer: Kathleen Oestreich
Address: Tucson Arizona 85756	Printed Name: Chief Executive Officer
City State Zip	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: Kathleen Oestreich	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 24, 2018	DATE:

AHCCCS
Arizona Health Care Cost Containment System

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

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

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

This Solicitation is amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Kathleen Oestreich	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 24, 2018	DATE:

Capitation - Non-Benefit Costs Bid Submission

Banner – University Family Care Plan agrees to accept the actuarially sound capitation rates computed prior to October 1, 2018. Banner – University Family Care Plan understands that AHCCCS' actuaries will develop components of the capitation rates including the medical services component, reinsurance offset, and premium tax. These components will not be bid. The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the definition given in 42 CFR Part 438. AHCCCS actuaries will follow all applicable Actuarial Standards of Practice in the development and documentation of the rates, and will follow generally accepted actuarial principles and practices.

Banner – University Family Care Plan
Company Name

2701 E. Elvira Road
Address

Tucson Arizona 85756
City State Zip

Signature of Person Authorized to Sign

Kathleen Oestreich
Printed Name

Chief Executive Officer
Title

Central GSA

Member Months to Use for Bidding	3,170,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 19.61
% of Admin PMPM that is Fixed	23.93%
% of Admin PMPM that is Variable	76.07%
Detail Admin Break Out	
Compensation	$ 13.05
Occupancy	$ 0.09
Depreciation	$ 0.24
Care Management/Care Coordination	$ 0.35
Professional and Outside Services	$ 2.18
Office Supplies and Equipment	$ 0.13
Travel	$ 0.06
Repair and Maintenance	$ 1.58
Bank Service Charge	$ 0.02
Insurance	$ 0.01
Marketing	$ 0.05
Interest	$ 0.11
Other Administrative	$ 1.74
Total Admin PMPM	$ 19.61

Underwriting Gain Component

	Year 1	Year 2	Year 3
Underwriting Gain	0.74%	0.74%	0.74%

South GSA

Member Months to Use for Bidding	1,630,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 23.41
% of Admin PMPM that is Fixed	41.26%
% of Admin PMPM that is Variable	58.74%
Detail Admin Break Out	
Compensation	$ 14.03
Occupancy	$ 0.14
Depreciation	$ 0.35
Care Management/Care Coordination	$ 0.49
Professional and Outside Services	$ 3.13
Office Supplies and Equipment	$ 0.18
Travel	$ 0.09
Repair and Maintenance	$ 2.25
Bank Service Charge	$ 0.03
Insurance	$ 0.01
Marketing	$ 0.07
Interest	$ 0.16
Other Administrative	$ 2.48
Total Admin PMPM	$ 23.41

Underwriting Gain Component

	Year 1	Year 2	Year 3
Underwriting Gain	0.94%	0.94%	0.94%

Central and South GSAs

Member Months to Use for Bidding	4,800,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 18.02
% of Admin PMPM that is Fixed	17.20%
% of Admin PMPM that is Variable	82.80%
Detail Admin Break Out	
Compensation	$ 9.76
Occupancy	$ 0.12
Depreciation	$ 0.31
Care Management/Care Coordination	$ 0.43
Professional and Outside Services	$ 2.75
Office Supplies and Equipment	$ 0.16
Travel	$ 0.08
Repair and Maintenance	$ 1.99
Bank Service Charge	$ 0.02
Insurance	$ 0.01
Marketing	$ 0.06
Interest	$ 0.14
Other Administrative	$ 2.19
Total Admin PMPM	$ 18.02

Underwriting Gain Component

	Year 1	Year 2	Year 3
Underwriting Gain	0.84%	0.84%	0.84%

5415 E. High Street
Suite 275
Phoenix, AZ 85054
USA

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Fax +1 480 348 9021

milliman.com

January 23, 2018

Actuarial Certification
Banner – University Family Care
AHCCCS Complete Care Bids
October 1, 2018 – September 30, 2019

I, Thomas D. Snook, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its qualification standards for rendering this opinion. I have been retained by Banner – University Family Care (BUFC) to provide a certification that the non-benefit costs bid submissions for Complete Care Services under the Arizona Health Care Cost Containment System (AHCCCS) meet the requirements of 42 CFR 438.5 (e).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Complete Care Services Request for Proposal (including amendments through the date of this certification) issued by AHCCCS. This certification may not be appropriate for other purposes.

The non-benefit costs to which this certification applies are attached in AHCCCS's required Non-Benefit Costs Bid Submission workbook and shown in Attachments 1-3. The administrative non-benefit costs apply to the period October 1, 2018 through September 30, 2019. The underwriting gain component applies to the period October 1, 2018 through September 30, 2021.

It is my opinion that the attached non-benefit cost components are adequate to fund administrative expenses and underwriting gain for BUFC during the time period for which they are intended, for the Complete Care program as outlined in the RFP. If the Complete Care program were to change materially from that described in the RFP, the attached rates may not be adequate. In addition, I am relying on AHCCCS's statement that the medical cost component of the capitation rate will be "actuarially sound" as defined in the RFP and its amendments.

Development of the Non-Benefit Costs

In determining the reasonableness of the administrative portion of the non-benefit cost bids, I relied on BUFC's budget, BUFC's internal claims data, and the Supplemental data provided by AHCCCS. I conducted several reasonableness tests:

1) I compared the projected administrative cost budget for the bid to the plan's current administrative costs. I also made allowance for additional administrative costs to be incurred

under the Complete Care contract that are not currently incurred under the existing Acute Care contract. These additional administrative costs largely relate to services currently provided by RBHAs.

2) I also compared these anticipated administrative costs to projected medical and behavioral claim costs levels under the Complete Care contract. In doing so I used BUFC's claim cost levels and claim cost levels provided in the AHCCCS Supplemental data. I projected claims cost (using both sources), accounting for programmatic changes, efficiency gains, risk differences, and overall trend.

3) As an additional test of reasonableness I compared BUFCs historical and projected administrative costs to those in audited financial statements of the other contractors in Arizona. This comparison included both the current Acute Care and RBHA contractors.

After examining the budget and conducting the tests described above, I have found BUFC's projected administrative costs (shown in Attachments 1-3) to be reasonable.

Underwriting Gain

AHCCCS defined the acceptable range of underwriting gain as 0-1% in the Request for Proposals (RFP). The underwriting gain amounts bid by BUFC are within this range, and were determined to be reasonable and achievable in the judgment of senior BUFC leadership. We have completed sufficient scenario testing using a wide range of assumptions and have found the underwriting gain bid amounts (shown in Attachments 1-3) to be reasonable.

In arriving at this determination, we considered:

1. Historical volatility in AHCCCS acute care claim cost levels;
2. The relative uncertainty of the cost implications of transitioning behavioral health services;
3. The additional uncertainty inherent in accepting a contract in which the medical component of the capitation rate is not yet known; and
4. The mitigating effects of the risk corridor structure present under this contract.

Capitalization Requirement

AHCCCS has included a requirement in the data supplement that "The actuarial certification must include a statement and description of why the Offeror has no concern with meeting the capitalization requirements with the UW gain bid".

I have confirmed that BUFC has no concern meeting the capitalization requirements with the UW gain bid for the following reasons: 1) BUFC's parent company, Banner Health, holds a sufficient amount of capital. Banner reported $7.6 billion of revenue and net assets of over $5 billion at the end of 2016. 2) Banner

Health has indicated to me that they are committed to adequately capitalizing this program throughout the life of the contract.

Caveats

My determination is based on a review of the claim experience and other information provided by AHCCCS; experience data; budget information provided by BUFC; and my professional judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and BUFC. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my analysis.

The administrative costs and underwriting gains in the attached bid submission sheets are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of BUFC and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience deviates from expected experience.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Thomas D. Snook, FSA, MAAA
January 23, 2018

Actuarial Certification
Banner – University Family Care
AHCCCS Complete Care Bids
Attachment 1

Central and South GSAs			
Member Months to Use for Bidding	4,800,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 18.02		
% of Admin PMPM that is Fixed	17.20%		
% of Admin PMPM that is Variable	82.80%		
Detail Admin Break Out			
Compensation	$ 9.76		
Occupancy	$ 0.12		
Depreciation	$ 0.31		
Care Management/Care Coordination	$ 0.43		
Professional and Outside Services	$ 2.75		
Office Supplies and Equipment	$ 0.16		
Travel	$ 0.08		
Repair and Maintenance	$ 1.99		
Bank Service Charge	$ 0.02		
Insurance	$ 0.01		
Marketing	$ 0.06		
Interest	$ 0.14		
Other Administrative	$ 2.19		
Total Admin PMPM	$ 18.02		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.84%	0.84%	0.84%

Actuarial Certification
Banner – University Family Care
AHCCCS Complete Care Bids
Attachment 2

Central GSA			
Member Months to Use for Bidding	3,170,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 19.61		
% of Admin PMPM that is Fixed	23.93%		
% of Admin PMPM that is Variable	76.07%		
Detail Admin Break Out			
Compensation	$ 13.05		
Occupancy	$ 0.09		
Depreciation	$ 0.24		
Care Management/Care Coordination	$ 0.35		
Professional and Outside Services	$ 2.18		
Office Supplies and Equipment	$ 0.13		
Travel	$ 0.06		
Repair and Maintenance	$ 1.58		
Bank Service Charge	$ 0.02		
Insurance	$ 0.01		
Marketing	$ 0.05		
Interest	$ 0.11		
Other Administrative	$ 1.74		
Total Admin PMPM	$ 19.61		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.74%	0.74%	0.74%

Actuarial Certification
Banner – University Family Care
AHCCCS Complete Care Bids
Attachment 3

South GSA			
Member Months to Use for Bidding	1,630,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 23.41		
% of Admin PMPM that is Fixed	41.26%		
% of Admin PMPM that is Variable	58.74%		
Detail Admin Break Out			
Compensation	$ 14.03		
Occupancy	$ 0.14		
Depreciation	$ 0.35		
Care Management/Care Coordination	$ 0.49		
Professional and Outside Services	$ 3.13		
Office Supplies and Equipment	$ 0.18		
Travel	$ 0.09		
Repair and Maintenance	$ 2.25		
Bank Service Charge	$ 0.03		
Insurance	$ 0.01		
Marketing	$ 0.07		
Interest	$ 0.16		
Other Administrative	$ 2.48		
Total Admin PMPM	$ 23.41		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.94%	0.94%	0.94%

EXECUTIVE SUMMARY

Banner-University Health Plan (BUHP) is a managed care plan and part of Banner Health (Banner). **On a mission to make health care easier so life can be better**, the greater Banner organization embraced BUHP's member-centric culture and member persona "Ana," launching a corporate-wide customer-obsessed culture and adopting the persona "Sophia;" a busy working mom caring for her family and aging parents. Ana and Sophia are personas our employees consider with each interaction. They are part of our DNA and collaborative culture to overcome care barriers and address social determinant inequities. We have vast Medicaid managed care expertise and fully support AHCCCS' transformative Complete Care program. We understand the AHCCCS Complete Care (ACC) requirements, and with our high-touch and value-added approach, BUHP stands ready to serve ACC members and offer integrated care for all.

Consistent with our culture of quality, BUHP understands integrating care means significant, system-wide transformation. In preparation for the ACC RFP, BUHP engaged community leaders from an array of local and national expertise to provide insight on topics pertaining to *integrated care, timely access, technology, payment transformation, children's system of care, opioids and special populations, such as tribal, veterans and justice members.* This was done to gain insight, guidance and to truly listen to their needs. These listening sessions allowed for open communication to understand what was working and what needed to change – with a shared focus on whole-person care which balances the emotional, physical, cultural, environmental, spiritual, occupational, intellectual, and financial needs of the member.

OVERVIEW OF THE ORGANIZATION AND RELEVANT EXPERIENCE

As the largest employer and Medicaid provider in Arizona, Banner has more than 30 years of experience in this state's health care and labor markets. As an Arizona non-profit anchor institution, we support local economic growth by positively impacting employment, revenue gathering and spending patterns. As a collaborator and innovator in health care delivery, Banner supports the Arizona safety net in significant ways providing stability and ongoing excellence in care and outcomes, with the Banner Foundation investing contributions locally to support Arizonans. Our workforce development efforts attract highly skilled individuals who contribute to our economy. We are a large purchaser of local goods and services and have an extensive fixed-asset footprint and commitment to Arizona health care infrastructure improvements. Our $500 M community reinvestment of Banner University Medical Centers in Phoenix and Tucson ensures optimal infrastructure into the future. Through a 30-year affiliation agreement, we partner with another anchor institution, the University of Arizona (UA), and together we act as centers of learning by supporting research and education; through Graduate Medical Education, with Banner sites serving as training grounds for residents, nursing students, peer support specialists, and other health care professionals, many which remain in Arizona post-graduation.

As a Banner division, BUHP is the only locally owned plan focused exclusively on Arizona and is a recognized Medicaid managed care leader. We have pursued transformation through innovation, reinvention and continuous learning. In 1985, we began as a Medicaid contractor and now have a history of successful operations in Medicaid, Medicare and integrated behavioral health (BH). BUHP owns and operates: University Family Care (UFC), Banner-University Family Care (BUFC) and University Care Advantage (UCA). We previously owned or managed University Health Care Group, University Healthcare Marketplace, Maricopa Health Plan (MHP) and Maricopa Care Advantage. Committed to serving vulnerable populations, we are the only Arizona plan that is a member of the *Association for Community Affiliated Plans*, a national trade association for not-for-profit safety net health plans. BUHP is also a member of the AZ Health Care Association, the AZ Association of Health Plans, Health Current's Leadership Council and Board, ASU College of Health Innovations Advisory Committee, AZ Alliance for Community Health Centers and AZ School-Based Health Care Council.

We share a passion with AHCCCS to serve Arizona's most vulnerable citizens in a manner that honors each member's unique needs, strengths, and goals. BUHP conducts ongoing member satisfaction surveys to continue meeting our member's needs, and we were an early adopter of the net promoter score (NPS) methodology. Our most recent NPS score (+63) is well above the national range for excellence (+50) and comparable to national companies such as USAA. Thus, our member-centric approach aligns with the values and guiding principles outlined by AHCCCS. Members will benefit from our experience, creativity, adaptability and agility needed to exceed member, provider and regulator expectations. We actively partner with AHCCCS' on its integration journey and have long embraced the provision of whole-person care. Since the inception of our DSNP plan in 2008, we have provided integrated Medicaid and Medicare services for all our DSNP members. During the 2014 greater Arizona transition, BUHP entered into an innovative partnership with Cenpatico of Arizona to form Cenpatico Integrated Care (CI), serving more than 13,000 members with

serious mental illnesses (SMI). As an acute contractor, in 2015, we successfully incorporated BH services for GMH/SA dual members. In 2017, BUHP was awarded the ALTCS Contract and is providing integrated physical health (PH) and BH care, including members with SMI for the E/PD population. Through all paths of integration, our disciplined focus has led to a history of successful member transitions. We had minimal member disruptions during both the greater Arizona and GHM/SA dual transition. During our MHP transition, AHCCCS lauded our member-centric approach that led to a seamless transition. Moreover, we recently transitioned more than 6,100 ALTCS members, which included onboarding more than 200 new employees to support the increase of membership with minimal member and provider complaints.

HIGH-LEVEL DESCRIPTIONS OF PROPOSED APPROACH TO MEETING CONTRACT REQUIREMENTS

BUHP is prepared to complete the full circle of integration by exceeding the ACC Contract requirements. As we continue to serve our members, we will build on our foundation and assure readiness. This will include employing seasoned key staff in areas such as children's and adult health care, member advocacy, tribal system, justice system and employment/vocational programs. In addition, BUHP has a robust provider network throughout Arizona that can already serve all ACC members, but we continually evolve to assure a fully array of integrated care providers. We have an extensive BH network for our GMH/SA dual population and are contracted with all MSICs in Arizona. Similar to past successful implementations, we will use multiple means to build provider relationships and thoroughly orient new providers to BUHP policies and processes. As responsible fiscal stewards of federal and state dollars, we have aligned more than 50% of our payments to a VBP agreement and are driven to achieve an 80% VBP goal by 2020. Furthermore, BUHP is recognized by the CMS Learning Action Network as a market leader and is the only Medicaid plan in the nation participating in a groundbreaking CMS Centers of Excellence Oncology Care Model pilot with the UA Cancer Center.

BUHP's Care Management program meets contract requirements and is overseen by physicians with more than 100 years of combined experience in urban and rural Arizona and expertise in PH/BH care needs of adults and children. Our clinical and care management teams are trained in all contract requirements, and we are well prepared for clinical contract additions, which include but are not limited to: monitoring and implementing interventions of members associated with HN/HC, outreach and care coordination for victims of sex trafficking, continued collaboration with the justice system, and collaboration with tribal nations and providers. BUHP also has an internal 24/7 nurse triage line ready to support members and providers while helping members navigate to the appropriate level of care.

BUHP's IT applications and infrastructure successfully support member whole-person care. Our clinical platform is integrated and as such supports all care, disease, utilization, quality of care, and referral management processes. Our Healthcare Analytics and Reporting Team (HART) uses modern technologies to drive predictive analytics and machine learning to support our outcome-based population health platform. The HART team also collaborates with the UA Center for Population Science and Discovery to apply best practices in data science. Additionally, BUHP's current provider online resources will be enhanced to not only improve access to tools for our existing providers, but allow for a streamlined integration for new providers.

HOW BUHP WILL BRING ADDED VALUE AS A COMPLETE CARE CONTRACTOR

BUHP will continue to challenge the status quo by identifying opportunities, creating value and introducing new ideas. We will implement Complete Care initiatives to reduce fragmentation, integrate delivery systems, realize positive outcomes and promote future sustainability. Additionally, as part of Banner's ongoing commitment to continuous improvement, 5 learning laboratory called "Imaginariums" work to identify innovation opportunities. The Imaginariums create a unique incubator where reinvention, testing and validation of new ideas can occur for the benefit of Ana and Sophia by focusing on the consumer experience, Medicare Advantage, affordability, technology and leadership.

To promote easy access to culturally competent care, BUHP is improving care coordination by aligning community, health plan and PH/BH health services. Our urban and rural *Neighborhood Networks* will organize providers across all provider types in a shared Neighborhood that aligns to community resources and provides members a full continuum of care. Neighborhoods will share incentives, work collaboratively through Neighborhood Advisory Councils and have a voice on the BUHP Board of Directors. Community stakeholders, members and families will have a voice on the councils as well, and will be empowered to solve problems unique to their Neighborhoods at a local level. BUHP has also entered a unique *partnership with Equality Health*. In addition to gaining access to their integrated, value-based care network, they are *exclusively contracting* with BUHP to offer our providers expertise on how to enhance their operations so they

can enter into and succeed with VBP contracts. Additionally, they have agreed to act as a VBP incubator, and we will use their IPA structure to test new contract models, providing BUHP with a platform for innovation and thought.

Listening to community stakeholders, we recognized the current structure and processes to initiate care often creates delays and reduced understanding of the member's condition and care plan. BUHP is introducing the *Banner Navigation Accelerator (BNA)*, an innovative technology response to problems cited. The BNA enables providers and community agencies to identify BUHP members; perform online algorithm-supported intake assessments; and access the framework for a single view care plan and linkage to our network, thus referring members to the most appropriate provider in their Neighborhood. BNA also connects users to Health Current, BUHP health plan data and community resource directories. Introducing such technology complements our long history of member engagement, and we will continue to utilize well-proven methods, such as member outreach through our Warm Health IVR, person-to-person contacts, first call resolution and enhanced utilization of social media for education and engagement. This variety lets members choose the most comfortable and supportive modality.

Our long-standing affiliation with UA will also result in various value-adds. An example of such value-add is our *Healthy Together Care Partnership (HTCP)*, an interdisciplinary home-based program established in 2013, serving complex members with co-morbid PH/BH conditions. In preparation for the ACC RFP, we partnered with the UA Family and Community Medicine in Tucson on 2 innovative pilots. First, by placing a priority on training medical professionals and expanding the scope of family physicians, we partnered with UA and Banner's Family Medicine Clinic to improve outcomes and decrease fragmentation. This TIP-awarded program, includes a collaborative care model that will test the current standards for peer and family support specialist certification and develop a standardized approach for utilizing proven peer and family support services. Secondly, BUHP partnered with Camp Wellness and sponsored 9-week programs for our members with a dual diagnosis of diabetes and depression. This pilot resulted in significantly reduced PHQ-9 depression scores and improvements in blood sugar, body weight and quality of life scores. We will continue to support these programs and expand throughout the awarded Geographic Service Area(s) (GSAs).

HOW BUHP WILL MEET REQUIREMENTS SPECIFIED IN SECTION D, MEDICARE REQUIREMENTS

BUHP has an integrated Medicaid/Medicare infrastructure and the expertise to meet all requirements. UCA contracts with CMS to operate a Medicare Advantage Part D Plan (MAPD), DSNP. UCA is dedicated to serving DSNP members in all counties in the contracted GSAs, and is an AHCCCS-certified risk-bearing entity. UCA's application will be submitted by February 14, 2018, to include a DSNP subset matching any ACC award. UCA is committed to complying with AHCCCS and CMS requirements:

- ACOM policy 318 – UCA has 50% of DSNP VBP arrangements in place and will continue to implement VBP contracts.
- UCA's policies align with AHCCCS policies designed to improve dual eligible care coordination and timely information sharing, including a DSNP care coordinator.
- BUHP is approved and currently participating in the seamless enrollment program. This allows BUHP to enroll members who are newly qualified Medicare beneficiaries into our DSNP, increasing alignment for our members.
- We maintain in-depth Medicare knowledge through ongoing review of laws, rules, policies, contracts and guidance.
- Provider contracts contain provisions that prohibit Medicare cost-sharing on UCA members for services covered by both programs. Our contracts ensure providers comply with AHCCCS billing requirements.
- We accurately verify Medicare and Medicaid eligibility of potential and enrolled members via access to AHCCCS and Medicare systems and portals as well as from data transmitted through AHCCCS daily files. BUHP submits Medicare encounter data as AHCCCS requests and has processes in place to support this.
- We actively participate in all meetings and other activities, which pertain to member transitions due to DSNP contract terminations. BUHP will notify AHCCCS in case of significant changes to the contract with CMS for non-renewals, service area changes, terminations, deficiencies, notices of intent to deny and novation agreements.
- BUHP will submit CMS warning letters or corrective action plans within 10 business days of receipt. BUHP will actively participate in new AHCCCS requirements that improve dual eligible alignment.

As a long-standing AHCCCS Contractor, BUHP understands the importance of excellence and compliance across all operations. BUHP also recognizes the ACC Contract elevates the requirements of health plan organizations. Through the consistent application of our member and provider-centric philosophy, BUHP is redefining the health care model to drive revolutionary solutions and we are ready to partner with AHCCCS through this transformation.

Moral or Religious Objections
The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

Banner - University Family Care Plan does not have any Moral or Religious Objections.

1. THE OFFEROR MUST IDENTIFY NO MORE THAN TWO CONTRACTS, IN ADDITION TO ARIZONA MEDICAID…

Banner-University Health Plans (BUHP), a subsidiary company of Banner Health (Banner), has in-depth experience managing Medicaid contracts similar to the AHCCCS Complete Care (ACC) program. BUHP will utilize our fully integrated operations to provide members with a complete care approach. Bringing more than 30 years of AHCCCS experience, we care for Medicaid and Medicare Advantage members who are enrolled in University Care Advantage (UCA), our Dual Eligible Special Needs Plan (DSNP). We are engaged with the University of Arizona (UA) through a long-term affiliation agreement and work together on multiple highly innovative BUHP initiatives. As a provider-based plan, BUHP also has experience through Banner Health Network's (BHN's) Accountable Care Organization (ACO). BHN was one of few ACOs in the nation to achieve sustained success during the 5-year Pioneer ACO contract with the Centers for Medicare and Medicaid Services (CMS). At BUHP, we develop processes, tools and programs that apply across our entire organization, regardless of benefit plan or contract type. And through continuous learning practices, we implement and refine processes and technologies for applicability and flexibility to support any contract, including the ACC program. In the sections below, we identify three contracts referenced in our response: our Arizona Medicaid contracts, our UCA DSNP contract and our BHN Pioneer ACO contract.

ARIZONA MEDICAID (AHCCCS) CONTRACTS

Since 1985, BUHP has participated in the AHCCCS program as a direct contractor, a joint owner and a health plan administrator. Our AHCCCS experience has been gained through our acute care plan, University Family Care (UFC); our long-term care plan, Banner-University Family Care (B-UFC); our role as Third-Party Administrator (TPA) for Maricopa Health Plan (MHP); and our Regional Behavioral Health Authority (RBHA), Cenpatico Integrated Care, LLC (CI).

University Family Care/Banner-University Family Care/Maricopa Health Plan: As the only locally owned and operated health plan focused exclusively on rural and urban Arizona, BUHP has a presence in all complete care GSAs. Through UFC, our acute care plan for more than 30 years, we manage the delivery of culturally competent services for more than 134,000 members in 10 Arizona counties. B-UFC, our long-term care ALTCS E/PD plan is also in 10 Arizona counties caring for more than 6,100 members. Our current acute care contract went into effect October 1, 2013, and our ALTCS E/PD contract went into effect October 1, 2017. Beginning in 2005 and until its transition/sale in January 2017, BUHP also operated MHP, serving more than 85,000 acute care members in Maricopa County. As MHP's TPA, we provided all turnkey management functions and performed all health plan operations.

Behavioral Health/Physical Health (BH/PH) Integration Status: We have successfully managed AHCCCS plans including the provision of BH benefits, and we have effectively managed the delivery of integrated BH/PH benefits for many years. In 2015, UFC successfully incorporated BH covered benefits for dual eligible General Mental Health/Substance Abuse (GMH/SA dual) members, developing all needed processes and policies to meet regulatory requirements. We seamlessly transitioned 1,661 UFC and MHP GMH/SA dual members who were receiving BH services through their RBHA without disruption. We now serve 10,488 GMH/SA dual members and offer them an integrated network, serving members by well-trained employees who operate in our fully integrated BH/PH infrastructure. In 2017, B-UFC began providing integrated BH/PH benefits to ALTCS members. Guided by the *9 Guiding Principles for Recovery-Oriented Adult BH Services and Systems* and the *12 Principles for Children's System of Care*, seasoned leaders integrate BH into every level of our operations. Our Medical Director, Sandra Stein, MD, is dually certified in general and child/adolescent psychiatry with more than 20 years of AHCCCS/RBHA experience; and our BH Director, Kristin Frounfelker, has more than 20 years of AHCCCS/RBHA experience. They lead a team of BH professionals with 100 years of combined experience. Additionally, Nancy Wexler, our Director of Innovation and Collaborative Care, holds a doctorate of integrated behavioral health and is associate faculty for Arizona State University's DBH Management program. Our successful BH/PH integration is supported by care coordination programs to reduce fragmentation of care. BUHP also continues to collaborate with all RBHAs to provide seamless transitions for members moving from a RBHA to our plans.

Cenpatico Integrated Care, (CI) LLC: In 2014, BUHP entered into an innovative partnership with Centene to form the CI RBHA. CI has served AHCCCS members for 2 years, including 13,395 members with serious mental illness (SMI). CI's geographic coverage extends to both central and south GSAs, which includes the following 8 Arizona counties: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma and Pinal. Our current contract went into effect on October 1, 2015, and a key component of our partnership includes allowing CI to access our DSNP license, UCA, for optimal alignment.

BH/PH integration status: As an AHCCCS RBHA, members with SMI obtain fully integrated BH/PH services through CI, and via our unique RBHA/DSNP arrangement, we work collaboratively to coordinate benefits between their Medicaid

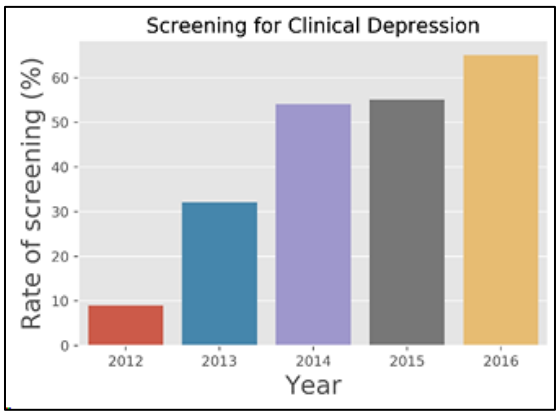
and Medicare benefit programs. BUHP employees received cross-entity training to respond to external inquiries as if they were contacting one entity. CI/UCA members are a vulnerable sub-group due to their SMI determination and prevalence of co-occurring substance use disorder. Our wrap-around care management services and interventions targeting this sub-group have successfully improved their whole-person health and reduced disparities as evidenced by their performance measure outcomes: current adult access to care rate is 93.24%, and A1c test rate is 85.82%.

UNIVERSITY CARE ADVANTAGE

UCA is BUHP's DSNP and has been serving Arizona DSNP members for more than 8 years. UCA is in 11 Arizona counties, caring for more than 8,800 members, with 61% residing in rural counties, including frontier areas. UCA currently contracts with CMS as a DSNP Medicare Advantage Part D (MAPD) plan. UCA received its Certificate of Authority by AHCCCS to operate a DSNP and is contracted with AHCCCS to coordinate care for members who are also eligible for Medicare. UCA has been caring for DSNP beneficiaries since 2008 in Pima and Maricopa counties; expanded the service area to include Santa Cruz, Cochise and Pinal counties on January 1, 2011, and again expanded the service area to include Gila, Yuma, La Paz, Graham, Greenlee and Yavapai counties on January 1, 2015. We currently provide DSNP services in all ACC GSAs. Additionally, UCA has always received the maximum 3-year approval for our Model of Care.
BH/PH integration status: In 2008, BUHP integrated all required processes from CMS into our acute operations as we launched UCA. Since 2014, via our unique RBHA/DSNP arrangement with CI, we have collaborated to help members with SMI experience seamless care transitions and coordination of benefits between their Medicaid and Medicare benefit programs. BUHP has operated our integrated BH/PH Care Management program since 2015. We successfully deliver integrated care management to our DSNP members, of which a high percentage have multiple co-morbid BH/PH disorders. This requires complex care coordination, as well as a focus on medication reconciliation. UCA contracts with Integrated Health Homes, Patient-Centered Medical Homes and also deploys our innovative Healthy Together Care Partnership (HTCP) home and community-based care team to serve this membership. Currently, more than 600 high-risk UCA members are part of the program and are receiving care by a team of nurses, behavioral and community health specialists, pharmacists, nurse practitioners and physicians. Members benefit from the use of collaborative high-touch integrated PH/BH care, which has demonstrated improved quality and utilization patterns.

BANNER HEALTH NETWORK'S PIONEER ACCOUNTABLE CARE ORGANIZATION CONTRACT

BHN is Banner's Accountable Care Organization (ACO) that comprises 13 Banner hospitals, a children's medical center, ambulatory and urgent care clinics, and more than 8,000 Banner-employed and independent Arizona providers. Based in Maricopa County and planning to expand into Pima County in 2018, BHN manages full-risk LAN category 4A and 4B APM contracts with multiple payers. From 2011 through December 31, 2016, BHN was chosen by the CMS Innovation Center to participate in the Pioneer ACO program and annually served more than 50,000 attributed members. While CMS began with 32 inaugural agreements, by the 5th year, only 8 remained. BHN was 1 of 3 Pioneer ACOs that realized savings during all 5 years and was the top earner 3 years in a row. BHN also prioritized quality, achieving high-quality scores. With the conclusion of the Pioneer ACO contract, BHN formed the Neighborhood Physician Alliance in 2016 and continues its collaboration with CMS, having been accepted into Track 3 of the Medicare Shared Savings Program (MSSP). BHN is also participating in the CMS Oncology Care Model and the CMS End Stage Care Organization Model.
BH/PH integration status: BHN's ACO manages the integrated delivery of PH and BH services to Medicare Advantage members and is acutely aware that BH conditions are prevalent in this complex population. CMS used more than 30 quality measures and other criteria to reward ACOs for providing beneficiaries with an improved patient experience, better health outcomes and reduced growth in Medicare expenditures. Through the delivery of collaborative, highly coordinated and integrated patient care, BHN realized significant improvement in many measures including two BH-related quality measures between 2012 and 2016: 1) *Screening for Clinical Depression and Follow-up Plan* improved the screening of members at risk of clinical depression from 9% in 2012 to 65% in 2016, which made our ACO eligible for improvement bonus points for 2016; and 2) The *Depression remission at 12 months of treatment* metric had a success rate of 5% in 2015.Through BH/PH integration, we were able to more than double the success rate to 12% in 2016.



2. AHCCCS HAS A COMPREHENSIVE BEHAVIORAL AND PHYSICAL HEALTH BENEFIT PACKAGE AND STRIVES FOR HIGH…

Banner-University Family Care (BUFC) has developed a service provision framework and continuum of complete services to drive health care transformation and meet the individualized needs of members and families. We believe true system change and accountability requires the *right people* with the *right intentions* doing the *right thing* in collaboration with the member at all levels of the system. As such, we curate our network with high-quality providers who genuinely embrace these concepts and build a solid therapeutic alliance with our members in order to promote the best possible whole-person outcomes. In the 2016 AHCCCS Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, BUFC was the only plan adult members **rated 5 Star** for satisfaction with both their personal and specialty providers. Building upon this strong network of providers, our successful population health management components that will remain foundational for complete care delivery are: 1) information-powered care management and clinical decision-making; 2) primary care-led workforce; and 3) member engagement and community integration. Specific to the integration of physical health (PH) and behavioral health (BH), we add the key components of team-based inter-professional care, system navigation and facilitation of cross-cultural dialogue among stakeholders to shift away from the current bifurcated systems of care. Our model is guided by the *9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems* and *the Arizona Vision and 12 Principles for Children's Service Delivery*. Over the past 2 AHCCCS contracts, BUFC has used these *Guiding Principles* to evolve our whole-person approach to care. The principles are foundational to our success with not only BH care, but also for addressing health related behaviors along with chronic and debilitating PH conditions. Consistent with these principles, we seek direct input and feedback from members, families, providers and stakeholders. During the past year, we have listened to stakeholders potentially impacted by the AHCCCS Complete Care (ACC) contract, including children's BH/PH, adult BH/PH, and children's rehabilitative service stakeholders – including providers, members, family, peers and community agencies such as first responders and educators. Throughout, the universal purpose of *caring* was palpable. This anchoring purpose of caring for each and every member we serve each day drives BUFC and our partners to continually improve our programs. In addition to the 9 critical strategies identified by AHCCCS to promote the integration of PH/BH service delivery, BUFC will employ a neighborhood focus and system *navigation* as key strategies, the latter of which was the *#1 needed strategy* voiced by community stakeholders during our Complete Care Think Tanks. Together these components are incorporated in the acronym *CARING* (Collaboration, Attention to change management, Responsive, Intentional, Navigable and Greater communication and care coordination) to laser focus all BUFC employees and external stakeholders to pursue and maintain the highest standards of whole-person care delivery.

Collaboration: Collaboration with members, families, peers, providers and community agencies is essential to provide whole-person care, which engages members and delivers improved outcomes along with positively impacting the 8 Dimensions of Wellness. Therefore, BUFC carefully curates our network by considering the whole-person needs of our members and sets clear expectations regarding collaboration and coordination among all provider types, including non-clinical safety net services. This includes effective provider and member engagement, training and support during this transformational change. BUFC has implemented this concept in the past as a critical component of achieving success with our Value-Based Purchasing (VBP) arrangements that were associated with a 16.5% decrease in Emergency Department (ED) visits, 2.6% decrease in hospital admissions and a 6% decrease in cost per admission from 2016-2017. We have collaborated with groups, such as Nurse Family Partnership programs, within our GSAs to improve pregnancy and child outcomes by streamlining our referral process, as well as implementing proven evidence-based programs with Southwest Human Development and Teen Outreach Pregnancy Services (TOPS).

Attention to Change Management: During Provider Think Tanks, we heard it is very challenging to maintain a high standard of member care while operationalizing system changes that are thrust upon providers without forewarning. BUFC embraces system transformation and recognizes it requires leadership, including clear and timely communication of expectations, to maintain optimal care of vulnerable AHCCCS members. BUFC's organizational structure and operational systems support delivery of integrated services and change management as core functions. As a provider-based health plan, BUFC has been a change agent within our organization and in the communities we serve. BUFC leaders provided technical assistance to Banner Health (Banner) to obtain Targeted Investment Program (TIP) funding and drive improvements in the delivery of integrated care by Banner, AHCCCS' largest provider.

Responsive: Foundational to being responsive to the needs of each unique member is a culture of continual learning that is nimble and focused on whole-health outcomes. Technology and robust data systems are mandatory today to successfully manage the health of populations in a data-driven and responsive manner. This culture includes proactively identifying members at risk along with having a toll-free phone line and 24-hour nurse triage line to assist members at

their time of need. BUFC has implemented this component in the past when new DSNP enrollees experienced an increased risk of hospital admission within 90 days after enrolling with us. We responded, improving our care management program for new enrollees, which included improved predictive modeling, quicker care management outreach and completion of the health risk assessment along with rapid deployment of specific, targeted interventions.
Intentional: In order to be successful, a clear intention to integrate must exist in the system and be addressed in a very purposeful manner. Interestingly, while much focus has deservedly been on cultural and linguistic competent care delivery, the importance of these values in regards to provider collaboration has received less attention. BUFC is keenly aware of the differences between PH and BH providers and will be sensitive to such "cultural" differences as we bring these systems together to communicate effectively. We successfully accomplished this in partnering with Cenpatico to offer Cenpatico Integrated Care to meet the whole-person needs of members with serious mental illness (SMI). Communication is also critical at the member care level since, by its nature, integrated care is team-based. Strategies must include coordination of services and the use of evidence-based clinical models of care.
Navigable: Timely access to the appropriate level of care to meet the members' needs is essential to delivering effective integrated care. This includes access to preventive care and more effective navigation when the member's care is more complex or emergent. Members and families must have access to a complete continuum of care, which includes stepped levels of care and defined care models to meet their unique needs efficiently and effectively. For example, BUFC has removed barriers and reduced time to access services within Banner by implementing an ED diversion program and supporting a Banner Integrated Urgent Care Pilot (Spring 2018).
Greater Communication and Care Coordination: While "integrated" has become synonymous with the delivery of PH/BH care, the same core challenge occurs throughout all aspects of health care for members with co-morbid conditions – communication between their providers. For example, ineffective communication between providers represents an unnecessary barrier for a member with both heart and kidney conditions as well as for a member with depression and diabetes. Comprehensive care coordination requires communication among all involved providers and community agencies touching a member. This includes implementing best practices for care coordination and care management and encouraging the use of integrated service settings. BUFC implemented this component when we partnered with the RBHA and BH providers to decrease our readmission rate for General Mental Health/Substance Abuse (GMH/SA) dual members discharged from BH facilities to less than 8%. Throughout our integration efforts we will remain cognizant of our members' privacy rights as mandated under 42 CFR Part 2 requirement.

IMPLEMENTATION OF COMPLETE CARE DELIVERY WHILE MAINTAINING THE HIGHEST STANDARD OF CARE

In order to meet the unique needs of our diverse populations of members, BUFC has developed an organizational structure and operational systems to support delivery of integrated services. The population needs, care management programs, network development and quality focus of each line of business is overseen by a Model of Care (MOC) Committee that reports to our Quality Management Performance Improvement (QMPI) Committee. Although developed for Special Needs Plans, BUFC will use this approach to develop a MOC specifically for our Complete Care members in order to meet their unique needs. For example, using machine learning and artificial intelligence techniques to identify clusters of members with similar disease profiles, we have identified distinct "*neighborhoods,*" as described below, for whom we will design targeted care management strategies and provider networks with value-based performance measures specifically to meet the needs of the distinct subpopulations of our members. BUFC recognizes the need for an integrated network to serve the PH and BH of our members. We have designed a highly responsive system of contracting that expedites the process for all providers that are deemed integrated, including Multi-Specialty Integrated Clinics serving children and young adults with CRS-eligible conditions. This is done to ensure the highest standards of quality and care for our members.

In response to health care changes since our adoption of Wagner's Chronic Care Model in 2008, BUFC now introduces **Complete Care Continuum (C3)** as a model of care and engagement that aligns all those involved in a member's life in a seamless supported environment. The model employs their personal *Member Supported Care Circles, Neighborhood Networks* and the *Banner Navigation Accelerator (BNA)* to improve care navigation, access, and coordination. The model also uses coordinated health management at both the health plan (*BUFC Complete Care Management*) and provider (*Integrated Case Management*) level for member-centric improved health and wellness outcomes. Under Complete Care, each BUFC member is empowered to achieve health and wellness by activating their natural supports (*Member Supported Care Circles*) and working collaboratively within a cohesive system of local PH/BH/integrated providers and community agencies (*Neighborhood Network*). This system is navigated easily and efficiently with the support of BUFC's

technology platform (*BNA*) and community-based staff aligned through equitable value-based arrangements. BUFC's *Complete Care Managers* located within the health plan and the providers' *Integrated Case Managers* located within each *Neighborhood Network* work seamlessly to coordinate optimal whole-person care. In order to maintain the highest standard of care throughout this system transformation, we keep an intentional focus on continual learning with the use of standard continuous quality improvement processes within our *Neighborhood Networks*, which includes oversight by *Neighborhood Advisory Councils* that include peers and family members, and accountability through use of *Neighborhood Score Cards.* This collaborative neighborhood approach promotes outcome-proven best practices consistent with clinical guidelines, evidence-based practices and consensus from the clinical and consumer communities since few guidelines exist for the care of a member with multiple co-morbid conditions. We use an evidence-based collaborative approach, supported by UA Center for Population Science and Discovery analytics, to offer the optimal whole-person care delivery, with consideration of individual member's desires and unique social determinants of health.

Use of Clinical Practice Guidelines (CPGs) and Evidence-Based Practices (EBPs): We adopt evidence-based clinical guidelines, including MCG Care Guidelines, which serve as a framework for clinical decisions and service provision that optimizes member care. These guidelines are selected from a variety of sources that address BH and PH, such as from the American Psychiatric Association Practice Guidelines, American Academy of Child and Adolescent Psychiatry Practice Parameters, U.S. Preventive Services Taskforce, American Academy of Family Physicians, American Academy of Pediatrics, and AHCCCS Practice Toolkits as well as numerous primary and subspecialty guidelines from national policies and standards, valid and reliable clinical evidence, and expert consensus in the identified field. Guidelines are each selected in consideration of the needs of our members, adopted in consultation with providers and approved by our QMPI Committee, which includes contracted AHCCCS providers, peers and family/members. We use these guidelines and best practices to select our value-based quality measures to drive integration within our *Neighborhood Networks* and meet the individualized complete care needs of members in compliance with mental health parity. To promote integration, our guidelines are available to all providers and members on our website; provider and member newsletters; through our provider manual and member handbook; prior authorization process and case management outreach; and through regular and consistent education, coaching and training. In addition, training occurs as a result of fidelity monitoring from the Children's System of Care Practice Reviews and for such protocols as Child and Family Teams, Generalist Direct Support Services (MMWIA), CASII and others as directed. If deficiencies are identified by our fidelity monitoring, we provide targeted technical assistance led by a team of BHPs and require corrective action plans to deliver service provision consistent with these guidelines. Providers use these clinical practice guidelines and EBPs, which are monitored by our Quality Management Program, through the re-credentialing process as well as through VBP contracting metrics. We continually seek and evaluate promising practices in any integrated care setting at all levels of provider, including peer run agencies, hospitals, psychiatric facilities and medical facilities. We have adopted multiple EBPs within our current service delivery array and will expand to include additional guidelines, including recommendations of our Technology Assessment Committee, to meet the needs of Complete Care populations.

Throughout the development and adoption of these CPGs and EBPs, we regularly receive input from the Clinical and Consumer Communities through our Value-Based Joint Operations Committees, Think Tanks, Provider Forums, Provider Target Groups, Member Satisfaction Surveys, Member Experience Call Center, QMPI, Grievance and Appeals, Office of Individual and Family Affairs (OIFA), Member Advocacy Council, Youth Member Advocacy Council, QMPI Committee, Technology Assessment Committee, Pharmacy and Therapeutics Committee and the Banner delivery system. We benefit from resources within Banner-University Medical Group, such as Dr. Karen Weihs the Medical Director of the UA Cancer Center's Psychosocial Oncology. Dr. Weihs is Board Certified in Family Medicine and Psychiatry, and a leader in defining optimal care pathways for those with cancer to provide optimal whole person outcomes. We will reach out to newly diagnosed cancer members to provide BH support. We will also meet regularly with our *Neighborhood Advisory Councils* to confirm mutual understanding of system expectations and align incentives to improve quality of care, long-term vision and goals, participation in strategic direction and definition of success along with standardization of demonstrated best practices throughout the community's provider network. *Neighborhood Advisory Councils* will include members, peer and family support, police, fire, justice, community agencies and provider representatives to specifically address the issues, barriers, concerns and opportunities for improving member experience. These *Neighborhood Advisory Councils,* serving the role of the required Governance Committee, will also have representatives on the BUFC Board Advisory Committee so the community voice is heard at our highest level, while ensuring transparency, collaborative goal setting, data sharing, aligned incentives, and shared governance at the Neighborhood level.

PAST EXPERIENCE AND FUTURE INNOVATIONS

Integration of Whole-Person Care into Primary Care: Past Experience: After the success of having a social worker in the BUMG-Tucson and Maricopa Integrated Health Systems (MIHS) pediatric clinics, BUFC expanded the delivery of whole-person services within primary care sites in 2009. This included funding a bilingual/bicultural diabetes nurse case manager in the MIHS Guadalupe Clinic and a social worker as a BH consultant in the BUMG Family Practice Clinic. The former initiative was foundational in MIHS's development of accredited patient centered medical homes (PCMHs) within its ambulatory sites and the latter BH consultant model remains a core component of integrated care delivery within BUMG today. The experience of building the BH consultant model in 2009 provided our integrated delivery system the opportunity to address numerous issues, such as supervision of licensed BH professionals within a PH clinic, integration of medical records that respect member privacy, and navigating facility licensing issues. This work ultimately led to BUMG opening the current Whole Health Clinic, a fully integrated clinic serving the BH, PH, and specialty needs of adults 18 years and older with a behavioral health diagnosis. While approximately 20% of the members seen at this site have an SMI determination, the majority have general mental diagnoses with substance use disorders being prevalent. Being part of the Banner family connects those receiving care within the Whole Health Clinic with a variety of specialty and inpatient services that many other local behavioral health providers do not have available. For example, the connection to the Department of Psychiatry provides ready access to experts in sleep, psychological and cognitive testing, ECT, etc. The Whole Health Clinic providers are able to directly share and review medical information, consistent with 42 CFR Part 2 requirements, from other Banner providers, including inpatient units without having to request records or waiting for them to be faxed. Having acted as a change agent within our safety net delivery system, we identified a diverse set of providers committed to whole-person care and facilitated collaborative program improvements. BUFC is now well situated to build upon its past success with this transformational ACC contract to continue to drive whole-person integration to yet a higher level. Future Innovation: In year 1 of the ACC contract, Dr. Anthony Arnold, Medical Director of BUMG Family Medicine; Dr. Karen Weihs, UA Psychiatry Department; Beverly McGuffin, UA Recovery Support Specialist Institute Program Director; and BUHP BH integration consultants will implement an evidence-based Collaborative Care program adding specialty trained peer and family Wellness Partners within Primary Care. This leadership team is working with peer and family support specialists and researchers within both Banner and UA organizations to test workforce development models that promote capacity building and implementation of primary care-based BH integration, and that prepare the peer and family workforce to serve in primary care settings with diverse populations. As such, we will test the current standards for peer and family support training, push beyond the traditional focus of working with BH populations, and develop a standardized approach for utilizing proven peer and family support services in this unique role. Not only do we embrace the role of peers and family members in integrated delivery of BH services, we will expand the use of peer and family support to focus on social determinants, promote self-management, adoption of healthy behaviors, and emotional support for individuals struggling with diabetes, cancer treatment, metabolic issues and more. Based upon the success of this program, through value-based arrangements, we will expand this Collaborative Care model throughout Banner primary care sites and other large healthcare delivery systems, such as MIHS, while building on lessons learned from earlier implementations.

Meeting Members Where They Are with Healthy Together Care Partnership (HTCP): Past Experience: HTCP is a home- and community-based care program that offers an evidence-based, high-touch, inter-professional, team-based approach to coordinating care for members with the greatest need and highest costs. In partnership with the member, family, PCP, specialists and local community-based providers, HTCP provides an extra layer of at-home supports to align care services and increase self-efficacy and independence during times of transition and heightened vulnerability. The HTCP team consists of an NP, nurse Care Manager, BH consultant, clinical pharmacist and community health worker. The team assists members and providers by helping them with care transitions, medication adherence and optimization, palliative and end of life care, chronic condition management, BH interventions and care coordination. Our data analytics and care teams work together to identify the highest risk members for outreach. In addition, alerts are generated from the Banner Electronic Health Record, with its decision support tools, and Health Current to trigger timely outreach by the care team. In 2015, Jonathan M. Hendrickson FSA, MAAA, a Principal and Consulting Actuary with Milliman, Inc., conducted the analysis in which he found HTCP realized a $61 PMPM savings in medical expense. In 2017, health economists with the UA Center for Population Science and Discovery evaluated HTCP's performance and found participants had a statistically significant 10% decline in total expenditures and a 16% decrease in the number of ED visits. Additionally, a member survey demonstrated a 97% satisfaction rate, with 92% reporting better ability to manage their health conditions and 87% reporting improved health status. A provider survey found 85% satisfaction with the

support they and their patients received from HTCP. Future Innovations: As a continually learning organization, BUFC will implement 2 innovative improvements to HTCP in Year 1 of the ACC contract. First, to build upon the success of HTCP and expand its services to more members with special health care needs, BUFC has partnered with SunLife Home Care. SunLife delivers care within the home to members with long-term care needs, developmental disabilities and chronic PH/BH disorders. By linking the HTCP team as the care "hub" with SunLife, CNAs as the "spoke" by smartphone and tablet, HTCP will expand the types of members it serves and its geographic reach. For example, under the ACC contract, SunLife employees trained in care support for families with a child with autism spectrum disorder (ASD) will offer in-home support services while in turn being supported by the HTCP team and Behavioral Developmental Specialists within BUMG. This hub and spoke approach will not only improve the reach of specialty care throughout Arizona, but also support paraprofessional workforce development. Second, since some members served by HTCP experience repeat exacerbations of their condition following HTCP "graduation," BUFC will offer graduating members support through *Member Supported Care Circles* technology to provide continuing support at a lower level of intensity as members transition to independent self-management of their health.

Integrating Clinical and Non-Clinical Care to Improve Health and Wellness at Camp Wellness: Past Experience: The University of Arizona (UA) RISE Health and Wellness Program, aka "Camp Wellness," is a nationally award-winning and highly specialized wellness program for individuals with BH disorders. Camp Wellness utilizes evidence-based strategies to improve participants' overall health while reducing risk for chronic disease with a recovery-oriented, peer-delivered format. In 2016, Camp Wellness was 1 of only 3 programs recognized across the entire United States for Excellence in Wellness by the U.S. Substance Abuse Mental Health Services Administration (SAMHSA). Camp Wellness is staffed with an experienced inter-professional team, the cornerstone of which is a team of trained peer health mentors who deliver classes on a wide variety of topics including health, nutrition, exercise, tobacco education, meditation and stress management. This program has historically been limited to RBHA members. Future Innovation: In 2017, BUFC completed a pilot with our GMH/SA population to provide a 9-week program for members with general mental health conditions (e.g., depression and anxiety disorders) and co-morbid pre-diabetes or diabetes. The goals of this pilot program were to reduce risk of diabetes, improve diabetes management, prevent cardiovascular disease and improve psychological well-being in a peer supported environment. In preparation for the Camp Wellness U program, the Camp Wellness team developed new programming with a focus on diabetes prevention and care. On average, participants lost 5 lbs., improved their blood pressure by 11-13.5 mmHg, increased the distance of their 6-minute walk by 20% and their self-reported SF-12 PH Scale (32.3 pre to 39.6 post). BH also improved among participants as documented in their PHQ-9 (18.5 pre to 3.5 post) and SF-12 Mental Health Scale (37.2 pre to 44.2 post). Therefore, BUFC will expand the use of Camp Wellness by offering it to our Complete Care members with co-morbid BH conditions and either diabetes or pre-diabetes with expansion to other chronic medical conditions, with availability in rural AZ through its Wellness on Wheels programs. We will work with UA to expand this program beyond Pima County to serve at least 2 other counties within the GSA and implement similar programming within at least 2 other P/FROs by 10/1/2020.

BUFC Organizational Systems Provide Responsive Process Improvement That Improve Complete Care: Past Experience: In 2013, we identified our UCA population had higher than expected disenrollment and admission rates, which were negatively impacting medical costs and appeared to reflect member dissatisfaction. Further analysis identified a disenrollment spike and admissions within the first 3 months of enrollment with BH conditions as a significant driver of admissions. Planning occurred in the latter half of 2013, with the initial launch of our UCA care improvement initiative in January 2014. Planned interventions were threefold: **1)** contract with UA Dept. of Systems and Industrial Engineering to re-engineer our onboarding process for UCA members during their first 3 months of enrollment; **2)** improve the predictive accuracy of our Health Risk Assessment (HRA) tool to identify members at high risk for admission within subsequent 3 months; and **3)** improve BH and adult case management collaboration within the Interdisciplinary Care Team (ICT) and have UCA Care Managers (CMs) complete all outreach, including HRA completion, to new beneficiaries within the first month of enrollment, versus the Medicare required 90 days. Using the Plan, Do, Study, Act (PDSA) model, we developed a process to improve communication between sales, enrollment and clinical teams during the critical first month of enrollment. The new enrollment timeline emphasized rapid risk assessment and triage to the appropriate level of care designed for distinct segments of the population. Both computerized machine learning techniques and standard statistical regression models were completed on UCA populations to identify which HRA questions were most predictive of subsequent admission within the first 3 months of enrollment and answers were re-weighted accordingly to improve tool accuracy. Following this initiative, admits/K decreased from 354 to 252, HRA

completion rates increased fourfold and the disenrollment Star rating improved from 3 to 4 Stars. Future Innovation: This initiative demonstrates BUFC's ability to use predictive modeling, process improvement and care management innovations to improve health outcomes and experiences for our members. These same components will be important for Complete Care as analysis of our current membership using AHCCCS Blind Spot data demonstrated less than 1% of our membership utilizes more than 60% of the BH services. BUFC will use Blind Spot data on our current members who will remain with us after 10/1/18 to initiate outreach and education well ahead of 10/1/18 to promote a smooth transition for them and their families. Feedback from that initiative will then be used to improve new member outreach at the time of contract initiation. Furthermore, collaborations with graduate students within Arizona's university systems are a cost-effective approach to solving system issues while supporting workforce development within higher education with skills applicable to AHCCCS membership. Therefore, to support this approach to system improvements within our Neighborhood Networks, BUFC will hire a *Neighborhood Network Program Manager* to oversee inter-professional teams of clinical and non-clinical graduate students to address local concerns identified as neighborhood priorities, with the analytic resources of the UA Center for Population Science and Discovery at their disposal. Program planning will occur during the summer and fall of 2018, with initial projects launched by 1/30/19.

Provider Education with Webinars to Evolve into ECHO: Past Experience: BUFC has successfully used webinars to deliver provider education. We believe virtual education has greater community potential with our Neighborhood Networks approach to improve community health. Future Innovation: We will utilize the Project ECHO (Extension for Community Health Care Outcomes) of the UA Telemedicine Program to extend the reach of community education in both urban and rural Arizona. Project ECHO is a guided-practice model that aims to increase workforce capacity by sharing knowledge. Specialists at the "hub" site meet regularly with primary care providers in local communities via videoconferencing to train the primary care providers in the delivery of specialty care services. The ECHO model™, developed in New Mexico, does not actually provide care directly to patients. Instead, it provides front-line clinicians with the knowledge and support they need to manage individuals with complex conditions – in their own communities. This dramatically increases access to specialty treatment in rural and underserved areas. In addition, UA Telemedicine has participated in a national ECHO program to improve wound care by having wound care specialists engage directly with members in group dialogue. We believe both the traditional ECHO model geared to health care providers and this new innovative direct-to-member approach have great potential to improve integration of clinical and non-clinical care providers along with engaging members through improved communication and understanding to address individual and community health barriers. The first ECHO program, for pain management, will begin by 8/2018.

Meeting Member Needs Where They Are While Reducing the Stigma of Mental Illness in Health Care: Past Experience: Banner Hospital ED Practice reduced BH hospital hold duration at Banner EDs in Maricopa County by 40% since 2016. This occurred through development of clinical care guidelines with community partners Crisis Prep and Recovery (CPR) and Community Bridges Inc. (CBI) to systematize processes in the ED for medical clearance, BH assessment, coordination and triage among different Banner providers and external parties. Key actions included developing a clear definition of medical clearance, an expedited BH assessment process coordinated with CPR and CBI on-site and through telemedicine, engagement of members by on-site peer support specialists in conjunction with active hospital-based case managers. Members with Opioid Use Disorder were offered expedited triage to CBI or other providers for MAT services addressing both addiction and pain management. The Joint Commission recognized this model as a best practice and we will support expansion throughout our *Neighborhood Networks.* Future Innovation: In partnership with Banner Urgent Cares (BUCs) and community BH providers, BUFC identified an opportunity to enhance the provision of complete care services for individuals with co-morbid BH and PH conditions at Urgent Care (UC) locations. UC settings are often unprepared to address the needs of these members, resulting in the UC provider deferring treatment to EDs. At 2 BUC sites in Maricopa County and 1 in Tucson, BUFC will initiate a pilot program prior to 10/1/18 that focuses on: coordination with and education to community providers to help facilitate appropriate referrals to UC; specialized training for employees in the selected BUC locations to increase competency and comfort level in meeting the needs of members with BH diagnoses; access to BH consultation, assessment and treatment, including on-site or remote service provided via telemedicine; and expedited coordination between BUFC, BUCs and community providers. Based on pilot results, additional sites will be added. Due to the combined telemedicine expertise of Banner and UA, BUFC's future model, dependent upon telemedicine policy changes, will incorporate telemedicine support to BUC and member access to behavioral services from the member's own smartphone or tablet at home, eliminating the need for transportation. This program will be scaled within Banner Health facilities based upon the success of this initial pilot.

Using Early Adopters of Complete Care as Neighborhood Network Incubators: Past Experience: Banner has launched multiple *Imaginariums* as design laboratories, with dedicated full-time design teams interacting constantly with the consumer and co-creating solutions. Design teams develop, test and refine designs with the front line. Rapid cycle prototyping is performed: fail fast, try again and prove it out. Proven designs are then scaled across the system. Throughout Arizona many community providers and agencies have already demonstrated their expertise at delivering complete care and can promote innovation in a similar vein as neighborhood incubators. Future Innovation: BUFC will designate existing early adopters of successful models and best practices of integration and Centers of Excellence as Neighborhood incubators. These Neighborhood incubators will be funded to test theories, best practices and value-based funding models that support integration. Community Reinvestment Funds will also be used in a strategic manner to solve current population health problems while supporting the adoption of innovative and EBPs. As such, we will invest in our incubators with additional funds for workforce development and community capacity building. Incubators will develop integrated solutions to community health and social determinant problems related to the following AHCCCS initiatives: opioid addiction, children and families who are DCS involved, ASD services for children and their families, and complete care for justice involved children and adults. It is expected these early adopter incubators will stimulate the late majority and laggards to follow this path of transformation. Two network incubators will be designated by 12/1/18.

Use of Technology to Improve Engagement in Complete Care Delivery: Past Experience: Using EBPs, BUFC implemented our *Change of Heart/Cambio de Corazon* program for members with co-morbid depression and chronic PH conditions, such as diabetes and cardiovascular disease. BUFC created a program using the Warm Health interactive voice response platform to deliver education in English or Spanish to members about depression and their co-morbid condition. The platform also provided them with the opportunity to speak with a Care Manager. Members receive messages that promote self-management of their disease, emphasize the importance of treatment, and provide support tools and screenings for depression and other co-morbid conditions. Information provided is intended to support full recovery from depression and avoid complications related to poor management and less than full recovery. During the educational messages, the member is screened with the Patient Health Questionnaire-2 (PHQ-2) for brief screening. For members who had a positive screen, a more comprehensive screening is conducted using the PHQ-9. Any member with an immediate risk of harm to self as identified with the PHQ-9 screen is provided an immediate transfer to the community crisis line to be assessed for suicidal ideation/danger to self. Future Innovations: By 10/1/18, BUFC will supplement Warm Health member engagement and health promotion technology with the use of *Member Supported Care Circles*, powered by PYX technology, to connect members with their chosen natural supports (family, friends, Care Managers, etc.) in a mobile-enabled platform that interacts with the member to monitor their physical and mental health status, provides proactive timely alerts to their Care Circle supports, allows for Care Circle members to support member self-care, and offers Care and Case Managers analytics dashboards to show trends of activities, mood and care access (including geo location when accessing urgent/emergent/crisis services) across the individual member and groups of members. This member-centric technology allows members to select their trusted group to empower their success in health improvement, self-management of their condition and crisis prevention.

Supporting Arizona Initiatives to Decrease Opioid Related Deaths with BUFC C-3: Past Experience: BUHP, AHCCCS, the Governor's Office and the AZ Department of Health Services have initiated many important programs targeting our opioid epidemic. Yet, there remains a concerning lag in translating policy into member care. Future Innovation: BUFC's change management expertise used within our *Neighborhood Networks* will speed the time from policy release to member care impact. Neighborhood Networks will create a *Neighborhood Action Plan* to synchronize the impact of all these interventions, such as but not limited to: provider training via ECHO on pain management (to launch by 8/2018) including policy changes; prescribing and monitoring of opioids; naloxone co-prescribing; evidence-based psychosocial interventions; community education forums at local libraries, schools and family resource centers to remove stigma and improve community engagement; promotion of Member Supported Care Circles for members struggling with substance use disorders and their chosen supports; and use of Banner Navigation Accelerator to access services expeditiously when members are ready to initiate treatment. Due to the State of Emergency, these programs have been initiated.

ALWAYS CARING AND CONTINUALLY INNOVATING TO IMPROVE INTEGRATED CARE DELIVERY FOR OUR MEMBERS

As Arizonans, the care of our fellow citizens is a very personal endeavor. BUFC will use funds donated to the Banner Foundation by our employees to augment our Community Investments in improving the care of our AHCCCS members. Together with our neighborhood partners, we are united and committed to truly *caring* for each member we serve.

3. THE IMPLEMENTATION OF THE AHCCCS COMPLETE CARE PROGRAM IS A TRANSFORMATIVE AND COMPLEX…

With more than 30 years of AHCCCS experience, we pride ourselves on member and provider satisfaction. By prioritizing and addressing the care needs of our members, Banner-University Family Care (BUFC) delivers on our mission ***to make health care easier so life can be better*** for our members, families and caregivers. We conduct ourselves at all times using the *AHCCCS mission and vision*, *system values and guiding principles* and the *vision for integrated services*. We recognize the upcoming delivery system changes and are implementing the appropriate network to support system changes, including changing the way providers will be contracted and compensated. We know issues will arise that must be resolved quickly, and we remain committed to working hard and transparently to mitigate member, provider and regulator concerns. As transformation takes hold, it is critical members can access and receive needed services. Through our long history, we have effectively managed complicated transitions, including: launching a new ALTCS contract in 2017; transitioning out of the Maricopa Health Plan (MHP) contract in 2016; forming Cenpatico Integrated (CI) and implementing a new RBHA contract in 2015 (with the complex DSNP alignment); adding GMH/SA dual members and benefits in 2015; and our DSNP integration in 2008. Each was complex, but by putting our members first, we experienced minimal member and delivery system disruptions. To continue these successes, we retain our member-centered focus and begin well before go-live to addresses access to care concerns.

ENSURING ACCESS TO NEEDED SERVICES BEFORE IMPLEMENTATION

To be most effective post-implementation, BUFC invested considerable up-front time and resources to understand delivery system strengths and pressure points. As large-scale change can lead to disruption and instability, we chose to listen first. We met with Arizona stakeholders who let us know what worked well and needed change. We held over 30 Think Tank sessions with hundreds of community and provider leaders, and met with PH, BH, Peer and Family Run Organizations (PFROs); Integrated Care (IC) providers; and community, member and family stakeholders. During our ALTCS implementation, we met with hundreds of providers at "Meet & Greets" who shared concerns. Once perspectives were gleaned from these sessions as well as through an analysis of AZ Community Health Needs Assessments (CHNAs) and other research, we developed transformation strategies. Stakeholders and research indicated access to care remains a concern. While AHCCCS requirements detail multiple "access to care" monitoring expectations, such as timely appointment availability, network adequacy and monitoring member grievances, we recognize access to care is much broader and developed a multi-faceted approach to build on AHCCCS requirements.

Before release of the ACC RFP, BUFC conducted in-depth analyses of current members' diagnoses to better pinpoint the mix of services to best meet members' needs. Our analysts identified several significant co-morbid correlations between PH/BH conditions for children and adults. Children with asthma were 2 times more likely to have co-morbid diagnoses of depression, anxiety and obesity. Adults with kidney disease were 9 times more likely to have co-morbid diagnoses of depression. Thus, in addition to our expansive network, we need to assure aligned PH/BH services to improve care. BUFC has already begun the launch of a key access to care strategy: to organize providers into Neighborhood Networks (Neighborhood) to better support delivery of cohesive and aligned care.

Go-Live Monitoring: Upon AHCCCS approval and prior to the 10/1/18 launch, BUFC will continue to use Blind Spot and Health Current data to identify our current member's needs in awarded GSAs (who will likely remain our members under the new contract). We will then initiate member and provider outreach to clarify roles and transition plans to meet members' needs seamlessly. Once in receipt of the AHCCCS DEF file, we will identify newly acquired members and merge Blind Spot and Health Current data to identify these member's needs; segment the population by location, level of need and specific Special Health Care Needs to target member and provider outreach and education; and monitor care for receipt of appropriate services. We will identify condition-specific key care metric bundles for members with Special Health Care Needs to support targeted monitoring of critical care elements tailored to the needs of individual members. During go-live, we will safeguard against members running out of medication by: monitoring rejected pharmacy claims 2-3 times per day for the first 30-90 days based on average length of prescription refills to avoid prescription access issues; open-access appointments at all psychiatric providers that allows same-day appointments to address emergent needs, including psychotropic medication refills; and use of emergency psychotropic medication clinics to offer emergent bridge prescriptions. BUFC takes a "lessons learned" and "Plan, Do, Study, Act" (PDSA) approach as we end each implementation to inform future efforts. We evaluate what worked well and what requires improvement. As we reflect, we enhance implementation processes such as requiring all production areas – including Grievance and Appeals, Customer Care, Claims and Prior Authorization Departments – to build contingency plans if

timeliness becomes a concern. We monitor timeliness metrics and should these be surpassed, contingency plans go into effect. Further, we monitor for time-sensitive access to care concerns at all member touch-points during implementation, such as in our call center, and developed Los Bomberos, our cross-functional rapid deployment team, to address escalating issues. This team develops workflows to determine how to quickly resolve a concern during or after business hours. If an access to care concern is identified, any member of Los Bomberos can call an immediate team meeting. This self-monitoring during times of transition resolves access concerns in a timely manner.

Network Design and Management: As an AHCCCS contractor, BUFC has an extensive provider network in Arizona, including 12,325 unique practitioners, 2,641 facilities, ancillaries and provider groups. We have established relationships with critical provider-types such as FQHCs, PCMHs, all MSICs, BH residential treatment facilities that can serve members with BH and PH comorbidity, rural health clinics, integrated clinics, Level 1 Sub-Acute Facilities and Community Service Agencies. Through current monitoring, we determined the need to add children's providers with expertise in respite, HCTC, eating disorders, trauma, sexually maladaptive behaviors, autism spectrum disorders and BH residential facilities. BUFC is engaged in this expansion, and will monitor our progress to fulfill these targets by August 31, 2018.

ENSURING ACCESS TO NEEDED SERVICES POST-IMPLEMENTATION

We have designed a multi-faceted approach, so members can access needed services post-implementation. The self-monitoring solutions detailed below includes traditional monitoring oversight as well as developing new solutions to address new ACC program concerns. In all cases, our approach focuses on complying with ACC and mental health parity requirements as we aim to be effective through outcome reporting, innovation and continuous testing of solutions.

Neighborhood Network: BUFC envisions a comprehensive and aligned provider network to create a cohesive Neighborhood of care based on cultural sensitivity, member choice and preferences. BUFC will launch a Neighborhood design based on Banner Health Network's (BHN's) successful 2016 launch of the Neighborhood Physician Alliance for BHN's Medicare Advantage. Neighborhoods are mapped to align where members reside or seek services in a given geography. Bringing providers together by geographic neighborhood across the PH/BH continuum allows for true integration, improvement in health outcomes and advancement of alternative payment models. Since health care is local, the Neighborhood design will vary in rural and urban settings. In rural areas, Neighborhoods will cover larger geographic areas and due to provider shortages, must incorporate multiple alternative care solutions. Thus, the Neighborhood design for Yuma County will incorporate telemedicine, mobile and field clinic solutions for Integrated, PCP, BH, dental, and specialty providers; engage in workforce development; and offer adequate non-emergent transportation options. In urban areas such as Maricopa County, our CHNA analysis pointed to socioeconomic and cultural factors that result in uneven access to care and transportation concerns. Thus, our urban Neighborhood design will offer expanded urgent care and transportation solutions, and will leverage provider partnerships for access to scarce specialty services, such as via telemedicine. Each Neighborhood will have a voice on Neighborhood Advisory Councils and representatives will have a seat on a standing committee of the BUFC Board of Directors. Neighborhood representatives will inform the Board of their access to care concerns, so self-monitoring occurs at the highest level within our health plan. BUFC will work with the Neighborhoods to identify areas of improvement and via our Neighborhood Incentive, will offer shared financial incentives across all provider types within a Neighborhood to improve population health outcomes of the entire Neighborhood, including those that affect access to care. BUFC will supply advisory councils with a Neighborhood scorecard which aligns to BUFC value-based and health outcome measures and includes access to care measures, such as 7-day follow-up visits or ED utilization. Sharing this scorecard with all participants in the Neighborhood's care continuum empowers aligned providers to make targeted, lasting change. This, in part, will occur through increased transparency. While providers will receive individualized scorecards, change occurs when providers across the continuum share data to improve the health outcomes of the people they serve. Each year, the performance measures

Banner University Health Plans
Banner – University Family Care

Date: _____
Provider Name: _____
Office Name: _____
Neighborhood: _____

Neighborhood Network Scorecard

Neighborhood Specific Measure

Performance Measures	Specifications	Benchmarks	Star Rating	Score
ED Utilization				
Inpatient Utilization				
Comprehensive Diabetes Care				
Opioid Use				
Hospital 7 day & 30 day follow up				
All Cause Inpatient Readmission – within 30-days of discharge				
Out of Home Admission & Readmission				
Access to Preventive/Ambulatory Care				
AHCCCS mandated EPSDT Visits with Use of Developmental Screener (0-18 yrs)				
Access to BHP & Integrated BH Home, 7 days				
Member and/or Family Satisfaction Survey Participation				
AHCCCS Targeted Investment Project Aligned Integration Ambulatory Project Milestones (including but not limited to: practice evaluation, BH screening, referral and follow up)				
Children's Dental Visits (Age 2-21)				
Metabolic Monitoring for Individuals Prescribed Antipyschotic Medication				
Use of Evidence-Based SROMs (may include Family Reported Measures)				
BH Screening with Follow Up				
Well Woman Measure (Chlamydia, Cervical CA, Breast CA Screening)				
Cancer Screening (including Colorectal)				
BP Control				
Multiple Concurrent Antipsychotic Use				
Zero Suicide Plan in Place				
Use of HIT & HIE - including participation in Health Current and BNA and Shared Complete Care Plan				

will be re-evaluated to remain relevant to overall AHCCCS, BUFC and Neighborhood goals, but BUFC will retain access to care measures year-over-year, thus guaranteeing ongoing self-monitoring of access at the Neighborhood level. Through a unique partnership with the UA Center for Population Science and Discovery, a team of experts will analyze performance measures to determine effectiveness in driving outcomes and desired clinical practice changes, recommending shifts when appropriate to promote an evidence-based approach at all times.

A key access to care measure is ED utilization. It increases when other avenues to care are unavailable. During the first year of the new ACC Contract, BUFC will enter agreements with its Neighborhoods to incentivize decreased ED utilization. BUFC will monitor ED and other access to care measures and share this information with each Neighborhood. By tying reduced ED utilization to an incentive and working collaboratively with Neighborhoods, we believe we will have a unique line of site into access to care and can drive improved access to care solutions.

Value Based Purchasing: In 2018, 57% of our acute care members will be seen by PCPs who are contracted via a VBP agreement. To monitor and incentivize access to care, in 2017 BUFC included the measure of timely appointment availability in PCP VBP agreements. On a quarterly basis, BUFC employees present VBP PCPs with a quality performance score card that includes trended appointment availability. Should we see a negative trend, we discuss the trend and work collaboratively to develop and launch a work-plan. Through these efforts, 90% of our VBP providers offered timely access to care and all improved access to timely appointments during 2017. Another key access measure is 7-day follow-up post hospitalization. This was a challenge for many PCPs but through VBP initiatives, most now meet at least 50% follow-up and 30% of our partners well exceed it, with 2 achieving over 65% follow-up within 7 days.

Employing State-of-the-Art Technology Tools: Listening to community stakeholders, we recognized the need for a centralized solution to accomplish the complex goals of integrated care. Members need up-to-date information to support their daily lives. Providers need efficient processes that support a timely care plan. BUFC is introducing the *Banner Navigation Accelerator* (BNA), which will deliver actionable self-monitoring reporting to drive results.

Monitoring member access utilization: BNA is a mobile and desktop care support and logistics platform that enhances care coordination by offering an easy to use, searchable listing of providers, services and supports; a built-in referral functionality; and management of member intake, assessment and Complete Care Plan (CC Plan). Using data from community agencies, BNA delivers community resources to address social determinants of health, such as helping members discover where to apply for Supplemental Nutrition Assistance Program, locate the nearest food bank, contact available housing resources, access emergency shelter services, etc. BUFC will partner with a community agency to identify, train and certify selected Neighborhood Navigators (NNAs) per GSA, who will improve member engagement and ease system navigation to assure access to care. The NNAs will become a connection point between the member and providers using BNA supported navigation aligning the best option for each member. BNA utilization will be monitored to identify high and low utilizers, trends by GSA and high-demand provider types. This self-monitoring will allow BUFC to proactively identify gaps in network adequacy and delays in referred services, thus allowing us to immediately bolster network design or enhance other approaches to improve access. Outcome information will be regularly reported to our Network Strategy Committee.

Monitoring BH access to services: Access to BH services is critical and the current structure to initiate care may result in arbitrary delays and lack of common understanding of the member's condition and care plan. As stated on the Office of Individual and Family Affairs (OIFA) website, "no wait lists" notice, members have a right to obtain needed services within ACOM policy 417 timelines, and in accordance with mental health parity (42 CFR Part 438). In response, BUFC designed BNA to address intake/assessment delays and unnecessary paperwork. If a member first seeks BH care at a Specialty Provider (SP) site, all BH SPs, including Peer and Family Run Organizations (PFROs), can utilize web-enabled tools to complete an abbreviated assessment intake form on the BNA platform. The SP will then electronically submit the abbreviated intake, Complete Care Plan (CC Plan) and Behavioral Health Home (BHH) referral, and begin care to address a member's immediate needs. Via BNA, BUFC and the BHH will concurrently receive the SP's abbreviated intake form, specialty plan and service referral. Upon receipt of referral via BNA, the BHH will engage members to schedule, assess, and arrange any ongoing routine care within required time frames. All intake assessment and service dates will be contained within the single CC Plan; that is easily viewed, updated and shared across providers via BNA. To self-monitor, BUFC will analyze collected data, such as measuring the time from initial SP assessment to BHH assessment to validate timeliness. Timeliness analyses will be reported at the Quality Management Performance Improvement (QMPI) and Network Strategy Committee.

Improving BH Members Access to ED Alternatives: Urgent care (UC) settings are typically utilized to address simple care concerns such as mild upper respiratory infections, gastrointestinal symptoms, minor lacerations or other routine services. As we've met with providers, they've advised us that some BH members who also have a simple care concern – such as a cold – face difficulties accessing UC sites. This may be due to UC providers having a level of discomfort, when treating a member with co-occurring PH and BH conditions. As such, these members face barriers to care, undue stress, re-routing to higher level service, ED holds and unnecessary cost to the Medicaid system. In response, BUFC and Banner Urgent Care Services (BUCS) are partnering with contracted BH providers, La Frontera and CODAC, to pilot an integrated PH/BH urgent care model. The pilots will begin Q2 2018 at 2 Phoenix BUCS sites and 1 Tucson site and will include: 1) Co-located UC and BH providers (in-person or via telemedicine) who work as part of a collaborative care team at the BUCS sites; 2) Education to community BH providers to help facilitate appropriate UC referrals; 3) Specialized training for BUCS providers and staff to increase competency in meeting the needs of BH members; 4) Access to BH consultation, assessment, and treatment; and 5) Expedited coordination between BUFC and community BH providers, including use of BNA and shared care and case management resources. Assessment of pilot outcomes will occur prior to 10/1/18 with plans to expand to additional sites over the course of a year. Ongoing self-monitoring will occur by using baseline UC utilization data from members with BH diagnoses and watching for improved use of UC for both PH and non-crisis BH diagnoses, decrease in ED use for the same conditions and reduction of escalation from the UC to ED.

INTERNAL ADMINISTRATIVE MONITORING OVERSIGHT PROCESSES

BUFC recognizes performance improvement is clinical and operational in nature and we self-monitor and self-correct as necessary for contract compliance and operational excellence. With continuous learning at our core, we deploy the Plan, Do, Study, Act (PDSA) approach to enhance our monitoring.

Administrative Monitoring Group (AMG): BUFC realized key performance indicators (KPIs) were not always being reviewed cross-functionally, so outcomes were not universally shared, lessening the advantage of shared knowledge. To resolve, we began the AMG. In place since mid-2017 and composed of cross-functional leaders, AMG meets monthly and monitors KPI trends, including multiple access to care metrics. Each AMG member is assigned metrics to monitor. If an unfavorable trend is identified, the AMG member meets with business owners to understand reason(s) for a trend, plans mitigation actions and provides a detailed report to the AMG. Further, the AMG chair reports all significant trends at BUFC's Director's Team (composed of BUFC Executives and Directors), so all cross-functional areas are aware of trends and actions being taken to correct. The Director's Team provides input and assesses cross-functional impact. This process has proven effective in acting timely on unfavorable trends. For example, in October 2017, AMG monitoring noted PCP urgent appointment availability was trending below the 95% goal. This resulted in the development of an improvement with oversight by QMPI and the Contract Strategy Committee. The plan includes more frequent comparison of network adequacy against areas of poor appointment availability performance and aggressive outreach to non-compliant providers to make sure they comply with contractual obligations. AMG will allow the plan to progress, but will escalate if improvements are not timely realized. The KPIs below will continue to be included in AMG's self-monitoring process so members have access to needed services post-implementation:

- Appointment availability favorable trend means members can access providers timely;
- Customer Care ASA and abandonment rate favorable trend means members obtain needed information timely;
- Grievances about access to care or services favorable trend means access to care grievances are relatively low;
- ED visits favorable trend means ED utilization rates are at or below benchmark;
- Readmission rate favorable trend means members are able to access care post-discharge effectively;
- Prior authorization (PA) volume favorable trend means members are able to access services requiring PA effectively;
- Quality measures (including HEDIS, well-child, adolescent care and annual dental visits) favorable trend means members are accessing preventive care effectively and timely.

Network Adequacy Management: In addition to the Network Development and Management Plan (NDMP), adherence to all related AHCCCS reporting requirements (ACOM 415,436,439), and mental health parity (42 CFR Part 438), BUFC's self-monitoring includes reporting results of quarterly network standards compliance analysis using Provider Affiliation Transmission (PAT) and Gap in Services Log. BUFC QMPI and Contract Strategy Committee is where corrective actions are addressed. We use geo-mapping software to identify gaps and conduct research utilizing Medicare.gov, Healthgrades.com, and other health plan provider directories. Additionally we use provider inquiries, letter of agreement creation, out-of-network prior authorization data, and internal/external stakeholder feedback. We also review appointment availability survey results, PCP open/closed panel results and member enrollment data to identify

market changes. We take actions to improve access, such as recruiting new providers. As demonstrated with our recent ALTCS implementation, we effectively contracted the additional needed required to meet our ALTCS member's needs.

Appointment Availability and PCP Panels: Per ACOM 417, BUFC self-monitors access through AHCCCS-required quarterly appointment availability studies, including secret shopper calls and provider visits. PCPs, dentists, maternity care providers, BH providers and high-volume specialists are surveyed to monitor appropriate wait times for all visit types per AHCCCS standards. Appointment availability is monitored as part of the letter of interest process, during credentialing and re-credentialing, before initiating new contracts, during new provider orientations, and for contracted PCPs who appear on the AHCCCS 1800 report. Appointment availability data is tracked, trended and reported to QMPI, Contract Strategy Committee and AMG. If a provider is out of compliance or has trended issues, BUFC closes the PCPs panel and requires corrective action. In serious cases, BUFC presents the PCP at Contract Strategy Committee to determine if any additional steps should be taken, up to and including termination. BUFC also analyzes PCP open and closed panels on a monthly basis. Our contracts require minimum provider panels of 100 members before closure is allowed. When the number of PCPs with open panels drops, BUFC begins immediate PCP outreach to reopen panels and BUFC recruits additional PCPs or related services so members have adequate access to PCP care.

Utilization Management: In BUFC's monthly UM/Finance Committee, attended by Executive Leadership and other cross-functional leaders, we review trended utilization patterns. When changes in trend are identified, such as spikes in ED services or reductions in outpatient utilization, we identify opportunities to improve. Data is analyzed as unique service types, i.e. pharmacy, lab, etc.; and trended to locate changes in patterns driving changes in cost. Monitoring for changes in utilization, like ED and Urgent Care, we seek additional data inputs to identify if loss of access is a cause and work with those providers to improve office hours, etc. In addition to the submission of all AHCCCS reporting requirements per AMPM policy 1020, BUFC will implement quarterly audits with indicators that address over and under-utilization, crisis/safety plans, and adherence to the BUFC Diversion, out of state, and DC Planning protocols.

Pharmacy Benefit Management: BUFC's Pharmacy Benefit Manager (PBM) MedImpact self-monitors access through routine analysis and reporting. MedImpact meets with BUFC leadership quarterly to report on pharmacy utilization trends, which may identify access to needed service concerns. In addition, a comprehensive drug utilization review process monitors prescribed medications consistent with AMPM 310-FF to provide oversight of prescribing practices. Rigorous monitoring occurs during transitions and implementation of new programs and includes medication reconciliation to safeguard against medication errors that are more likely to occur during complex system change. We monitor the rejected claims multiple times a day to assure claims are processing as intended. This allows us to identify and rectify any issues quickly. On an ongoing basis, we review claims during our daily work to identify issues. More commonly, we receive calls from members, providers and pharmacies if they are having issues related to obtaining medications or processing of claims at the pharmacy.

AHCCCS Performance Measures: BUFC self-monitors access to needed services by tracking and trending AHCCCS performance measures. Inovalon, our NCQA-certified HEDIS software, calculates monthly rates. Our QMPI Committee reviews progress and makes recommendations for changes in approach. As a result of this rigor, CYE 2017 Access to PCP 7-11 Years and Access to PCP 12-19 Years measures exceeded AHCCCS contractual minimum performance standards.

Quality Management: BUFC self-monitors access to needed services through our Quality Management (QM) Program. In conjunction with other Medical Management Departments, this includes monitoring care delivery for populations, such as fidelity monitoring for Children's System of Care Practice Reviews and protocols for Child and Family Teams, Generalist Direct Support Services (MMWIA), CASII and others as directed; children and transitioning youth with CRS-eligible conditions; and other designated Special Health Care Need populations. QMPI supports performance improvement across all initiatives by tracking and monitoring trends. QMPI recommends process improvements and corrective actions. The QM Department also handles quality of care investigations, such as those impacting access to care. A corrective action plan may be required when a QOC investigation outcome is substantiated. If an adverse action is taken with a provider due to a QOC, BUFC reports it to the AHCCCS Clinical Quality Management Unit.

Feedback: BUFC uses member, provider, stakeholder, and regulator feedback to self-monitor access to needed services. Quarterly member satisfaction surveys, monthly member non-emergent transport surveys, outreach, the Member Advocacy Committee, Quarterly Provider Forums, Provider Surveys, outreach work of the BUFC Office of Individual and Family Affairs, Neighborhood Advisory Councils, and trended grievances, appeals, and complaints are utilized. Our 24/7 Nurse Triage Line also surveys members to determine whether they received needed services.

Compliance: BUFC reviews the validity of our self-monitoring approaches through the arms-length auditing conducted by our Compliance Department, which evaluates our self-monitoring processes, such as appointment availability surveys to make sure policies and procedures are current, the process is in compliance and being conducted timely and properly.

4. INTEGRATING THE DELIVERY OF BEHAVIORAL HEALTH AND PHYSICAL HEALTH CARE UNDER A SINGLE ENTITY…

Banner-University Health Plan (BUHP) acknowledges improving health is about more than just treating an illness, it is about understanding and addressing all 8 Dimensions of Wellness – emotional, financial, social, spiritual, occupational, physical, intellectual, and environmental; and supporting children to achieve developmental milestones through engaging with their families and natural environments. However, our approach to integration is not just about Physical Health (PH) and Behavioral Health (BH) integration at the payer and practice levels, it is also about knitting together neighborhoods that work collectively to impact *Elements of a Healthy Community*, such as: transportation, access to care, housing, community safety, economic and educational opportunity, quality affordable food, and social/cultural cohesion. As the only locally owned and managed health plan (serving AZ since 1985), part of the largest health care delivery system in the state, AZ's largest private employer, and through a 30+ year affiliation agreement with the University of AZ (UA), we are integrated into the community and continually deepen our understanding of the vast diversity of strengths and needs across our state. Our company operates here; our leaders live here; we will still be here. Everything we develop, test, and implement is made specifically and exclusively for our AZ communities and neighborhoods. BUHP understands the pressure providers face during times of transformation; if it happens too hastily without taking provider, member/family and community perspectives into consideration, it can cause disruption and instability across the system. Providers, members, natural supports and community stakeholders need to be brought in at the planning stage, help develop transformation goals, be part of defining and measuring success, and be engaged in educational efforts to prepare for the new landscape. During BUHP sponsored Community Think Tanks, providers, peers, family advocates, first responders, educators, and other stakeholders voiced concern that positive aspects of the system are often lost during times of transformation. They encouraged health plans to recognize and preserve aspects that are working well in our system today. They emphasized there is no "one-size-fits-all" approach to integration. BUHP will utilize our experience coupled with insights from members, family, providers and stakeholders to administer an integrated benefit, enhance care coordination through an integrated Care Management program, and engage members in health promotion and system navigation while enabling access to integrated service delivery at the practice level.

ADMINISTERING INTEGRATED BENEFITS – THE BUHP COMPLETE CARE CONTINUUM

BUHP will administer integrated benefits while incenting integrated service delivery, enhancing member experience and improving quality of life through the *BUHP Complete Care Continuum (C3)*. C3 includes: 1) BUHP Complete Care Management, 2) Neighborhood Networks, 3) Banner Navigation Accelerator and 4) Member Supported Care Circles. C3 is built from the *AZ Vision and 12 Principles for Children* and the *Adult Service Delivery System 9 Guiding Principles* and contributes to research supporting evidence-based approaches to integration at the service delivery level.

1) BUHP Complete Care Management

BUHP's Complete Care Management program, functioning with a population lens, will include a core team of *Generalist* Care Managers at the health plan level with expertise in both PH and BH, and a focus on member engagement and community and provider referrals to address both social determinants of health (SDOH) and acute episodic needs. This *Generalist* core handles in-coming calls and internal referrals, responses on the member's Health Risk Assessment (HRA)/Health History Questionnaire (HHQ), and analytic monitoring. Generalist Care Managers will work with child and adult members – offering same-day referrals, triage and assistance connecting with social supports while outreaching those who can be difficult to reach, have care gaps and/or have sporadic attendance at appointments. They will offer "Red Phone" communication with community providers and social service agencies, enabled by our information platform, to provide rapid intake and timely care. BUHP Generalist Care Managers will be supported by *Specialty* Care Management Teams formed to provide ongoing care management for members with the most complex needs and/or specific specialty care needs. Specialty Care Managers will include licensed BH Professionals, Adult and Pediatric RNs and LPNs, and Certified Peer/Family Support Specialists. Specialty Care Managers provide high touch care management to child and adult members experiencing chronic pain, justice involved, struggling with BH challenges and/or addiction, multiple PH and/or BH comorbidities, undergoing transplant, coagulation disorders, eating disorders, autism spectrum disorder, involvement in CRS, CMDP transitions, high-risk pregnancy or postpartum, victims of sex trafficking, and other specialty foci. Members are assigned to these Care Management teams through use of population segmentation by our clinical analytics team, responses to HHQs, decisions made during our Interdisciplinary Care Team (ICT) huddles, and input from members and their providers. This Care Management model is best suited to meet the needs of the entire population, from the acute episodic needs of lower risk members to the chronic needs of our high-risk populations who account for most health care utilization and medical expense. Analysis of our GMH/SA dual population has

demonstrated 0.7% of members account for 62% of the use of BH services. This validates the need for specialty teams to meet the unique needs of the diverse segments of this Complete Care covered population, yet at the same time, rapidly addressing the short-term acute and episodic needs of most members in Care Management.

Critical to successful transformation of care is cross-training of employees, focusing on family and natural supports, and inter-professional learning at our ICT clinical rounds. BUHP Care Managers will share expertise through cross-training activities. In addition to trainings outlined in the AMPM, Chapter 1060, all Care Managers will engage in ongoing training in the *Adult Service Delivery System 9 Guiding Principles*, *12 Principles for Children*, trauma-informed care, crisis intervention and planning, solutions-focused problem solving, overview of system partners and social service delivery system (including first responders, justice departments, Department of Child Safety, Vocational Rehabilitation, Division of Developmental Disabilities and others), cultural competency, coordination of benefits, evidence-based assessment tools, person-centered planning, environmental risk factors and SDOH, Ticket to Work, use of DB101.org, and standard trainings related to internal operations. We will continue to make sure all Care Managers are certified through the AZ Coalition for Military Families as *Resource Navigators* and *all* member-facing BUHP employees receive training in Safe Talk, motivational interviewing and Mental Health First Aid. Additionally, BUHP adopted the Zero Suicide Model and has initiated a self-study and Zero Suicide Workplan. BUHP employees will participate in Zero Suicide workforce development efforts, and Care Managers will receive ongoing training in the use of Suicide Care Management Plans.

2) Neighborhood Networks

Member-Centered Care in Your Backyard: BUHP will organize providers and community stakeholders into Neighborhood Networks, creating customized local strategies and aligned payment models to respond to the unique strengths, needs, cultural aspects and SDOH of each Neighborhood. Shared outcomes payments and cross-system shared savings strategies will drive a cooperative approach and inspire collective impact. Consistent with population health, BUHP has and will continue to analyze our covered populations to discern distinct neighborhood characteristics and needs. Given the rural nature of AZ, needed services may not always be available in a defined neighborhood. In these instances, BUHP's provider network will augment and make sure needed services are available statewide, including use of field clinics and telemedicine when needed. Additionally, BUHP will offer enhanced transportation programs – including ride-share programs, same-day scheduling, and the ability for providers to offer transportation directly. We will use Project ECHO for tele-grand rounds and tele-training of providers giving them access to needed specialists.

Transparency and Collaboration: Through Neighborhood Advisory Councils, representatives of each designated Neighborhood Network will set priorities and goals openly and transparently. These Councils afford the opportunity for providers, members, family and stakeholders within each Neighborhood to build mutual understanding of system expectations, inform vision and goals, participate in strategic direction and definition of success, while promoting mutual accountability and standardization of demonstrated best practices. In addition, peer and family voice will be embedded at every level of the system through the BUHP Office of Individual and Family Affairs, a Member/Family Advocacy Council with a Youth Advisory Subcommittee, and member/family representation on internal committees.

Models of Integration and Critical Neighborhood Components: Neighborhood Networks will make sure members have access to integrated Health Homes and providers are incentivized to take steps towards integration. We will categorize PCPs and BH Homes into levels and pay increased rates based on level of integration: ***Level 1*** *– Screening Strategy with Warm Hand-Off and Follow-up on Referral****; Level 2*** *– Cooperative Referral Process and Mechanism for Co-Management and/or Co-Location;* ***Level 3*** *– Fully integrated BH and primary care services – including team-based care, availability of same-day consultations, care coordination and a population-based approach to care.*

Some providers may initiate a BH screening within a primary care setting or primary care preventative screening within a BH setting; others will implement evidence-based collaborative care and other paths to complete integration within a primary care setting, fully integrating primary care within a BH setting, integrating BH services within specialty medical settings, or creating virtual integration and field clinics through multi-provider groups and collaborative ventures. All contracted PCPs and BH Homes will be expected to achieve a minimum of Level 1 competency. Our technology solution, *Banner Navigation Accelerator (BNA)*, allows providers to achieve Level 1 through streamlined intake, care planning and referral process, including the opportunity to follow up on and track status of referrals. We will offer providers training,

technical assistance, hands-on consultation and support on BNA to increase integration. We also help smaller providers join *collaborative ventures such as Equality Health*, an integrated network of providers, to enable integration and align culturally appropriate care while offering analytics and care management resources and support.

Additional critical components include availability of Peer and Family Run Organizations (PFROs), Behavior Analysts, Psychosocial Rehabilitation specialty providers – including those who mutually contract with Vocational Rehabilitation, First Episode Intervention Programs, jail reach-in and transition programs for forensic populations, transportation providers, specialty medical care networks, dental providers – especially those meeting the American Academy of Pediatric Dentistry guidelines for treating children with special needs, health promotion and prevention services, residential, day treatment, supported housing, inpatient services, crisis stabilization, and medical and support services as outlined in the BH Covered Services Guide. BUHP will carefully consider adding providers to each Neighborhood Network. Consideration will be given to standardized business criteria, ability to engage in Value-Based Purchasing (VBP), population needs by specialty and geography, total members served, achievement of performance measures, and scores on our proprietary *BUHP Assessment of Quality and Recovery Orientation*. This assessment evaluates elements such as: member-centeredness, welcoming environment, trauma informed, use of evidence-based practices and achievement of outcomes. This tool was developed based on processes used to evaluate the recovery orientation of BH systems and providers across the country, including but not limited to: NAMI *Grading the States*, DBHS *Recovery Culture Roadmap* and Mental Health America's *Ranking the States*. The assessment will be completed through provider self-report along with the submission of supporting evidence, including outcomes and enrollment data.

Neighborhood Summary: Each Neighborhood will focus on **quality improvement and outcomes driven service provision** – participating in Health Current (Health Information Exchange) and optimizing use of BUFC analytics and neighborhood scorecards. We embed **VBP** within our contracting approach to address quality measures and costs associated with health care. We offer **member and family-centered care**, providing opportunities for members and families to direct their care while easing challenges of system navigation. Neighborhoods will promote use of **evidence-based care**. Members will have a **Complete Care Plan** developed at the provider level based on their complete needs, which will include as applicable: diagnoses, treatment interventions, review of SDOH and *Complete Care Core Elements*. **Complete Care Core Elements** address ways BH and medical diagnoses may impact each other, potential risks identified in the review of SDOH, and plans to address these factors. In addition, Complete Care Planning will include **Health and Wellness Reviews** related to modifiable lifestyle and behavioral issues including nutrition, exercise, stress and smoking.

3) Banner Navigation Accelerator (BNA)

BNA is a HIPAA compliant care support and logistics platform that will enhance care coordination at the health plan and provider levels. BNA enables access to information to reduce barriers in seeking care, reduce delays in accessing care, eliminate fragmentation, address SDOH and offer community stakeholders (such as first responders) a single point of contact. BNA manages intakes, assessment, Complete Care Plan and other data – allowing providers to complete a member intake and Complete Care Plan in a single tool while combining intake, claims and user-contributed data to create a longitudinal member view. Providers can reference member aligned Health Current data and historical claims data to understand and guide the completion of intake and care planning in the BNA tool. Self-service and built-in algorithms can then support provider selection related to a member's preferences and needs. Care Managers and providers can easily update and review a member's Complete Care Plan, so each member has *one* comprehensive plan. This eliminates gaps in care that occur when specialty providers wait for plan updates prior to serving a member or develop their own separate care plan, often leading to fragmentation. In later stages of BNA development, we will also automate, capture and share data for other intake forms, such as housing applications, to expedite care. This information will all be added to longitudinal data centered on our members, creating an actionable set of information for logistics and Care Management support – including the proactive identification of members in need of Care Management or other services. BNA provides desktop and mobile tools which allow users to easily navigate and gain access to services. Users choose from self-service and intelligent tools to provide supported navigation to align members' care most appropriately. Using BNA, we can carefully guide care to where it is most appropriate and convenient, based on the user profile created. This assures care is on time, in-network and accessible no matter who is guiding the process. Over time, our system will continue to become more intelligent and improve capabilities to suggest care based on new information coming into our platform through assessment and administrative data.

A built-in referral functionality is available to administrative and clinical users to enhance care coordination. Referral workflows allow providers to make warm-referrals, share Complete Care Planning recommendations and follow-up post referral to confirm engagement. New data is added to the overall profile of each member and will be included in population health and care opportunity analytics to inform and support care coordination. BNA includes a community resource clearinghouse to coordinate resources across systems. Use of this clearinghouse can help identify where a member should go to apply for food stamps, how to access the nearest food bank, identification of emergency utility funds, navigate available housing resources, access emergency shelters in the case of exposure to violence, find emergency pet-care while being hospitalized and many more important resources that address SDOH.

Establishing *Neighborhood Navigators*, we will utilize the BNA platform to reduce challenges and intimidation often faced when navigating the system. In conjunction with our investment in BNA, it is important for BUHP to invest in human touch – offering access to someone who can help determine what services and programs make the most sense for members based on their needs, interests, location and resources. Leveraging the functionality of the BNA platform, *Neighborhood Navigators* will be focused on connecting members with services and improving their ability to navigate the complexities of the health and social service delivery systems. Navigators will include community members already working diligently to impact SDOH, such as: staff at First Things First Family Resource Centers, PFROs, homeless shelter staff, DES and DCS staff, justice department health coordinators, first responders, school personnel and hospital-based Care Coordinators. BUHP has engaged key stakeholders in conversations about becoming Neighborhood Navigators. The First Things First Family Resource Network has confirmed this approach is viable and offers solutions for helping Family Resource Centers improve their ability to connect community members with resources and improve their understanding of BH system navigation. The AZ Department of Education is committed to partnering with us during Phase 2 of BNA implementation to make BNA meaningful and accessible to teachers throughout AZ and across grade levels. The Department of Education confirmed this approach to improving system navigation and accessibility aligns well with their current push to shift the focus in the classroom from academics to *Whole Person*, with a focus on understanding the social and emotional development of students. In partnership with first responders, including leaders from the Glendale Fire Department and Tucson Police Department, BUHP has explored the need for first responders to have easy access to system resources to avoid unnecessarily escalating situations and dropping people off at hospitals and/or jails. The Glendale Fire Department has confirmed BNA is a viable solution and has demonstrated early commitment to partnering to inform its development and identify Neighborhood Navigators within the Department. We have also explored how this need presents itself within the justice departments – especially seeking early guidance and feedback, and building partnerships with the Pima County Juvenile Court Center and Maricopa County Correctional Health Services.

To further extend our investment in human touch for supported navigation, BUHP will invest in the Family Involvement Center's (FIC) evolution of the Parent Assistance Line. Developing a Family Assistance Line staffed by trained Family Support Partners who utilize evidence-based approaches to engage with family members, offer family support, and assist families in accessing care and resources for their loved ones. Built on the research that family support dramatically increases member engagement and therefore improved member outcomes, BUHP will offer family support for all populations through engaging with FIC to establish the Family Assistance Line call center.

4.) Member Supported Care Circles

An innovative approach to member support, our *Member Supported Care Circles* is incorporated into the BNA platform. Care Circles will bring together members, family, friends, Care Manager and others – connecting members with their chosen support network in an easy to use, member-centered mobile application. Members choose who they want to include in their Care Circle to promote family/natural support involvement in the promotion of health and wellbeing. Care Circle members can receive actionable alerts and information. Members can communicate with their Care Circle, direct levels of authority within the Care Circle and remove people from the Care Circle as desired. As a differentiator, use of geolocation technology allows us to 'sense' utilization as it is occurring to activate rapid intervention. If a member agrees to participate with our mobile application, they may choose to allow their smartphone's geo-sensing technology to help with care. So, if they find themselves needing services and go to an ED, their Care Manager could receive a notification. The member and Care Manager could easily communicate via voice or text without ever leaving our application. The mobile app also offers direct linkage to our *Nurse Line* and the *Family Assistance Line*. If members do not have engaged natural supports to include in their Care Circle, BUHP Care Managers will encourage them to consider utilizing a Family Support Partner to fulfill that role. We will engage in specialized contracts with PFROs to offer this

unique approach for members experiencing a time of complex need. Use of Family Support Partners in this role will help extend the role of both the BUHP Care Manager as well as the provider-based Case Manager when needed.

PROVIDER-BASED CASE MANAGEMENT

The impact of BUHP's Complete *Care* Management team will be further extended by provider-based Integrated *Case* Managers to offer a boots-on-the-ground, assertive approach for those members with the most complex needs. Provider-based case management shall be made available to all members in need, regardless of whether it's related to their PH, BH and/or substance abuse condition(s). As an ACC Contractor, BUHP understands *ALL* members have the potential to benefit from case management during times of complex need. For many members with complex needs, case management will only be needed on a short-term, transitional basis, while other members may need it on an ongoing basis. C3 is designed to respond to both scenarios.

Members in Need of Case Management are Proactively Identified: The plan-based Care Management team constantly monitors for members in need of additional support, especially those with special health care needs, through use of predictive analytics (which includes consideration of utilization patterns, diagnoses, pharmacy data, BNA and Member Supported Care Circle alerts, key demographic and SDOH data) coupled with clinical judgment. While the health plan is monitoring need, we empower our providers to utilize clinical judgement and act nimbly to respond to members' need for additional assertive supports through case management. As such, we have developed a VBP program that incentivizes quality outcomes and affords PCPs, BH Homes, MSICs and Centers of Excellence the ability to provide case management under an enhanced rate, care management fee (via PMPM), or capitated all-inclusive payment to provide comprehensive care and achieve outcomes when clinically appropriate and medically necessary.

Payment Models that Incentivize Proactive Delivery of Case Management: With the awareness of historical patterns within the BH system to pay providers based on volume, the BUHP funding model creates opportunities to shift away from fee-for-service payment of case management while promoting appropriate and meaningful use of this important service. We enable providers to deliver this service as needed through VBP agreements. The VBP agreement may look different based on the readiness of each provider – as an example, some may be compensated for this service through shared savings or bundled payments, while others may receive a PMPM as they build readiness to take on more risk. We will help those providers who are not ready to take on risk and those small, independent providers who need to connect through virtual health integration by connecting them with our special network partners, such as Equality Health and Banner Health Network (BHN), who provide population management teams, systems and transformation support. BUHP offers uniquely customized solutions for independent physicians and smaller providers to function as *Virtual Health Homes* and *Field Clinics* through alignment in collaborative ventures. BUHP is working with these partners to alleviate physicians of some of the overwhelming and time consuming administrative work necessary to make practices financially solvent, while creating opportunities to participate in new alternative payment models.

Providers without the Capacity to Provide Case Management: Some members in need of Case Management may be receiving care through an independent provider who does not have the capacity to offer such services. Dependent on a member's needs, continuing with their current PCP may be in his/her best interest. In other cases, the BUHP Care Manager may encourage the member to transition care to a provider that offers comprehensive services. However, if a member with complex needs selects to stay where they are, the member will be referred to an *Equality Health Complex Care Clinic or our Healthy Together Care Partnership (HTCP)* team to assess need and deploy a provider-based case management group such as the provider-based Banner case management program, or through a unique contract with an organization such as Crisis Response Network (CRN) to offer integrated case management support. These provider-based case management groups help fill the gap and allow for all members, including those in rural and frontier areas, to be connected to an integrated health home via this virtual connectivity and support extension.

BENEFIT COORDINATION

The management of integrated benefits offers the opportunity to promote optimal use of both BH and PH services, driving success in bending the cost curve. We work with our providers to increase understanding of coordination of benefits, and our processes align AHCCCS as payer of last resort. With ACC and the changing landscape, some small BH providers may be challenged by the need to work with multiple payers. As such, we will offer technical assistance to help them understand Medicaid and Medicare billing requirements.

PAST EXPERIENCE ADMINISTERING INTEGRATED CONTRACTS

Integrated Care Management: BUHP has experience administering integrated contracts through our B-UFC ALTCS, UFC Acute (GMH/SA Duals), MHP Acute (GMH/SA Duals) and University Care Advantage (UCA) DSNP plans. Through this experience, we have implemented an integrated approach to Care Management, establishing specialty Care Manager roles and enabling BH Professionals (BHPs) to work in conjunction with our generalist and other specialty Care Managers. Although the member interfaces with one primary point person, the Care Management department offers a team-based approach to care while working together to staff cases, share resources and engage in cross training.
Healthy Together Care Partnership (HTCP): HTCP is a BUHP exclusive program offering integrated, targeted, high-touch care to members in need across all our integrated contracts. Based out of Banner Medical Group's primary care clinic, HTCP provides primary care co-management through intensive home -based care of members with multi-morbid chronic conditions and emergent needs to assist with community-based stabilization and transitions in care. This program uses the Global Health PROMIS survey to identify self-assessed health status and which indicates 64% of enrollees are at least one standard deviation below the national physical health mean and scores 35% below the mean for mental health. The program achieved a 16% drop in ED visits with even more marked improvements in inpatient stays, particularly in chronic disease subgroups such as those with diabetes (29%) and kidney disease (32%).
RBHA: As a minority-owner of Cenpatico Integrated Care (CI), the RBHA for Southern AZ, we are familiar with the BH needs in this region and opportunities to transform the current system. We administer an integrated BH and PH benefit through managing Medicare benefits for aligned beneficiaries with CI. Our wrap-around care management services and interventions targeting this sub-group have successfully improved their whole-person health and reduced disparities as evidenced by their performance measure outcomes (93.24%access to care and 85.82% A1C testing).
Innovation and Collaborative Care (ICC) Department*:* We established an ICC Department in 2015 to incubate new VBP models to support integrated service delivery in partnership with our valued providers. For example, we recently launched 3 programs in conjunction with the UA Workforce Development Program, UA Sleep Medicine COE, and Camp Wellness U, with an emphasis on helping our GMH/SA members engage with peer support services to promote health and wellness and/or access integrated services in an integrated primary care setting. The 9-week Camp Wellness U initiative for people with diabetes and depression achieved marked improvements in PHQ-9 scores and SF-12 quality of life and health indicators, and HbA1c, blood pressure and body weight. Our Collaborative Care program is aligned with TIP beneficiaries to promote successful launch and financial sustainability of the model. We are utilizing lessons learned to expand these and similar integrated models. Such integration efforts are rooted in SAMHSA's 6 Keys to Integration Success: 1) hire peers, 2) get organizational buy-in, 3) address cultural and linguistic competency, 4) co-locate for better communication and better care, 5) implement HIT, and 6) make wellness fun, accessible and social.
Pain Clinic: Driven by our commitment to continual learning and research-driven innovation, we worked with UA medical students to analyze interventions to prevent opioid related deaths and evaluate the efficacy of the Banner-University Medical Center South Campus Pain Clinic. Through these evaluation efforts, we uncovered most of our providers are implementing clinic procedures consistent with CDC 2016 Guidelines and are experiencing the greatest challenges implementing Naloxone co-prescribing and referral to MAT services. Providers reported appreciating the education, mutual problem-solving and support offered through our provider-outreach efforts. It was demonstrated that program participants decreased their opioid use by an average of 50%, achieved an average 33% reduction in pain, there was significant reduction in opioid dosages across all participants and the pain clinic achieved an 85-100% participant satisfaction rate. We concluded this treatment model is effective and are now pushing this information from an academic setting to the medical community, using this success as a template at other health care facilities.
ALTCS Implementation: We achieved early success in implementing our newly awarded, integrated ALTCS contract through our preparedness, workforce development, network development, member engagement and operational efficiencies. By day 1 of go-live, we had a fully staffed and trained care management department, ready to meet the needs of our ALTCS members. Before, during and post initial implementation, we have maintained our high level of customer care, addressing all provider contracting issues within a 24-hour turn-around time. All members were contacted by their BUHP Care Manager within the first 3 days of going live. Within the first month post go-live, 1,174 members were identified as having an overdue assessment, of which 97% were rapidly completed within the month.
DSNP Management: Through our integrated UCA DSNP contract, we have continually improved members' experience as evidenced by a decreased disenrollment rate from 3.5% to 1.5% in 2016 and then to 1.28% in 2017. Our Stars disenrollment went from 13.32% for the 2017 Stars Measure to 10.76% for 2018. Our UCA Model of Care (MOC) committee has always received the maximum 3-year approval. Our MOC has identified frail, elderly and members with SMI as vulnerable populations with specialized programs to meet their needs. Due to our DSNP success, UCA offers increasing levels of supplemental benefits each year, including: eye care, dental, over-the-counter medication and

personal emergency response system. We successfully incorporated the Medicaid BH covered benefits for eligible GMH/SA duals on 10/1/15. During CYE 2017, we engaged in multiple initiatives to improve our Star Rating. The Grievance and Appeals team made workflow changes to improve timely review of appeals. The ICC team increased number of Medicare VBP contracts and achieved a 93% improvement in Annual Wellness Visit measure from 2016 to 2017. We made substantial outreach enhancements to improve HRA rate. We implemented a Pharmacy 90-day fill Warm Health Interactive Voice Response program. We created a supplemental database to track non-traditional wellness measures. Additionally, we promoted annual wellness visits, instituted a marketing campaign with rotating monthly focus on a health promotion topic, conducted welcome/appreciation member calls, and targeted member outreach to improve colorectal cancer screening, diabetic eye exam completion, and uncontrolled diabetes. Through these efforts, our overall Star Rating went from a 3 in 2017 to a 3.5 in 2018, we improved our Star Rating in 17 individual categories, and we achieved the maximum 5 Star Rating in 9 categories.

ENGAGING MEMBERS AND IMPROVING OUTCOMES THROUGH USE OF TECHNOLOGY AND SOCIAL MEDIA

In partnership with the UA Health Sciences and Eller College of Management, Banner has launched a *Digital Health Collaboratory* based in Phoenix – creating opportunities for BUHP to beta test and incubate technology solutions with AZ tech companies, helping to launch local businesses and positively impacting the local economy. Early work in the Collaboratory is identifying new ways of improving our member engagement, health outcomes, and quality of life through a combination of pharmacogenetic testing and business marketing principles. Two of the tech companies we are currently partnering with (Pyx and Health Trio) are local AZ -grown businesses.

BUHP has been using *Warm Health* for 10 years, offering automated interactive phone calls, texts, and emails to support member's individualized needs by providing practical advice for staying well, helping manage chronic diseases and tracking and supporting health concerns. Members can send an alert to BUHP Care Management and receive individualized support. We have several uniquely focused programs within the Warm Health platform, including but not limited to: ED Avoidance, Pregnancy Support, Postpartum, Well-Baby, Depression and Pharmacy Programs. Members report feeling more comfortable completing the PHQ-2 and PHQ-9 via automated Warm Health calls than during live calls with Care Managers, with 88% engagement rate for those involved in the Warm Health Depression program.

To increase annual well-child visits with UFC members between the ages of 2-20, we implemented a 3-month **text messaging pilot** to offer parents of EPSDT members visit reminders tied to educational information promoting the importance of well-child visits. We utilized lessons learned from this pilot to develop our *Member Supported Care Circles*, powered by Pyx, and *BNA platform*. This technology, as previously described, becomes an extension of the Care Management team. The BNA platform will support access to our Member Portal – a HIPAA compliant, secure, web-based solution that facilitates communications with our members. The Member Portal, powered by HealthTrio, will enable members to review their eligibility and benefit package, find providers, request a change of PCP, request new ID card, submit feedback, and review claims and prior authorization status. Each component of the BNA platform is immediately accessible from all other areas, assuring consistent look and feel across our platform's toolset. Our technology guides each user to the appropriate functionality and the proper information to support their needs.

Through our **BUHP Social Media Strategy** we will package and present information that promotes members' health by providing authentic and helpful native content – including use of infographics, short videos, top 5 lists related to healthy behaviors, and more. We will also share news stories relevant to our members' lives, fact check fads, and address dangerous trends in social media (such as unrealistic body image). We will use social media platforms to create moderated and curated communities where we seek input, answer questions, and provide a safe space for sharing. Our video content will include: 1) short videos designed to comment on news, share fast facts, and offer motivations, and 2) longer videos that address things that make members nervous, such as what it is like to get an MRI, what to expect at your first OBGYN appointment, and the importance of preventive care. Our Social Media Specialist will monitor and respond to daily feeds, create engaging content to develop a significant relationship between our members and BUHP, and work in conjunction with the Banner Public Relations team. Through alignment with our Facebook, YouTube, Twitter and Pinterest presence, we can drive our health promotion and education messages out to a larger user-base and decrease the stigma that may be associated with publicly interfacing with a Medicaid plan. We will continually adapt and pivot content strategies to provide value, create an emotional connection, and inform members on a wide range of topics, including preventive care, strategies for health, and reducing anxiety around the health care experience.

5. THE OFFEROR HAS A MEMBER WHO IS A 54-YEAR-OLD FEMALE WITH SCHIZOPHRENIA, OPIOID USE DISORDER…

By prioritizing and addressing the care needs of our member Val, Banner-University Family Care (BUFC) delivers on our mission *to make health care easier, so life can be better* for our members, families and caregivers. We conduct ourselves using the *AHCCCS mission and vision*, *system values and guiding principles* and the *vision for integrated services*. BUFC provides comprehensive care coordination to proactively identify and engage members like Val in a strengths-based, member-centric manner, to reduce fragmentation and create a roadmap for whole-person wellness based on choices and preferences and in consideration of her social determinants of health (SDOH). Using proactive care coordination, shared decision making and interdisciplinary care team collaboration, we tailor services to maximize outcomes, independence and connection to supports. Our robust and integrated **Complete Care Management** program, integrated **Neighborhood Networks** and investment in innovative **health information technology** (HIT), will help Val optimize wellness, including stability in treatment of her diabetes, schizophrenia, opioid use disorder and chronic pain, and facilitate reconnection with her family and natural supports. We will help her establish goals related to living, learning, working and socializing. Through rapid response in the emergency department (ED), active discharge planning and use of our complete care approach to physical health (PH), behavioral health (BH) and risks associated with SDOH, we work with Val in a transparent manner to build trust and address needs expeditiously, in accordance with best practices.

In 2015, BUHP integrated PH and BH care for more than 11,000 GMH/SA dual members with minimal disruption as demonstrated by only 1 grievance within the first month and a total of 14 over the course of the first year. Our member-centric culture shined during the 2016 Maricopa Health Plan (MHP) transition and was noted as a best practice by AHCCCS. MHP member transitions included warm handoffs and open communication with the receiving contractor, resulting in only 4 member grievances throughout the transition of more than 68,000 members. In 2017, we successfully transitioned 6,139 ALTCS members, deploying a fully staffed, trained and integrated Care Management team before day 1, addressing all provider contracting issues within a 24-hour turn-around time and updating more than 1,000 overdue assessments within the first 30 days.

***9/15/18 to 10/15/18*: TRANSITION OF CARE FROM UNSUCCESSFUL INCUMBENT OFFEROR TO BUFC**

BUFC's Proactive Outreach Efforts: Prior to Val's 10/1/18 transition to BUFC, the BUFC Care Managers identified Val on the transition AHCCCS DEF file as having been in active case management by the incumbent plan and reviewed her diagnoses, which included schizophrenia, IV heroin use, opioid use disorder, brittle diabetes, and chronic pain due to peripheral neuropathy and pharmacy utilization, which included Percocet and metformin. Our Supervisor of Complete Care Management reviewed Val's information and assigned her to Sue, a BUFC Specialty Care Manager who is a licensed BH Professional (BHP), to best match her needs and strengths. While Sue will be Val's primary point of contact, she is supported by an interdisciplinary team of Care Managers to help provide expertise and engagement when needed, including licensed BHPs, RNs, MDs, and certified Peer Support Specialists with extensive experience in meeting the needs of members with complex needs and knowledge of community-based supports. Sue reviewed Val's history with the incumbent plan's case manager prior to the 10/1/18 transition. Sue received a copy of Val's Service Plan, learned Val has had frequent relapses of drug use in recent months, failed outpatient treatment twice and had been receiving intermittent services with the RBHA. Prior to the 10/1/18 transition, Sue unsuccessfully attempted to reach Val with 3 telephone calls, spoke with her RBHA provider-based case manager, informed the PCP listed on the DEF file of her availability and sent Val a letter welcoming her to BUFC Care Management. Sue documented a summary of Val's case in Acuity Advanced Care system and because of inability to contact this high-needs member, she added Val's name to the Health Current cohort to trigger an alert if Val should be admitted to an ED or hospital. On October 15th, Sue receives an alert: Val is in the ED in Goodyear.

Val's Personal Struggles: Val has been in a tailspin since the death of one of her closest friends in the summer. Her family ultimately completed an intervention with Val and no longer allowed her to stay in their guest house, and her PCP stopped refilling her Percocet since she repeatedly broke her pain contract. She stopped her medications, began to use heroin and began sleeping at a local park. On October 12th, she is brought to the ED by police after they were called to the park due to her unusual behavior and unsteady gait. Due to challenges with her current placement, she remains in an *inappropriate* care setting in the ED as she uncomfortably withdraws from heroin.

The ED's Frustration: Val is admitted to the ED as a "Jane Doe," delusional, without any identification and with a blood sugar of 500. Due to her co-morbid schizophrenia, substance use disorder (SUD) and diabetes, they are unable to find a placement for her. The hospital will not place her in observation status since her diabetes is not severe enough to meet InterQual criteria. Both psychiatry and internal medicine consults are obtained and treatment initiated for her psychosis, agitation, withdrawal, elevated blood sugar and infected heroin injection sites. Although the ED is not the ideal care

setting for Val, the ED physicians monitor her care with consultant recommendations until a placement can be arranged. Val gradually improves and after 2 days identifies herself. The ED social worker wished to contact Val's family, but Val refused. Val's ED admission is uploaded to Health Current, which triggers an alert to BUFC received on 10/15/18.

If Val were treated at a Banner Health (Banner) ED, she would have benefited from a clinical improvement initiated in 2016 that reduced the duration of BH hospital holds in Maricopa County Banner EDs by approximately 40%. This utilizes an interdisciplinary, integrated approach to care driven by the development of Clinical Care Guidelines, which systematizes processes in the ED for medical clearance, behavioral health assessment, coordination and triage within different Banner Departments, the Banner Medical Group and external parties, including Crisis Prep and Recovery (CPR) and Community Bridges Incorporated (CBI). Key action included development of a clear definition for the required elements of medical clearance that were implemented consistently, an expedited behavioral health assessment process coordinated with CPR and CBI both on-site and through telemedicine, engagement and support of members using on-site peer support specialists in addition to active hospital-based case management to help coordinate triage and transitions focused on timely provision of intensive community-based services to support stability. Recognizing its role as a safety net provider, Banner initiated a targeted strategy for members with Opioid Use Disorders to provide expedited triage to CBI or other providers for engagement in MAT services to address addiction and pain management. Given the success of the initiative, the Joint Commission recognized this model as a best practice. BUFC will support the expansion of this practice throughout our *Neighborhood Networks*.

***10/15/18*: BUFC CARE MANAGERS RESPOND QUICKLY TO MEET VAL'S IMMEDIATE CARE NEEDS**

After receiving the Health Current alert, Sue immediately contacts the ED nurse caring for Val to review her status and needs. Sue then contacts Crisis Preparation & Recovery (CPR) to have a BHP sent to the ED to complete an intake, referral, assessment and treatment/service planning with Val consistent with AMPM Policies 320-O and 580, which includes initiating the process for determination of serious mental illness (SMI). Sue maintains regular communication with the CPR BHP. The ED assessment shows Val's blood sugars are now below 200 and with the changes to her psychiatric medications, having a few solid meals and no heroin usage, her neuropathy pain is somewhat controlled although she has unsteady gait due to foot pain and poor balance. Although improved, Val still reports gradually subsiding withdrawal symptoms and cravings to use heroin again. Due to the complexity and acuity of Val's situation, Sue consults with her supervisor and the BUFC Medical Directors with expertise in both PH and BH. BUFC Medical Directors focus on Val as a whole person, communicate with the treating ED doctor, review the BH assessment and determine Val remains at risk to herself due to her multiple co-morbid conditions that are interacting negatively with each other, her lack of independent living skills, insufficient nutrition, ongoing psychosis and poor ability to manage her diabetes. Her collection of BH and PH diagnoses, recent relapses, behavior and poor level of functioning made her incapable of safe independent self-care and self-regulation in the community. Due to her recently failed attempts at lower levels of care prior to enrolling with BUFC and current danger to her whole-person health, the BUFC Medical Director determines she meets criteria for treatment within a Behavioral Health Residential Facility (BHRF) for the intensity of services necessary to stabilize her symptoms. At this point Sue arranges for an Adult Recovery Team (ART) meeting to review service options with Val and understand her goals. Sue and the CPR BHP invite Val to meet with them and the ED provider, BUFC Medical Director and BUFC Peer Specialist Care Manager, Paul, to review her options and understand her preferences. Val desires immediate release for Medication Assisted Therapy (MAT), but initially refuses placement in a BHRF due to, "not wanting to be told what to do for the next months." Through motivational interviewing and Paul's ability to connect with Val through their shared experiences, Val begins to trust the ART and provides written consent (or a Release of Information) to coordinate care with health care providers, confirming she understands the 42 CFR Part 2 requirements of this consent and her ability to rescind the consent at any time. She ultimately chooses her services, which include immediate initiation of MAT treatment at Community Bridges Inc. (CBI) Access Point and a short 3-5 day stay at CBI Transition Point, which includes an ongoing assessment and treatment for her BH/PH needs by their BH/PH Medical Practitioners. Sue arranges for home health nursing services to be provided in order to support Val's PH needs, especially her infected heroin injection site, while in this setting. Sue contacts Val's PCP (who is not in the BUFC network) to coordinate care. Sue explains although he was not contracted with BUFC, we would honor the 90-day transition period through a Letter of Agreement (LOA) should Val choose to continue under his care. The PCP reports Val has repeatedly broken her opioid contract, her follow up with care was erratic and he had recently contacted the incumbent plan to change Val to another provider. However, he does agree to continue to serve as her PCP for another 30 days to give her time to transition to a new provider.

***10/16/18 to 10/20/18*: STABILIZATION OF VAL'S ACUTE SITUATION AND CONTINUED CARE PLANNING**

Access and Transition Points are designed to bridge the gap in the public BH system between inpatient and crisis services on one end of the spectrum and routine BH care on the other. At Access Point, a thorough evaluation, including urine drug testing, is conducted prior to initiation of MAT, including assessment for PH and BH comorbidity, use of alcohol and other addictive drugs, such as benzodiazepines or other sedative hypnotics, which could cause safety concerns in combination with MAT. The BH Medical Practitioner (BHMP) utilizes the Arizona Controlled Substance Prescription Monitoring Program (CSPMP) to obtain a utilization report for controlled substances for the past 12 months. After this comprehensive assessment, it is determined MAT treatment is clinically indicated for Val and options are reviewed with her, including the use of naloxone. She selects buprenorphine, group and individual therapy. Evidence-based therapeutic approaches are used, including cognitive behavioral therapy, contingency management and motivational interviewing, and Val is linked to family, peer and community natural supports. The care plan requires close ongoing collaboration between the treating BHMP and therapist, and reassessment of services in the event Val does not engage in the plan agreed upon as continued buprenorphine treatment requires participation in psychosocial interventions. Using CBI Access and Transition Points enables Val to be treated in the least restrictive setting, avoid hospitalization and expedite initiation of MAT services to reduce her relapse risk on heroin. During Val's stay at CBI Transition Point, she continues her medications, receives wound care from a home health nurse, is provided meals to meet her nutritional needs and learns of needle exchange programs in her community. Sue reviews primary care options with Val as she will need ongoing care upon release from this setting. She is encouraged to use an integrated provider and chooses Terros as she prefers one location where her diabetes, schizophrenia and SUD can be co-managed. Val's self-reported symptoms improve from "crummy" to "OK," primarily related to her withdrawal, but she continues to decline contact with her family. Following this stabilization within Transition Point, Sue initiates a second ART. Now that Val's immediate needs have been met it is time to create a roadmap for her long-term wellness based on her choice and preferences, placing Val at the center of all support and service planning decisions. Sue and Paul reinforce with Val that, similar to the previous ART, this meeting is held for her to express her wishes and that Sue's role will be to keep the meeting positive and focused on how the agencies can come together to assess and meet her needs and goals with Paul there to support her and advocate on her behalf through the process. Two options are considered with Val – either moving to supported housing or a short stay in a BHRF. All parties agree Val will benefit from a short BHRF stay to gain greater control of her situation, assure proper wound care and nutrition, further stabilize psychosis, increase medication management skills, and learn independent living skills. As Val improves and is given more choices of BHRF settings, and time to review their programs, she ultimately agrees to transition to Terros Maverick House BHRF and obtain her primary care at Terros' Olive Avenue Integrated Care site, but only if the stay at Maverick House is short. She appreciates the partnership she has felt with collaborative teamwork from BUFC and Transition Point, and their willingness to offer shared decision-making built on a foundation of trust. Since the BUFC Medical Directors have been involved with Sue regarding this case, it has already been determined Val met medical necessity criteria and there was no requirement to submit a Prior Authorization packet that would create a burden for the provider and unnecessary delay in Val accessing appropriate care and be inconsistent with Mental Health Parity since this is the standard process for PH transitions of care.

***10/20/18 to 11/19/18*: VAL TAKES STEPS TOWARD GREATER INDEPENDENCE WITH ADDITIONAL SUPPORT**

Upon admission to Terros' Maverick House, Sue and Paul connect directly with Val the next day to formally welcome her to BUFC with her New Member Kit and ID card (that had been returned in the mail) and explain their ongoing roles now that Val is past her immediate crisis. Sue and Paul continue to build greater rapport with Val and empower her in line with the *9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems*, including respect, hope, and choice and helping Val develop her identified whole-person goals and natural supports. Sue has previously identified Val's need of personal toiletry products (shampoo, deodorant, toothbrush, etc.), some clothing and undergarments, shoes and possibly a cane, since her gait was affected by her neuropathy. Sue contacted the Shoebox Ministries and Goodwill for these items, which are provided at little to no cost. Sue will continue to review Val's care with the BUFC Medical Director, including weekly reassessment of her progress and active discharge planning that starts at the time of admission consistent with BUFC procedures and Val's wishes. We are committed to this stay being as brief as possible to address Val's needs. Val understands that Sue will assist her with identification of short and long-term whole-person needs, service planning and coordination, facilitating and advocating on her behalf for covered and non-covered community-based services, conducting ongoing monitoring and reassessment of needs, and identifying and coordinating benefits. Sue and the Terros case manager also schedule a third ART to support Val's continued recovery and because of her change in PH and BH providers. To help Val identify participants, Sue asks Val who she would like to

have at the ART meeting. Based on Val's preference for a fresh start with a new care team, Sue and the Terros case manager, who will serve as facilitator, invite Val's BH and PH medical practitioners, Paul, the peer assigned at CBI Transition Point, the BUFC Housing Liaison and the BUFC Vocational Liaison. Sue and the Terros case manager again revisit the idea of engaging with Val's estranged family and possibly inviting them to the ART. Val prefers not to, but now feels more comfortable explaining her embarrassment of this latest relapse after her family completed their intervention. She understands her son's and daughter-in-law's reservations about exposing her grandchildren to her drug use. Since she feels as though she might only get one more chance, she prefers to continue treatment before involving them in the ART. Ultimately, she agrees to have the peer contact her son, after signing a release, to let him know she is well and engaged in treatment. During this ART, Val's Complete Care Plan (CC Plan) with all elements of a service plan, is updated by the Terros case manager with participation from the ART, providing copies to Val and all providers. The plan is also electronically accessible on the *Banner Navigation Accelerator* (BNA), BUFC's new technology solution to improve care navigation, access, and coordination among all providers.
Issue 1: Val is homeless. **Plan:** Assist Val in obtaining her benefits, such as SSDI, food stamps along with securing permanent supportive housing in the community to promote the highest level of independence possible, including arranging for SMI Eligibility Determination. **Goal:** A stable income and safe place to live. **Issue 2:** Complex behavioral and physical health challenges, including schizophrenia, heroin addiction, diabetes, neuropathy and pain. **Plan:** Secure services within an integrated health home to address Val's whole person needs to include Medication Assisted Treatment (MAT), pain management, diabetes management, health promotion and support from specialists, including psychiatry. **Goal:** Reduction of symptoms and sobriety. **Issue 3:** Val finds it difficult to check her blood sugars and take her medications. **Plan:** Establish a monitoring system that will work for Val, including setting up and monitoring her medications weekly providing her a list of medications with dosage regimen, indications and side effects; and enrolling in the BUFC Warm Health interactive voice response program to receive phone and text message support to promote self-management. **Goal:** Val will adhere to the most effective and simplest medication regimen. **Issue 4:** Estrangement from family. **Plan:** Encourage/support Val to reestablish connection with family and other natural supports and to identify other natural supports able to assist Val in life domain activities, such as community events, social activities and activities of daily living. Engage Val's son in family counseling and family psychoeducation with Val. Sue assists her in completing an application for a government provided cell phone and phone services through the federally funded FCC Universal Service Fund program in order to optimize access to care, communication and coordination. Val uses her new cell phone to connect to the BUFC *Member Supported Care Circles*, a tool that enables her son to continue supporting her complete care goals and furthers her self-management ability. Paul helps Val connect with the Terros Peer Specialist to take the lead in working with Val on these goals through one-on-one and group peer support services. **Goal:** Incorporate family/natural supports into treatment planning and support of Val.

Appointments are scheduled at Terros Olive Avenue Integrated Health Home to ensure continuity of medications where the BHMP reviews her current regimen as well as potential options. This appointment is readily available as all psychiatric providers are required by contract to have daily open access appointments to meet expedited needs. To minimize fragmentation of care the BHMP will provide ongoing treatment with buprenorphine/MAT as well as medications to treat her co-morbid schizophrenia. In collaboration with Val, she continues oral aripiprazole, which has resulted in improvements in psychotic symptoms and no reported side effects or metabolic complications since it was begun in the ED after obtaining required screening laboratory tests and reviewing her vital signs. The BHMP also conducts an Abnormal Involuntary Movement Scale (AIMS), her abdominal girth was measured as these were not completed at the ED prior to initiation of medication and these parameters will continue to be monitored by the BHMP every 6-12 months as indicated. All of these monitoring metrics are tracked by BUFC to identify gaps in appropriate services and inconsistencies with best practice. Informed consent for BH medications was obtained that reviewed her diagnosis and target symptoms of the medications, potential benefits, risks and side effects, alternatives, results of not taking the medication as recommended, possibility that the dose may need to be adjusted, and the right to withdraw consent. Follow-up BHMP appointments are scheduled to closely monitor her ongoing response to medications, development of potential side effects, review if Val is taking medication as prescribed and to assess for adjustments that might be needed. At the 2-week appointment, Val reports she was doing well without psychotic symptoms and tolerates the medication without side effects, but she has had difficulty in taking medications as prescribed and misses doses occasionally despite ongoing education related to the need to take medications as prescribed and supports. In order to maximize the benefit of medication, the BHMP, in collaboration with Val, determines she would benefit from a switch from oral aripiprazole to Abilify Maintena, a long-acting injectable preparation of the medication.

Following this BH-focused visit, Val is also seen by her new PCP within Terros Olive Avenue who will work collaboratively with the BHMP to address her whole person needs. The PCP reviews her past health information within the transferred records from her past PCP, completes a medication reconciliation and blood sugar level check, which is now 100, and makes adjustments to her dosages as appropriate, documenting all her information in a single integrated medical record. The PCP identifies the need for specialty referrals, including an endocrinologist. Working collaboratively and practicing under evidenced-based clinical practice guidelines, it is discovered through conducting a detailed history that Val experienced a period of stability in her diabetes prior to becoming homeless. Val's brittle diabetes was not the typical Type 1, but rather uncontrolled Type 2 diabetes, which had been complicated by her co-morbid conditions. The PCP completes a nutritional status, including vitamin levels to make sure Val is not deficient in vitamin B12, which could contribute to her peripheral neuropathy. The PCP evaluates all treatment options for Val's DM neuropathy and prescribes Pregabalin, which is consistent with evidence-based practice guidelines and simplifies her regimen to oral medications. Due to Val's risk factors she is also prescribed intranasal naloxone with instructions on its use. Education is also provided regarding the benefits of diet and exercise. The PCP worked closely with the BHMP within the integrated clinic to co-manage and monitor Val's health, progress, medication management, life style modification, exercise and psychosocial interventions, with all documentation occurring with a single integrated medical record. In addition, all of Val's BH services are overseen by her assigned BHP at Terros Olive Avenue.

Due to close coordination between Sue and the Terros provider-based case manager, the CC Plan is updated as changes occur with Val's treatment and is readily available in the BNA. In addition, they are able to encourage Val to participate in health promotion education and training to better understand her illness, behaviors and how to prevent relapse. They also monitor completion of the SMI determination process and application for Medicare benefits. Val is encouraged to follow up with her PCP for preventive health exams, including influenza and pneumonia vaccinations, woman preventive health services, diabetic eye exam and kidney screening. Sue also coordinated specialty referrals along with the Peer Support Specialist. Due to the IV heroin use, the PCP also screened Val for HIV and hepatitis C. Throughout her care, Val is given choice and treated with dignity, independence and individuality.

BUFC recognizes that each member's life journey toward health and hope is unique. Members in situations similar to Val might make different choices taking them along other paths. BUFC listens to their voices and respects their right to self-determination when they are not assessed as potential danger to self or others. BUFC provides assertive outreach and engagement for those who choose to decline all offered care options. This includes on-going monitoring through Health Current and follow up by our Care Managers and provider-based case managers. Those declining services following Transition Point would be congratulated for the steps they did take in their recovery and supported by our Care Managers to identify alternative, safe and stable living arrangements. Although the manner in which members connect with our Care Management program is unique, the care they receive is consistent. Every "Val" receives care consistent with AHCCCS' mission and vision, system values and guiding principles and the vision for integrated services as we aim to make health care easier, so life can be better for our members and their families.

BUILDING ON HER STRENGTHS, HOPE EMPOWERS VAL TO DEFINE HER OWN RECOVERY

Following her BHRF stay, Val moves to Via de Confianza, a housing opportunity offering independence in the community with supportive resources to maintain stability and promote recovery. With ART team support and coordination of care provided by her BUFC Care Manager, Val reports significant improvement in her overall health and continues to work hard toward her chosen goals. She is supported to attend all of her appointments, including making and following up on referrals, arranging or providing transportation and being present for critical milestones. Sue continues to monitor Val's progress through participation in the ART and documents progress in the *Acuity System*, including any changes in treatment or outcomes. Paul fades out now that Val has developed rapport with a provider-based peer specialist. Val reports no significant side effects from a new medication regimen and manages medications with minimal assistance. Val is elated when her son reaches out to join her ART and invites Val to join her grandchildren on daily walks. The Terros Case Manager works with Val to update her Social Security information and Val begins receiving SSI and SSDI benefit payments, and assists Val apply for Vocational Rehabilitation to further her financial health. The Terros Case Manager also works with Val to develop an Advance Directive, and a comprehensive Crisis Plan to support community stability and prevent relapse. Val participates in Terros' Life Affirming Dual Diagnosis Education and Recovery (LADDER) program, which offers substance abuse treatment, as well as breakfast, lunch and transportation.

6. THE OFFEROR HAS A MEMBER WHO IS AN 18-YEAR-OLD FEMALE WHO WAS DIAGNOSED WITH SICKLE CELL…

Banner-University Family Care (BUFC) is a purpose-driven organization that operationalizes our mission daily by making each member touch positive and meaningful. This courageous 18-year-old female with Sickle Cell Anemia (SCA), *Leah*, will face significant challenges and probable social stigma as she experiences a severe, life-long chronic condition that can impede normal adolescent social and emotional growth, painful crises treated by providers who are suspicious of her opioids use, societal views of depression, and her teen pregnancy along with vocational and financial barriers associated with a criminal record. Throughout her journey, BUFC will work to inspire hope, demonstrate faith in Leah's resiliency, and offer her choice in a respectful, culturally appropriate and strength-based, family-centered manner to address her unique needs and leverage her strengths as she courageously transitions to become an independent adult and loving parent. As an Arizona, provider-based, non-profit health plan with years of experience managing the care of AHCCCS and DSNP members with multiple physical, behavioral and social conditions, BUFC has successfully decreased care fragmentation through improved care coordination both vertically among levels of care and horizontally among the 8 dimensions of wellness. We optimize member outcomes by activating members' natural supports, coordinating care, sharing information among our *Neighborhood Network* providers, using evidenced-based practices and systematic monitoring of our members to provide support at their times of need. We will tailor our approach and work closely with Leah and her family as she transitions through adolescence using the *AHCCCS Transition to Adulthood Practice Tool* while respecting their cultural heritage to build trust and address their needs in the most appropriate, timely manner and in accordance with best practices. BUFC, our providers and community partners will conduct ourselves using *Arizona's System of Care for Children 12 Guiding Principles* and *9 Principles of Adult Recovery*.

BUFC commits in Year 1 of the AHCCCS Complete Care (ACC) contract to address 2 key issues currently hindering optimal SCA care in Arizona. First, BUFC will create an effective outreach, engagement and monitoring program in collaboration with SCA providers and families to increase the use of hydroxyurea for the prevention of SCA crises. Second, since national SCA mortality rates peek in early adulthood, BUFC will create clear protocols and resources to address the fragmentation of care currently experienced by SCA members transitioning to the adult SCA system of care. Our current proposal includes, but is not limited to, creation of an adult SCA Comprehensive Clinic at Banner University Medical Center (BUMC)-Phoenix staffed by Phoenix Children's Hospital (PCH) Med-Peds SCA expert, Dr. Gomez, to provide a smooth transition from child to adult systems of care overseen by the same physician. He will also consult with BUMC-Tucson, thereby providing adult SCA expertise in Arizona's 2 largest metropolitan areas.

MANAGING LEAH'S CARE BEGINS WITH BUILDING TRUST AND ACTIVATING NATURAL AND COMMUNITY SUPPORTS

Leah enrolled with BUFC at 16 years of age during a hospitalization for a pain crisis under prior period coverage following her family's relocation to Tucson from Los Angeles after the sudden death of her father. The BUFC Concurrent Review Nurse identified Leah as having a Children's Rehabilitative Services (CRS) condition and reviewed her case at the BUFC Interdisciplinary Care Team (ICT) to coordinate a smooth discharge transition for Leah. Our Supervisor of Complete Care Management reviewed Leah's information and assigned her to Anne, a BUFC Pediatric Specialty Care Manager, to work with the family and the Tucson Children's Clinic (TCC) Nurse Coordinator, who acts in the provider-based case manager role, to submit a CRS referral to the Division of Member Services consistent with ACOM Policy 426 and arrange a timely appointment to establish care. A Quality of Care (QOC) referral was also made to the BUFC QOC Department as it became apparent that the day before the admission an Emergency Department (ED) provider underestimated Leah's pain and accused the family of seeking opioids, which resulted in pain escalation and this avoidable admission. Leah's acute crisis resolved and she had a smooth transition home. Within one week after discharge she had her initial appointment at the TCC, Tucson's MSIC, where she completed her Health History Questionnaire (HHQ) with creation of a *Complete Care Plan* (CC Plan), which meets the content and timeliness Service Plan requirements in AMPM Policy 560, identified her immediate and long-term healthcare needs and included an action plan. These interventions, along with timely communication regarding Leah's care and her QOC disposition, built a foundation of trust that gave Leah and her mother hope that she would be treated respectfully and achieve her best outcomes in her new home. Over the next year, Anne and the TCC Nurse Coordinator continued to collaborate and help Leah receive all her care needs in a timely manner within the TCC and the BUMC-Tucson Comprehensive SCA Clinic. Due to her age, this included member transition activities in AMPM Policy 520. A CASII was completed with a score of 4. As a result, the team conducted a Strengths, Needs and Cultural Discovery, which served as a foundation for care planning. Leah is a risk taker with resilience, fortitude and close friendships as strengths. Providers at the TCC are trained in Screening, Brief Intervention and Referral to Treatment (SBIRT) and motivational interviewing, which is valuable for Leah's ongoing care. Dr. Bhasin of BUMC-Tucson sees patients with SCA at both the TCC and BUMC SCA Comprehensive Clinic, maintaining a single

integrated medical record between the two sites. The TCC Care Team includes Dr. Bhasin, primary care, nurse coordinators, behavioral health (BH), women's health and rehabilitation services as necessary to provide family-centered, coordinated and culturally competent care to meet Leah's unique physical, behavioral and holistic needs. As Leah neared her 18th birthday, her CC Plan continued to move forward in all areas to meet her age-appropriate needs, including participation of adult system staff in her Child and Family Team (CFT) to address her transition-age youth planning, including her educational, vocational, and social goals and transition to the adult system.

BUFC introduces **Member Supported Care Circles**, by PYX technology, to connect members with their chosen natural supports (family, friends, etc.) in a mobile-enabled platform that interacts with the member to monitor their physical and mental health status, provides proactive timely alerts to their care circle supports, allows for care circle members to support member self-care, and offers care managers analytics dashboards that show trends of activities, mood and care access (including geo location when accessing urgent/emergent/crisis services) across the individual member and groups of members. This member-centric technology allows members to select their trusted group to empower their success in health improvement, self-management of their condition and crisis prevention.

Now, 18 years old, Leah struggles with the demands of her depression, pregnancy and sickle cell pain crises as she aims to complete high school after release from incarceration. An Adult Recovery Team (ART) is formed at the TCC to assess her needs and update her personal CC Plan to address her 8 dimensions of health and wellness. Throughout this journey, her natural supports and peer support engage with Leah through use of *Member Supported Care Circles*. Engaging Leah and her family at all levels of our *BUFC Neighborhood Network (NN)* care system will be critical for both prevention and treatment of her acute crises, which are anticipated due to her diagnosis of SCA. These *NNs* refer to BUFC's holistic view of community-based care, which developed out of Banner Health Network's successful CMS Pioneer Accountable Care Organization. This includes, but is not limited to, the integration of clinical and non-clinical services, such as close collaborations between health care providers and schools to be sure Leah's care is optimized throughout her day. BUFC continually innovates to promote evidence-based care so that members, such as Leah, receive preventive, health promotion, wellness and condition management services to obtain optimal health outcomes. Evidence-based guidelines for SCA, depression and transitioning to adulthood are posted on our website and shared with providers. The compliance is monitored and results are shared with our Value-Based Purchasing (VBP) providers and Neighborhood Advisory Committees. We also embrace the ACC program values and give Leah choice, dignity, independence, individuality, privacy and self-determination with respect to her way of life.

PROACTIVELY ADDRESSING LEAH'S 8 DIMENSIONS OF WELLNESS WITH PERSONAL COMPLETE CARE PLANNING

BUFC monitors our covered populations to expeditiously identify and comprehensively assess each member with special health care needs to develop and maintain a personal CC Plan, provide appropriate interdisciplinary staffings and monitor receipt of their needed care. Children with a CRS diagnosis appear on the Children's High Risk Report to trigger care interventions and AHCCCS reporting as per ACOM Policy 426. During her time with BUFC Leah likely would have been identified on the BUFC High ED Use, At Risk Opioid, Pregnancy and Justice System Reports, which trigger outreach by Leah's personal BUFC Specialty Pediatric Care Manager, Anne. Our information systems database includes administrative data, claims, pharmacy, Blind Spot data, HHQ and access to both Health Current information and connectivity to provide a 360^0 view of each member. Compliance with EPSDT visits, including dental care, is closely monitored due to the importance of immunizations (especially pneumococcal vaccine), medication compliance (such as penicillin prophylaxis) and self-care practices for children with SCA. BUFC Care Managers utilize MCG evidence-based Chronic Care and BH Guidelines, which also include member and family educational handouts in both English and Spanish. Throughout Leah's adolescence, BUFC Care Managers monitor compliance with the *AHCCCS Transition to Adulthood Practice Tool* to reinforce her recovery process, provide a smooth transition from the AHCCCS Children System of Care to the Adult System of Care and foster an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond age 18. Her depression would have been identified through a pharmacy report if she were prescribed psychotropic medications, her HHQ, provider screening or during a CFT meeting. Anne, who is regularly co-located at the TCC, and the TCC Nurse Coordinator, would then contact Leah and her mother, as age-appropriate, to reassess Leah's needs and update her personal CC Plan.

The CC Plan is developed using evidence-based guidelines and includes desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified objectives through an effective action plan and documented in BUFC's *Acuity Advanced Care Management System.* During care planning with transitional age youth we

increasingly empower the youth to express his or her preferences as we add providers from the Adult System of Care to participate in the process. Leah's **current** care planning flows from her **past** care plans and health care events. Therefore both are described below as Leah matures from adolescence into adulthood and achieves her best outcomes for the 8 Dimensions of Wellness.

Physical health: Concern 1: SCA. **Action Plan:** Due to Leah's challenge managing her continued pain crises and urgent needs she is given an appointment with her hematologist within 3 business days consistent with ACOM 417 requirements. The hematologist assesses the cause of her pain crises, such as consideration of avascular necrosis of bone, and reviews her treatment plan and use of opioids. She is reeducated about self-care and her crisis plan for managing painful crises, including the importance of early use of non-opioid treatments, such as NSAIDs and acetaminophen along with hydration. This is coordinated with her PCP, who is located at the TCC, to provide Leah preventive care consistent with EPSDT requirements, including additional care specific to SCA best practices. After review of treatment options, Leah agrees to initiate chronic transfusions during her pregnancy. After she gives birth, consideration can be given to restarting hydroxyrurea, an effective medication to minimize pain crises. Leah is reminded that compliance with follow-up appointments for medication monitoring and use of contraceptives will be required in order for hydroxyurea to be a viable option. Newer medications, such as L-glutamine, are also available but not as well tested as hydroxyurea. She is also encouraged to seek ED care within BUMC-Tucson, where her hematologist practices and where her integrated medical record is shared with the TCC to support optimal care and prescribing of opioids. It is important she contact her hematologist during emergencies so the doctor can guide her ED care, including early initiation of lower doses of opioids, which has less addictive potential. Subsequently, Leah experienced improvement in her painful crises after the hematologist adjusted her treatment, and Anne reminded Leah and her mother to utilize the TCC's on-call system, Dr. Bhasin's on-call service or the BUFC 24-hour Nurse Line at times of concern. **Personal Goal:** Leah wants to manage her pain crises early in order to decrease ED visits for pain to one or less per year. **Concern 2:** High-risk pregnancy. **Action Plan:** A referral was made to a BUFC Specialty High Risk Obstetrics Care Manager, Heidi, who has more than 25 years of experience supporting pregnant women and adolescents with AHCCCS after Leah's name appeared on the *Pregnancy Report* due to a positive pregnancy test when Leah was 2 months pregnant. Heidi coordinated her OB Care Management activity with Anne and the TCC Nurse Coordinator working from Leah's single personal CC Plan. Heidi understood from Leah that although the pregnancy was not planned, Leah and her boyfriend desired to have the baby; their relations were consensual and he is a caring partner. Heidi completed a full assessment and identified Leah would soon be having a court sentencing. She was also experiencing depression due to the stress of the hearing, although she denied having thoughts of hurting herself. Heidi used evidence-based screening tools, such as the PHQ-2 and PHQ-9, to screen for depression. Heidi is also trained in *SafeTalk* to prevent suicide, as are all BUFC care management and customer care employees. Following the assessment, Heidi worked with the TCC Nurse Coordinator in collaboration with the ART to reach a consensus about revisions to the CC Plan, which is driven by Leah's needs and choices. Two obstetricians provide care for members at the TCC and an appointment was made within 2 days to see Dr. Moreno at BUMC-Tucson. Heidi provided expertise to Leah and her ART to support the ongoing needs assessment and service planning process. With Heidi's support, Leah informed her mother of the pregnancy as she continued to be an essential natural support for Leah. The ART included Leah, her mother, Heidi, Anne, her PCP, hematologist and CC's social worker. At this meeting, Leah learned the risks posed to her pregnancy by SCA, depression and opioid use. She was instructed in proper self-care (including dental care) throughout her pregnancy and given instructions for her OB appointment, including arrangements for transportation. Heidi also provided technical assistance to the TCC Nurse Coordinator and ART that connected Leah to community agencies to leverage resources, such as WIC and Nurse Family Partnership (NFP). Leah was excited to be pregnant, engaged with her NFP Nurse and invited her to be part of her *Care Circle*. She was reminded life's journey can have setbacks, but it is important to have faith and hope through challenges, as she has done with courage in managing her SCA. **Personal Goal:** Leah desires to complete a full-term pregnancy without complication. **Concern 3:** Newborn health. **Action Plan:** Leah is informed there is an increased risk of preterm birth and a small for gestational age newborn with SCA. Therefore, it is critical she prevent additional risks to her developing child, such as tobacco and drug use and associated neonatal abstinence syndrome. Leah received transfusion therapy during her last trimester of pregnancy to prevent painful crises. Since Leah did not require opioids during this time, her newborn did not demonstrate symptoms of Neonatal Abstinence Syndrome. The NFP Nurse continued to follow Leah's child for the first 2 years of her life to provide parenting coaching for Leah and support her baby to receive timely EPSDT visits, preventive care and appropriate stimulation. Leah attended her postpartum appointment, which included postpartum depression screening and initiating contraception of Leah's choice. **Personal Goal:** Leah desires a

healthy baby girl, but will be happy as long as the baby doesn't have SCA and is without signs of neonatal abstinence syndrome.

Emotional health: Concern 4: Depression. **Action Plan:** As Leah progressed through adolescence with her painful SCA crises, learning disability, educational challenges and underlying trauma associated with the sudden death of her father and chronic illness, she intermittently screened positive for depression during her visits at the TCC. The TCC social worker and child psychiatrist provided short-term interventions, including Trauma Focused-Cognitive Behavioral Therapy, which helped Leah with both her depression and frequency of pain crises. At 17 years of age it was clear that she was not eligible for services as an adult with Serious Mental Illness. Leah was assessed with the CASII every 6 months by appropriately trained TCC employees. BUFC monitored fidelity to the model along with a standardized substance use screen as per AHCCCS Policy 320-O. The TCC social worker was added to Leah's integrated CFT/ART. After Leah became pregnant and experienced worsening depression, she was provided with prompt and easy access to BH services to help her through the stressful time. Leah was adamant that she did not want to take any medications due to concerns for her unborn child. Furthermore, Leah preferred BH counseling outside of TCC as she felt, "everyone knows my business there." Anne identified good options for Leah by using BUFC's Provider Look Up system within the *Banner Navigation Accelerator; BUHP's web-based member navigation platform that* shows which BH services are offered at specific provider sites. Leah was offered two choices of BH providers near her home providing best practices, such as trauma focused-cognitive behavioral therapy (TF-CBT), for adolescents and young adults. TF-CBT is not only effective for Leah's depression, but also for transitioning youth to adulthood to help develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals and acquire skills across various domains. These are important as Leah faces new obstacles in her life. To support the likelihood of Leah following through with participation in her chosen BH services, a warm handoff is made by Anne who calls the BH provider with Leah to briefly discuss her needs and schedule a first appointment. Anne and Heidi also make a referral for the mother to seek out support from one of the Peer and Family Run Organizations that operate as BUFC stand-alone providers to offer family support to the mother and possible Youth Peer Support and Transitional Age Youth, evidence-based, skill development programming. **Personal Goal:** Leah wants to be happier demonstrated, in part, with improved scores on depression screening tool.

Social health: Concern 5: Lack of positive social support. **Action Plan:** When Leah began to take herself to the ED with increased frequency and without notifying her mother, they were offered *Member Supported Care Circles* to provide Leah with support from her chosen Care Circle. This included notification to the Care Circle when Leah was in an ED or urgent care through geo-location. This provided an acceptable balance for this family as Leah transitioned to adulthood and her mother was reassured she would be notified if Leah experienced a crisis. When Leah was assigned a Certified Peer Support during incarceration, the peer was able to join her Care Circle upon release to remain aware of her progress and help her remain engaged in her care and, ultimately, her child. Leah continued to have ART meetings facilitated by TCC, including Anne, Heidi, her PCP, counselor, the Job Corps Case Manager, her probation officer, her hematologist and her chosen natural supports. She successfully transitioned to the AHCCCS Adult System of Care, in part, due to BUFC's support for co-management of SCA by a pediatric and adult hematologist since 17 years of age. She gained self-confidence in herself and her parenting skills with the support provided within the comprehensive clinic. Leah also received an updated list of available supportive resources, such as Anne during normal business hours, her Care Circle members, the BUFC 24-hour nurse line, her PCP on-call availability for both physical and BH concerns, her hematologist's on-call phone line, the National Suicide Prevention Lifeline, and the National Substance Use and Disorder Issues Referral and Treatment Hotline. **Personal Goal:** Leah desires increased connectedness with family and friends.

Environmental health: Concern 6: Incarceration. **Action Plan:** Unfortunately, the judge sentenced her to 3 months of incarceration. Due to Leah's inclusion of the NFP Nurse in her Care Circle, the NFP Nurse notified the BUFC Specialty OB Care Manager, Heidi, who had referred Leah to the NFP program prior to the incarceration. Notification was also received from the BUFC *Court Coordinator*. Heidi worked with Anne and the BUFC *Justice System Liaison* to transfer Leah's *Integrated Medical Record* and Personal CC Plan to the justice facility for coordination of care, including need for her scheduled hematology visits. Contact information was provided with the justice facility so subsequent *Reach-In* would be initiated expeditiously when Leah was within 30 days of her release. Anne also emphasized the need for Leah to have an educational assessment completed and attend school while incarcerated. Because of this setback and expecting her incarceration would be of relatively short duration, Heidi reviewed the case with Anne and they recommended an ART be scheduled prior to Leah's release. Along with the BUFC Care Managers, the TCC Nurse Coordinator, hematologist, Probation Officer assigned at the pre-sentencing hearing, Correctional Health Liaison, Leah's boyfriend and mother were invited to participate. During Leah's incarceration, the TCC Nurse Coordinator remained in contact to coordinate Leah's hematology visits. Leah lost her AHCCCS eligibility during her incarceration but CC case

management services continued as part of the VBP contract between BUFC and TCC. Two months later, the BUFC *Justice System Liaison* was notified Leah would be released within 30 days and contact was made with Leah to plan for her release, including assigning her a Peer Support. Heidi and the TCC Nurse Coordinator joined the BUFC *Justice Liaison* and Peer Support via video streaming to meet with Leah and the Corrections Health Liaison to discuss her choices for care upon release from jail. Plans were discussed for her to establish herself in an integrated health home where she could receive both physical and BH services along with transitioning into school to complete her high school diploma. Leah was encouraged to continue her care within the TCC, which she agreed to after hearing of community alternatives that would not have offered such comprehensive services. Heidi, having been trained in *SafeTalk*, also asked Leah if she has considered hurting herself and made sure Leah is aware of suicide prevention resources in case she finds herself feeling hopeless. Heidi and Anne work with the TCC Nurse Coordinator, care team and educators to coordinate care during Leah's transition out of jail. **Personal Goal:** Meet all requirements of her probation and not return to prison.
Intellectual health: Concern 7: Educational challenges. **Action Plan:** Leah's initial assessment at the TCC identified she had received special services at a Los Angeles school. Records were obtained and the teacher, who is an employee of the BUMC-Tucson SCA Comprehensive Clinic, advocated with Leah's school for completion of a formal educational reassessment, which confirmed her diagnosis of a learning disability and an IEP was completed. When Leah turned 17 years old, Anne reminded the TCC Nurse Coordinator to arrange a combined CFT/ART meeting to address requirements outlined in the *AHCCCS Transition to Adulthood Practice Tool*, such as, but not limited to, signing documents to update her responsibilities related to her BH treatment as an adult; continuing to offer a Family Support Partner and a Youth Peer Support to assist in the transition to adult services; understanding her schooling may continue through age 21 due to her special education services; crisis and safety planning; sharing of IEP and educational processes consistent with the Individuals with Disabilities Education Act of 2004; considering referral to Vocational Rehabilitation; assistance with preparing an application for submission at 18 years of age to AHCCCS for on-going Medicaid services; review of family planning services; and having her Individual Service Plan, which includes her Individual Recovery Plan, updated. Leah is offered choices to complete high school in an online charter school, obtain her GED at community classes, enroll in Tucson Unified School District's Teenage Parent Program, or at the Fred Acosta Job Corps. She prefers to complete her high school diploma and begin vocational training at Job Corps. **Personal Goal:** Receive her diploma at Job Corps.
Occupational health: Concern 8: Develop job skills. **Action Plan:** Leah decides to complete her high school diploma and begin vocational training at the Fred Acosta Job Corps to become a medical assistant. Job Corps will be supportive of Leah's recovery as it is a drug-free environment with close supervision and monitoring. She feels her life's journey will be a strong asset in health care and she would like to help others encountering similar challenges. Disability Benefits 101 and RSA Vocational Rehabilitation services are provided as appropriate. **Personal Goal:** Gain employment skills.
Financial health: Concern 9: Developing financial independence. **Action Plan:** Leah continues to receive support from her mother as she completes her education. However, she is excited to receive payments from Job Corps as she desires to gain independence and not be such a burden on her mother. She feels earning a salary at Job Corps will help repair some of the trust she has lost with her mother. **Personal Goal:** Become financially self-sufficient.
Spiritual health: Concern 10: Lack of sense of purpose in life. **Action Plan:** Leah's Peer Support invites her to activities of the Tucson Chapter of the NAACP, including their Health, Criminal Justice, and the Youth and College Committees. This exposes her to positive role models and helps her gain a sense of purpose and mission for her life. Along with gaining confidence in her parenting skills through the NFP, she finds her Medical Assistant training at Job Corps to be a valuable asset on the NAACP Health Committee. She begins to participate in outreach to early teens to discuss family planning and healthy relationships. **Personal Goal:** Enjoy participation in at least one community activity in the next 6 months.

IMPROVING CARE FOR ALL CHILDREN WITH COMPLEX CARE NEEDS IN ARIZONA

BUFC will have Pediatric Care Managers regularly scheduled on-site at MSICs to maximize care coordination between MSIC Case and BUFC Care Managers. This will include on-site presence on 10/1/18 at each MSIC to clarify member attribution and address any immediate member needs. BUFC is contracted with all MSICs in Arizona to care for children and young adults not only with CRS conditions, but also with equally complex needs due to non-CRS conditions. This improves the care of all children with special health care needs and supports the viability of value-based contracting with MSICs, by increasing the volume of attributed members, as they move from one to multiple AHCCCS payers. Banner Health owns 2 of Arizona's children's hospitals and due to its adult medical specialists and facilities is committed to providing comprehensive clinics for adults with CRS conditions transitioning to the AHCCCS Adult System of Care. These and other organizational priorities allow BUFC to meet the care needs of all children and young adults like Leah as BUFC lives our mission *to make health care easier, so life can be better* for our members, families and caregivers.

7. DESCRIBE HOW THE OFFEROR WILL IMPROVE MEMBER ENGAGEMENT, DEVELOP AND IMPLEMENT BEST…

Banner-University Family Care (BUFC) has been meeting the needs of AHCCCS members in the special populations in this response for 30+ years through our acute care plan, in both urban and rural markets; our recently implemented long-term care plan; our Regional Behavioral Health Authority (RBHA), Cenpatico Integrated Care (CI); and our role as Third-Party Administrator for Maricopa Health Plan. BUFC utilizes a Neighborhood Network approach to adapting best practices. This local approach enhances member engagement at all system levels, benefits from the combined expertise within our provider network and communities, and improves accountability for member outcomes.

REIMAGINING HEALTHCARE – DEVELOPING BEST PRACTICES THROUGH INCUBATION

BUFC focuses on building a structure and process that is committed to continual learning and improvement to meet our members' needs. BUFC will work with existing COEs and early adopters of emerging, promising, and best practices, using the scientific theory of "Diffusion of Innovation", first popularized by sociologist Everett Rogers. According to Rogers, "Diffusion is the process by which an innovation is communicated over time among the participants in a social system" (2003). Using this theory, we will invest in the innovators and early adopters of integrated healthcare solutions to current population health problems. Through the creation of incubators, we will give high performing providers the flexibility to test theories and funding models to support promising practices. Additionally, we will utilize Community Reinvestment Funds in a strategic manner to solve current population health problems while supporting the adoption of innovative and evidence-based practices. As such, we will invest in our incubators with additional funds for workforce development and community capacity building. As supported by the Diffusion of Innovation Theory, our incubators will inspire early adopters and an early majority, then moving to influence the late majority and laggards. The use of incubators to transform healthcare is not a new idea to BUFC. We initiated this work through the Banner Imaginarium, launched as a response to the unprecedented and highly disruptive changes of the healthcare industry. Multiple Banner Imaginariums have been established as design laboratories, with design teams that develop, test, and refine solutions with the front line. Rapid cycle prototyping is performed: fail fast, try again, and prove it out. Imaginariums then port proven designs across the system. Building from this experience, BUFC will establish incubators to develop integrated solutions to health and social determinant problems facing the following populations: justice involved children and adults, court ordered evaluation and treatment, members with high needs and high costs, members with substance use disorders, children at risk of removal by DCS, and transitioning from CMDP.

COMPLETE CARE MANAGEMENT IS FOUNDATIONAL TO OUR APPROACH TO SERVING SPECIAL POPULATIONS

Members with special health care needs or chronic health conditions need care coordination tailored to meet their unique needs. Our current, whole-person comprehensive *Complete Care Management* program includes a core team of *generalist* Care Managers with expertise in member engagement, community referrals to address social determinants of health (SDOH), provider referrals for acute episodic needs, and addresses members' immediate care needs. These generalists are supported by s*pecialty* care teams to provide ongoing care management for members with complex needs. Our Care Managers participate in CFTs/ARTs to provide clinical and technical assistance, so services are provided in accordance with the *Arizona Vision-12 Principles for Children's Behavioral Health Services* and *9 Guiding Principles for Adults* within a trauma informed framework and meet fidelity to best practices, including AHCCCS BH Practice Tools. Our *Complete Care Management* program addresses social risk factors of members and their families, and identifies services and supports to address PH, BH and social needs of the family, including housing, employment, transportation, and more. To support this family-focused approach, Complete Care Plans (CC Plans) are aligned to minimize redundancy and address comprehensive family assessment and care planning to foster family stability, minimize risk for removal from the home by the Department of Child Safety (DCS) and support transition of youth from Comprehensive Medical and Dental Program (CMDP) upon family reunification. Our Care Managers coordinate care across complicated systems, effectively integrating care for members whose care is being delivered by multiple providers and systems, such as with DCS/CMDP; adult and juvenile probation/parole organizations; and the RBHAs to help members and families resolve barriers to navigating fragmented systems. Our *Complete Care Management* program incorporates recommendations of the Association for Community Affiliated Plans (ACAP), on innovative models to provide care coordination and high-quality care to children with special health care needs to improve outcomes. Some examples of the ACAP evidence-based best practices included as part of our *Complete Care Management* program are:

- **Expanded provider supports:** Providers are supported through Banner and the University of Arizona (UA) to serve members with complex needs. BUFC will make psychiatric expertise available to urban and rural PCPs to provide general consultation and one-time psychiatric evaluations to answer diagnostic and treatment questions related to

serving members with BH conditions. Through UA's Telemedicine ECHO programs, PH providers can participate in weekly ECHO™ clinics, like virtual grand rounds, that combine mentoring and member case presentations with specialists focused on serving members who are justice involved, on COE/COT, associated with HNHC, with substance use disorders, at risk of removal by DCS, and those transitioning from the CMDP program.

- **Enhanced engagement of members/families:** In Year 1 of our contract, we will launch *Member Supported Care Circles* offering a health promotion, self-management and communication platform for members and their family of choice via smartphone or computer application. Members choose people to add to their "Care Circle," making it easy for the "family of choice" to support the member while gaining insight into the member's health.
- **Supporting non-medical needs of members and families:** BUFC will introduce the new role of *Neighborhood Network Program Manager* as a liaison between BUFC, UA Health Sciences programs and community social service agencies to coordinate alignment of community programs and resources addressing the SDOH.

NEIGHBORHOOD NETWORKS – BEST PRACTICE DELIVERY & PERFORMANCE MONITORING

BUFC will organize Complete Care contracted providers and community stakeholders into *Neighborhood Networks*, creating customized local strategies and aligned payment models to respond to the unique strengths, needs, cultural aspects and SDOH of each Neighborhood. Through the *Neighborhood Networks*, members in the identified special populations will have open access to providers through a continuum of care with traditional and non-traditional methods to address their complex needs, such as providers offering services outside of regularly scheduled hours, through in-home options and via telemedicine and virtual clinics. Through our existing AHCCCS contracts, our provider network already includes providers trained to implement evidence-based best practices and clinical guidelines for treating our members, including but not limited to: MCG Care Guidelines; Substance Abuse and Mental Health Services Administration (SAMHSA) clinical guidelines, including principles of Trauma Informed Care, Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Applied Behavior Analysis, Moral Reconation Therapy, Contingency Management, 12-Step Facilitation Therapy, Crisis Intervention Training, Mental Health First Aid, Youth First Aid, adult basic public safety specific for paramedics and EMTs, American Society of Addiction Medicine (ASAM) and SAMHSA justice related trainings, peer specialist training; and systems to evolve our whole-person approach to care. BUFC develops relevant and effective provider training and education materials, and involves many levels of our organization in the provider education process. We use site visits, provider forums and provider newsletters as methods to educate providers. Our Provider Representatives, who serve as provider educators and act as a liaison between the provider and BUFC, lead meetings with providers, offer training, and provide one-on-one support. We will routinely monitor providers' application of evidence-based best practices and clinical guidelines through targeted clinical record reviews, quality audits, quality measures, provider self-monitoring plans with self-report, and our Value-Based Purchasing (VBP) strategy based on areas of need and targeted focus for each Neighborhood. Neighborhood Scorecards are shared to promote transparency and track performance on an individual and population level.

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

Improving Member Engagement: A significant barrier to engagement of our adult and juvenile members involved with the justice system is timely identification for involvement in BUFC Care Management. To identify more members for engagement in our Reach-In program, our **Justice System Liaison** conducts an in-depth historical claims review of incarcerated members to identify those not meeting the initial medical criteria, but who could benefit from Care Management. We expanded our Reach-In criteria to include Veteran status to connect veterans with the Veterans Outreach Program. In addition to scheduling the 7-day post release PCP visit and psychiatric follow up visit for members on psychotropic medications and addressing barriers to community integration including housing, employment and transportation, it is critical that interventions for our members with Opioid Use Disorder (OUD) begin during incarceration and are continued immediately upon release to minimize overall risk. We have contracts with providers treating the OUD population with 24/7 access to develop programs specifically for justice involved members. For example, to improve continuity of care, we contract with Community Medical Services for opioid related services already operating within jails. Beginning on 10/1/18, we will partner with juvenile justice organizations to timely identify justice involved juveniles and their families for inclusion in our *Complete Care Management* program to coordinate transition to the community and provide family supports. For example, we currently partner with the Pima County Juvenile Court Center whose Juvenile Detention Center utilizes a change-based delivery system called the Step Up to Juvenile Justice, which seeks to stabilize youths' harmful or out-of-control behavior, assist their recognition of the need to change and teach appropriate accountability to prepare youth for successful transition to the community.

Developing and Implementing Best Practices

Intervention During Incarceration: Upon notification of a release date, we enroll members in BUFC Care Management, send a *BUFC Re-Entry Kit* describing community resources and initiate a video or face-to-face visit to conduct a Health Risk Assessment and create a plan for release – all while the member is still incarcerated. During contract Year 1, we will develop a Re-Entry Kit specifically for parents of justice involved juveniles. We follow the SAMHSA GAINS Center APIC (Assess, Plan, Identify and Coordinate) model guidelines for successful transition of individuals with BH disorders from jail/prison; for example, we arrange care during incarceration for immediate access upon release to improve the transition to the community. Our Care Managers confirm attendance at the 7-day post-release appointment (for which members receive a $15 gift card) and outreach members to re-schedule missed appointments, as well as coordinate with members' probation/parole officers and participate in members' CFTs and ARTs, as applicable. An on-call liaison will be available to assist members released from incarceration outside of normal business hours. Our **Justice System Liaison** will improve care coordination with the jails by making information available for our incarcerated members, such as CC Plans, during incarceration in preparation for release.

Peer Jail Liaison: By 4/1/19 and through partnership with Peer/Family-Runs, we will co-locate **Peer Jail Liaisons** at county jails to provide peer/family supports during incarceration and at release for adults, juveniles and their families. Peer Jail Liaisons will utilize *Banner Navigation Accelerator (BNA)*, our web-enabled care support and logistics platform, to complete an abbreviated assessment and intake during incarceration for immediate enrollment upon release.

Innovative Contracting: Through our VBP contract with COPE Community Services, Inc. in Pima County, PCP appointments are scheduled prior to release. We will implement similar VBP contracts with providers throughout the Central and South GSAs partnering with jails, as well as contract with eligible Targeted Investment Providers (TIP) serving adults transitioning from the criminal justice system. For example, HOPE, Inc. currently operates within Pima and Yuma County jails providing support and referrals to community resources. We are engaging with Wellness Connection for southern counties and Terros in Maricopa County to implement similar programs. We are in contract negotiations with providers, such as Touchstone (located throughout Maricopa County and Tucson), trained in Multi-Systemic Therapy, an intensive evidenced-based program focused on addressing environmental systems impacting chronic/violent juvenile offenders – including their homes and families, schools and teachers, neighborhoods and friends.

Partnerships: We have established relationships with many county health departments, probation departments, public defenders' offices and law enforcement. We consider how we can support stakeholders within the justice system, including aligning efforts with the AZ Mental Health Criminal Justice Coalition. We will continue to be a critical collaborator within the justice system by working with justice system partners to develop protocols and MOUs for coordinating care to ease the burden on the justice system. Our **Court Coordinator** will collaborate with the Drug and Mental Health Courts. During contract Year 1, we will initiate a diversion program with Tucson Police Department (TPD) to divert members to Substance Use Disorder services rather than be taken to jail for a first-time substance use related arrest. Based on program outcomes, we will engage with other municipalities to implement rapid expansion plans.

Tracking and Monitoring Outcomes: We track and monitor outcomes for justice involved members through: 1) VBP metrics; 2) Health Current alerts; 3) recidivism; 4) ED and hospitalization utilization rates; and 5) review of data in our Quality Management Performance Improvement (QMPI), Justice Steering and Condition Management Committees. Baseline data is established, trends are reviewed and the PDSA approach is applied to improve outcomes.

COURT ORDERED EVALUATION (COE)/COURT ORDERED TREATMENT (COT)

Improving Member Engagement: Our **Court Coordinator**, Patricia Soto, has 30 years of experience working in the COE/COT (Title 36) process and is the single point of contact for coordination of COE and COT. When a member is court ordered for evaluation and/or treatment, they will immediately be entered into our Care Management program (if not already), and the BUFC Care Manager will deploy a **Peer Liaison**, through specialized contracts with PREOs, to support the member and his/her family (if applicable) during this time of vulnerability and crisis. Peer Liaisons will educate members about their diagnosis and symptoms, give step by step explanation of the COE/COT process, and share their similar history to inspire hope. The Peer Liaison will remain with the member after conclusion of COE and/or COT inpatient stay to help the member transition to community-based care while maximizing self-determination.

Upon notification from facilities accepting members on COE, we track members, in accordance with CFR-42, throughout the COE process in our Title 36 database: engaging in discharge planning when appropriate. For members on COT, we work with the facility, our providers and the member's ART to make sure the member has an appropriate discharge plan,

crisis plan and ongoing CC Plan. We will refer members to First Episode Clinics for services at the point of a first psychotic episode, early psychosis, or prodromal stage. We require all contracted outpatient BH agencies to submit a monthly COT report and notification of pre-petition screening via our dedicated mailbox. Our Court Coordinator maintains policies and procedures outlining BUFC's role and responsibilities related to Title 36 processes. Providers are advised of their responsibilities through the Provider Manual and quarterly meetings with our Court Coordinator.

Developing and Implementing Best Practices

Capacity: The Banner delivery system is currently evaluating COT facility capacity and Banner's ability to meet COT inpatient needs through two sites, Banner Del E. Webb and Banner Thunderbird, in Maricopa County.

BUFC/Connections Health Solutions (CHS) COE Program: In partnership with CHS, we are implementing a specialized program in both Pima and Maricopa Counties involving current BUFC members that are on COE and awaiting their judicial hearing. When the judicial hearing is delayed due to the volume and scheduling of hearings in the facility, members are forced to remain in the facility post COE days and utilize "detention days" while they are awaiting the determination of COT or until they stipulate and become voluntary. To address this problem, our initiative allows for CHS to conduct discharge planning and wrap around services for members that are able to be discharged, per the facility and judge, while they await their judicial hearing. CHS provides high touch case management utilizing a team with an RN, BHP, Case Manager, Psychiatrist and Peer Support Specialist. CHS ensures the member remains engaged in their high touch program and provides transportation and facilitation of the judicial hearing back at the facility. The goal is to reduce the detention days when applicable and medically appropriate, promote the member to become voluntarily engaged in services, and reduce the bottleneck of the facilities that are at or above their capacity to meet the timeliness to have a judicial hearing. Additionally, historically, members have remained in the Maricopa County facilities due to lack of discharge planning and placement for the GMHSA population. This initiative provides strong proactive planning and interventions to avoid discharge delays due to system barriers.

Tracking and Monitoring Outcomes: We monitor and track outcomes specific to COE through: member identification, facility, total number of COE admits, COE dates, court ordered status, total length of stay, and readmits under COE. We monitor and track outcomes specific to COT through: member identification, mental health number, supervising agency, date of COT, judicial review dates, suspension dates, and annual review completed by a psychiatrist. We will add a metric to track and monitor when an order is terminated versus filing for roll over/continued order. We will track and monitor that providers have informed members of their right to judicial review. These metrics provide information on processes that support our overall goal of persons on COT subsequently engaging in voluntary treatment.

MEMBERS WITH HIGH NEEDS AND/OR HIGH COSTS (HNHC)

Improving Member Engagement: We proactively identify and intervene early with members with HNHC to engage in preventive/primary care and BH services to improve health outcomes, reduce costs and reduce over use of high cost services. We use claims review and population segmentation by our clinical analytics department to track data such as ED visits, PH/BH admissions/re-admissions, authorizations, PH/BH utilization and social risk factors to identify HNHC members. Members are also identified based on responses to HRAs; decisions made during Interdisciplinary Care Teams (ICT) rounds, ARTs/CFTs; and input from members and providers. We collaborate with our VBP partners to share data and strategies enabling provider communications, so the most appropriate care is provided, navigation support is available, and the member is engaged in care planning and self-management activities. Children with HNHC, which may include children with special health care needs and children with eligible Children's Rehabilitative Services conditions, are enrolled in health plan specialty pediatric care management and are referred to contracted integrated health homes or MSICs for care coordination. BUFC already employs a BH staff person who leads the HNHC program at the administrative and clinical levels through coordinating and collaborating with the RBHAs and providers regarding this population. During contract transition, we will proactively identify HNHC members via the DEF file and Enrollment Transition Information (ETI) Forms to enroll them in our Complete Care Management program.

Developing and Implementing Best Practices:

Integrated Care Teams (ICTs)/Plans: HNHC members' PH/BH needs and SDOH are addressed through at least monthly ICT meetings to make recommendations for clinical interventions or alternative treatments. Our interdisciplinary ICTs will be transformed into integrated CFTs and ARTs, as applicable, by participation of Complete Care Managers providing clinical and technical assistance to teams and assisting with development of a CC Plan. CC Plans will include the required

elements of Individual Service Plans (ISP), but will also include PH/BH conditions and their influence on each other; a focus on overall health and wellness; and SDOH with services/natural supports to address the complete care needs.
Condition Management Program: Through our Condition Management Program and collaboration with the RBHAs to coordinate care for HNHC members, we have seen a **10% reduction in ED visits** with CI shared members and a **7% reduction in ED visits** with Health Choice Integrated Care (HCIC) shared members. We achieved an **83% reduction in medical admissions** with CI and a **44% decrease in medical admissions** with HCIC shared members. **Overall costs were reduced by 40% with HCIC and 71% with CI**. Due to the success of this program, we will expand our population criteria with this AHCCCS Complete Care (ACC) Contract.
Healthy Together Care Partnership (HTCP): HTCP is a home and community-based care program that offers an evidence-based, high-touch, inter-professional, team-based approach to care for members with HNHC. In partnership with the member, family, PCP, psychiatrist, specialists and other local community-based providers, HTCP provides an extra layer of at-home supports to align services and increase self-efficacy and independence during times of transition and heightened vulnerability. The HTCP team consists of an NP, nurse Care Manager, BH consultant, clinical pharmacist and community health worker. The team assists members and providers by helping them with care transitions, medication management and optimization, palliative and end of life care, chronic condition management, BH interventions and care coordination. A 2015 actuary analysis concluded that HTCP realized a $61 PMPM savings in medical expense. A 2017 evaluation found HTCP participants had a statistically significant 10% decline in total expenditures and a 16% decrease in the number of ED visits. Additionally, a member survey demonstrated a 97% satisfaction rate, with 92% reporting better ability to manage their health conditions. A provider survey found 85% satisfaction with the support they and their members received from HTCP. In anticipation of the ACC Contract, BUFC will build upon the success of HTCP and expand its services to more members with special health care needs through a partnership with SunLife Home Care. SunLife delivers care within the home to members with long-term care needs, developmental disabilities and chronic PH/BH disorders. By linking the HTCP team as the care "hub" with SunLife CNAs as the "spoke" by smartphone and tablet, HTCP will expand the types of members it serves and its geographic reach. This "hub and spoke" approach will not only improve the reach of specialty care throughout Arizona, but also support paraprofessional workforce development.
Connections Health Solutions Pilot: BUFC partnered with Connections Health Solutions to target overutilization of the Crisis Response Center, Urgent Psychiatric Center, EDs and psychiatric hospitalization, often the result of undetected/untreated SUD. Preliminary results demonstrate reductions in crisis utilization and increased community-based stabilization. *Care Connections Teams,* including a peer, case manager, crisis worker, RN, psychiatrist and PCP, support the member after discharge from the crisis setting until they are fully stabilized and engaged in community-based services to meet their needs. BUFC will expand this model with implementation of the ACC Contract.

Tracking and Monitoring Outcomes: BUFC will continue to monitor and track outcomes that demonstrate the impact of interventions focused on whole-person care through AHCCCS required data sets for members with HNHC. Data and trends are reviewed in our UM Finance, QMPI and Condition Management Committees to find solutions for continuous performance improvement. Member outcomes are monitored through: our Acuity Care Management system, which houses members' CC Plans and triggers our specialty Care Managers when member intervention is needed; Health Current Alerts of ED presentation or hospital admissions; and self-reported outcome measures.

MEMBERS WITH SUBSTANCE USE DISORDERS (SUD)

Improving Member Engagement: Early intervention is critical to improve member engagement for members with SUDs. Our contracted PFROs and other providers will engage members during hospitalization for PH/BH services when there is evidence of an SUD. Engagement occurs prior to member commitment for SUD services by developing a relationship with the member and their natural supports to continuously assess their readiness. BUFC fully supports the efforts of the Arizona Opioid State Targeted Response Grant to reduce the number of individuals with OUDs and the number of opioid-related deaths through implementing administration, prevention and treatment activities. Our Opioid Management program identifies and engages members with concerning Morphine Equivalent Dose (MED) scores. Our **Justice System Liaison** outreaches members who have presented at the ED with opioid overdose diagnosis to educate them about available SUD services and supports, encourage engagement, and educate about Naloxone.
BH Screening and Referral: BUFC will incorporate BH and SUD screening as a required component for all PCPs, at a minimum of annually with evidence-based screening tools. BNA will support ease of referral and follow-up.
Member Choice: Through our *Neighborhood Networks*, members will have access to a full array of culturally competent SUD services. Our providers will have appointment availability outside of normal business hours and BUFC will provide

transportation. We understand one size does not fit all with SUD treatment and each person's recovery is individualized. During points of relapse, we will not just repeat the same services, but will engage the member in a thorough assessment to identify what led to the relapse and what services and supports can best support the member's recovery.

Developing and Implementing Best Practices:
We focus on contracting with providers skilled at providing evidence-based integrated treatment for co-occurring disorders in all levels of care. We refer members to providers who follow evidence-based practices for MAT and other SUD services, specifically, the Adolescent Community Reinforcement Approach (A-CRA), Assertive Community Care and Global Appraisal of Individual Needs (GAIN). We contract with providers who offer 24/7 availability for MAT.
Integration of Primary Care within BH Settings: BUFC has experience with embedding PCPs in BH settings and plans to expand availability of this model of integrated care. We will contract with pain management Centers of Excellence to address the co-morbid and often complex BH, medical and pain management needs of members. This model will include integration of primary medical care, sub-specialty medical care and BH with pain management specialists to address the high morbidity/mortality associated with addiction.
Pain Management: To support our providers treating members with SUDs, ECHO telemedicine training will be available to PCPs, dentists and other prescribers regarding pain management, use of opioids and co-prescribing of naloxone. Dr. Christopher Peterson, a Family Physician and Addiction Specialist, is training family practice residents to treat addiction and provide MAT for SUD within primary care to improve outcomes and decrease fragmentation by expanding the scope of family physicians. Our providers follow national and local guidelines for providing pain management services. Our Opioid Management Program provides support and education to prescribers and members on the safe utilization of opioids and includes a pharmacy lock down program. Medical management staff contacts prescribers of 120 MED or more to notify them their patient is over the recommended dosage limit and to provide support and education, encouraging a gradual titration to a safe MED and non-narcotic treatments for chronic pain. Members are contacted by nurse Care Managers to educate on appropriate opioid use, offer support and assist them with accessing MAT for OUD. In 2017, **24.1%** of the members outreached had a decrease in their MED to <120 and **53.01%** had a significant decrease but were still >120, demonstrating our outreach had a significant effect.

Tracking and Monitoring Outcomes: Our Opioid Management and Complete Care Management programs monitor members through ED utilization, pharmacy data, opioid and naloxone utilization, readmissions, out-of-home placements, PCP screening and referral completion, prescriber utilization of the AZ Controlled Substance Prescription Monitoring Program (CSPMP), care management referrals, and over and under-utilization. In collaboration with our providers and members, we will develop audit tools to determine appropriate metrics for outcomes related to SUDs.

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

Improving Member Engagement: Children are identified as at risk for removal from the home during the initial assessment and care planning processes and through review of EPSDT utilization data. Newborns in the NICU are assessed for various diagnoses associated with Intrauterine Drug Exposure, including Neonatal Abstinence Syndrome (NAS), and for potential social factors/risks that may increase the potential for removal. Our Care Managers monitor progress during DCS investigations of newborns with NAS. We engage specialty pediatric care management and monitor newborns at risk of removal during the NICU stay and following discharge. We work collaboratively with inpatient case managers and social workers to coordinate and streamline discharge plans. Following discharge, we closely monitor the family to help adjust to taking the baby home and quickly resolve any issues that may put the child at risk for removal. Being proactive, we use data review to identify children at risk, such as increased PH/BH needs or services indicative of abuse. We focus on pregnant teens at risk of having their babies removed by engaging them in our high-risk specialty OB care management to link them to services and supports to keep their babies safe and healthy at home. Children with high service intensity needs, including children with CRS eligible conditions and American Indian children covered by the Indian Child Welfare Act, can strain the family so we identify risk factors for potential removal from the home.

Developing and Implementing Best Practices:
BH Screening/Referral: Providers screen for BH needs through EPSDT visits and make BH referrals, improving our ability to intervene early with the family – possibly preventing removal from the home. PH and BH providers screen for trauma and make trauma specific interventions available such as Trauma Focused Cognitive Behavioral Therapy, Seeking Safety and dyadic relational therapies for young children.

Smooth Way Home: In partnership with Southwest Human Development we will fund expansion of the *Smooth Way Home Program* to fill the gap between discharge from the NICU and eligibility for AzEIP when mom and baby are at high risk for mental health needs. Team members visit mom and baby in the home, providing developmental guidance, social support and parental coaching while helping the family connect to community resources and medical care.
Family Support Services: Through contracts with PFROs, we will support parents with risk factors for abuse, including poverty, SUDs, low education, single parenthood, history of abuse and BH conditions. If the parent(s) are our members, we make referrals for PH/BH services and supports. The Family Involvement Center (FIC) and MIKID coordinate with DCS on behalf of incarcerated pregnant women to prevent children from being placed in DCS custody and support reunification of the family. They co-locate peers in DCS offices in Central and South GSAs and in dependency courts in Yavapai County. Early reviews indicate parents/guardians who quickly access supportive services during DCS involvement have improved outcomes and a positive experience for the family. Based on the continued success, we will expand this program to other areas of need.

Tracking and Monitoring Outcomes: BUFC will track and monitor the following outcomes: improved engagement and collaboration in service planning between children, families, community providers and DCS; improved functional outcomes of children at risk of or removed from the home; improved identification and incorporation of strengths and cultural preferences into the planning processes; rate of children removed from the home by DCS; and increased statewide practice in accordance with the Arizona Vision and 12 Principles for Children Service Delivery. Our **Children's Health Care Administrator** will oversee the children's PH/BH service delivery system for member's birth to 20 years of age, including our *Complete Care Management* approach for families with children at risk of removal from the home.

CHILDREN TRANSITIONING FROM CMDP TO THE AHCCCS COMPLETE CARE (ACC) CONTRACTOR

Improving Member Engagement: Our Maternal and Child Health (MCH) employees follow established processes for review of ETI Forms received for children/adolescents enrolling with BUFC to identify the need for *Complete Care Management* and provider-based Integrated Case Management. Each child/youth transitioning from CMDP is assigned a specialty Care Manager for at least one year following transition to BUFC. During review of the ETI, MCH staff research any historical information about the child/youth, including changes in AHCCCS identification numbers as children become enrolled and dis-enrolled from CMDP. Our specialty Care Managers outreach to members' providers to obtain additional information that can inform the assessment and care planning processes.

Developing and Implementing Best Practices:

Trauma Informed Care: Children/youth transitioning in and out of the home, or who are fully adopted, and move on and off CMDP may have BH needs because of the disruption in their family life, instability and history of trauma. Providers apply TIC principles and treat youth in the least restrictive, most family-like setting minimizing the use of higher levels of care, unless medically necessary, as they can contribute to ongoing trauma. For members needing higher levels of care, we refer to providers with programs to minimize the use of seclusion/restraint as these can be traumatizing. Our highly respected providers serving youth in accordance with TIC principles include Casa de los Ninos, Blake Foundation, Southwest Human Development and Arizona's Children Association.
Continuity of Care: We prioritize continuity of care as disruptions in care can be traumatizing for youth. If a child has an established relationship with an out of network, AHCCCS registered, CMDP or RBHA provider they are satisfied with, we will attempt to add that provider to our network if they are in good standing with no quality concerns. If they are not interested in joining our network, we will execute a single case agreement, so the child has continuity of care.

Tracking and Monitoring Outcomes: BUFC will identify and separately track data for children who transition to our plan from CMDP. We will use the same measures to monitor outcomes for all children, which includes all EPSDT measures and access to care data. We will track and monitor provider fidelity through Children's System of Care Practice Reviews. As youth in DCS custody are at risk for overutilization of psychotropic medications including antipsychotics, we will conduct Drug Utilization Review when children transition from CMDP to our plan for appropriate prescribing practices. We will track seclusion/restraint with youth and implement Practice Improvement Projects as needed to minimize use of these interventions. Quarterly, our MCH workgroup will review and monitor these measures separately for children transitioning from CMDP.

8. AHCCCS IS RESPONSIBLE FOR PAYMENT OF MORE THAN 50% OF ALL BIRTHS IN ARIZONA. NOT INCLUDING…

Banner-University Family Care (BUFC) is focused on providing culturally competent complete care to the entire family, promoting healthy mom and baby. We will continue to provide evidence-based approaches to family planning, prenatal, and postpartum care for mom, baby, and family. In our 2013 University Family Care (UFC) proposal, we committed to a 10% reduction in NICU days and have greatly exceeded this commitment by achieving a 49% reduction. We continue this commitment to high quality and continual improvement as a Complete Care Contractor. We listen to our members and providers, continually incorporate best practices, and together test new strategies to improve member experience and outcomes before, during, and after pregnancy. The BUFC Maternal Child Health (MCH) Team proactively identifies pregnant members: engaging high-risk pregnant or postpartum members in our Obstetrics (OB) Care Management program and reaching out to all pregnant women. Led by MCH, we partner with providers and community agencies; track and trend quality data related to pregnancy, birth, postpartum health of the mother and health of the newborn; and implement performance improvement plans to respond to trends as needed. All OB Care Managers are well experienced with interdisciplinary credentials, including RNs, LPNs, BSNs and Licensed Baccalaureate Social Workers.

POTENTIAL BARRIERS TO HEALTHY PREGNANCY AND BIRTH

According to the CDC, many factors can affect a healthy pregnancy and childbirth, including preconception health status, age, access to appropriate health care, and poverty. Environmental and social factors – such as early intervention services; educational, employment, economic opportunities; social support; and availability of resources to meet daily needs – influence maternal health, pregnancy outcomes, and child health. BUFC's approach to maternal child health considers these factors and achieves positive outcomes. In CY 2016 the total C-section rate was 25.7% for Maricopa Health Plan (MHP) and 28.9% for University Family Care (UFC), lower than the U.S. Vital Statistics rate of 32%, and the total low birth weight was 7.1% for UFC, lower than the U.S. rate of 8% (2015). Through our efforts, we have identified specific barriers to healthy pregnancy and birth outcomes. Lack of receipt of timely Notification of Pregnancy (NOP) becomes a barrier to providing early and proactive prenatal care and engaging members in care management support when necessary. As such, we revamped our NOP process and invested in robust analytics to identify and outreach to pregnant members as early as possible. Members not adhering to the recommended Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) schedule is a barrier to a healthy baby. As such, we have increased emphasis on improving EPSDT engagement through focused efforts of our Quality and OB Care Management Departments in addition to use of technology solutions. Lack of social support is a barrier to mom's mental health and well-being and a predictor of baby's safety and wellbeing. As such, we have invested in *Member Supported Care Circles* and Peer and Family Support to enhance the natural support network. Through the Maricopa Integrated Health Systems (MIHS) Maternity Health Home program, we learned providers face administrative burdens and struggle to gather meaningful data. As such, we have invested in technology solutions through *Banner Navigation Accelerator (BNA)* and a *partnership with Equality Health*, an integrated network of local providers that enables integration while offering analytics and care management resources and support to reduce provider hassle. Pregnant women taking medication to manage symptoms of a behavioral health (BH) disorder may select to stop their medications or need to change their medications during pregnancy. This puts them at a higher risk for pregnancy complications and increased BH challenges. As such, we established, through our partnership with Equality Health an exclusive program - *Women and Infant Care Program*, helping pregnant women with BH needs receive quality comprehensive prenatal and postpartum care.

PROACTIVE IDENTIFICATION AND ASSERTIVE ENGAGEMENT

Complete Care Management: In the past two AHCCCS contracts, we have integrated our Care Management program and expanded relationships with key community BH and integrated providers to optimize the care of our members with complex needs. This has resulted in our current, whole-person BUFC *Complete Care Management* program, which will include a core of *Generalist Care Managers* with expertise in member engagement, community referrals to address social determinants, and provider referrals for episodic needs. *Generalist Care Managers* are supported by our *Specialty Care Manager* teams, including our **OB Care Managers**, with licensed physical and BH professionals.

Notification of Pregnancy (NOP): Always focused on continuous learning and evolution, we believed we could improve the timeliness of pregnancy notification. In March 2017, we implemented a new NOP process with providers. We demonstrated a sustained **5-fold increase** in monthly notifications since – allowing earlier screening for elevated risks as well as earlier outreach and engagement of high-risk pregnant members. Between March and September, 60% of initial NOPs received were during the member's first trimester. Our improved process includes internal data monitoring and

reporting capabilities – allowing us to track when a member transfers OB care; member demographics; provider information; entry into prenatal care by trimester and gestational age; care management engagement; and analysis of claims data, hospital census data and prior authorizations to identify potentially pregnant members. Data monitoring is tied to proactive member outreach and provider education to identify pregnant members and offer prenatal care and health promotion activities as early as possible. Our NOP approach offers provider education related to our OB Care Management program and the importance of identifying and referring pregnant members early, especially those with medical, social and/or BH needs. We identify high-risk members based on history as well as key social determinants.

Community Engagement: Through our population health initiatives, members and their families are educated about the importance of preventive care. Social determinants of health have a direct impact on the rate of pregnancy, early access to prenatal care, postpartum depression (PPD), oral health, healthy delivery and healthy parenting. Our OB Care Managers assess for homelessness or the potential existence of domestic violence for the pregnant woman and any children and provide referrals for safe housing as needed, such as Maggie's Place (Phoenix), Good Neighbor Alliance (Sierra Vista), Emerge Center (Tucson), Wings for Women (Tucson, Nogales) and homeless shelters. OB Care Managers work closely with providers to link members to community-based resources that address social risks related to maternal and child health, such as: Health Start, Nurse Family Partnership, Healthy Families, Arizona Coalition to End Sexual and Domestic Violence, Public and County Health Departments, TOPS (Teen Outreach Programs), WIC, Birth to Five Helpline, and PPD resources, such as the Arizona Warm Line. Our partners also include non-clinical partners, such as school systems that allow pregnant teens to complete their education while becoming successful mothers. When a BH need is identified, the OB Care Manager works collaboratively with the BH Specialty Care Manager to coordinate with community-based BH services and connect the member and her family with peer and family support services. Community-based resources are communicated to all identified pregnant members via outreach calls, print collateral and social media platforms. BUFC will expand its education efforts within the first 6 months of the contract by hiring a new position dedicated to outreach and education to strengthen relationships that empowers other stakeholders and resources to actively identify pregnant women, connecting them to the support they need. Through our partnership with the First Things First Family Resource Centers (FRCs) and the Family Resource Network, BUFC will offer FRCs access to our *Banner Navigation Accelerator (BNA)* web-based provider engagement tool and training as *Neighborhood Navigators*, on or before 7/1/19. FRC personnel will use *BNA* to connect families they serve to prenatal and postpartum supports, while enabling NOP submission when appropriate. Partnering with the FRCs not only increases identification of pregnant members in need of support, it also makes the health care system less intimidating and easier to navigate. FRCs contribute to a cohesive network of support, focused on strengthening families, providing parenting tools and nurturing the development of children. Through such partnerships, BUFC will create accessible and supportive neighborhoods while building the capacity of existing community assets to remain sustainable and viable over time.

Prenatal and Postpartum Outreach*:* Every identified pregnant member receives outreach, offering education to support positive pregnancy and delivery outcomes and access to OB Care Management as needed. Our Specialty OB Care Managers address physical, behavioral and social factors a woman may face during pregnancy that encompass the whole family's needs, such as housing, safe environment, needs of other children, education/vocational and nutritional needs. When applicable, care is co-managed with other Care Managers involved before pregnancy to meet needs during prenatal and postpartum periods. Following the postpartum period of 12 weeks, the woman transitions back to the general Care Management program, as applicable. Following identification of pregnancy, we implement various outreach strategies to encourage and maintain member engagement, including:

- Enrollment in our **Warm Health** interactive technology solution increases member engagement through automated telephonic, text, and email messages that provide health education while asking follow-up questions with the option to connect with a live person for assistance. Member responses trigger alerts, to which our OB Care Managers respond. Warm Health assists with medication management, self-care coaching, appointment reminders, nutrition support and more. The Warm Health Pregnancy Support program focuses on promoting a healthy pregnancy and providing education about expected physical changes based on trimester and gestational age. The Postpartum and Well-Baby Warm Health programs promote postpartum healing, breastfeeding, newborn pediatric visits, parenting support and screening for perinatal mood disorders. **MHP's Obstetric Medical Home pilot** with MIHS from 2011-16 included the Warm Health program to educate and monitor pregnant members and resulted in a significant decrease in neonatal intensive care unit (NICU) admissions. MIHS continued use of Warm Health as a component of their *Strong Start for Mothers and Newborns* initiative, funded through the Centers for Medicare and Medicaid

Innovations, to reduce preterm birth and low-birth-weight rates. Lessons learned through our work with MIHS allowed us to launch additional successful maternal medical homes.

- **Telephonic outreach** is made by our Quality EPSDT staff at 2-weeks postpartum to schedule initial EPSDT appointments and screen for other needs, such as mental health support, parenting classes, support groups and postpartum doula services. We refer members needing further follow up to an OB Care Manager. Quality ESPDT employees send **well baby postcards** with reminders for appointments. If the Quality EPSDT employees are unable to reach a member, they follow standard protocols for attempting to outreach members, in addition to adding an alert to the member's record so employees can assist in promoting EPSDT if the member contacts the health plan.
- **Prenatal education packets** are sent to pregnant members following receipt of a NOP. **Postpartum/baby care education packets** are sent to members following live delivery. Both packets are available on our website and are distributed to libraries, FRCs and other community anchors. For non-live deliveries, our OB Care Managers make a "**grief call**" to conduct a postpartum screen and refer to Specialty BH Care Management, as appropriate.
- Because the most effective motivators for a member are their natural supports, in Year 1 of our contract, we will launch use of ***Member Supported Care Circles*** – offering a health promotion, self-management and communication platform for members and their natural supports via smartphone or computer application. Members choose people to add to their "Care Circle," making it easy for families to support their loved one while gaining insight into the member's health. This allows Care Managers to better understand and identify risk, while enabling the member's network to identify and respond to psychosocial indicators and social determinants. Members can receive push notifications that include health tips, nutritional guidance and tracking of baby's development. We will outreach to all pregnant members and encourage them to enroll in Member Supported Care Circles.
- OB Care Managers focus on strengthening the family. This includes helping mom, her family, and new baby connect with parenting classes, postpartum support groups – including groups for dads and grandparents, and evidence-based programs such as the First Things First **Nurse Family Partnership**; where a nurse connects with the mom during pregnancy and follows the baby for the first 2 years of life.

STRATEGIES TO IMPROVE MEMBER EXPERIENCE AND OUTCOMES WHILE ADDING VALUE

Streamlined Access to Care through Alternative Payment Models (APMs): BUHP does not require prior authorization to begin OB care and has been engaging in APMs with OB providers through use of bundled payments for more than 10 years: offering streamlined access with improved continuity of care. Our OB bundled payment contracts demonstrate effective cost containment, with the past 4 years achieving an **annual savings of $1,110,000** compared to the estimated cost for Fee for Service prenatal care and delivery. On or before 10/1/18, we will tie quality measures to our payment model, including incentives for activities that lead to improved outcomes, such as cervical cancer and chlamydia screening, breastfeeding education, attending a parenting class, first pediatric visit, oral health for mom and baby, and depression screening and intervention. We will tie performance payments to self-reported outcome measures through use of a questionnaire derived from the *Listening to Mothers Survey* and the *Maternity Multi-Stakeholder Action Collaborative*. The first population of focus for this initiative will be those under age 20, given the risk of birth complications in teens, the higher than average teen pregnancy rates in rural AZ, and the current fragmentation of care in rural AZ to meet their whole person and family needs.

Family Planning: Every $1 of public funding spent on contraceptive and preventive health services in AZ saves $11.27 in Medicaid costs. We will reach out to our FRC partners and organizations participating in the AZDHS Teen Pregnancy Prevention Program – such as the Cochise County program and other partners – to collaboratively implement strategies for increased access to family planning. By 10/1/19, we will contract with Arizona Family Health Partnership (AFHP) to develop curriculum for family planning and sexually transmitted infection (STI) education for providers, offering both webinar and live training opportunities for our providers and ongoing support and technical assistance post training. AFHP uses evidence-based CDC Quality Family Planning Guidelines. AFHP is dedicated to making reproductive health care and education available to all Arizonans and has been receiving the Title X AZ grant since 1983 and the Title X Navajo Grant since 2014. Leveraging the ground work laid through Title X, the only federal grant program dedicated solely to providing comprehensive family planning services, we will increase access to family planning education, contraceptive care, screening for STIs, HIV, and cervical cancer; and decrease preterm and low-birth-weight births.

Nurse Midwifery Services and Birthing Centers: BUHP promotes the use of Certified Nurse-Midwives (CNMs). According to a substantial body of research and a meta-analysis conducted by the American College of Nurse-Midwives published

in 2012, midwifery care is associated with high quality care comparable to or better than care provided by OB/GYNs. Individuals who receive care from CNMs report high levels of patient satisfaction. Additionally, midwifery care results in lower costs due to fewer unnecessary, invasive and expensive interventions. BUHP has compared cost of care, health outcomes and member satisfaction for members receiving midwifery services to those receiving OB/GYN services and identified the following outcomes for 2017: **higher gestational age at time of delivery** (37.4 weeks with CNMs compared to 36.4 weeks with OB/GYNs), **higher birth weight** (3,309 g compared to 3,241), **decreased C-section rate** (19.9% of total births compared to 29.2%) and **decreased cost of care** (with CNM deliveries costing 23.0% less on average). An analysis of these measures over the past 5 years supports a consistent trend in outcomes achieved. While the research shows cost savings and patient satisfaction with the use of CNMs and birthing centers, their use remains lower than desired. While immigrant women are familiar with non-physician birthing support in their native countries, they often are not aware of the options in the US. We will place emphasis on access to CNMs and birthing centers through culturally appropriate member outreach and provider education, identification and outreach to midwives and birthing centers to invite them to join our network, and expansion of current contracts to support their team care approach and attention to social determinants through Value-Based Purchasing (VBP).

Premature Births: In partnership with Southwest Human Development (SWHD), by 10/1/19 we will use community reinvestment to fund a formal initiative of the *Smooth Way Home Program,* while testing funding models for long-term sustainability. Smooth Way Home was set up to fill the gap between discharge from the NICU and AZ Early Intervention Program (AzEIP) eligibility. During this time, mom and baby are at high risk for mental health needs. Smooth Way Home offers care coordination and support before and after discharge. Team members visit mom and baby in the home, giving developmental guidance, social support and parental coaching while helping the family connect to community resources and medical care. Team members meet with providers, hospital staff and the family regularly to coordinate care in a supportive and expedited manner. By engaging in this initiative, we will identify ways to increase availability of this high-touch approach for all members in need while also promoting the program's continued success through APMs.

Oral Health: The Oral Conditions and Pregnancy (OCAP[i]) study shows maternal periodontal disease increases relative risk for preterm, spontaneous preterm and very preterm births. Dental cleaning and maternal education about vertical caries transmission and infant oral health is an important mechanism for preventing transmission of caries from mom to baby. VBP contracts will incent OB providers and PCPs to improve pregnant members' use of preventive dental care, and incent pediatricians to conduct infant screenings and fluoride varnish application. We will use our outreach mechanisms to encourage pregnant members to obtain a teeth cleaning and exam, and will offer scheduling assistance. On or before 10/1/18, we will also expand our OB bundled payment model to include performance incentives for all teen OB referrals to dentists completed by their patient in addition to developing performance incentives related to healthy birth weight.

PPD and Equality Health Seguro y Sano Partnership: PPD affects 25% of women and up to 60% of vulnerable populations. Depressive disorders were a primary diagnostic category for the 2017 adult GMH population. Identifying and preventing PPD and providing wrap-around support for existing depression during and after pregnancy is critical for infant health, emotional well-being and child development. BUHP encourages members to schedule a postpartum visit within 60 days of delivery. Members enrolled with OB Care Management receive telephonic follow-up 2 weeks after delivery and informational mailings. We train all staff with member contact in *SafeTalk*. During the prenatal period, we identify women with a history of depression or PPD at higher risk for PPD and, therefore, our OB Care Managers use the PHQ-9, Edinburgh Postnatal Depression Scale (EPDS), and Postpartum Safety Screening to screen and then refer positive PPD screens to appropriate interventions. OB Care Managers coordinate with PCPs, BH providers and BH Care Management. BUHP monitors provider compliance with prenatal/PPD screenings via the OB medical record review process. On or before 10/1/18, we will expand our OB bundled payment model to include incentives for PPD screening and warm referrals plus follow up for positive screens. To improve our postpartum care rate, we are taking these efforts to the next level by partnering with *Equality Health***.** Through an exclusive agreement we will implement a program targeting the 2-year cycle of pregnancy and infancy, beginning Year 1 of the ACC Contract. This partnership reduces the data monitoring burden on providers and uses Equality Health's systems to monitor and analyze outcomes. All pregnant women will be screened for substance abuse, depression and diabetes upon presentation for prenatal care. Education on mood disorders, diabetes and fetal development will occur throughout pregnancy. Postpartum diabetes and depression screening will occur at 6 weeks and 6 months. A developmental screening survey is completed at 9-12 months. Providers and practices will receive hands-on training, including CMEs and CEUs. Equality Health and BUFC will

launch an awareness campaign around a healthy start for healthy families, focusing on social media/mobile platforms. We will monitor and track quality measures at critical visits: first trimester/initial presentation, 6-week postpartum and 9 months well visit. The quality measures include Hemoglobin A1c during first-trimester visit and if abnormal, again at 6-week postpartum visit; and completion of screenings using evidence-based screening tools for depression, anxiety and substance abuse. Monitoring and care interventions, including telehealth for rural residents, are provided and care is coordinated between the OB, pediatrician, family practice, other specialties and social service agencies.

SPECIAL POPULATIONS

Pregnant Teens: Teen births can be harmful to teenagers' health, and babies are more likely to be born with a low birth weight or preterm. Teens have a decreased rate of initiating prenatal care in the first trimester. The adolescent pregnancy rate in AZ was 47 per 1,000 women aged 15-19 in 2013; the national rate was 43 per 1,000. We will engage local resources in efforts to prevent teen pregnancy via our AFHP partnership for Family Planning education. We consider pregnant teens at high risk and enroll them in our OB Care Management program. OB Care Managers outreach pregnant teens to assess physical, BH and psychosocial needs. We provide a tailored informational packet including information about obtaining a GED, pregnancy programs in their school system, well child care, newborn care, TOPS and nutritional needs. The OB Care Manager encourages teens to participate in our **Member Supported Care Circles**, and refer to peer and family-run organizations, such as the Family Involvement Center (FIC) and MIKID, who support pregnant teens throughout pregnancy and following childbirth. Peers educate teens about the importance of prenatal care and work with the teen and their natural supports to address needs, including psychosocial needs, such as housing, nutrition, education and involvement with juvenile justice, Department of Child Safety and/or Comprehensive Medical and Dental Program. Peer support is critical, as teens are at increased risk for removal of the baby from the home. We partner with organizations such as MIKID, who have invested in the training of young adults to deliver specialized peer support to youth. OB Providers serving teens will be financially incentivized through VBP for measures such as rate of participation in Member Supported Care Circles, oral health, and member experience.

Pregnant Women in the Justice System: Through our Reach-In program, we provide timely face-to-face visits with pregnant women incarcerated prior to release. Upon identification that one of our pregnant members is incarcerated, our Justice System Liaison, in coordination with the OB Care Manager, conducts a face-to-face visit prior to release to assure care is in place upon release. Through partnerships with Peer and Family-Run Organizations (PFROs) by 4/1/19, we will co-locate Peer Jail Liaisons in the jails to provide peer support during incarceration and at point of release. FIC proactively coordinates with DCS on behalf of incarcerated pregnant women to prevent children from being placed in DCS custody, or support reunification of the family. FIC co-locates peers in DCS offices in Maricopa County and within dependency court in Yavapai County. We will expand these resources throughout each county.

Pregnant Women with Substance Use Disorders: Pregnant women constituted approximately 4% of the 46,007 individuals with a primary diagnosis of Opioid Use Disorder (OUD) in AZ in 2015. AZ Opioid State Targeted Response project objectives include expanding peer support services, recovery homes, and recovery support to pregnant and parenting women. In partnership with PFROs and by 4/1/19, we will support pregnant women with SUD by making peers available to coordinate with DCS to prevent removal of children. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor and fetal distress or demise. The use of Medication Assisted Treatment (MAT) during pregnancy is a recommended best practice for pregnant women with OUD[ii]. A high-risk pregnancy can be a barrier to locating substance use services, especially in rural areas. Prior to 10/1/18, we will identify resources in each county and, in alignment with the Governor's Substance Abuse Task Force Report, support increasing MAT capacity for special populations such as pregnant women. We are developing VBP partnerships with BH and SUD providers serving pregnant women and contract with existing Centers of Excellence providing SUD services for pregnant women. We refer pregnant women to providers who have trauma-informed SUD programs for pregnant women, such as La Frontera's Hope Center in Tucson; ConnectionsAZ in Maricopa County; and CODAC through a partnership with Tucson Medical Center and DCS offering transitional housing and MAT services. Additionally, we are partnering with CPI/Assurance Health to develop a neonatal abstinence and MAT program for pregnant women in Cochise County.

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[i] Offenbacher S, Boggess KA, Murtha AP, Jared HL, Lieff S, McKaig RG, et al. Progressive periodontal disease and risk of very preterm delivery. Obstetrics and Gynecology. 2006;107(1):29–36.

[ii] American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, & American Society of Addiction Medicine, 2012

9. DESCRIBE HOW THE OFFER WILL ADDRESS THE DEVELOPMENTAL NEEDS OF YOUNG CHILDREN INCLUDING…

Banner-University Family Care (BUFC) meets developmental needs of young children by building upon our extensive experience serving AHCCCS members and leveraging diverse services available through our provider-based plan as part of Banner Health, our affiliation with University of Arizona (UA) College of Medicine (COM), and through further expansion of value-based partnerships with community-based providers. At all EPSDT visits, providers monitor achievement of developmental milestones. BUFC monitors provider activity for compliance, supports members to comply with EPSDT and follow-up visits, and encourages solutions through value-based contracting. To help families access early care, we introduce the *BUFC Complete Care Continuum* (*C3*), which includes *Complete Care Management* (*CCM*), technology-enabled engagement solutions and a *Neighborhood Network(NN)* approach to working with providers through shared governance and aligned incentives. This model of care activates member and family-focused supports, provides comprehensive care coordination, and meets the needs of youth with developmental delay (DD) through services aligned with the *Arizona Vision* and *12 Principles of the Children System of Care* within a Trauma Informed Care framework. Through *C3*, we offer accessible, member and family-centric care. BUFC streamlines service provision and minimizes burden of accessing care through a multidisciplinary approach, reducing fragmentation and providing integrated services driven by member choice. This makes health care easier while also bending the cost curve.

STEP 1: PROVIDER-BASED SCREENING ACTIVITIES PROVIDE EARLY IDENTIFICATION OF DD

DDs may impact several areas of normal development potentially leading to diagnoses, such as Intellectual Disabilities, Communication Disorders, Learning Disorders, Motor Disorders and Autism Spectrum Disorder (ASD). A broader definition from the DSM-5 of Neurodevelopmental Disorders includes ADHD. Regardless of the area of concern, it is critical to provide surveillance and screening during EPSDT and acute care visits. A national study published in the journal *Pediatrics* found 2 of 3 key breakdowns in office-based DD screening involved office staff. As such, BUFC offers Primary Care Providers (PCPs) *and* their staff training in the use and scoring of approved developmental screening tools. In addition to AHCCCS requirements, BUFC expects developmental screening to begin at the first EPSDT visit for at risk youth, such as members born prematurely, ones with siblings with DDs and Neonatal Intensive Care Unit (NICU) graduates. BUFC's EPSDT Quality Management (QM) Team coordinates with *BUFC Complete Care Management (CCM)* to track data related to developmental screening and facilitate provider completion. This team also outreaches parents to support early access to care and compliance with the EPSDT schedule. *NNs* within *C3* provide comprehensive care, aligned through value-based incentives. We will utilize NNs to align a cohesive system of local physical health (PH) and behavioral health (BH) providers and community agencies to meet member and family needs. The *NN* includes masters and doctoral trained staff in social work, counseling and psychology with expertise in best practices for DDs. Each *NN* prioritizes use of Centers of Excellence (COE) and Integrated Health Homes (IHHs) for youth with ASD. Our local approach to care will lead to earlier diagnosis, quality accessible care and better outcomes.

> BUFC achieved one of the two highest baseline measures for developmental screening during a recent AHCCCS Performance Improvement Project. We build on our substantial experience ensuring that developmental screenings through use of the PEDS, ASQ or MCHAT tools are conducted consistent with EPSDT requirements at the 9, 18, and 24-month well child-visits.

Key Strategies*:* Breakdowns in the timely treatment of DDs occur when EPSDT and follow-up visits are not made. BUFC has numerous strategies to support family engagement and early screening, including:

- **The BUHP Website, Newsletter, and Social Media Platforms** provide information about DDs.
- **Member Postcards and Text Blasts** encourage participation in EPSDT visits and include content about development.
- **Pregnancy Packets** share information related to early childhood development and EPSDT newborn well visits.
- **Targeted Cultural Outreach/Provider Engagement** tackles disparities in identifying youth with DDs. Hispanic youth with ASD are less likely to receive early diagnosis and treatment due to cultural and language barriers associated with screening. BUFC provides culturally competent outreach and support with promotoras and educational materials, such as *Indicadores del Desarrollo* from the *CDC's Learn the Signs* toolkit. Our *NN* partners include schools, preschools and providers serving high percentages of Hispanic youth. BUFC improves provider engagement in a culturally-aligned model through our partnership with *Equality Health***.** The integrated care network incentivizes providers for culturally appropriate care, member engagement, education and traditional wellness measures.
- **Partnership with the AZ Department of Education** collaboratively supports screening within the classroom (such as the *Teaching Strategies Gold* formative assessment) and leverages efforts currently underway related to school-based screening for social and emotional development, which includes BUFC membership on the AZ Department of

Education K-3 Formative Assessment Implementation Group and the involvement of Ambassador Teachers in the development of our *Banner Navigation Accelerator* (*BNA*) technology solution.

- **Collaboration with AZEIP providers** is prioritized to support ongoing needs of youth with delays. BUFC found AZEIP providers who were new to AHCCCS often had difficulty with billing and navigating the system. Provider Relations trains them so they understand how to bill, contract and find helpful resources to sustain their business.
- **Coordination between NICUs and PCPs** supported by the BUFC CCM program targets discharge planning and follow-up care through Banner NICU's successful partnership with Southwest Human Development (SWHD) Smooth Way Home Program, which assists in transitioning fragile infants and their families from the NICU back to their home.
- **Value-Based Purchasing (VBP) Performance Measures** include provider financial incentives tied to EPSDT visits with use of developmental screeners.
- **BUFC OB Care Managers (CMs)** offer new mothers postpartum support, education and reminders about EPSDT visits.
- **Warm Health interactive technology solution** increases member engagement through automated telephonic and text messages that provide health education while asking follow-up questions with the option to connect with a live care management employee for assistance. As a component of our Well-Baby Warm Health program, families receive information and reminders about newborn pediatric visits and screening.

STEP 2: POSITIVE SCREENING LEADS TO TIMELY AND ACCURATE DEFINITIVE DIAGNOSIS

Timely comprehensive assessment after a positive screen is critical to support young children with potential DDs and their families. Developmental conditions are heterogeneous and the assessment process can be limited to an individual provider or require a multidisciplinary approach, which may include behavioral assessment, physical evaluation conducted by primary care and specialty providers, and/or allied medical professionals such as speech, occupational, physical, audiology, nutritional or feeding therapists, psychoeducational, cognitive, developmental, laboratory, neuroimaging and/or genetic testing. BUFC CMs support timely access through a streamlined referral process.

Child and Family Teams (CFTs) and Complete Care Plans (CC Plans): BUFC makes sure all members are assigned to a designated BH Professional (BHP) to oversee the BH assessment and service planning process within a BH home model in accordance with AMPM Policy 580. This includes an enhanced, multidisciplinary integrated approach to traditional CFTs, including BH and PH providers, as applicable to support member and family-driven complete care for youth with special health care needs (SHCNs). An essential part of CFTs is intensive coordination with AZEIP, Head Start Providers, schools and child care settings, including involvement in development of Individualized Educational Programs (IEPs) for youth 3 years and older and Individualized Family Service Plans (IFSPs) for youth birth through 2 years of age. CFTs engage in active assessment and service planning through implementation of personalized CC Plans that address individualized member and family needs and support choice. CC Plans include all required service plan elements plus an enhanced approach to service planning with inclusion of BH and PH conditions, their influence on each other, a focus on overall health and wellness, social determinants of health, and the services and natural supports to address a member's complete care needs. To support BUFC's family focused approach all families with multiple BUFC members will have all their family's CC Plans aligned to minimize redundancy for simplicity, address comprehensive family needs assessment and care planning that fosters family stability, minimizes risk for removal by the Department of Child Safety and supports transition of youth from CMDP upon family reunification. To support service provision with the appropriate intensity, BUFC providers will implement the CASII for youth 6 and older and will develop a crisis plan for all youth with a score of 4 or higher and those with a crisis episode or hospitalization within the last year. In addition, BUFC focuses on training and implementation on the AHCCCS toolkits, including *Psychiatric Best Practices for Children Birth to 5 Years of Age*, *Working with the Birth Through 5 Population*, the *Unique Needs of DCS Youth* (as youth with delays are at increased risk of removal from parents' custody), and the PCP AHCCCS Clinical Toolkit for the *Management of Childhood and Adolescent ADHD*. This innovative approach to service provision with multidisciplinary teams, CC Plans and implementation of best practices will drive early identification and treatment.

Trauma Informed Care (TIC): Trauma screening is an essential component of PH and BH assessment as trauma-related symptoms may be confusing and lead to incorrect diagnoses. BUFC prioritizes services aligned with the key principles of TIC; including trauma screening as a component of our EPSDT VBP performance measure and TIC as a component of our provider *Assessment of Quality & Recovery Orientation* used to build our Neighborhood Networks. Our employees are trained on the principles of TIC and we make training available for our providers.

Banner Navigation Accelerator (BNA): Timely information sharing among providers is critical to children receiving an accurate diagnosis and treatment, as such BUFC has developed BNA – incorporating Health Current information and offering a clearinghouse to aggregate information related to intake, assessment, CC Plans, referrals and community

resources. BNA enables providers to easily determine availability of specific services within accessible locations.

STEP 3: COMPREHENSIVE TREATMENT OF DEVELOPMENTAL DISORDERS FOLLOWS ACCURATE & TIMELY DIAGNOSIS

Community-Based Services: Following accurate diagnosis, early treatment occurs by the NN of BH and PH providers. BUFC's procedures allow direct access to specialists to expedite access to care. Family-focused and community-based BH services are prioritized that include therapeutic preschools, Family Support and Family Run Organizations, respite, treatment, generalist and specialty support and rehabilitation services/Meet Me Where I Am that incorporate the use of Positive Behavioral Supports. COEs have staff endorsed by the Infant Toddler Mental Health Coalition of Arizona (ITMHCA) or other endorsing body as well as on-site and community-based family support. Psychotropic medications may be prescribed in rare situations by providers with specialized training, but only as one part of a CC Plan. Parents of youth 5 and older with uncomplicated ADHD may choose to receive care by a PCP with expertise and knowledge of the *AHCCCS Clinical Toolkit for the Management of Childhood and Adolescent ADHD*. Identified BUFC providers will provide general psychiatric and face-to-face consultation to support PCPs in providing care. Allied medical services including speech, physical, occupational therapy, primary and specialty PH services will be available as needed for complete care.
Out-of-Home (OOH) Services: If community-based services are insufficient for a child's needs, OOH therapeutic services provided in the least restrictive setting will be available among Arizona providers. The youth's outpatient team supports transitions and minimizes the length of stay. Proactive crisis and diversion planning are key to the CFT along with BUFC care management and provider-based integrated case management processes to minimize risk for OOH placements.
Emergency Department (ED) and Crisis Settings*:* EDs and other crisis settings are far from ideal for children with DDs. To support quality care for youth who present to crisis settings, BUFC provides training to crisis facility staff on evidence-based care for youth with DD. If a member is in an emergency care setting, BUFC and the provider are notified from Health Current to trigger real-time outreach and support. In addition, the BNA will provide real-time granular information about diagnosis, CC Plan, needs and community resources to expedite disposition to the community.
Member Supported Care Circles: In addition to traditional family support, BUFC introduces *Member Supported Care Circles,* an innovative cell phone-based technology solution to enhance the power of real-time communication for parents of youth with complex needs with their chosen supports, including a Family Peer, therapist or case manager.

COMPLETE CARE REDUCES FRAGMENTATION IN ASSESSMENT AND TREATMENT FOR YOUTH WITH ASD

For quality assessment and treatment of ASD, the BUFC NN includes COEs and IHHs with specialized expertise and provides accessible, family-centered, comprehensive care. BUFC collaborates with the UA COM and Departments of Developmental and Behavioral Pediatrics and Child and Adolescent Psychiatry. BUFC also partners with community-based providers, including Touchstone, Southwest Behavioral Health Services, SWHD, Intermountain Centers, Southwest Autism Research and Resource Center (SARRC), Tucson Children's Clinics and other regional Multi-Specialty Interdisciplinary Clinics (MSICs). VBP contracts include COEs that incorporate key indicators related to timely comprehensive evaluation and access to evidence-based treatment. BUFC requires comprehensive diagnostic assessment within 45 days of a positive screen for ASD. These assessments are available within our network of providers and supported by network development activities and use of technology. A multidisciplinary approach to assessment is utilized and includes a comprehensive clinical assessment performed by a psychologist, psychiatrist, developmental pediatrician or pediatric neurologist for diagnostic purposes. The Autism Diagnostic Observation Scale (ADOS) is available as part of assessment. Additional assessments are available as needed. Technology may be used to support timely diagnostic assessment via telemedicine in rural and underserved urban settings. BUFC partners with SARRC and their use of Natural Observational Diagnostic Assessment (NODA) that allows for remote diagnostic assessment as parents produce videos reviewed by diagnosing ASD providers.

Comprehensive early treatment is expedited for youth with ASD. Along with primary PH and BH services, our comprehensive network provides early access to specialty medical and dental treatment for conditions associated with ASD as well as care provided by allied professionals including physical, occupational, speech, nutritional and feeding therapy. Services focus on developing individualized person-centered CC Plans with access to evidence-based practices, including but not limited to: Applied Behavioral Analysis (ABA), such as Early Intensive Behavioral Interventions (EIBI), Functional Behavioral Assessments (FBAs) and Behavioral Treatment Plans (BTPs); and a focus on communication, including the use of alternate communication modalities, such as Picture Exchange Communication System (PECS) and other forms of augmented communication with intensive coordination with school and daycare settings. BUFC medical leadership has extensive experience with this population, including the BUFC Medical Director of Care Integration, who

has participated in the AHCCCS ASD Advisory Committee and provided leadership in the implementation of the Intermountain Centers demonstration project that has successfully implemented complete care for ASD.

Aligned with AHCCCS ASD Taskforce recommendation, the Intermountain Centers pilot project with El Rio FQHC includes streamlined referrals for youth with positive ASD screens, expedited multidisciplinary assessment, care planning, care coordination through integrated care teams and expedited access to evidence-based services. Data from Year 1 revealed increased multidisciplinary care and use of evidence-based services. This model expanded to Sun Life FQHC, enabling a youth in Pinal County who had been waiting 8 months for an ASD diagnostic assessment to initiate treatment within 2 weeks. This program will expand this successful model in awarded GSAs.

MONITORING FOR EARLY IDENTIFICATION OF MEMBERS AND SERVICE PROVISION

BUFC tracks and monitors screening for all young children and service provision for those with identified DDs. Our multipronged approach includes auditing and oversight by our Quality Management (QM) Department, real-time monitoring and support through our CCM program and Provider-based integrated case management. Quarterly QM audits developed with input from providers, members and stakeholders include indicators focused on key clinical outcome measures related to: communication skills; socialization and reduction of problematic behaviors; and access to evidence-based screening, assessment, treatment and coordination with schools. A comprehensive drug utilization review (DUR) process monitors prescribed medications consistent with AMPM Policy 310-FF to provide oversight of prescribing practices with indicators for any youth aged birth through 5 on psychotropic medications along with targeted review of antipsychotic medications. The DUR process is overseen by a board-certified child and adolescent psychiatrist and PharmD. All PCPs are required to submit EPSDT forms and developmental screening documentation, including results from EPSDT visits conducted at 9, 18 and 24 months within 7 business days of completion. Our EPSDT QM Team reviews this information and reaches out to our member's PCP for deficiencies. Actions include training and technical assistance followed by formal plans of correction for continued deficiencies. Data from Grievance and Appeals, Customer Care, CCM and QM audits are aggregated to understand system and provider performance, potential network gaps, system level or member specific Quality of Care (QOC) concerns, and/or best practices to build upon. This comprehensive information is utilized for continuous performance improvement using Plan-Do-Study-Act methodology. To monitor rapid response to positive developmental screens, the EPSDT QM Team refers all members screening positive to CCM within 72 business hours of receipt of this information. The BUFC CM then reaches out to the parent or guardian within 72 hours to support access to care. The CCM program includes a core of *Generalist CMs* with expertise in member engagement, community referrals and provider referrals for acute episodic needs. This group is supported by our *Specialty CMs* including licensed PH and BH CMs to provide individualized care management for our high needs members. These teams have expertise to support members with SHCNs, including young children with ASD. To supplement the care management teams, physician consultation is available to provide guidance for complex clinical issues, including Dr. Sandra Stein, a Child and Adolescent Psychiatrist, and Dr. Thomas Ball, CMO and Board Certified Pediatrician. BUFC initiates condition management programs to meet the needs of our members and as part of AHCCCS Complete Care (ACC) will implement an ASD program by contract implementation to monitor and address barriers associated with care, while providing education and support to parents and monitoring parental satisfaction. BUFC CMs in collaboration with the 24/7 nurse triage line and BUFC contracted providers are available to provide real-time monitoring and support of emergent needs. BUFC's CCM program is extended by provider-based Integrated Case Managers, offering a boots-on-the ground, community-based assertive approach for members with the most complex needs. Furthermore, BUFC will meet required caseload ratios by ACC contract implementation with a 1:15 target to support intensive, provider-based monitoring for youth who meet the requirements for High Needs Case Management, including youth with developmental disabilities involved with AZEIP.

MANAGEMENT OF EARLY INTENSIVE BEHAVIORAL INTERVENTION (EIBI)

Starting Oct. 1, 2018 EIBI services will be available and an authorization process will be implemented. EIBI will most commonly be provided for children from birth through age 5 with an intensity of 20-40 hours a week. Services focus on development of individualized plans to build family, caregiver and school-based capacity to meet the needs of children with delays in communication, problematic behavior and socialization. All EIBI services will be identified for easy reference in the BNA and will be provided or overseen by Board Certified Behavioral Analysts (BCBAs) who supervise home and community-based clinicians with specialized training in ABA (i.e. Registered Behavioral Technicians [RBTs] or equivalent training). ASD assessors are trained for a comprehensive understanding of EIBI. An expedited and

streamlined Prior Authorization (PA) process completes determinations within 72 business hours of a request. BUFC *Specialty CMs* will coordinate with the parent and provider to support timely submission of PA requests and access to services. The referring provider will be notified within 24 hours of the authorization decision. A Notification of Adverse Benefit Determination will be provided for all denials detailing the process to appeal the decision, and appeals will be processed with an expedited timeline. The initial authorization period will cover 30 days for appropriate initiation of skill assessment, goal development, data collection procedures and treatment planning, and 90 days for ongoing services thereafter. During the initial 30-day period, a provider-based BCBA will complete a comprehensive assessment to collect data related to skill level (deficits and excesses), and identify and develop targeted goals, including skills tracking and recommendations for the intensity and duration of EIBI or other services. Evidence-based progress monitoring tools will be utilized as best practices, including: Assessment of Basic Language and Learning Skills Revised (ABLLS-R), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or comparable tools. The continued authorization process will include review of progress requiring submission of an updated ABLLS-S, VB-MAPP or other comparable tool with documentation of the frequent and ongoing skill assessment, progress and treatment planning process. *MCG Care Guidelines* along with use of the Practice Guidelines for Health Care Funders and Managers for ABA Treatment of ASD from the Behavior Analyst Certification Board (BACB) will be used for all authorization decisions. Services included in the authorization for EIBI will include behavior-analytic assessment, behavioral plan development and modification, treatment, along with parent and caregiver training and consultation. Ongoing reassessment of need and service planning will be part of the multidisciplinary CFT and CC Plan process with the EIBI provider. A critical component of managing this benefit is parental engagement, school collaboration and service provision within the home and community. Parents will be educated before initiation of this service. If parental engagement is not sufficient, strategies will be implemented through motivational interviewing and contingency management to support ongoing treatment. If parents do not participate in EIBI as needed, the service will no longer be authorized and alternate services will be provided. In addition, QM audits will monitor for provision of services with fidelity. BUFC will also monitor service provision for potential fraud, waste and abuse. This comprehensive approach will improve access to EIBI when medical necessary with quality services provided within the timeframes and with the intensity needed to drive positive outcomes.

BUILDING RESOURCES WITHIN THE BUFC NEIGHBORHOOD NETWORKS FOR EARLY IDENTIFICATION AND TREATMENT

Since workforce training and development is critical to meet the needs of children with DDs, BUFC prioritizes training for our employees, members, providers and the community. We commit to implement the following:

Prior to implementation: Extensive training through webinars, office-based provider orientation and educational forums will be provided to support the transition to complete care. We will implement a comprehensive training plan so appropriate employees are knowledgeable on the *Arizona Vision* and *12 Principles,* and the *AHCCCS Toolkits*.

By contract implementation: Through affiliation with the UA COM, BUFC is in a unique position to enhance capacity through partnering with residency and fellowship training programs, including Family Medicine, Pediatrics, Child and Adolescent Psychiatry and the new Developmental and Behavioral Pediatrics Fellowship. In addition, BUFC will partner with the UA leadership training program, *ArizonaLEND***,** to enhance the workforce in meeting the needs of youth with DDs. We will also utilize community reinvestment dollars to partner with the *SWHD Harris Institute and the Early Childhood Mental Health Training Institute* to enhance capacity and expertise of professionals that work with infants and toddlers and *Early Access to Care Arizona (EAC-AZ)* to continue support of rural PCPs managing members with ASD. EAC-AZ has recently lost funding and its leader. However, BUFC is committed to facilitating discussions with all stakeholders, including all ACC contractors, to continue this critical telemedicine specialty support for providers caring for children with ASD and other behavioral or developmental disorders in underserved rural areas, including Hispanic and Native American communities.

During the first year of contract implementation: The **ECHO** telemedicine training model will provide statewide training by leading experts and serve as a virtual support group for members, parents and community members with specific shared conditions. BUFC will partner with Intermountain Centers who currently employs 9 BCBAs across the state to provide services and further develop capacity through a *focused ABA training model* and *ABA telemedicine model* to support rural and NA communities by building upon their extensive history in partnering with numerous tribal communities. BUFC will also build the ABA workforce through development of RBTs.

Through our affiliation with UA, partnerships with key providers and the use of technology, BUFC will have a comprehensive integrated NN to provide early screening, assessment and treatment for youth with DDs that minimize fragmentation and enhance efficiency, leading to more cost-effective care and optimal member outcomes.

10. DESCRIBE HOW THE OFFEROR WILL MINIMIZE ED HOLDS FOR BEHAVIORAL HEALTH CONDITIONS, REDUCE THE…

Driven to make health care easier so that life can be better for our members, Banner-University Family Care (BUFC) builds on extensive experience serving AHCCCS members through multiple contract cycles, including implementation of integrated care management and multiple innovations to successfully reduce Emergency Department (ED) and hospital utilization. As a provider-based plan, we leverage our rich array of services available at Banner Health (Banner) and the University of Arizona (UA) College of Medicine, as well as our comprehensive provider network. In preparation for this transformation, we hosted a series of community Think Tanks focusing on the integration of Physical Health (PH) and Behavioral Health (BH). We heard the same resounding messages from peers, family, providers, first responders, educators and other stakeholders regarding the improvements needed to treat mental illness in the context of whole-person care: 1) we need to improve early detection of mental illness and rapid access to community-based treatment options to prevent hospitalization; 2) today's fragmented health care system is challenging and intimidating to navigate for members and health care professionals alike; and 3) the stigma often associated with BH services is compounded by lack of awareness amongst health care professionals on how to identify and respond to early warning signs. Therefore, our key strategies to minimize long ED holds for BH conditions, unnecessary psychiatric hospital admissions and out-of-state (OOS) placements include: 1) improve members' overall health through our *Complete Care Management* (CCM) program; 2) a highly collaborative *Neighborhood Network* & Value-Based Purchasing (VBP) program; 3) innovative use of technology; and 4) increasing the availability of alternative community-based services and crisis planning. Foundational to these efforts are the *12 Principles of the Children's System of Care* and the *Adult Services Delivery 9 Guiding Principles* provided within a *Trauma Informed Care* (TIC) framework. As the AHCCCS Complete Care (ACC) launch might be associated with confusion and risk to the most vulnerable members, BUFC prioritizes member and provider training prior to and immediately after program launch as we did effectively prior to the successful launch of our ALTCS plan.

BUFC's Care Management model demonstrated effectiveness with our AHCCCS High Needs/High Cost cohort, which experienced a 7-10% reduction in ED visits, 44-83% decrease in medical admissions and overall cost reduction of 40-71% since 10/1/2015. Simplifying PH and BH coordination, ACC will further improve the impact of our CCM model.

THE BUFC CCM PROGRAM ACHIEVES BEST OUTCOMES AND PROMOTES FOLLOW UP FOR MEMBERS IN ARIZONA

The BUFC *CCM* program proactively identifies members at risk and provides immediate support to those experiencing a vulnerable moment to prevent crisis utilization. Our *BUFC Care Managers* develop *Complete Care Plans* (CC Plans) in collaboration with providers and work with community resources, members and natural supports to coordinate optimal care, including addressing social determinants of health (SDOH). These CC Plans include all Service Plan elements plus an enhanced approach to service planning with inclusion of BH and PH conditions, their influence on each other, overall health and wellness, and SDOH. A core of *Generalist Care Managers* with expertise in member engagement coupled with community and provider referrals connects members with acute episodic needs to timely services. These Generalist Care Managers are supported by *Specialty Care Managers* who are licensed PH, BH, and certified peer specialist employees that support members with chronic ongoing needs in close collaboration with provider-based case managers. PCPs screen for BH disorders to facilitate prevention with immediate referral to BH providers often in the same location and on the same team. We provide BH supports to members with new catastrophic diagnosis, elderly members with declining health and veterans who are at risk for depression and suicide. This approach supports early intervention before ED use or hospitalization for vulnerable populations, such as those with risks associated with SDOH, BH and PH comorbidities; addiction and substance use disorders; chronic pain; aggressive and impulsive behaviors; court orders; justice involvement; and youth with recent or risk of involvement with DCS. To reduce risk of ED services and recidivism by justice involved members, our Justice System Liaison and Court Coordinator engages BUFC Care Managers in reach-in activities. For members with opioid use disorders, coordination occurs with justice facility medical staff for Medication Assisted Treatment (MAT) including 30 day pre and post-release assessment for initiation of MAT. When members seek emergency care, BUFC Care Managers, provider-based Case Managers, and our 24/7 nurse line receive alerts from Health Current to mobilize crisis and diversion planning; including timely communication with the RBHA for members who engage in crisis services. We have adopted the *Zero Suicide Model* and are implementing a Zero Suicide Work Plan, including use of Suicide Care Management Plans. All BUFC staff interacting with members will be trained in *SafeTalk*, proactive identification of suicide risk and development of plans to support community-based stabilization by 10/1/18.

Coordinating follow-up care, especially following care transitions, is a core component of our CCM program. Supporting timely follow-up care during the first 3 months following a crisis episode or hospitalization, our Care Managers provide

intense outreach activities in collaboration with provider-based case managers to support engagement and stability. Our whole-person approach to Child and Family Teams (CFTs) and Adult Recovery Teams (ARTs) with personalized CC Plans drive complete care, engaging BH and PH providers in follow-up care to meet member needs. Strategies to facilitate member engagement include ensuring access to transportation, service accessibility during extended business hours, provision of in-home services including in-home telemedicine as well as use of Healthy Together Care Partnership, Connections Health Solutions (CHS) and other community-based team approaches. ED and crisis facility follow-up reminders occur with collaboration between BUFC Care Managers and provider-based case managers upon receipt of a Health Current alert, when members have already left the facility before receipt of the alert. Targeted investment Program (TIP) dollars have been secured with plans to enhance these strategies at Banner facilities across the state, including Banner University Medical Center Phoenix, to improve care coordination for individuals being discharged from inpatient facilities and EDs. BUFC conducts medication reconciliation to safeguard against errors at transition points, such as EDs, hospitalization and BH Inpatient Facilities. BUFC will continue to track, trend, and analyze ED/hospital utilization and access to care data for continuous performance improvement. BUFC also uses technology to support members receiving appropriate follow up and is discussed below.

When members meet medical necessity for therapeutic BH placement, but there are barriers to securing in-state services, our innovative *BUFC OOS Protocol* is initiated to meet the member's time sensitive needs. Our Care Managers are knowledgeable about resources for placements and provide proactive technical assistance to support in-state care. They take the lead in implementing the OOS Protocol, which includes rapid outreach to in-state providers to support timely care consistent with Mental Health Parity. If all providers initially refuse admission, the BUFC Medical Director and Care Manager reach out to all in-state providers to begin negotiations: discussing strategies to meet the member's needs with specialized programming, intensive staffing patterns, single rooms and higher rates. Prior to any OOS placement, BUFC exhausts in-state options and engages AHCCCS for technical assistance. When a member must go OOS, the Care Manager reviews the member's progress at least twice weekly for psychiatric hospitals and monthly for other levels of care. Member admission to any inpatient facility initiates the BUFC *Discharge (DC) Planning Protocol* that addresses integrated PH/BH needs and SDOH. This protocol goes beyond the traditional DC plan components and focuses on DC not as an event, but as an individualized process addressing cultural issues and member strengths. Traditional transitions of care activities are supplemented with a *Post-Acute Care Transition Plan* to enhance support and intensive community-based services for at least 30 days post DC or until stabilization.

Healthy Together Care Partnership (HTCP): BUFC Care Managers have partnered with provider-based Banner University Medical Group (BUMG) HTCP since 2013 to improve care for vulnerable BUFC dual eligible members with results of a 41% decrease in ED visits, 33% decrease in hospitalizations and 27% decrease in hospital readmissions. HTCP provides intensive community-based services for members with chronic and emergent needs to assist with community-based stabilization and transitions in care, including service provision in the home. A critical component of this program is the unique focus on BH, PH and SDOH comorbidities, which, without appropriate care, leads to fragmentation and overutilization of hospitals and emergency services. Over the past 5 years, HTCP has evolved to meet the needs of our members, including specialized programming to address the needs of our ALTCS members. By 3/1/20, BUFC will expand this model by partnering with community BH and PH specialty providers as an extension of our core HTCP team, enabling a greater impact, especially in geographic areas with limited resources.

NEIGHBORHOOD NETWORKS AND VALUE BASED PURCHASING

BUFC organizes providers and community stakeholders into "*Neighborhood Networks*" to decrease care fragmentation by creating coordinated strategies and aligned payment models to respond to the unique strengths, needs, cultural aspects and social determinants of each *Neighborhood*. Taking a *Neighborhood* approach enables us to respond to the diverse set of health care needs across AZ while creating an aligned, comprehensive and high-performing provider network. All provider types within a *Neighborhood* are financially incentivized to work together to coordinate resources, care and expertise to meet members' needs. Shared outcomes payments and cross-system shared savings strategies drive this cooperative approach and inspire collective impact, along with accountability, to make sure the entire *Neighborhood* is responsible for preventing hospitalization, helping members engage in community-based treatment post hospital care

BUFC will continue to evolve our successful VBP program, which has resulted in a 17% decrease in ED visits and a 3% decrease in admissions among our VPB providers from 2016 to 2017 (P<.001).

and implementing evidence-based hospital diversion programs. For example, BUFC members cared for by providers non-compliant with access to care standards have 8% more ED visits. As such, providers within each *Neighborhood* will share responsibility for such an outcome with aligned *Neighborhood Incentives* related to the following performance measures during year one of the contract: reduction in psychiatric hospital admissions, psychiatric hospital readmissions, ED utilization and ED holds. *Neighborhood Incentives* will be based on the health outcomes of the entire *Neighborhood*, not just the members attributed to a single provider. Additionally, as part of our VBP contracts, providers typically have both telephonic and face-to-face case managers available to proactively engage members in EDs and other crisis settings when they present, including after-hours, weekends and holidays to facilitate timely disposition. We also help smaller providers join collaborative ventures such as Equality Health and Banner Health Network, integrated networks of providers who enable integration and aligned incentives while offering analytics and care management resource and support. Working collaboratively with all stakeholders within our Neighborhood Network allows us to successfully launch community-based programs, such as our innovative *BUFC Diversion Protocol* that will be implemented prior to any hospital admission. The protocol requires EDs, other crisis settings and psychiatric hospitals to contact the member's BH provider with a goal of diversion. Steps include involving the appropriate providers, coordination with the RBHA for members who have engaged in crisis services, a review of the member's CC Plan, crisis plan and community-based treatment options. For unassigned members, the BUFC Care Manager takes the lead while identifying a provider. This approach utilizes alternative community-based services including dedicated crisis settings for immediate access to care aligned through efficient care management processes targeting crisis prevention.

BUFC has built a strong foundation of provider partnerships focused on expanding alternative, community-based services. These include, but are not limited to: 1) *Banner Hospital ED Practice Improvement Project* has reduced BH hospital hold duration at Banner EDs in Maricopa County by 40% since its inception in 2016. Clinical Care Guidelines were developed with community partners Crisis Prep and Recovery (CPR) and Community Bridges Incorporated (CBI) to systematize processes in the ED for medical clearance, BH assessment, coordination and triage among different Banner providers and external parties. Key actions included developing a clear definition of medical clearance, an expedited BH assessment process coordinated with CPR and CBI both on-site and through telemedicine, engagement of members by on-site peer support specialists in conjunction with active hospital-based case managers. Members with Opioid Use Disorder were offered expedited triage to CBI or other providers for MAT services addressing both addiction and pain management. The Joint Commission recognized this model as a best practice and we will support expansion throughout our *Neighborhood Networks*. 2) *Outpatient Alcohol Detoxification and MAT within Primary Care* led by Dr. Christopher Peterson, a Banner Family Physician trained in addiction medicine, is an innovative model for both outpatient alcohol detoxification and MAT provided within a PCP setting that prevents admission to inpatient facilities. This program provides outpatient detox for members referred from EDs or other crisis settings and resulted in diversion from medical and psychiatric hospitals and abbreviated length of stay. Workforce capacity is also expanded with this program through Dr. Peterson's teaching role with family practice residents. BUFC will scale this best practice throughout the Banner system and include Dr. Peterson in ECHO trainings for rural providers during contract Year One. 3) *BUFC initiative with CHS* addresses overutilization of crisis services and EDs targeting members insufficiently engaged in care following a crisis episode. It utilizes an integrated Care Connections Team (CCT) to support the member after discharge from the crisis setting until they are fully stabilized and engaged in community-based services, thereby preventing readmission. The CCT focuses on member engagement through use of motivational interviewing, critical time interventions and eventual reengagement back to community-based providers through a warm handoff and continued post handoff support. Preliminary results demonstrate reductions in crisis utilization and increased community-based stabilization 4) *Strong Families Healthy Communities* is a collaborative made up of the Institute of Early Psychosis Intervention Center, Mental Health America of AZ, National Alliance on Mental Illness Valley of the Sun and the Family Involvement Center to connect families with community-based support post hospital discharge by working with hospital care coordination departments and ED personnel to extend the role of care coordination staff by offering a certified Parent and Family Support Specialist to provide one-on-one assistance to individuals and their families. This peer-to-peer and family-to-family support and psycho-education in the hospital and ED setting delivers provider education related to system resources, engagement and identification of first episode psychosis along with offering hospitals a single point of contact for community-based referral and follow-up. BUFC will expand these efforts to a minimum of 2 additional hospitals by Year 2 of the Contract. 5) Banner Urgent Cares (BUCs) will undergo substantial workforce development to address BH stigma within the health care system, enhancing the provision of ACC services for individuals with co-occurring BH and PH conditions at urgent care (UC) locations. UC settings are often unprepared to address the needs of these members,

resulting in the UC provider deferring treatment to EDs. A pilot will be implemented in the second quarter of 2018 at 2 BUC sites in Maricopa County and 1 in Tucson to focus on: coordination with and education of community providers to help facilitate appropriate referrals to UC; specialized training for employees in the selected BUC locations to increase competency and comfort in meeting the needs of members with BH diagnoses; access to BH consultation, assessment and treatment, including on-site or remote service provided via telemedicine; and expedited coordination between BUFC, BUCs and community providers. Based on the success of the pilot, expansion will occur by Contract Year 2.

TECHNOLOGY SOLUTIONS IMPROVE PROACTIVE ENGAGEMENT AND REDUCE ED HOLDS AND HOSPITALIZATIONS

For 10+ years BUFC has been using Warm Health, our interactive voice response and text platform, to increase member engagement and self-management while supporting member's individualized needs by providing advice for staying well, managing chronic diseases and keeping track of and supporting health concerns. Members with concerns can alert BUFC staff to receive immediate individualized support. BUFC's Warm Health ED Avoidance Program contacts all members with 2 or more ED visits in a 2-month period. Members complete the PHQ-2 and PHQ-9 via these automated calls more frequently than during telephonic calls with Care Managers, demonstrating its utility in serving members with co-morbid BH conditions. This program provides education about the appropriate use of EDs, crisis services and alternative community-based options and links members to BUFC Care Managers for additional support as needed.

BUFC's *Member Supported Care Circles* by PYX, is a mobile application available to members – offering the opportunity to add people they choose, including natural supports, to their "Care Circle" to enable real-time communication with members and chosen supports as it relates to the member's health and self-management. The member's Care Circle can be activated through geo-location when the member enters an ED or Urgent Care, to ensure immediate proactive member outreach. If a member agrees to participate with our mobile application, they may choose to allow smart phones geo-sensing technology to help with care. Once activated, the Care Circle, which may include a peer support or care/case manager, can easily communicate via voice or text without ever leaving our application. Furthermore, our exclusive *Banner Navigation Accelerator (BNA)* offers a resource, including intake data and CC Plan clearinghouse, to aggregate information to make it readily available to our providers for transitions of care, care coordination optimization and improved access to timely care. Health Current data is accessible in the BNA with information from BUFC such as health risk assessments, CC Plans, crisis plans and SDOH to provide a real-time complete view of the member. BNA offers an easy way for providers to send warm referrals and follow up to confirm member engagement post referral. Finally, telemedicine enables providers to send a secure link accessible through a smartphone, tablet or computer to provide real-time services in a member's home for community-based stabilization. These solutions transform service provision and enhance member stabilization in the community, reducing the risk of ED utilization and making sure providers have access to the right information at the right time to best support members when they seek care in the ED.

INCREASING THE AVAILABILITY OF ALTERNATIVE COMMUNITY-BASED SERVICES AND CRISIS PLANNING

In addition to the programs described above, BUFC will enhance *Complete Care Planning* by improving upon the traditional approach to CFTs and ARTs. These interdisciplinary teams will be enhanced to include an integrated focus, as applicable, to utilize a complete care approach to needs assessment and service planning through implementation of CC Plans. A critical component of the CFT and ART process includes on-going tracking and adapting of CC Plans to address member's needs that often fluctuate. Care planning will take place face-to-face or virtually supported by information available through electronic medical records and the BNA. This facilitates timely plan revision and access to alternative, community-based services when needs escalate, while integrating all care decisions into a single CC Plan for each member, avoiding a member having multiple plans with multiple providers. This approach will remove delays in service planning and access to care that often occur when teams are struggling to schedule a CFT or ART meeting, which ultimately can result in ED or hospital placement. Proactive crisis, diversion and DC planning will be a key part of the CFT and ART process. Crisis plans are required for all members at risk of crisis, including youth with a CASII of 4 or higher and those with a crisis episode or hospitalization within the last year. Crisis plan components include predicting potential risks, conducting functional assessment, making modifications to daily routines, engaging natural supports and planning effective interventions for a community-based response 24/7 in the least restrictive setting. These activities are supported by BUFC Medical Directors (representing pediatrics, internal medicine, general surgery and psychiatry) working as a cross-functional team with interdisciplinary care teams and care planning. In addition to Complete Care Planning, a comprehensive *Continuum of Specialty Care Services* is key to provide alternatives to ED use and psychiatric hospitalization. Hence, BUFC will implement a comprehensive community-based continuum within the *Neighborhood*

Networks, including masters and doctoral level clinicians trained in best practices for medically and behaviorally complex conditions by contract implementation. BUFC will make sure all members are assigned a designated provider BH Professional (BHP). Community and family-focused psychosocial interventions including support and rehabilitation services, such as Meet Me Where I Am for youth, incorporation of Positive Behavioral Supports, psychosocial rehabilitation for adults, Home Care Training to Home Care Client (HCTC), family and peer support, supported housing, respite and natural supports, are prioritized components of the continuum. BUFC also values partnerships with Peer and Family Run Organizations (PFROs), understanding they are critical to the care of our most vulnerable members and prevention of misuse of emergency services. We will make sure trained PFRO support partners are utilized in community, ED, and hospital settings. In conjunction with the UA Department of Family and Community Medicine's *Recovery Support Specialist Institute* and *Camp Wellness*, the Family Involvement Center (FIC), and MiKID, BUFC is expanding peer/family employment training curriculum development efforts while creating opportunities to expand focus on peer/family support staff working in medical settings, including EDs. Such strategies also include in-depth training for medical staff to understand the crucial role of the peer/family partner.

Our continuum of integrated services utilizes evidence-based approaches, including intensive Behavioral Interventions (BI) with development of Functional Behavioral Assessments (FBAs) and Behavioral Treatment Plans (BTPs), Applied Behavioral Analysis (ABA), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), trauma-specific interventions and MAT. Services will be available face-to-face or through telemedicine to offer care in underserved and rural locations. All providers of psychiatric services will be contractually required to have daily appointment availability through open-access scheduling that allows for same-day appointments to address emergent needs, including psychotropic medication refills. Our emergency psychotropic medication clinics offer emergent bridge prescriptions with extended hours and 7 day/week availability. Targeted interventions, including use of pain management Centers of Excellence and MAT, address members with chronic pain or challenges with opioid use. We offer improved coordination with first responders using *BUFC CCM*, the 24/7 nurse triage line and information available through BNA for proactive ED diversion. As providers complete the process to be certified in *Treat & Refer* (T&R), BUFC will expedite contracting with them to address members who have accessed 911, but whose illnesses do not require ambulance transport to EDs.

Targeted OOH therapeutic services are utilized for members with the most severe needs that cannot be treated within their community. All therapeutic OOH treatment is followed by intensive, community-based transitional services to support timely return home. Dedicated therapeutic crisis placements for all levels of care, including non-IMDs, allow for immediate diversion and step down to least restrictive, community-based settings. We make sure members with most severe needs, such as highly aggressive, impulsive behaviors, BH and PH comorbidity, ASD, intellectual disabilities, sexual maladaptive behaviors and chronic medical diagnoses, who meet criteria for BHIF access this level of care in-state through specialized programming developed in partnership with contracted providers, such as Devereux. BUFC will not require PA for emergency placements in any level of care, but will balance immediate access to care with implementation of a 5-day precertification process followed by retrospective review and authorization to make sure medical necessity criteria are met. The BUFC network includes access to supportive and transitional housing with on-site wrap around services including peer and family support, living skills focused on health, wellness and vocational supports.

BUFC monitors our network consistent with AMPM policy 1020. In addition, we will implement quarterly audits with indicators that address over and underutilization, potential gaps, crisis/safety plans, and adherence to the BUFC Diversion, OOS and DC Planning Protocols. On-going monitoring of data from Grievance and Appeals, Customer Care, and CCM monitoring system is supplemented with provider performance, potential gaps, and Quality of Care concerns to drive continual improvements in our programs. The UM/Finance Committee and the QM/Performance Improvement Committee provide oversight to all QM activities. Actions include training and technical assistance followed by formal plans of correction for continued deficiencies. Throughout, BUFC identifies local, state and national best practices for implementation as continually seek to improve our services to our members.

COMBINING THE EXPERIENCE OF BUFC WITH THE BANNER PROVIDER NETWORK TO IMPROVE MEMBER CARE

BUFC's position within Banner Health is a unique opportunity for us to spread the use of the *12 Principles of the Children's System of Care* and the *Adult Services Delivery 9 Guiding Principles* provided within a *Trauma Informed Care* (TIC) framework throughout Arizona's largest provider group. Together we will utilize the strength of our clinically integrated network to positively impact the health and wellness of AHCCCS members.

11. DESCRIBE THE STRATEGIES THE OFFEROR WILL UTILIZE TO ENSURE DEVELOPMENT OF A COMPREHENSIVE…

Banner-University Family Care's (BUFC's) high-performing and culturally diverse contracted Complete Care provider network will exceed accessibility requirements to consistently meet the whole person needs of our members. BUFC is part of the greater Banner Health (Banner) organization, and can tap into our legacy relationship with the University of Arizona (UA), a statewide anchor institution for education, innovation and improvement in the social and economic health of AZ's citizens. Banner is commitment to the needs of AZ's most vulnerable population as the largest safety net provider of care to AHCCCS members, its support for the growth of BUFC and by training the next generation of health care providers. Furthermore, as one of the most successful CMS Pioneer Accountable Care Organizations (ACOs), Banner has utilized Neighborhood Networks to engage providers in value-based transformation to improve member health outcomes in Medicare Advantage populations. Following this approach, BUFC will organize providers and community stakeholders into *Neighborhood Networks*, creating customized local strategies and aligned payment models to respond to the unique strengths, needs, cultural aspects and social determinants of each neighborhood.

Network development and management data (e.g., access to care, service gaps, satisfaction) is reviewed formally through BUFC's committee structure to develop overarching network development and retention strategies and implement processes compliant with AHCCCS requirements. Many areas within AZ are considered Health Professional Shortage Areas (HPSAs) with shortages of primary care, dental care and/or mental health providers. In response to these shortages, we will implement strategies to improve access to care, especially in rural areas, such as using telehealth/telemedicine, mobile providers and virtual clinics. Through our approach to network development, we will transform traditional payment systems that promote volume over value by defining a new model to incentivize value and quality while balancing principles of managed care with member choice and provider accountability.

BUHP has an expansive network of over 13,000 unique providers with over 57,000 service locations across AZ. Our network includes both large and small providers that span the continuum of integration, specialty providers, Federally Qualified Health Centers (FQHCs), Patient Centered Medical Homes (PCMHs), MSICs, Peer and Family Run Organizations (PFROs), AzEIP providers, providers of court ordered evaluation services, homeless clinics, and more. BUHP partners with the AZ Association of Health Plans (AzAHP) and will help identify a single LMS vendor to increase administrative efficiencies. Our members have access to top pediatric specialists/sub-specialists through pediatric outpatient providers and hospitals in Maricopa and Pima counties. We will implement a multifaceted approach to network development for the AHCCCS Complete Care (ACC) Contract. Our primary strategies include:

Ensuring Adequate Access to Care: BUFC utilizes well tested geo analytics, coupled with an Integrated Care (IC) Manager model and payment innovation to drive needed changes in accessing specialty and BH services, as described below.

- We analyze network-wide data through geo mapping software to identify gaps based on the location of membership and our network providers. We use Quest Analytics for network optimization to identify the closest PCP, specialist, dentist, BH provider, crisis center or other desired provider for any member – allowing us to prioritize providers for inclusion in our network. Through our network analysis, we have identified gaps in the full continuum of BH services and are actively outreaching to BH providers across the Central and South GSAs for inclusion in our network.
- We will employ a dedicated IC Manager to develop relationships within the provider community and expand our network by enhancing the capacity of providers and identifying new providers. The IC Manager will collaborate with Centers of Excellence (COEs) and early adopters of successful models of integration to an innovative care environment, giving providers flexibility to test theories and funding models to support integration. By partnering with Equality Health's Practice Transformation Assessments Team, we will provide technical assistance to providers interested in advancing their practices to better meet the changing health care delivery requirements.
- We will align incentives for higher volume specialty and BH providers who drive culturally competent, evidence-based, outcomes-driven care models. Engaging high-volume specialists in a more meaningful way and enabling them to participate in APMs is critical to long-term success and improvement.

Creating Cohesive Neighborhood Networks: BUFC will build our Complete Care network through a *Neighborhood Network* design. Our prior experience shows aligning providers with their community of care and recognizing the unique needs of each neighborhood creates the greatest opportunity for improvement in access to care and health outcomes. With the addition of BH and specialty BH providers, such as PFROs, we can align all providers within a neighborhood and offer a framework to identify and solve problems unique to their neighborhood. Rural communities need to be aligned

to each other with BUFC to meet the continuum of care needs. Offering rural communities this type of voice allows for faster innovation and improvement than each working individually with limited resources. In addition, greater use of telemedicine, telehealth, virtual and mobile services will provide broader access to services typically limited by capacity and geography. Utilizing innovative payment models of aligned incentives empowers providers to drive their success. As we build *Neighborhood Networks*, we have engaged with large existing ACOs, IPAs and collaborative ventures, such as Banner Health Network, Equality Health and the AZ Alliance for Community Health Centers, to offer providers support mechanisms to enhance their ability to engage in VBP and build their capacity to offer an integrated team-based approach to care. We have developed detailed expansion plans, including geo-mapping, gap analysis, addition of key providers into ACOs/IPAs and outreach to new providers, to enable partnerships with smaller independent practices. We have forged relationships with emerging collaborative ventures (such as a unique group of small psychosocial rehabilitation and peer specialty providers, including DKA, Our Place Clubhouse, NAMI Southern AZ, Hope and The Haven) to offer guidance and advice. We are also initiating a contract with and providing consultation to an emerging Clinically Integrated Network, made up of fully integrated health homes (including La Frontera and CODAC) and BH specialty providers. Offering providers consultation to establish consortiums and working with existing groups helps smaller providers engage in VBP and coordinate care through virtual integration and field clinics.

Training the Next Generation of Health Care Providers: The combined Banner – University Medical Educational Complex trains students throughout the health care continuum in innovative and transformational models of care. In partnership with the UA Workforce Development Department, we are launching a Collaborative Care and training program to expand peer and family support across other populations – beyond just those members with general mental health and/or substance use needs. Banner University is implementing a new pediatric fellowship program focused on serving children with Autism Spectrum Disorder (ASD). UA is increasing capacity of BH professionals (BHPs) to provide BH specialty services, such as Dialectical Behavior Therapy (DBT), through programs with master's level students. We are partnering with ASU's Colleges of Health Innovation and Health Solutions to collaborate with student-run programs, such as the Student Health Outreach for Wellness (SHOW) clinic for the homeless and will serve as an internship site for the Doctor of Behavioral Health (DBH) and Master of Health Innovation students to train the future workforce on conducting interdisciplinary assessments. BUHP supports GME Residency Training Programs and pursues contracting opportunities with graduates and providers opening new practices in, or relocating to, AZ, especially in rural or underserved areas. Additionally, we participate in the AZ Community Health Worker (CHW) Workforce Coalition and Leadership Council – supporting core competencies, curriculum, and voluntary certification for CHWs.

Using Innovative Technology Solutions to Support Providers and Members: The *Banner Navigation Accelerator (BNA)* care support and logistics platform will allow providers and community organizations to complete intakes, assessments, Complete Care Plans, and referrals in a single location. Trained and certified *Neighborhood Navigators* will have access to *BNA* and become part of a feedback loop to continually enhance and update the tool for long-term relevance. We will engage several community members, including PFROs, to serve as *Neighborhood Navigators*.

Multi-Specialty Interdisciplinary Clinics (MSICs): BUFC is currently contracted with each of the 4 MSICs serving children with a Children's Rehabilitative Services (CRS) qualifying condition across the state in Flagstaff, Phoenix, Tucson and Yuma. When children see specialists and other providers outside the MSIC setting, care will be coordinated through our *Complete Care Management Program* – a fully integrated care management department with strong neighborhood ties to providers, provider-based case managers and community agencies to address the whole-person needs of our members. To increase access to specialists across the state, we will facilitate field and virtual clinics, allow specialists to see children in community settings and use telehealth as well as the HIE so all providers involved in the child's care have access to the Complete Care integrated medical record. BUFC has been working with Children's Clinics in Tucson to identify opportunities to create further Complete Care alignment for CRS children and their families, as well as non-CRS eligible children with complex needs. We are excited to apply Children's Clinics lessons learned in managing the complete needs of CRS members and bringing those lessons to our larger population of members. In addition to VBP enhanced contracts for primary care domains, we are developing payment models for populations not eligible for CRS but with high needs, such as children with Down's syndrome, ASD and those in need of palliative care.

Developing and Maintaining a Network Development and Management Plan: BUFC will develop and maintain an annual Network Development and Management Plan for the ACC Contact, as we have for our other AHCCCS contracts.

The Network Development and Management Plan will demonstrate we maintain a sufficient network and meet workforce development standards to meet the needs of the anticipated number of members in each GSA.

STRATEGIES FOR DEVELOPMENT OF A COMPREHENSIVE NETWORK OF ADULT AND CHILD BH PROVIDERS

BUFC currently contracts with 633 BH providers and facilities. We continue to build additional BH capacity. BH services are provided consistent with the **9 Guiding Principles for Recovery-Oriented Adult BH Services and Systems and the AZ Vision -12 Principles for Children's Service Delivery**. Our network providers are trained in using Adverse Childhood Experiences (ACEs) and other evidence-based screening tools for trauma – delivering services within a Trauma-Informed Care Framework. Our providers are trained in implementing best practices in compliance with AHCCCS' Practice Tools. We place an additional focus on developing a comprehensive network of BH and integrated providers for adults and children, including workforce development efforts, supporting providers to expand their scope to meet special healthcare needs, and partnering with AHCCCS Targeted Investment Program (TIP) grantees. We value both clinical and non-clinical integration. For example, we contract with Banner Cardon and Banner Diamond Children's Hospitals - where Banner pays for teachers to work within the hospital, enabling children to continue working towards their education goals while hospitalized. Along these same lines, we have engaged in a partnership with the AZ Department of Education to better support students' social and emotional development both in and outside of the classroom. We carry this same focus on non-clinical integration to all of our providers while emphasizing the importance of social determinants of health (SDOH) and utilizing SDOH related performance measures. Through use of our proprietary *BUHP Assessment of Quality and Recovery Orientation*, we evaluate our providers based on elements such as: member-centeredness, welcoming environment, trauma informed, use of evidence-based practices and achievement of outcomes.

Workforce Development for BHPs and BH Medical Professionals (BHMPs): BHPs trained in best practices for treating members with comorbid PH/BH conditions, fulfill the role of "Case Manager" in a traditional evidence-based Collaborative Care model, offering integrated PH/BH care in a primary care setting. BUFC will engage in substantial workforce development efforts to address the need for BHPs and BH Medical Professionals (BHMPs) throughout the South and Central GSAs. As the largest employer in AZ, we will harness Banner's recruitment power to help build the necessary workforce at the local provider level. Through our 30+ year affiliation with the UA, we will influence curriculum and training at the undergraduate, graduate, and postgraduate levels to build the workforce of tomorrow. We will also continue our work with the UA to establish on-roads for graduates to achieve successful job placements in the healthcare industry; including the development of internships, externships, fellowships, and recruitment plans.

Supporting Providers to Expand Scope: Through partnerships with providers like Deverauex, Intermountain and CPES, we enhance the capacity of BH residential providers to meet the complex needs of members, including those with PH/BH comorbidities. Residential providers are often hesitant and/or ill-prepared to accept members with comorbid and complex PH conditions. As such, we will build individualized agreements, offer technical assistance, and pay enhanced rates to enable successful treatment outcomes when residential settings are needed. Additionally, we will continue to leverage our Healthy Together Care Partnership (HTCP) program to provide an extra layer of support for both the member and the provider. HTCP is a home- and community-based program that offers an evidence-based, high-touch, team-based approach to care for members with complex needs that cannot be met within their current provider setting alone. HTCP provides an extra layer of at-home supports to align services and increase self-efficacy and independence during times of transition and heightened vulnerability. The HTCP team consists of an NP, nurse Care Manager, BH consultant, clinical pharmacist and community health worker. The team assists members and providers by helping them with care transitions, medication management and optimization, wound care, palliative and end of life care, chronic condition management, BH interventions and care coordination. We will expand HTCP services to more members with special health care needs through a partnership with SunLife Home Care or a similar agency. By linking the HTCP team as the care "hub" with SunLife CNAs as the "spoke" by smartphone and tablet, HTCP will expand the types of members it serves and its geographic reach. This "hub and spoke" approach will not only improve the reach of specialty care throughout AZ, but also support paraprofessional workforce development, enhance the capabilities of our contracted residential providers, shorten residential stays, and increase in-home support to avoid escalation to higher levels of care. Another example is our support of PH providers in expanding their scope to provide services for low acuity BH conditions. For example, Dr. Christopher Peterson, an AHCCCS registered Family Physician and Addiction Specialist, is training family practice residents to treat addiction and provide Medication Assisted Treatment (MAT) within primary care to improve outcomes and decrease fragmentation by expanding the scope of family physicians. Through UA's

Telemedicine ECHO programs, providers can participate in weekly teleECHO™ clinics, like virtual grand rounds, which combine mentoring and case presentations with specialists. As a result, providers can deliver comprehensive, best practice care to members with complex health conditions, right where they live.

AHCCCS TIP: BUFC contracts with TIP providers to further develop systems for integrated care. BUFC is contracted with Equality Health, who has been awarded 12 TIP grants, and assisted Banner to obtain 8 TIP grants. We will work with these and other TIP grantees to accelerate integration while extending VBP contracts to other providers using some of the same processes and measures to incentivize integration for groups not receiving TIP but expressing interest and readiness to increase both integration and accountability while working together to improve member outcomes.

COEs: BUFC will identify existing COEs for adults and children with specialized health care needs. During contract year 1, BUFC will contract with MAT COE providers to address the comorbid and often complex PH/BH and pain management needs of our members. This model will include integration of PH, BH and sub-specialty care, including pain management specialists, to address the high morbidity and mortality associated with addiction. Additionally, during contract year 1, BUFC will contract with COE providers serving children with specialized health care needs, including children birth to 5 years old, children with ASD, adolescents with SUDs, and transitional age youth.

Critical Components of a Neighborhood Network: We continue to make certain that comprehensive specialty BH services are available through the BUFC network, including assessment, treatment, support, rehabilitation, inpatient, residential, day programs and crisis services. We will refer to specialty BH services for members with complex, often comorbid PH/BH conditions, including adults and children with intellectual or cognitive disabilities, sexual offenders, sexual abuse victims, substance use disorders, individuals in need of DBT, and special age groups such as transitional age youth and members aged birth to 5 years old. We also maintain contracts with specialty providers with expertise working with DCS engaged populations, offering HCTC, working with members with maladaptive sexual behaviors, eating disorders, specialty support and rehabilitation, and respite for both children and adults. Additionally, members with special health care needs, as defined by AHCCCS, may be appropriate for referral for BH specialty services, as well as members we identify as having high needs and/or high costs due to complex, comorbid PH/BH conditions. Prior to the contract effective date, we will secure a contract with the AZ State Hospital (AzSH). We contract with PFROs for services and supports, such as employment and rehabilitation services, housing services, respite, skill development and peer/family support services. We have contracts with Approved Peer Support Employment Training Programs and will contract with other programs in the awarded GSAs on or before 10/1/18, and will assist with job placements for graduates to fulfill paraprofessional workforce needs; including the expansion of youth peer support.

IDENTIFIED AREAS OF CONCERN AND OVERCOMING CONTRACTING CHALLENGES TO ENSURE ACCESSIBILITY

Through analysis of our current networks in the Central and South GSAs, as well as feedback from numerous Think Tanks with providers, peers and community stakeholders, we have identified the following as areas of concern presenting challenges to ensuring accessibility. Also included are strategies to overcome these contracting challenges.

Increasing Medication Assisted Treatment (MAT) Capacity: In alignment with the AZ Opioid State Targeted Response Grant, BUFC is working with provider partners to implement innovative strategies to increase MAT capacity, especially in rural areas. We have identified providers treating substance use disorders (SUDs) through integrated settings and are developing initiatives for specific populations in need of SUD services, such as pregnant women and justice involved members. For example, CODAC provides expert care for pregnant women needing MAT services; applying best practices for low and slow induction, including divided doses, and routine assessment. ConnectionsAz is increasing their MAT capacity from 350 to 800 in Tucson. Terros provides MAT services, Suboxone Induction and Vivitrol in Maricopa County. Community Medical Services provides Methadone, Suboxone and Vivitrol via 5 clinics throughout Maricopa and Pima Counties, for a total capacity to serve 4,000 members. Native American Connections provides MAT services for pregnant women released from jail, provide split dosing, have a 70-bed residential program for the American Indian GMH/SA population, and offer transitional and permanent housing. Additionally, we are contracted with providers offering MAT services in rural areas, including in Sierra Vista, Nogales, Ajo, Safford, Yuma, Casa Grande and Payson.

Continuity of Care: Prior 10/1/18, we will have a comprehensive BH provider network to sufficiently meet the needs of our members in every level of care. For those members receiving services in an Institute for Mental Disease (IMD) who

are not ready to discharge to a less restrictive level of care before exhausting their limited days, we will coordinate transition to providers capable of offering services for the duration to maintain continuity of care. For example, La Frontera and Community Bridges both manage care for members with SUD discharge from the highest intensity level of care through community-based care by offering a full continuum of care at every level of need.

Inappropriate ED Use: We are working to align Banner resources with community partners in BH and specialty services to provide a full continuum of integrated and coordinated services across the BUFC network. For example, Banner Urgent Care Services (BUCS) and community BH providers identified an opportunity to enhance Complete Care services for our members with comorbid PH/BH conditions who present with PH/BH urgent needs to target overutilization of EDs and crisis settings. Prior to 10/1/2018, BUFC and BUCS will enhance urgent care services in 2 Banner Urgent Care sites in Maricopa County and 1 in Tucson. Enhancements will include BH training, BH provider staff, and ED diversion through delivery of urgent BH services and assertive care coordination with community providers – resulting in more cost effective, efficient, community-based and person-centered care that reduces overutilization of EDs and other crisis settings. Banner will expand services to other Urgent Care locations around the state with the lesson learned from these beta sites. Additionally, we have participated in statewide efforts to promote the Treat and Refer (T&R) program; addressing non-emergent needs through assessment and referral to a more appropriate level of care. We will contract with providers recognized as T&R agencies, assist others to become T&R certified, and fund T&R community training.

Oral Health Capacity: During contract year 1, we will develop VBP oral health initiatives with CRS providers, as well as programs to incentivize oral health of pregnant women and children by aligning incentives for OB/GYN, dental and pediatric providers; with a special focus on caries prevention education and fluoride varnish. Additionally, in CY 2018, we will launch 2 affiliated dental hygiene programs in Tucson and Yuma to connect hygienists, supported remotely by a dentist partner, with pediatric centers to provide oral health screenings and varnish in the medical practice.

Tribal Services: BUFC has already engaged with tribal leaders and Urban Centers. Prior to 10/1/18, BUFC will formalize relationships with IHS, Urban Centers, Tribes and Tribal Organizations to support American Indian (AI) members' choice in where to get services. During contract year 1, we will collaborate with these entities, as well as AHCCCS and other Compete Care Contractors, to establish protocols for coordinating care and sharing information and will establish MOUs, MOAs and/or secure Tribal Resolutions to authorize services on tribal lands for tribal members. BUFC will coordinate Community Forums prior to contract start and will update the Coordination of Care booklet exclusively focused on AIs. In partnership with Equality Health, we are implementing initiatives to improve services for our AI members, such as: development of a tracking system for tribal youth in residential facilities off tribal lands to engage youth in education and vocational activities; and development of pain management training to develop treatment expertise.

Mobile Services: We already have contracts with mobile providers in Maricopa, Pima and Yuma counties and a provider with statewide services, and are currently assessing availability of additional mobile providers to build additional capacity, especially for pediatric and other specialists in short supply across the state. This is critical to increasing access to care for members in rural areas who may have barriers to going to a provider site, such as transportation challenges.

Birth to 5: BUFC will partner with Southwest Human Development to offer provider training focused on increasing expertise in serving the birth to 5 population. Building capacity for service provision during early childhood is critical as conditions left untreated can lead to school problems, delinquency, BH/PH risk factors and potential lifelong impairment. These trainings support BUFCs family-focused approach to care.

Transportation: Through our *Neighborhood Networks,* BUHP will offer enhanced transportation programs – including ride-share ventures, same-day scheduling, and the ability for providers to offer transportation directly.

Our experience serving the AHCCCS population and innovations of a Neighborhood Network based continuum of services combined with our commitment to community reinvestment will transform the current system of care to a Complete Care model leading to improved health outcomes that bend the cost curve, reduce fragmentation, and simplify services to members and families**.** To further impact these outcomes and as a community anchor, Banner Foundation financial contributions will be invested locally to support member care and Neighborhood programs.

12. DESCRIBE THE OFFEROR'S SPECIFIC PROCESSES TO EFFECTIVELY MANAGE PROVIDER RELATIONS …

Banner-University Health Plan (BUHP) considers our providers an essential partner in the delivery of AHCCCS Complete Care (ACC), and we have implemented efficient and effective provider relations and communication processes to fulfill the quadruple aim's fourth goal of "improved provider experience." With the transformational changes outlined in ACC, BUHP evaluated current operational readiness to assure alignment with new ACC expectations such as Value Based Purchasing (VBP) and physical health (PH)/behavioral health (BH) integration, including children with CRS diagnoses. BUHP will deploy effective strategies to equip providers with information necessary to succeed and minimize provider complaints, claims and prior authorization issues, and contracting concerns.

BUHP'S SPECIFIC PROCESSES TO EFFECTIVELY MANAGE PROVIDER RELATIONS AND COMMUNICATIONS

Effective provider relations and communication processes are especially important as BUHP launches our innovative *Neighborhood Network* (NN) design. Based on Banner Health Network's (BHN's) successful 2016 launch of the Neighborhood Physician Alliance, BUHP's NN builds upon the Patient Centered Medical Home (PCMH) neighborhood concept best practices and is focused on meeting member's needs while incorporating aspects of population health and solving community health problems. Establishing NNs requires a true partnership between plan, provider and other community resources/stakeholders, with health plans playing a key role by: 1) establishing comprehensive provider networks (ACOM 436); 2) paying for care and providing incentives for clinicians to work collaboratively to improve the quality of care for their entire neighborhood; and 3) supplying providers with the tools, technology, and information necessary to succeed. To transform the health care delivery landscape, we must work with our providers to understand the unique strengths and needs of our members; varied aspects of the neighborhoods where they live, work, learn, socialize and seek health care; the available resources; and population health trends in each neighborhood. BUHP will establish Neighborhood Network Advisory Councils (Councils) with providers, stakeholders, members, and families to achieve collaborative goal development, shared governance and transparency.

Effective Provider Relations and Communication Begins with Dedicated Employees and Training Processes

At BUHP, provider relationships are taken seriously and our leaders set the cultural expectation. They participate on provider boards, visit providers in their offices, field provider calls and hold Think Tanks for feedback or new solutions. This leadership engagement enhances provider understanding, builds strong relationships and expresses a cultural intention of support and collaboration, which employees understand as the service expectation.

Local and Experienced: BUHP employs over 600 experienced personnel and during implementations, we have proven our ability to nimbly scale to serve AHCCCS members and providers. Based on our successful ALTCS implementation, we have an established process for team competence and readiness. At contract go-live, BUHP will fill all required positions and assure adequate staff are trained and in place, including contracting, provider relations, prior authorization (PA), claims, customer service, grievance and appeals (G&A), and other supporting departments (ACOM 415). BUHP hired additional claims and customer service positions: overstaffing in anticipation of attrition and hiring early so well-trained employees are in place. In compliance with ACC requirements, we continually evaluate our Provider Relations Representative (Reps) staffing levels and will assure adequate Reps for our Neighborhoods. Based in Arizona, Banner Health (Banner) is an anchor institution, 97% of our workforce local. Banner is the largest employer in AZ and a leading employer in the Southwestern U.S.; employing over 50,503. BUHP attracts skilled individuals with extensive AHCCCS and Medicare experience and we can utilize Banner's labor pool as we evolve and grow.

Well-Trained: BUHP has developed robust education processes to assure a well-trained, cross departmental workforce enabled to effectively communicate with providers. Employees receive initial and mandatory annual training on all AHCCCS and CMS-required elements, such as compliance; fraud, waste and abuse (FWA); Stark Law and the False Claims Act; HIPAA; BUHP policies and procedures (P&Ps); and Cultural Competency. In support of DSNP integration, BUHP began training our employees on AHCCCS and Medicare requirements in 2010. In support of PH/BH integration, we will also train on new provider types, such as MSICs and PFROs. Our Reps receive in-depth training on BUHP operational areas, especially key provider touch-points, including claims; credentialing; PA; case management; utilization management; G&A; Office of Individual and Family Affairs; claims disputes; quality management; member services; network development; provider contracting, data, and registration; benefits and coordination of benefits. They also receive in-depth training in customer service; relevant software systems; the Adult Service Delivery System 9 Guiding Principles; 12 Principles for Children; trauma-informed care; solutions-focused problem solving; and an overview of system partners and social service delivery system. Member-facing employees will receive training in Safe Talk;

motivational interviewing; Mental Health First Aid; and the core competencies for integrated BH and primary care, which are supported by SAMHSA and provide skills for quality integrated care. BUHP also adopts the Zero Suicide Model and has initiated a self-study and work plan. BUHP employees will participate in Zero Suicide workforce development.
Dedicated Provider Relations Team: BUHP has seasoned and responsive AZ-based provider relations teams who engage in one-on-one communication with providers. In anticipation of contract award, we are re-designing our provider relations processes to align with our NN model. We have developed an Internal Resource Team (IRT) composed of cross-functional members who directly interact with providers and assure a positive and comprehensive experience. As an integral member of the IRT, the Reps engage, inform and train providers. In addition to Reps, the IRT includes Innovation and Collaborative Care (ICC) Department employees, our Medical Director of Care Integration, Claims Educator as well as employees from contracting, provider data, credentialing, and customer service departments. Our ICC team manages VBP provider relationships and as the VBP program grows, they fill critical provider relations roles: assessing provider readiness to engage in VBP, communicating with individual providers who have entered into VBP agreements and NN leadership, and regularly meeting to review results. They help drive VBP performance improvement. Our Claims Educator, who acts as a direct liaison and conducts on-site provider visits and training, educates providers on claims submission, payment and coding accuracy. All other IRT members directly assist providers, timely and effectively addressing any question or concern while cooperatively building Neighborhood capacity.
How BUHP Employment and Training Processes Minimizes Complaints, Issues and Concerns: Employing experienced and engaged personnel is foundational to effective provider relations and communication processes. Our well-trained employees have knowledge, resources and relationships that allow us to understand and meet the needs of our provider community. Through this provider relations redesign to support the new ACC programs, our cross-functional team members can more effectively assist and interface with providers which will minimize complaints, issues or concerns.

BUHP Develops Useful Technology to Enhance Provider Relations and Communication Processes
During Think Tank sessions, providers advised they need efficient tools to support transformation. They complained of historic barriers, such as limited IT infrastructure/interoperability, outdated paper referral processes, having to manage large amounts of data in a time-constrained practice and outdated resource directories. BUHP introduces a forward-looking solution to enhance communication and support ACC transition.

State-of-the-Art Technology: *The Banner Navigation Accelerator* (BNA) is a HIPAA compliant, web-based, easy-to-use mobile and desktop support and logistics platform that will be available to contracted providers for their day-to-day use. BNA delivers an array of resources to our provider's fingertips and enhances provider communication as follows:
1) BNA contains a current self-service data repository. Using data from BUHP and various community agencies (e.g., provider look-up, AZ 2-1-1 - Community Information and Referral Services), the platform has searchable lists of BUHP's comprehensive provider network, and community resource listings, such as food bank or emergency shelter locations.
2) BNA supports and promotes use of Health Current, AZ's Health Information Exchange (HIE), by linking to providers so they may gain access to near real-time, member-specific and population based data to guide service delivery.
3) A common BH assessment form and member's Complete Care Plan (CC Plan) will be housed in the BNA. Providers will be able to complete an automated intake and CC Plan in a single tool. BNA makes certain the CC Plan can be shared across and easily updated by the providers working with the member. With built-in referral functionality to enhance care coordination, providers can submit automated intakes, make warm referrals, communicate complete care planning recommendations with other providers, and then follow-up post-referral to elicit engagement.
Over time, our system will become more intelligent and with improved capabilities to support care based on new information coming into our platform from assessment and administrative data. We will offer provider training, technical assistance, hands-on consultation and support to increase integration.
Provider Service Hub: Via a link in BNA, BUHP gives providers and their staff access to our *Provider Services Hub* (Hub). Through *HealthTrio Smart Connect* technology, this HIPAA compliant, secure, web-based Hub enables providers to securely submit claims and PA requests. The document management and sharing feature allows BUHP and providers to share member rosters, remittance advices, VBP scorecards, data identifying gaps in care and other data. Office staff can conduct eligibility and benefit inquiries, claims status, referral and authorization status, and submit provider demographic changes. The Hub was launched during our recent ALTCS implementation to assist long-term care providers with no alternative way to submit claims. Based on provider feedback, we championed a "copy" enhancement that was of great value over prior incumbents' systems. Once a member was created and all static fields populated, providers could copy data to the next service period and update service dates to reflect a new reimbursable period.

Providers laud this feature as a time saver and error reducer. BUHP Claims leadership and Reps continue to train new providers by webinar, in person, and telephone. Providers have said how easy it is to submit claims through this portal.
VBP Technology Support: To complement Health Current and make actionable population health data available to our VBP providers, during the first quarter of the ACC contract, BUHP is implementing *Cerner Health eRegistries*. BUHP will give VBP providers access to this tool to proactively identify gaps in care, better manage their attributed membership and receive targeted recommendations. Building from lessons learned through Banner's implementation of Cerner within our ACO, BUHP's adoption of this tool further empowers our providers and NN Advisory Councils. Through a unique contract with UA Center for Population Science and Discovery, we offer expert data analytics support to each provider through the NN Councils, including analysis of performance measures and alignment to population trends.
How BUHP Technology Minimize Complaints, Issues and Concerns: With the introduction of our BNA platform and deployment of other software resources, providers will have immediate access to efficient tools that remove barriers, replace outdated processes, streamline prior approvals and automate workflows to shorten the current access to care delays -- including an efficient way to share and update a CC plan for a single member across multiple providers. These technologies make healthcare easier by providing powerful resources that minimize complaints, issues and concerns.

BUHP's Effective Provider Relations, Education and Communication Management Processes
BUHP develops relevant materials and approaches to help providers interface with BUHP and AHCCCS.

Provider Education/Engagement: Our integrated Provider Manual located on BUHP's website or available as a hard-copy supports all lines of business and contains all AHCCCS-required elements, including integrated PH/BH information and outlines provider expectations. BUHP has also developed a quick Provider Resource Guide, which contains practical navigation assistance and addresses pressing questions. We survey providers for requested topics to be included in our quarterly Provider Newsletters, which cover PA/claims submission basics, dual eligible General Mental Health/Substance Abuse (GMH/SA duals) benefit FAQs, contracting processes or new initiatives, such as a recent child and adolescent well care article. BUHP maintains and updates our current website with all provider materials and our Complete Care website will be available June 1, 2018 (ACC contract D.28, Network Management). BUHP has P&Ps on communicating with network providers on contractual and/or program changes and requirements and we send communications using provider preferred modalities. BUHP provides written notification of any significant changes 30 days prior to the effective date of the change. For example, when procedures change, we use in-person training sessions or webinars to update providers. We accommodate providers who prefer fax or e-mail blasts so they have information needed to adhere to requirements. Using a variety of methods enables our communications to reach all -- from small rural providers to large urban facilities. We disseminate written manuals, newsletters and guides in paper and electronic formats and update our electronic website with relevant information. Our social media strategy creates useful content to develop a significant relationship between providers and BUHP. This includes a presence on Facebook and YouTube and the Social Media Specialist will monitor and respond to daily feeds. Provider Webinars allow large numbers of providers to receive information easily, without leaving their office. So far, we conducted over 12 webinars and estimate over 175 providers participated. We will continue to offer webinars, to include annual and ongoing training for BH providers as outlined in AMPM 1060. In-person communication includes semi-annual Provider Forums chaired by the CEO and open to all providers. The forum may include reviewing clinical guideline criteria, discussing health plan clinical decisions or actively listening to concerns. For ALTCS, we held forums by provider type to address unique issues facing each group. Select providers also attend BUHP QMPI Committee meetings and the Technology Assessment Committee and are actively involved in the QM process, including participation in the development of audit tools, selection of clinical practice guidelines for system-wide implementation and development of quality improvement activities. These communication modes enhance understanding, build strong relationships and identify opportunities for improvement.

> 457 ALTCS providers from 8 AZ counties attended our new provider training forum and 98% rated it "Excellent or Good."

Provider Education and Communication Processes: Our effective deployment of Reps has led to long-lasting provider relationships. BUHP Reps live in or near the communities they serve, establish direct relationships by visiting provider offices, offer continual education and maintain ongoing contact with assigned providers. Reps are required to visit PCPs at least quarterly (ACOM 417), and with the new ACC contract, this will be expanded to include all BH Homes, Patient-Centered Medical Homes and Integrated Care Clinics. Reps will have an active and visible role on the NN Advisory Councils, managing any issue that might arise. Reps routinely conduct on-site visits to all contracted providers. When educating a new provider, Reps deliver an in-person New Provider Orientation.

This allows for in-depth review of the Provider Manual, BNA and our Provider Service Hub while allowing for question and answer follow-up. When educating PH and BH providers, we prioritize training on: 1) applicable AHCCCS and CMS requirements; 2) contracting and credentialing processes; 3) where to find and how to utilize BUHP resources and software solutions; 4) our provider manual and member handbook; 5) PA and claims submission requirements; and 6) how to submit a complaint on behalf of themselves or their patients. For BH providers, we also review added BH elements in the Provider Manual such as crisis intervention, peer support, and grant-funded services. These visits may result in requests for technical assistance to address immediate issues. Provider inquiries coming into our call center are logged and tracked for timely response and closure. In fact, over 98% of provider inquiries are closed within 1 business day, well in advance of the prescribed 30-day time frame. Providers must also participate in annual reviews as detailed in AMPM 940 which include on-site visits and medical record audits where BUHP monitors providers' compliance with applicable laws and regulations using audits, desk reviews and self-audit reports. Providers may be selected for and subject to external audit as detailed in the ACC contract, section D.58, Corporate Compliance.

Recurring Provider Meetings: In alignment with our network management plan, provider meetings alert us to provider issues before they escalate and help us develop solutions together. The Network Department meets regularly with delegated partners, provider groups and hospitals to better coordinate operations. Joint Operating Committees (JOCs) are held with large providers to identify potential operational issues or concerns, review utilization and cost reports before they become problems. Recurring JOCs resolve service issues, such as reimbursement methodology and medical management processes. Ongoing JOCs are held with individual dental, health, labs, medical, pharmacy, BH, CRS, and transportation providers to improve services that impact providers, such as delayed member pick up or drop off that affect provider's schedules and member treatments. Our ICC Department's VBP provider-specific JOCs review provider's performance on quality outcomes, clinical outcomes and financial performance reviews to meet the quadruple aim.

Provider Complaints: While we strive to minimize provider complaints, when communication methods are unsuccessful or processes don't work, we value and encourage provider feedback and complaints. Complaints come in a variety of ways, but resolution is managed by Provider Reps. We understand the importance of contacting providers within 3 business days of receipt to let them know we are working to resolve their concern. Reps bring issues to any department for resolution and because of their organizational knowledge; they identify and help resolve complaints, issues or concerns, such as identifying and resolving claims issues or provider demographic information. Complaints are trended and should we identify a systemic issue within BUHP, we issue a corrective action plan to address and correct. To address provider complaints before they escalate, employees notify their leaders for expedited resolution when needed.

How BUHP's Communication Processes Minimize Complaints, Issues and Concerns: By creating meaningful provider materials, such as provider manuals, resource guides and newsletters, we simplify health plan navigation. By maintaining an updated website, providers can access needed tools. Conducting routine, ongoing and frequent communication, using modalities providers prefer, reduces confusion and misunderstanding: minimizing complaints, contract issues, claims or PA concerns. By regularly meeting with providers, they are afforded more opportunities to bring up issues or concerns, and we continually work to improve processes. In 2017, we streamlined our provider inquiry processes and achieved quicker turnaround times by reducing the number of outstanding inquiries, improving our response content and enhancing our reporting. This reduced receipt of duplicative inquiries by 96%.

Continuous Improvement to Optimize Provider Relations and Communication Management Processes

BUHP has implemented well-considered P&Ps and workflows to drive effective processes, but all processes require upkeep and revision. During our long history as an AHCCCS plan, we have implemented multiple process improvements, deploying a Plan, Do, Study, Act process improvement methodology. After every major implementation, project or audit, we identify "lessons learned" and make any needed adjustments: a project management best practice.

Minimizing Contract Issues: BUHP implemented *McKesson's Contract Manager* (MCM) in early 2017 and *Provider Manager* (MPM) software in 2015. Provider demographics are housed in MPM, which directly interfaces with MCM, our claims system, IDX, and our provider look-up: eliminating duplicate data entry into multiple systems and delivering consistent data. MCM is a centralized repository with a configurable workflow and standard template library. Through MCM automation, we can email contracts to providers, retain all revision versions and capture electronic signatures. These applications have improved contracting efficiency, provider data accuracy and document control. BUHP also improved provider data accuracy through a departmental restructure. As formerly structured, highly cross-functional workflows that supported provider data and contract loads crossed back and forth between departments, sometimes resulting in miscommunications. Given provider data is foundational to many operations, BUHP added a Program

Manager to the Network Development Department to oversee provider data and credentialing teams. Processes were re-designed to improve communication, accuracy and timeliness of updates and contract loads (e.g., the provider data team can now access provider data in CAQH, which expedites their ability to confirm accuracy of provider demographic changes and disseminate changes within 48 hours). These improvements enhanced our ability to nimbly respond, such as loading large numbers of ALTCS contracts in 2017. We rapidly pulled together a cross-functional team to develop expedited workflows to load and test large volumes of new contracts within 30 days. We improved timely contract load by 15 days and retested every contract in our live environment so claims paid correctly.

Minimizing PA Concerns: BUHP began utilizing *Acuity* to process PA requests in 2016 and Acuity's automated workflows assure efficiency. Our PA Department reviews PA requests substantially faster than AHCCCS requirements; does not require burdensome documentation submissions that BH providers may have historically experienced; continually updates clinical guidelines with provider input to remain consistent with best practices; and transitions services from our PA Grid to retro-review monitoring to optimize use of system resources. BUHP continues to exceed AHCCCS mandated turnaround times for PA requests. During the past 90 days, we processed, on average, 5,985 standard requests in 1.99 days and 1,467 expedited requests in 7.18 hours from receipt to decision. In 2016, we improved the PA grid to reduce complexity. Through UA Eller College of Business analysis, we were able to eliminate rarely utilized or infrequently denied codes from the grid: including 5% of codes, representing 9% of requests. Post-implementation analysis found no increased utilization after the update and efficiencies were realized. This work continues in a data-driven manner as we optimize use of pre- and post-service reviews to maximize evidence-based care while minimizing provider hassle. The PA Department also offers providers a "same-day phone line" for real-time reviews when in our member's best interest and our CMO, Medical Directors and Pharmacy Director conduct peer-to-peer calls with providers.

Minimizing Claims Concerns: BUHP utilizes *GE Centricity's IDX* platform for claims processing, a flexible system that allows us to load contracts at individual practitioner, group, provider type, benefit or line of business level. IDX offers fee schedule flexibility, supporting a variety of payment mechanisms and, should regulatory changes be required -- such as enhanced nursing home payments -- we can rapidly input customized logic in a nimble manner. It is an intuitive system and easy for claims processors to navigate. Despite IDX system consistency, BUHP experienced a claims inventory spike in 2015 and early 2016, which resulted in claims timeliness falling below acceptable levels. To remedy, BUHP entered into a Corrective Action and took steps to improve, including implementing multiple process improvements. We have been in full compliance for more than a year, with timeliness measures now exceeding AHCCCS requirements: 30-day timeliness is 98.7% and 60 days is 99.0% (ACOM 203). For consistent compliance, multiple contingency levers are also in place, such as offering high-skilled production employees the option to work remotely and initiating voluntary overtime when inventory exceeds 60K and mandatory overtime at 85K. The Claims Department also created a trainer position to assure consistently trained employees. Newly hired claims employees are provided initial training on systems, contracts and processing, which is augmented with one-on-one training by experienced processors. Once fully trained, supervisors conduct one-on-one monitoring prior to allowing independent processing. We also increased our claims auditing team by 50% to oversee and correct processing errors. In partnership with the G&A Department, Claims also improved the overturned claim dispute payment process, resulting in claims payment within 5-7 days after payment approval and reducing the process timeline by 50%. Additionally, when new BH providers were on-boarded, tracking revealed an unusually large number of complaints from BH providers who were confused about claims disputes versus appeals. Claims were getting denied and the providers did not know why or how to fix it. BUHP sent a blast fax, explaining how to properly submit claims. This resulted in more than a 200% reduction of claim status inquiries.

Other Provider-Facing Process Improvements: BUHP's G&A Department engaged in a process improvement to reduce State Fair Hearings requests. By conducting more thorough and timely reviews and calling providers to understand the issue more clearly, hearing filings are down 80%. Provider claims disputes have decreased by 78% during the last quarter compared to last year. In 2016, we cross-trained Call Center staff so they could also address provider calls and deployed a "Provider Rep of the Day," to assure a timely response to provider issues. With this, BUHP's provider first call resolution percentage has remained steady between 98.9 to 99.5%. Finally, during large-scale implementations, we developed our Los Bomberos rapid deployment team to quickly identify and resolve escalating, time-sensitive issues. For example, as we launched our ALTCS plan, our Los Bomberos team convened and problem-solved to quickly respond to access to care issues, claims payment concerns and other provider-facing processes. Through this escalation team's efforts, BUHP received only four provider complaints in the first month of ALTCS go-live.

How BUHP's Continuous Improvement Efforts Minimize Complaints, Issues and Concerns: Through reliable processes and continuous improvement efforts, we minimize provider complaints, contract issues, Claims and PA concerns. Improvements were implemented not only with the provider in mind, but often with the provider by our side.

13. HOW WILL THE OFFEROR EFFECTIVELY OBTAIN AND UTILIZE MEMBER AND PROVIDER FEEDBACK…

At Banner-University Health Plan (BUHP), we work with our members, providers and stakeholders to make life better for each member while achieving improved member outcomes and experience, lower cost of care, and improved provider experience. Listening and responding to our community's needs is engrained in our culture. We value every interaction with our members, their families, our providers and stakeholders. Our member-centric culture encourages continuous learning and drives our transformation to an integrated system. From Customer Care to our CEO, feedback is received and directed to the right person and followed through to resolution. We continue to improve our current mechanisms for obtaining and utilizing feedback while being committed to implementing new mechanisms and communication loops. As a provider-based plan, we gain insights and feedback from our own delivery system, which is the largest safety net provider of Medicaid services in the state. We will continue to utilize provider, member and family feedback to make process changes and continuous improvements. We place emphasis on transparent feedback loops, data sharing strategies and ability to communicate with members in their native language. We establish unique and culturally competent feedback mechanisms for our youth members and their families. In addition to gathering our own feedback, we listen to what others are hearing; working with stakeholders at the AZ Association of Health Plans, legislature, and through policy changes to engage in joint dialogue and work together to identify solutions to community problems.

OBTAINING AND UTILIZING MEMBER AND FAMILY FEEDBACK – CURRENT MECHANISMS AND FUTURE INNOVATIONS

Office of Individual and Family Affairs (OIFA)

Upon contract award, we will establish an OIFA with an Administrator who has a direct reporting line to the CEO. OIFA team members will be peers and family members with experience receiving services in the Medicaid system – some with personal experience related to behavioral health (BH) and some with experience related to other health care challenges. In line with the *9 Guiding Principles for Adults* and *AZ's Vision and 12 Principles for Children,* we embrace the philosophy of *Nothing About Us Without Us*. Our OIFA establishes peer and family voice at every level of the system while educating and informing the community. Our goals are to increase opportunities for peer and family influence, increase number of peers and family members actively serving on committees, and engage in community outreach and education. The OIFA team expands our community presence, offering a supportive ear to listen and learn about the issues facing our neighborhoods, and elevating those issues to BUHP leadership. The OIFA Administrator helps close the feedback loop, and any solutions to issues are relayed to the parties who brought them to our attention. In partnership with our Healthcare Analytics and Reporting Team, our formal feedback loop includes an OIFA Dashboard that tracks and prioritizes issues while increasing accountability, transparency and access to population health data.

Embedding Peer and Family Voice Within all Levels of the System – Committee Representation and Advisory Councils

BUHP has experience engaging members in conversations regarding health policy, access to care and system improvements through our ALTCS and Acute Member Advisory Councils – made up of our members and their families with the goal of gathering their insights in continual improvement of member experience. Our Member Advisory Councils have assisted in making improvements, such as reformatting our member satisfaction survey to increase the response rate and revising preventive care postcards to better capture members' attention. We build from this experience to establish member and family representation on each Neighborhood Advisory Council, which will enable shared governance and transparency within each Neighborhood Network. Additionally, we will establish a Complete Care Member Advocacy Council (MAC) with a Youth Leaders Subcommittee (YLS) upon contract award notification. The MAC will include regional member and family representation from each Neighborhood Network and will have the ear of BUHP Executive Management Team. As we prepare for implementation of the Complete Care Contract, the MAC and YLS will assist in organizing and implementing community outreach and education – providing members and families with the necessary information to prepare for system changes. We will work with these Councils to establish community feedback loops. Each Council will meet regularly, reviewing process, quality and outcomes reports (such as member surveys, quality management reports and Neighborhood Score Cards), and offering recommendations and feedback for continuous improvement. The YLS will focus on youth-specific issues and youth empowerment initiatives. BUHP OIFA will work in collaboration with the Councils to identify additional culturally competent mechanisms to gain member input, beyond the formalized committee work, including establishment of Member and Family Forums, Youth Forums, Virtual Community Meetings, and *The CEO on Your Corner* – Neighborhood Outreach and Education events.

As required by AHCCCS, BUHP will establish a minimum of 2 peer and family member positions on each of our BUHP committees, except for those that pertain to issues of member and/or provider confidentiality. We will provide these

representatives with the necessary support and orientation to optimize their input – especially considering the intimidating complexities of industry jargon and processes. Additionally, members and families will be financially compensated for their contributions to our committee work. Upon contract award, we will release an RFP to contract with a member advocacy organization (such as Mental Health America of AZ, the Statewide Peer and Family Coalition, or PFROs) to oversee this effort. The contracted vendor will be responsible for recruitment, selection of and management of payments to peer/family committee representatives. The vendor, in conjunction with our OIFA and other departments, will offer initial training and orientation, written guidance, and ongoing check-ins with all committee members. Development of skilled peer and family advocates helps build our future workforce.

Member Survey

BUHP conducts a Member Survey annually, with results tabulated quarterly and cumulatively to develop an annual measure. The quarterly Survey provides more timely assessment of and response to member needs. Survey results are shared with multiple BUHP committees and published in the member newsletters. As a valued mechanism for improving member experience, Member Survey Participation is a performance measure included in our Complete Care Value-Based Purchasing (VBP) strategy. While the 2017 Member Survey reflected high levels of satisfaction with medical care received (94.1%), it also demonstrated an overall dissatisfaction rating related to transportation. In response, BUHP began issuing itemized transportation surveys to those who utilized transportation services in the 2 weeks prior. Our Transportation Joint Operations Committee (JOC) increased their meetings from quarterly to weekly (and daily during ALTCS implementation). Solutions implemented included: pulling vehicles out of circulation and creating an expedited communication channel to reach vendor supervisors. As a result, transportation grievances have dropped by 14% in comparison to the 12-month average.

Enhancements to our pregnancy and postpartum outreach program is another example of positive changes implemented in response to member feedback obtained through the 2017 Member Survey. Feedback alerted us to the issue that mothers of still-borns were being contacted for standard new baby information and care coordination. In response, we put together a workgroup to identify and implement process changes to remedy the issue. For example, we initiated a “grief call” to provide comfort and assess for BH needs. Since implementation of process improvements, we have not received any further complaints related to this matter. Results from this year’s Survey also indicated lower levels of satisfaction related to provider availability for maternity appointments. In response, we formed a Process Improvement Committee including representatives from Network, Maternal Child Health and Customer Service, who are reviewing the results, conducting a Plan-Do-Study-Act Cycle (PDSA) and making rapid changes, such as: targeted member education, appointment availability alerts driven by the member/family, a proactive care management approach where a sample of pregnant members are contacted to confirm appointment availability, immediate health plan intervention upon receipt of member/family-driven alert, offering VBP agreements exclusively to providers with excellent appointment access, increasing use of birthing centers and other solutions to be uncovered by the PDSA.

Grievances and Appeals (G&A) Processes

Feedback is also received through our G&A processes – which received a score of 100% compliance during our October 2017 AHCCCS operational review. The G&A Department records and tracks the issue and sends it to the department it concerns. Identified issues are addressed within the department of concern to remediate the situation, close the loop with the member, and engage in corrective action with the provider when necessary. All trending issues are addressed within the responsible department and a PDSA may be used as a method for testing an intervention. The PDSA is completed by developing, implementing and evaluating the results of a performance action plan, followed by systematic improvements. Our tracking, analysis and reporting on trends, including root-cause identification, has resulted in continuous quality improvement efforts to avoid issues from recurring. Reports are reviewed quarterly by the G&A Reporting Committee, trends are reviewed monthly by the Administrative Monitoring Group, and findings shared monthly with the Claims and Network Departments as well as the transportation and dental vendors, so performance improvement plans can be implemented rapidly when necessary. Such efforts have resulted in improvements, including a reduction in disenrollment issues based on trending grievances. Our DSNP members were grieving the loss of their Medicare plan due to their AHCCCS eligibility status change. We improved the clarity of our disenrollment letters so dual eligible members understood how the change in their AHCCCS status impacted their benefits and eligibility on the DSNP plan. Once implemented, disenrollment grievances were reduced from 4 to 0.

Customer Care Representatives

Our Customer Care Representatives in our call center frequently receive member feedback and have consistently achieved a 98% first call resolution rate for the past 4 years. All member issues are documented within the Siebel call tracking system and are promptly reviewed to determine the appropriate resolution process and responsible internal department to take the lead. The Customer Care Representative tracks the issue through resolution and completion of the feedback loop. Each Customer Care Representative completes 10 days of training prior to operating independently on the phones. Training includes shadowing a current Customer Care Representative, systems overview, AHCCCS orientation, policies and procedures, benefits package and pharmacy education, BH orientation, HIPAA compliance, and joint calls with supervisors for monitoring and coaching. As we expand our populations served through the ACC Contract, we are actively preparing enhancements to include training and coaching on active listening, Safe-Talk, trauma-informed care and person-centered communication. Additional Customer Care staff development enhancements will include sitting in on forums where the member/family perspectives are shared, and time spent shadowing service providers in the community, especially within integrated settings and PFROs.

Self-Reported Outcome Measures (SROMs)

BUHP will seek member input by having members define their own health outcomes and satisfaction with care. A self-reported outcome is defined by the National Quality Forum as "information on the [member], told by the [member], without interpretation." We will utilize SROMs as performance measures incentivized through VBP and leverage provider kiosks for this purpose. We employ multiple technology solutions to ease the gathering and analyzing of SROMs while reducing provider hassle, including the use of our *Member Supported Care Circles* solution, which allows members to input self-reported outcomes via their cell phone. Care Circles offer a communication pathway for members, their chosen natural supports, and BUHP, making it easy for members to provide information about wellbeing and satisfaction with services. Additionally, we will continue to offer members access to *Warm Health*, our interactive voice response and text application for self-management, member communication with one's care manager and care team, and generation of care alerts. Our Healthy Together Care Partnership (HTCP) program currently utilizes tools, such as care experience surveys, drawing questions from validated SROMs, and the PROMIS Global Health assessment, to elicit member-reported outcome information and gather member feedback on services. Our program experience survey, administered post-HTCP intervention, indicates 87% of participants feel their health has improved and 94% say they are better able to manage their health. We also utilize our Health Risk Assessment as a SROM. A growing body of research supports the use of SROMs as evidence-based measures that are tied to improving quality outcomes and achieving desired changes at the clinical practice level while also enhancing providers' focus on social determinants of health.

Member Portal

BUHP will continue to invest in HealthTrio technology to offer secure solutions that facilitate communications with our members. The Member Portal will allow members to offer feedback to and receive direct response from BUHP, in addition to standard functions such as reviewing eligibility, finding providers, and requesting a change of PCP.

Additional Member Feedback Mechanisms

In addition to formal member feedback options, every employee in contact with a member is a medium for feedback. Our Care Managers receive feedback daily – evaluating within their department and elevating for process improvement if necessary. Members use our Confidential Comply Line to report concerns. We gather feedback through the Quality of Care (QOC) and Annual System of Care Performance Reviews processes. Our Provider Representatives receive member feedback when on-site working with providers. Members can also send an email to the Provider Representative of the Day. All emails are tracked with rapid-cycle resolution. When members call into our Nurse Line, we will ask where they would've gone without the nurse call line service; utilizing this information to further inform our network development needs. We also gain and respond to member feedback through social media, such as Facebook and the AHCCCS Consumer Assessment of Health Care Providers and Systems Survey. Every team member within BUHP is trained on the importance of member accessibility and customer service. As such, all members of our C-suite, including our CEO, receive phone calls from members to provide feedback and share ideas. As an example, when addressing transportation issues during our ALTCS implementation, our Chief Administrative Officer and Chief Operating Officer remained on the phone with a member until her transportation arrived to see the issue through to successful resolution. Employees at every level within BUHP spend time in the community at events, stakeholder committees, provider celebrations and more. Through this presence, we are always getting a pulse on our members' needs, satisfaction and community trends.

As a provider-based plan, we have unique access to individual satisfaction surveys at the provider-level. Banner has been analyzing satisfaction surveys to better understand the concerns of the people we serve. In 2016, 41% of individuals surveyed told Banner they didn't always understand how to care for themselves when they left the hospital or provider's office. They also stated that enhanced communication of diagnosis, medications, and special instructions are needed to feel confident managing their health. Based on this, Banner has launched a system-wide strategic initiative for 2018 to improve the patient experience through *teach-back*. This communication strategy clarifies the patient's and their families' understanding of instructions by identifying learning gaps and providing an opportunity for health care providers to address misunderstandings and target learning needs. Teach-back has been associated with improved learning outcomes, more effective discharge processes and safer hospital to home transitions.

OBTAINING AND UTILIZING PROVIDER FEEDBACK – CURRENT MECHANISMS AND FUTURE INNOVATIONS

Neighborhood Advisory Councils – Community Partnerships through Shared Governance

Through our Neighborhood Network approach to contracting with providers, we will create accessible, supportive and collaborative neighborhoods. Our Neighborhood Advisory Councils (comprised of provider, peer, family and community partner representatives) will play a pivotal role in offering provider feedback to BUHP. These Councils will review local issues, solutions, and data to drive local initiatives and neighborhood payment models. The Neighborhood Advisory Councils provide the opportunity for providers, members, family and neighbors to work together to solve community problems through collective impact. Representatives from the Councils will serve on the BUHP Board's Advisory Council.

Grievance and Appeals (G&A)

All provider appeals are reported at the Quarterly G&A Reporting Committee to discuss trends and needed remedies. Trending provider issues are referred to our Network Department, Claims Educator and Claims Dispute Analysts for education and outreach, which has helped resolve and decrease the amount of appeals related to system and processor errors. The Network Department meets monthly with the G&A Department to investigate trends and identify solutions. All appeals are tracked through Siebel to resolution. All member and provider claim disputes are reported monthly in the AHCCCS GS report, providing opportunities for internal department improvement and provider re-education. We utilize feedback obtained through the G&A process to increase operational efficiencies. As an example, through a collaborative effort between G&A and Network departments, we realized an increase in complaints from BH providers who were confused about claims disputes versus appeals. Their claims were getting denied and the providers did not know why or how to fix it. We remedied this by explaining our processes via a blast fax to all BH providers, in-person communication, phone calls and our JOCs. We also held a meeting with the Council of Human Service Providers to explore other ways to advertise our claims process. With a commitment to continuous improvement, we utilized a PDSA to improve our service request process. Service requests are now completed through Siebel by Provider Representatives or the G&A Department. Through this process improvement, we reduced open service requests by nearly 100% from August 2016 to March 2017 and maintain a manageable volume. Additionally, our Claims Processors have been trained to expedite the dispute process. As required by AHCCCS, our Provider Claims Educator frequently communicates with providers, including site visits, to effectively exchange information and gain feedback.

Provider Inquiries, Provider Survey & Clinical Initiatives

The Provider Relations Representative logs all Provider Inquiries into Siebel. The Provider Relations Manager pulls a monthly report for all inquiries, identifies trends, takes action as required and closes the communication loop with the provider. Results from these reports are incorporated into our Provider Forums. Beginning 3/1/18, our Operations Team will institute a bi-annual Provider Survey. Survey results will be reviewed by the Cultural Competency Committee and reported to the Quality Management and Performance Improvement (QMPI) Committee. We also gather feedback on clinical initiatives through the QMPI Committee, peer-to-peer reviews, and the Technology Assessment Committee.

Innovative Provider Communication Mechanisms: Webinars, Meet and Greets, and Forums

System transformation leads to risks for negative system disruption and instability. We leverage our past transition experience to support our providers on this new journey toward Complete Care. In preparation for the AHCCCS GMH/SA duals integration implementation, we understood not all providers could take time away from their busy practices for educational meetings and implemented multiple provider webinars, allowing us to outreach and educate more providers in a short period of time. In preparation for our ALTCS implementation, in addition to continuing to offer

webinars, we implemented a new approach to provider outreach. We first conducted "Meet and Greet" sessions, working with community and provider associations to offer general orientation: including detailing our member-centered philosophy and desire for a smooth transition. Led by our CEO and attended by our Executive Team, more than 35 additional leaders from all areas of the health plan attended these sessions in-person – answering questions and listening to more than 300 providers' concerns about the upcoming contract transition. Then, we conducted large-scale Provider Forums to offer more expansive education and held forums based on provider type to allow for drill down discussions related to unique issues facing each provider group. Our consistent and frequent use of forums and webinars, coupled with significant up-front relationship development enabled us to implement this new line of business smoothly. Based on the success of our ALTCS implementation, we will utilize a similar approach to enhance Complete Care preparedness and transparency. Provider meet and greets, webinars and forums have already begun and will continue monthly upon contract award notification. These activities will include educational presentations, participatory dialogues, listening sessions, panel discussions, small group break-outs and focused training.

Provider Representatives and Provider Services Hub

To empower our Neighborhood Advisory Councils, we established an Internal Resource Team (IRT) that offers focused services to our providers with the intent of driving performance and providing extraordinary customer service to each provider. Based regionally and part of the IRT, a Provider Relations Representative (Provider Rep) is assigned to each of our providers. They conduct regular provider site visits, offer one-on-one communication, and establish ongoing relationships. They are responsible for improving provider experience, assisting to remove barriers to optimal performance, and identifying training and technical assistance needs. They also assist with coding/documentation, quality metrics, and support on claims and contracting. To improve our operational efficiency, we established a Provider Rep of the Day and utilize our call center and a dedicated email to field, log and track each contact through resolution. This approach enables providers to talk to a live staff person (via the call center) when they call BUHP, and allows a knowledgeable Provider Rep (via the Provider Rep of the Day) to begin immediately addressing their needs that same day while also coordinating with the provider's assigned Provider Rep. To enhance our role as a valued partner, we are revamping our IRT: expanding capacity by adding more employees and developing specialty groups. This team will help train providers on integration, screening, and more, while also creating a strong connection to the Neighborhood Advisory Councils and local resources within each neighborhood. Our Maternal Child Health team will add a new Health Plans Program Manager to collaborate with the Provider Relations team as it relates to Maternal Child Health specialty groups. Through HealthTrio Smart Connect technology, our Provider Service Hub offers our providers the ability to securely submit claims and prior authorization requests, share member rosters, VBP scorecards, data identifying gaps in care and other data. This Hub also serves as a feedback mechanism with direct response from the health plan.

Innovation and Collaborative Care (ICC) Department

Our ICC team supports our providers by offering consultation to build provider readiness for VBP and integration, enhance performance, and gather feedback. This department recently conducted a formal provider survey asking for feedback on our VBP program. We recently revised quality measures and reporting capabilities based on provider feedback. This team meets each provider where they are – taking the time to shadow provider staff, help develop appropriate workflows, assess readiness to engage in VBP and collaboratively customize solutions to improve readiness. The ICC team tracks all feedback in a database and constantly re-evaluates payment models, communication strategies and training needs. Informal feedback is given to the provider through an organic, supportive and ongoing relationship.

CONCLUSION

Driven to meet the needs of our community, we partner with our members, their families, providers and stakeholders to enhance feedback opportunities. To gain community input on our changing health care landscape, BUHP hosted a series of Community Think Tanks starting in spring 2017, with member, family, provider, first responder, school system, DCS, justice system and other community representation. Think Tanks focused on topics such as Children's System of Care, integration models, substance abuse, payment models, technology and more. We utilized insights gained through these efforts to develop our approach to Complete Care. We will continue to utilize this Think Tank approach to gain fresh perspectives on industry trends and develop community partnerships throughout the life of the contract.

14. AHCCCS BEGAN ITS INTEGRATION EFFORTS ALMOST 10 YEARS AGO, AND THROUGH THIS RFP IS MAKING MAJOR…

Banner-University Health Plan (BUHP) will utilize Value-Based Purchasing (VBP) strategies to accelerate behavioral health (BH) and physical health (PH) integration at the provider level while aligning incentives, reducing fragmentation and improving member outcomes. VBP will help our providers focus on integration, quality and efficiency to better serve members with limited time, health care knowledge and resources while simplifying the complexity of health care. As a Committed Partner of the Health Care Payment Learning and Action Network (LAN), whose mission is to accelerate the transition to alternative payment models (APMs), BUHP will continue to promote the Quadruple Aim: improved health outcomes, member experience, value of care and provider experience. BUHP will exceed AHCCCS VBP standards while meeting providers where they are and building APM and integration readiness. We currently exceed AHCCCS VBP requirements – with VBP spending 10 percentage points above the State target and with the portion in a LAN 3 45 points above target. By 2020, our goal is to achieve 80% payment under an APM. BUHP is a market leader in APM implementation – using bundled and capitated approaches with provider groups more than 10 years ago; initiating VBP with our DSNP plans before required; and having our payment model strategies published in the Association of Community Affiliated Health Plans (ACAP) VBP Tool Kit. Today, 70% of our shared savings partnerships have reduced their Medical Expense Ratio (MER); our VBP partners have improved quality measures; and with our support, a leading partner (Mariposa Community Health Center) recently received an ACAP Safety Net Provider Award for Innovative Programming. We are participating in the ACAP/Bailit Health Nationwide VBP Collaborative and were invited as panelists at the 2017 LAN Summit to share our APM success translating the CMS Oncology Care Model to a Medicaid population. We build from the experience and success of the Banner Health Network (BHN), as AZ's leader and early adopter of APMs. BHN achieved demonstrable success through the Pioneer ACO and continues to drive quality and cost containment through the Neighborhood Physician Alliance – introduced in 2016 to help independent providers progress along the value-based glide path. BHN was the top earner of all Pioneers for 3 consecutive years, was one of only 5 Pioneers to demonstrate substantial savings for all 5 years of the CMS pilot and saved the Medicare Fund over $114M over the course of the pilot. Through our 30+ year relationship with the University of AZ (UA), we have been committed to researching payment models and transformation strategies. We leverage this experience to create a Neighborhood Network model, where providers of all service types share incentives and outcome goals, promoting integration and enabling payment methodologies that foster partnership over custodial siloes of care.

ACCELERATING INTEGRATION THROUGH CREATING NEIGHBORHOOD NETWORKS

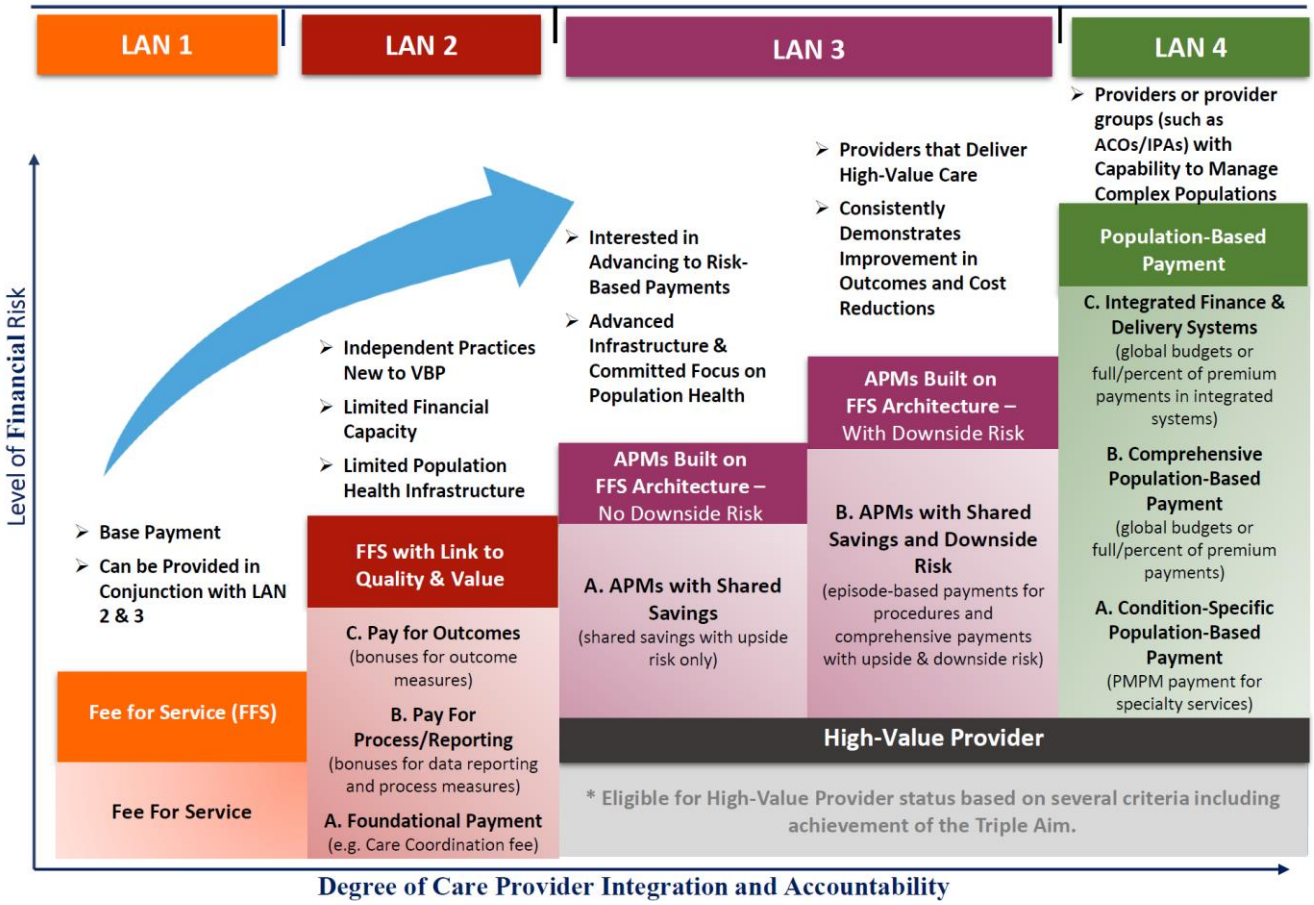
BUHP will organize providers and community stakeholders into "*Neighborhood Networks*" to break down fragmentation in care by creating customized strategies and aligned incentives to respond to the unique strengths, needs, cultural aspects and social determinants of each Neighborhood. This approach responds to the diverse health care needs across AZ, while creating an aligned, comprehensive and high performing provider network. Providers in a Neighborhood will be financially incentivized to work together: coordinating resources, care and expertise to best meet a member's and community's complete care needs. Shared outcomes payments and cross-system shared savings strategies will drive this cooperative approach by enhancing communication and accountability for comprehensive Quadruple Aim outcomes. Through this approach, BUHP works toward integrating care across services for our members, rather than the siloed approach that results from current fee-for-service and block purchase models. We also align incentives for specialty care providers, so an entire Neighborhood is working on the goal of improved quality of life while bending the cost curve. To incent PH/BH integration at the practice level, we will pay increased rates based on level of integration and alignment with AHCCCS Targeted Investment Program (TIP) strategies to incentivize providers toward integration. Levels include: ***Level 1*** *– Screening Strategy with Warm Hand-Off and Follow-up on Referral****; Level 2*** *– Cooperative Referral Process and Mechanism for Co-Management and/or Co-Location;* ***Level 3*** *– Fully integrated BH and primary care services – such as team-based care, availability of same-day consultations, care coordination and a population-based approach to care.* PCPs and BH Homes will be expected to achieve a minimum of Level 1 to be included in our network. Our technology solution, Banner Navigation Accelerator (BNA), helps providers achieve Level 1 through streamlined intake, care planning and referral process, including the ability to follow up and track referral status.

OUR COMPLETE CARE PAYMENT MODEL FRAMEWORK: PROGRESSING ON THE LAN GLIDE PATH

If a health plan establishes a separate payment model for integrated, BH only and PH only provider types, it is not truly managing an *integrated* benefit and only continuing the bifurcation of services experienced today. As such, BUHP continues our consistent integrated approach to the administration of AHCCCS benefits, utilizing the same framework consistently for all provider types. Our framework allows for multiple entry points based on provider readiness and

incentivizes integration with aligned measures, shared Neighborhood Incentives based on an entire population's health, and the deliberate selection of infrastructure and process measures to enable a stepped path toward integration – using HIT to support care coordination, incentivizing preventive screening of BH needs within PH settings and conversely incentivizing preventive screening of PH needs in BH settings, such as those related to STIs, women's health, and cancer. Our carefully designed payment model supports multiple evidence-based approaches to integration at the service delivery level, including: primary care based integration, the inclusion of PH services within a BH setting, integration within a medical specialty provider setting, and virtual integration through HIT, telemedicine, and care coordination – enabling complete care even when all services are not under the same roof. While we embody a flexible approach to APMs, Figure 1 provides the framework for our approach, which is used consistently across all provider types. We outline the readiness factors, characteristics and accountability requirements needed to continue climbing in elevation.

Figure 1. The Climb to Complete Care – BUHP Payment Model Framework



<u>Provider Accountability Readiness:</u> One indicator of ability to progress toward higher levels of risk and integration is growth in population served. To create an accessible entry point while aligning incentives for population health, we have developed Neighborhood Incentives, which include bonus payments based on the health of an entire Neighborhood. FFS coupled with Neighborhood Incentives is a viable starting point for providers lacking the infrastructure and/or population size to take on risk. For providers serving 200-1,000 members (including independent practices new to VBP, those with limited financial capacity and limited population health infrastructure), we work together to determine readiness for LAN 2, with a PMPM for care coordination, Neighborhood Incentive and performance incentives. We target providers with an advanced infrastructure and committed focus on population health, especially those serving 1,000-3,000 members for opportunities to move into LAN 3A and providers serving 3,000-5,000 for movement to LAN 3B. Providers serving more than 5,000 or part of a large coordinated system are identified to move to LAN 4. While these bands are designed to help target and build readiness across all provider types as appropriate, providers are <u>not</u> restricted to a specific category based on population size, nor is this the only indicator of readiness.

<u>Medical Expense Ratio (MER):</u> Effectively bending the cost curve, for providers at LAN 3 and above, the mechanism for receiving shared savings is based on improvement over a prior performance baseline MER for each practice. Based on the MER achieved, up to 50% of shared savings is attainable. Participating providers must achieve a specified MER as a

minimum to qualify for a share of savings. The share increases accordingly, based on decrease in MER – starting at 20% to a maximum 50% share available when 84.9% or lower MER is achieved. The gate to earn this share is dependent upon the number of quality measures met. Currently, providers must achieve a minimum of 4 performance measures to gain access to their shared savings and can receive up to 100% of the share by meeting 9 or more measures. Minimum MER and performance measures will shift as providers enhance capabilities in this space and based on ongoing analysis.

Total Cost of Care (TCOC) vs. Partial Cost of Care (PCOC): TCOC models are an integral part of developing a sustainable integrated delivery system. Currently, 11 of our 16 APMs encompass TCOC, including BH and pharmaceutical expenses. Our primary care and integrated providers are under a TCOC shared savings, LAN 3A arrangement, using MER targets based on prior performance. The Oncology Care Model (OCM) is under a TCOC arrangement, where FFS, a PMPM care coordination fee, and quality incentives cover all care delivered by the integrated OCM team, while financial targets are set based on TCOC for members receiving cancer center services. Given OCM is a fully integrated model, this approach will translate well with some BH Homes. PCOC works well for providers who are under a shared savings arrangement for care under their direct purview or a sub-capitation arrangement for services within their scope. As an example, our dental benefit manager receives a PMPM plus quality incentive for excellent oral health delivery. This same model can be applied to specialty BH providers as appropriate. Our PCOC encourages subspecialty and smaller providers to focus on quality and cost containment. To help BH Homes enter contracts that truly reflect the services they provide under their scope and avoid penalizing use of critical specialty providers (such as Peer and Family Run Organizations), we will offer PCOC sub-capitated arrangements that do not recoup the specialty service expenses. Specialty provider costs that aren't within the BH Home's scope are managed separately via traditional utilization management control practices by BUHP. BH Homes will not be forced to take on TCOC but may choose to do so as they gain experience. Finally, bundled payments for PCOC are some of the most effective APMs for specialty services. We currently utilize this approach for sleep apnea care with the inclusion of peer support and for all our OB providers.

Transitioning BH Providers Off Block Purchasing: As a fiscal steward of federal funds, we develop compensation methodologies, which link to the delivery of Medicaid services. As a Complete Care Contractor, BUHP will not engage in block purchasing. During our Think Tank sessions and one-on-one meetings with BH providers – many who have relied on block purchasing – we explored funds flow concerns and strategized on APMs. We determined these will range from fee-for-service (FFS) foundations with incentives to capitated or sub-capitated models, while historical trends are examined and LAN scale readiness determined. We are already working with several BH providers to offer consultation and readiness development assistance and have enhanced our provider APM readiness survey to apply to a broader set of service providers. Upon contract award, we will meet with BH providers who require a bridging strategy to map out payment model details and identify temporary supports for success in this new landscape. For those providers who have an interest in VBP, but are not sure of their capability or infrastructure, BUHP will offer technical assistance at no cost. Through an **exclusive partnership with Equality Health**, BUHP offers individualized consultation services. Equality Health will utilize their proprietary and proven assessment tool to guide this process with each individual provider – analyzing various components of a practice, from operations and cultural care to care management and collaborative care, and advising them on improvements needed to succeed in VBP. Additionally, and in some cases, BH providers may be eligible for supplemental, short-term care coordination payments or enhanced reimbursement that can be tied to an encounter.

THE BUHP APPROACH IS ROOTED IN LAN'S 4 STANDARDS OF SUCCESSFUL APMS

Standard 1 – Member Attribution: Member attribution is fundamental to the structure of APMs as it defines the population a provider is accountable to and specifies the axis upon which payment and performance measurement rest. We will designate member attribution based upon the LAN recommendations – encouraging member choice, offering transparency to members and providers, and maintaining alignment across all lines of business. To respond to actual care patterns and respect individual choice, we will utilize concurrent attribution. Concurrent attribution is a look-back at historical claims and gives providers a defined list of members at the start of the contract measurement period. Attribution lists are not fixed nor final, as members may be added or subtracted to the attributed list based on care patterns observed through the measurement period. Through a concurrent attribution verification process, lists will be refreshed, reconciled and updated at least quarterly. For members without claims, their attribution is based on their PCP assignment. This attribution model will help us provide our integrated, BH, and PH providers with clear, actionable data about their attributed members.

Standard 2 – Financial Benchmarking: Our methodology for financial benchmarking adopts LAN's guiding principles and is achieved by a 3-phase approach. Phase 1 encourages providers to participate in delivery system reform (such as full BH/PH integration) by offering a financial reward for incremental improvements in efficiencies, employing a historical look-back at the prior year's financial performance to include BH/PH historical spends. Phase 2 allows for acclimation to a new reimbursement model and the opportunity to invest in practice improvements. Phase 3 rebases the initial benchmark according to broad-based population trends within the applicable Neighborhood and fixed financial targets, while applying risk-adjustment strategies that combine regression-based models with reinsurance or outlier payments.

Standard 3 – Performance Measures: BUHP adopts the International Consortium for Health Outcome Measures (ICHOM) goal of developing performance measures that address 50% of the global disease burden and identifies appropriate measures based on population health data, trends, and the research and analysis conducted by our partners at the UA Center for Population Science and Discovery. Measures chosen are specifically focused on accelerating integration. As an example, through our research and analytics, we have identified treatment of cancer is twice as expensive for BUFC members with a BH condition, which is consistent with numerous studies demonstrating the need for improved screening and early detection of cancer among individuals with mental illness. As such, we have included Cancer Screening as a performance measure shared across all provider types. Through BH provider meetings, we have determined that their first step towards integration is often focused on promoting PH preventive care screenings. As such, Well Woman Measures are included as performance measures for BH providers to encourage those first steps towards complete care. As suggested by ICHOM, we will use a comprehensive outcome measure set that addresses acute complications, self-reported outcome measures (SROMs), disease control, psychosocial factors and mortality. For all VBP contracts, we will utilize a set of Core Measures and Choice Measures. We will also utilize Neighborhood Measures to incent the health outcomes of an entire neighborhood, beyond just those members attributed to a particular provider. During Year 1, we will incent the Neighborhood and Core Measures outlined in Figure 2 below:

Figure 2.
Complete Care Measures Promoting BH & PH Integration

Neighborhood Measures
- ED Utilization
- Inpatient Utilization
- Comprehensive Diabetes Care
- Opioid Use

BUHP Exclusive

Category
- Utilization
- Access to Care/Member Experience
- Population Health and Preventive Care

- Child Measure
- Adult Measure

Core Measures	Integrated Provider	Primary Care Non-Integrated	BH Non-Integrated
Hospital 7 day & 30 day follow up	✓	✓	✓
All Cause Inpatient Readmission – within 30-days of discharge	✓	✓	✓
Out of Home Admission & Readmission	✓		✓
Access to Preventive/Ambulatory Care	✓	✓	✓
AHCCCS mandated EPSDT Visits with Use of Developmental Screener (0-18 yrs)	✓	✓	
Access to BHP & Integrated BH Home, 7 days	✓		✓
Member and/or Family Satisfaction Survey Participation	✓	✓	✓
AHCCCS Targeted Investment Project Aligned Integration Ambulatory Project Milestones (including but not limited to: practice evaluation, BH screening, referral and follow up)	✓	✓	✓
Children's Dental Visits (Age 2-21)	✓	✓	✓
Metabolic Monitoring for Individuals Prescribed Antipyschotic Medication	✓		✓
Use of Evidence-Based SROMs (may include Family Reported Measures)	✓	✓	✓
BH Screening with Follow Up	✓	✓	✓
Well Woman Measure (Chlamydia, Cervical CA, Breast CA Screening)	✓		✓
Cancer Screening (including Colorectal)	✓	✓	✓
BP Control	✓	✓	
Multiple Concurrent Antipsychotic Use	✓		✓
Zero Suicide Plan in Place	✓	✓	✓
Use of HIT & HIE - including participation in Health Current and BNA and Shared Complete Care Plan	✓	✓	✓

Additional Choice Measures will include: Zero Suicide Plan, Cardiovascular Health Monitoring for Individuals with Cardiovascular Disease who are Prescribed Antipsychotic Medications, Member/Family Satisfaction Score Improvement, and Follow-up Care for Children Prescribed ADHD Medication. As providers achieve foundational/infrastructure measures, we will introduce enhanced Phase 2 Measures, including incenting improvement in SROM scores across all provider types, especially as it relates to National Outcome Measures such as social connectedness, employment and education. We will also expand Phase 2 Neighborhood Measures to include BMI improvement, DCS removal, flu shots and others. Additionally, we will develop specific measures for certain groups of specialty providers and Centers of Excellence (COEs). For example, we will expand our OB Bundled Payment to include outcomes incentives for the

pregnant teen population related to engagement in oral health, postpartum primary care engagement, maternal experience, depression screen and follow up, parenting and bonding education, and eventually, birth outcomes. We will also create aligned savings for pediatric dentists, OB providers and pediatricians as it relates to the health of the newborn. Another example is our Autism Spectrum Disorder COE Bundled Payment, which incorporates key indicators related to timely comprehensive evaluation and access to evidence-based treatment.

Standard 4 – Data Sharing: To accelerate integration, data sharing must enable providers to obtain timely information that supports the cost containment of whole-person care while achieving optimal health outcomes and eliminating fragmentation. Health Current, AZ's Health Information Exchange (HIE), brings together 3,000+ AZ providers as a central data hub to overcome barriers of fragmentation and coordinating care between providers. Banner Health (Banner) and BUHP have been and remain strong supporters and key participants in Health Current since its inception. Banner's data represents 1/3 of all discharge data transmitted to Health Current annually. BUHP's CEO, Kathy Oestreich, along with other Banner executives are Health Current board members. Banner IT leadership participates in all 3 Health Current Advisory Councils and other special workgroups. BUHP will incentivize providers to participate in a bi-directional connection with Health Current. BUHP staff assist providers in setting up their HIE connection. To complement Health Current and make actionable population health data available to our VBP providers, BUHP is implementing *Cerner Health eRegistries*. VBP providers will gain access to this tool to proactively identify gaps in care, better manage their attributed membership and receive targeted recommendations. Building from lessons learned through Banner's implementation of Cerner within our ACO, BUHP's adoption of this tool further empowers our providers and Care Managers. BUHP will develop and publish Quarterly Neighborhood Scorecards to attribute, measure, and monitor members and providers at an individual and population level. Additionally, we developed *Banner Navigation Accelerator* (BNA), as an innovative platform to offer deep analytics and application of intelligence to provide administrative data and evaluate performance. To accelerate integration, BNA offers a fluid intake process with seamless identification of network options and the ability to generate and follow up on referrals. As a component of the BNA platform, our *Member Supported Care Circles* and *Warm Health* mobile applications create an easy mechanism to regularly and frequently gather SROMs while promoting member engagement and self-management.

IT'S *NOT* ONE-SIZE-FITS-ALL – INDIVIDUALIZED SUPPORT FOR PROVIDERS

As we build our Neighborhood Networks, we offer varied support mechanisms to help providers engage in VBP and build capacity to offer an integrated team-based approach to care. For providers lacking the infrastructure and/or population size to enter into VBP agreements independently, we will assist in organizing or joining existing collaborative ventures based on our established relationships with these large organizations, such as: BHN, Equality Health and the AZ Alliance for Community Health Centers. We have developed detailed expansion plans, including geo-mapping, gap analysis, addition of key providers into ACOs/IPAs and outreach to new providers, to enable partnerships with smaller independent practices. We have forged relationships with emerging collaborative ventures (such as a unique group of small psychosocial rehabilitation and peer specialty providers, including: DKA, Our Place Clubhouse, NAMI Southern AZ, Hope and The Haven) to offer guidance and advice. We are also initiating a contract with and providing consultation to an emerging Clinically Integrated Network, made up of fully integrated health homes (including La Frontera and CODAC) and BH specialty providers. Offering providers consultation to establish consortiums and working with existing groups helps smaller providers engage in VBP and coordinate care through virtual integration and field clinics. Our Innovation and Collaborative Care (ICC) team and Provider Representatives invest in each provider, working together to determine readiness and identify a clear path to advance integration and APM engagement – including on-site shadowing, evaluation, and coaching. Examples of our customized approach include: 1) partnership with Assurance Health and Wellness, using PMPM payments to enable use of peer support for high risk maternity and substance abuse populations; 2) providing practice consultation to COPE to help them take steps towards full integration; 3) implementation of a wellness promotion pilot with UA Camp Wellness for High A1C Diabetes and Depression – providing bundled payments for phase 1 and a plan for outcome payments in phase 2; and 4) working with the Banner South Campus Clinic and UA Department of Family and Community Medicine to collaboratively respond to AHCCCS Targeted Investments Program (TIP) opportunities – building models for care and payments to support a Collaborative Care model that incorporates the use of specialty trained peer and family health mentors.

> "*Cope's leadership has had the pleasure of working with the ICC team on practice performance. BUHP's staff consistently brings invaluable expertise, insight, and guidance on methods to strengthen our integrated care systems and improve quality*."
> -Tom Donovan, COPE CEO

15. EXPLAIN THE OFFEROR'S APPROACH TO MONITORING AND CONTROLLING HEALTH CARE COST TRENDS…

As a locally owned non-profit organization, Banner-University Health Plans (BUHP) is committed to being a valued partner of AHCCCS as a good fiscal steward of public funds by delivering health care with improved quality and bending the health care cost curve. BUHP's program contains all elements required in the RFP and AHCCCS policies. This includes an organizational committee structure and comprehensive processes to monitor and control both administrative and medical expenditures along with improving system efficiencies. These operations prevent unnecessary health care spending through the early detection of negative trends, detailed root cause investigations of unwanted trends, and appropriate reporting and/or correction. To minimize administrative expense within BUHP and throughout the health care system, we use Lean Six Sigma methodologies to remove waste and improve process efficiencies consistent with Governor Doug Ducey's Arizona Management System. To control medical spend, BUHP monitors service utilization, cost of services and accuracy of submitted claims along with provider and member input to create an optimally efficient system of care for all stakeholders. BUHP believes spending can in part be controlled by payer actions that decrease hassle, unnecessary costs at the level of the provider and member, and improve quality and prevention.

BUHP has always existed as a provider-based plan and, in that unique role, is a driver of population health within our greater safety net organization. Now, BUHP is a significant population health partner within Banner Health (Banner), Arizona's early adopter and leader of accountable care and delivery system innovation aimed at controlling costs by continually improving and streamlining health care delivery. For example, in 2016-17, BUHP and Banner leaders of urgent care, emergency care and addiction medicine have launched improvements in care pathways for members with co-morbid behavioral disorders and co-occurring opioid addiction who present acutely for care. Banner has supported the legacy inter-professional home-based care program, Healthy Together Care Partnership, which offers a team-based, member-centric approach by "hot-spotting" high-utilizing AHCCCS members with complex needs for care interventions. Through this type of collaborative, team-based, system-wide drive for continual improvement involving all stakeholders, care transformation will be felt by each of our members while we control costs. Banner is committed to change, its role as a health care safety net, and recognizes the value of BUHP as a key part of delivery system transformation for AHCCCS members, as well as all Arizonans seeking the best health care.

ORGANIZATIONAL STRUCTURE AND PROCESSES MONITORING HEALTH CARE COSTS

BUHP primarily monitors administrative costs through our Stewardship Committee (Stewardship) and medical spend through the Utilization Management Finance Committee (UM Finance). All BUHP executives serve on both committees, with the CEO chairing Stewardship and the CFO and CMO co-chairing UM Finance. Information from Stewardship is also reviewed by the Banner Senior Leadership Team, while the information from UM Finance reaches the Banner Senior Leadership Team through the joint BUHP Quality Management/Process Improvement and Medical Management Committee, consistent with AHCCCS requirements in AMPM Chapters 900 and 1000. The Banner Senior Leadership Team ultimately reports BUHP outcomes to the Banner Board of Directors.

The Stewardship Committee: Each month, department directors present to the executive team their report of requested positions, capital expenses and/or other proposed expenditures along with departmental updates, which include potential process or program improvements. Any additional administrative expenses are discussed and vetted by the committee to realize the most efficient use of administrative funds to achieve regulatory compliance and the optimal system of care for our members and providers. Status updates regarding departmental challenges and successes are reviewed in order to remove barriers to success and support each department to continuously develop mechanisms to improve program efficiency and reduce administrative cost, including reducing program complexity, administrative burden, and unnecessary administrative and medical costs for providers.

The UM Finance Committee: In addition to BUHP Executives, other standing members on this committee are from Medical Management, Care Management, Pharmacy, Network Development, Claims Department, Compliance Department, Claims Recovery Unit, Finance, Administrative Monitoring Group, Innovation and Collaborative Care, Information Technology, and the Healthcare Analytics and Reporting Team (HART). This allows for group monitoring of utilization and cost trends, as well as interdepartmental problem-solving regarding how to expeditiously investigate and address the root cause of any negative trend identified. This also includes BUHP's Program Integrity efforts along with identification of Third Party Liability. Should fraud, waste or abuse (FWA) be suspected through this committee or by any BUHP employee, referrals are sent to our Special Investigation Unit (SIU). Each referral is researched and validated concerns are reported to AHCCCS OIG. Our SIU unit reported 15 providers and 131 members to the OIG in 2017, with

one provider referral originating from a trend identified in the UM Finance Committee.

CONTROLLING ADMINISTRATIVE EXPENDITURE

The BUHP Finance Department conducts monthly budget reviews with each department to compare budget to actual expenditures related to staffing, capital expenditures and budgeted performance targets. As noted above, any administrative non-budgeted expenditures or position replacements are also reviewed by the BUHP Executive Team at the monthly Stewardship Committee to make sure all directors and managers continue to meet AHCCCS and operational requirements in the most cost-effective manner possible. Each director can access their financial budget compared to actual budgetary spend on an internal reporting tool. Each department, led by their director, monitors health care cost trends at the departmental level, is empowered to mitigate negative trends in the timeliest manner, seeks opportunities to improve efficiencies and brings these identified opportunities to Stewardship for review by the Executive Team. Staff and leader training in process/quality improvement is important for this program as engagement by front line staff to identify improvement opportunities and implement change is critical to our success. BUHP believes this AHCCCS Complete Care (ACC) contract offers opportunities for decreased administrative costs for BUHP and our provider network, similar to how we have managed complete care benefits for our General Mental Health/Substance Abuse (GMH/SA) dual members, ALTCS members and DSNP enrollees, who include members of Cenpatico Integrated Care with serious mental illness. Through management of these populations, we experienced the challenges behavioral health (BH) and integrated providers faced adjusting to the loss of block grants, which necessitated improved billing capabilities. Our Provider Relations and Claims Departments collaborated to educate these providers during this time of transformational integration of benefits. The value of this proactive partnering with providers was demonstrated during the launch of the new B-UFC ALTCS Plan when provider challenges were minimal and multiple providers expressed their gratitude for BUHP's collaboration and availability to resolve issues expeditiously as they arose in order to prevent increased administrative burden for both payer and provider due to rejected claims. This level of operational precision is a hallmark of BUHP and the result of combining the best practices of Lean Six Sigma with proactive provider partnering. Furthermore, BUHP has deployed electronic solutions in order to reduce health care administrative burden throughout the entire system. These electronic solutions include a provider services hub for claims submission, exchange of information to support population health management and prior authorization. *Cerner eRegistries* not only saves administrative expenses, but also improves the quality of care delivered through immediate access to discharge summaries, disease registries, gaps in care and referral management while also allowing for direct provider-to-provider communication to improve care transitions within a clinically integrated delivery system. As evidenced by Banner's success with the Medicare Pioneer Accountable Care Organization, these tools provide the capability to use IT systems effectively in order to advance clinical outcomes, improve quality and lower costs. With this new contract, BUHP will implement *Banner Navigation Accelerator*, as an innovative platform to offer deep analytics and application of intelligence to provide administrative data, evaluate performance, and allow users to quickly identify which services are available within our network at specific provider sites.

Although the prior authorization (PA) process minimizes waste by ensuring services are provided consistent with evidence-based care, it results in an administrative cost for both payer and provider. In 2016 BUHP completed a comprehensive review of our process in conjunction with the UA Eller College of Business that reduced program complexity and administrative burden by eliminating service codes from the PA Grid that were either rarely utilized or infrequently denied. Analysis comparing the medical expense associated with these codes from before and after these PA Grid changes found no increased utilization after deletion of the codes. However, administrative costs to both BUHP and our providers were decreased due to this change along with less provider hassle associated with requesting services rarely denied due to their regular compliance with evidence-based criteria. This work continues in a data-driven manner as BUHP continues to optimize the use of pre- and post-service reviews to maximize evidence-based care while minimizing member, provider and payer hassle and expense.

CONTROLLING MEDICAL EXPENDITURE

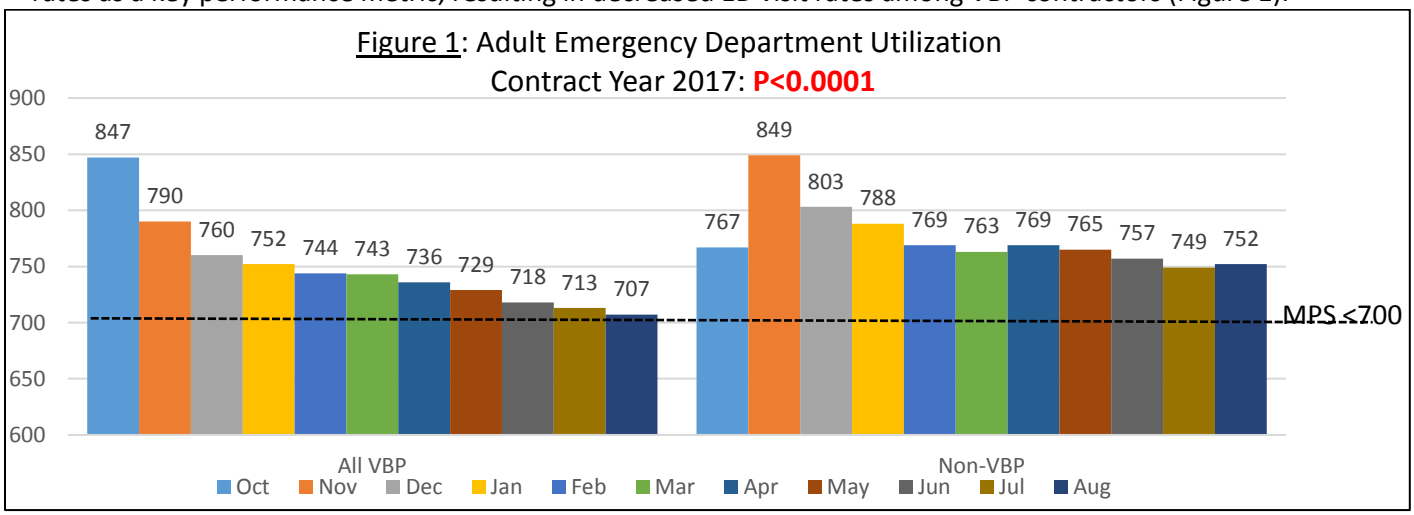
Interventions to control medical spend depend upon the root cause of the negative trend identified. Hence, BUHP has built a large collection of interventions over its decades as an AHCCCS contractor and valued partner. In general, if utilization increases, then care and utilization management interventions are explored along with Value-Based Purchasing (VBP) contracting; if unit costs are rising for a service, then provider contracts are reviewed and potentially renegotiated to achieve improved pricing or preferably transitioned to a VBP contract; if medical spend is rising in the face of flat utilization and unit costs, then our Claims Recovery Unit works with the Claims Department to investigate

claims billing patterns associated with the identified services. Each BUHP employee is empowered to bring improvement opportunities forward to be implemented within their department and/or vetted for wider implementation as appropriate. This process and quality improvement approach that permeates all levels of the health plan is supported by the committee structure noted above. The UM Finance Committee has the primary responsibility to monitor trends and recommend interventions to mitigate negative trends in medical expenditures.

BUHP's HART works closely with Medical Management and Finance Departments, believing a shoulder-to-shoulder approach drives population health management forward while bending the cost curve. BUHP has robust reporting mechanisms to closely monitor PMPM costs, service costs and per 1,000 utilization trends across the benefit array, including monitoring of subpopulations such as those classified as having special health care needs, high utilization or multiple co-morbidity. Data analytic capabilities, including those of our partners within the University of Arizona (UA) Center for Population Science and Discovery, are advanced and include predictive analytics along with core statistical and data science tools to detect trends and identify cost drivers. Generated reports are accessible to all committees and workgroups focused on monitoring and controlling health care costs. As a continually learning organization and in collaboration with researchers from UA, HART remains on the cutting edge of population health and health economic analytics, including machine learning techniques to leverage the latest advancements in technology, such as the incorporation of Health Current information. Furthermore, we engaged *Evolent Health* to help us evaluate our health care medical economics approaches, leveraging their expertise through their Medicaid Center of Excellence partnership with Passport Health, a 300,000 member Medicaid plan in Kentucky.

Examples of Past Unfavorable Medical Expense Trends Identified and Controlled by BUHP:

1. Trend: The DSNP enrollees were experiencing an increased rate of hospital admission soon after enrollment. Action: Process improvement methods were implemented to improve care management of new enrollees, which resulted in a 5.5% decrease in admission rate between 2016 and 2017.
2. Trend: Nurse Practitioners and Physician Assistants were providing Physical Therapy (PT) and billing under PT codes not within the scope of their license. Action: A claims review showed $7,013.96 paid in claims to providers who were not credentialed with BUHP or licensed to practice PT. Therefore, a referral was made to AHCCCS with ultimate investigation to be completed by the Office of Inspector General (OIG).
3. Trend: Overall increase in Emergency Department (ED) utilization. Action: Expanded VBP contracting with ED visit rates as a key performance metric, resulting in decreased ED visit rates among VBP contractors (Figure 1).



4. Trend: Pharmacy costs for diabetic testing increased over time. Action: An exclusive contract with Abbott resulted in a 70% reduction in test strip-related expenses, which has been maintained for more than $1M in annual savings.
5. Trend: Laboratory costs increased over time. Action: Lab Corp contracted rates were renegotiated and, in 2017, an exclusive contract was reached with Sonora Quest Laboratories at a significant annual savings of $1,433,108.
6. Trend: Increased costs due to MRI utilization. Action: Self-monitoring identified gaps in our PA process, which led to re-education of nurse reviewers on MRI criteria and use of MCG Guidelines with subsequent focused IRR auditing. This resulted in greater adherence to evidence-based criteria and fewer inappropriate MRI approvals.
7. Trend: ED utilization in Gila County was out of line with other counties. Action: Discussions within Banner to hire additional primary care providers in their Payson clinic and plan for a fuller service Urgent Care site.

COMPLETE CARE OPPORTUNITIES FOR SYSTEM EFFICIENCY IMPROVEMENTS

In addition to controlling administrative and medical expenses, BUHP believes opportunities exist to control health care costs by decreasing redundancies and system inefficiencies. In preparation for initiation of this transformational contract, BUHP has met with community stakeholders to clarify care coordination roles and responsibilities between provider-based case managers and BUHP care managers to not only decrease administrative redundancies regarding completion of health risk assessments and multidisciplinary care planning, but also to address the concern of members with co-morbid conditions regarding knowing who can provide assistance to help educate, coordinate and secure their chosen services to meet their individual needs. The improved efficiencies of this collaborative approach to care coordination is further enhanced by having one BUHP nurse line to call for all whole person needs and targeting efforts on the less than 1% of members utilizing over 60% of behavioral health services guided by BUHP's advanced predictive modeling techniques. BUHP will continue to work with HSAG's *Care Transitions for Improvement in BH* to share our lessons learned from our successful collaboration with Regional Behavioral Health Authorities and BH providers, which decreased readmission rates for our GMH/SA dual population to less than or equal to 8% through improved screening, care planning and development of effective crisis/diversion plans. BUHP will implement a process of warm handoffs between physical health and BH providers within the first year of the contract to decrease no-shows by increasing the likelihood of follow through with BH referrals. We identified low-cost interventions addressing social barriers to optimal health outcomes, such as food security, that can prevent significant health care expenditures among members living in an identified food desert.

This ACC contract offers additional opportunities to improve health care outcomes, and their related costs, while bending the cost curve by efforts at both the member and population level. Members with chronic physical health conditions due, in whole or part, to past traumatic experiences in their lives will now be more efficiently managed for optimal whole person outcomes by addressing the underlying emotional cause of their physical condition. At the population level we developed and have evolved our Healthy Together Care Partnership (HTCP) to target whole person care for high needs members. Through delivery of both physical and behavioral health within one complete care team this program achieved a 16% drop in ED visits with even more marked improvements in inpatient stays, particularly within chronic disease subgroups such as those with diabetes (29% decrease admissions) and kidney disease (32% decreased admissions).

These are examples of improved efficiencies BUHP has undertaken as part of our Lean Six Sigma program by listening to our members, providers, community partners and employees. In conjunction with our *Neighborhood Advisory Councils* (meeting the RFP requirements of Governance Committees) and hands-on provider partnering, we aim to empower all persons at all levels of the system of care to identify opportunities and act upon them quickly and effectively in order to improve health care delivery, especially during times of transformation. A key partner in these system improvements will be our providers designated as Centers of Excellence (COE) due to their high-quality, comprehensive complete care. Because of their demonstrated expertise as early adopters of complete care, these COEs will be funded to continue their innovation to solve system issues identified within the Neighborhood Advisory Councils, incubating solutions that can then be scaled throughout our *Neighborhood Networks*. These networks are supported by not only the advanced reporting and analytics from BUHP HART, but also the University of Arizona Center for Population Health as an independent trusted steward.

PAST UNFAVORABLE TRENDS WITH STRATEGIES AND SPECIFIC ACTIONS TAKEN

1. Trend of Increased Inpatient Costs: In 2016, the UM Finance Committee identified an unfavorable trend of 6% increase in PMPM costs over 2015 for inpatient care. UM Finance tasked HART to complete an in-depth analysis to identify cost drivers of this increase. This team conducted a detailed analysis and presented their findings to the committee for discussion and decisions regarding actions to be taken to address the identified drivers of this negative trend. The combined strategies and actions taken resulted in a 5% decrease in PMPM inpatient medical spend from 2016 to 2017 for a total annual savings of $3,640,022. Strategies/Action Taken: The first foundational strategy BUHP uses is for HART to analyze trends and identify underlying drivers. In this case, the primary drivers were found to be increased admission rate and increased cost per admission. With an increased cost per admission, the BUHP Claims Recovery Unit then reviewed inpatient DRGs, but did not identify this as a significant driver of this trend. Importantly, there had been no changes in our concurrent review or other utilization management programs during this time, which assured us that all admissions met medical necessity criteria for admission and the length of members' stay. This led us

to focus on a VBP strategy with our network partners. Our VBP relationships with ambulatory providers had evolved beyond the narrow focus on preventive measures to include improved collaborative care processes focused on high-risk members and management of their global medical loss ratio. Tapping into this new capability was one strategy utilized to target specific care management actions aimed at decreasing the use of higher levels of care, such as ED and inpatient facilities. This VBP approach successfully decreased the rates of ED visits (see Figure 1 above), hospital admissions (2.6% decrease among members assigned to VBP contractors from 2016 to 2017) and the cost per admission (6% decrease among members assigned to VBP contractors from 2016 to 2017). These findings were consistent with overall improved care coordination between health plan and provider-based care management activities leading to improved access to care, decreased need for admission and lower acuity of admitted members.

2. Trend of Increased Outpatient Expense Out of Line with Utilization: As we improved inpatient cost trends in 2017, the UM Finance Committee identified an increased cost trend of outpatient services that was out of line with service utilization. Since there had been no change in provider contracted rates, this trend was investigated by our Claims Recovery Unit. One key finding was an increase in the use of "*By Report*" codes, which AHCCCS policy allows to be paid for at 58.66% of billed amount. This led to a number of specific actions, including dialogue with AHCCCS OIG, which resulted in the Director of the Claims Recovery Unit being invited to present our process and findings to the complete OIG team. Under Medicare and Medicaid, an unlisted procedure code and/or a Not Otherwise Classified (NOC) code, indicates to the payer there is no listed/defined code available to bill for the service or procedure performed. If, in the opinion of the provider, there is no defined code, the provider can submit an unlisted or NOC code. Strategies/Action Taken: An analysis of this impact demonstrated that BUHP experienced a 24% increase in the use of BR codes using unlisted and NOC codes in 2016 and 2017 that now total over $60M annually. BUHP's claims system uses nationally and locally acceptable edits that result in a denial of the NOC code (such as maximum unit edits required NDC for drugs edits), but due to the increased volume of such claims, we instituted increased scrutiny. BUHP implemented a new detailed clinical coding review process, which includes checking whether there is clinical documentation to identify, define and support use of the unlisted service; if this service is billable with a listed/defined code; and if the NOC code is medically necessary, investigational or cosmetic. BUHP also defines "excessive" for providers contractually as *"not to exceed 15% of a regionally known amount for a similar listed NOC code"* as these claims often include prices that are many multiples of Medicare acceptable amounts.

3. Trend of Increased Generic Pharmaceutical Prices Out of Line with Utilization: This trend of unchecked pricing increases seen for *By Report* codes was also identified for generic pharmaceuticals. Strategies/Action Taken: In conjunction with our Pharmacy Benefits Manager, MedImpact, we initiated strategies that included an aggressive Maximum Allowable Cost (MAC) List Program for accurate reimbursement of generic and multi-source brand drugs. This included addressing the inadequacy of Average Wholesale Pricing (AWP) for these products and preventing unnecessary pharmacy spend in a manner fully compliant with CMS guidelines and as aggressive as possible with our MAC List process, while allowing the dispensing pharmacy a reasonable profit margin. Ingredient pricing based on AWP; Wholesale Acquisition Cost (WAC), or Federal Acquisition Cost; direct price; or contracted program costs from the wholesalers was reviewed. The hierarchy was based on average price of the Generic Code Number using all manufacturers of the product. Pricing updates are now received from Medi-Span and loaded weekly. The pricing algorithm is based on the lowest, actual acquisition cost readily available to the pharmacy provider community. Calculations are based upon discount percentage from AWP, mark-up percentage to WAC or mark-up to contracted wholesaler program prices as obtained. By using these various methods, MedImpact enables pharmacy providers to readily obtain these drugs at the listed prices. This initiative has saved $2.9M from 1/1/17 through 9/30/17.

CONTINUAL IMPROVEMENTS FOR THE COMPLETE CARE CONTRACT

BUHP's experience as a contractor with AHCCCS and CMS for integrated care in conjunction with our successful launch of the ALTCS Contract has resulted in our systems and programs being fully prepared to implement and manage this ACC contract with precision, while monitoring and addressing negative health care cost trends. Our continual drive to improve, remain at the cutting edge of health care transformation, and self-monitor, combined with our openness to scrutiny by external parties allows BUHP to maintain excellent outcomes and operational precision in its performance as a valued partner with AHCCCS. Together, we aim to pursue multiple long-term strategies that can effectively bend the cost curve, including system alignment and integration, payment modernization, program integrity, health information technology and continuous quality improvement initiatives.

16B. IF BIDDING SOUTH GSA: DESCRIBE THE UNIQUE ASPECTS OF SERVICE DELIVERY TO MEMBERS IN THE SOUTH…

Many Banner-University Family Care (BUFC) employees call Southern Arizona (S. AZ) home and, for some, our roots go back generations. Our S. AZ family histories include mining, ranching and farming. Some of us are native Arizonans from nearby rural communities or American Indian (AI) reservations. We may be from other countries or are new transplants that have come for sun, jobs or academia. Regardless of history or origination, we are part of BUFC because we are passionate about making a difference, especially for those less fortunate. BUFC members are our neighbors, family or friends, and we take our jobs personally: embracing BUFC's persona, named 'Ana,' a single Hispanic mother who navigates a fragmented health care system to care for her family. We have driven every S. AZ backroad and know the towns and residents. In short, we have extensive experience serving S. AZ members and understand the S. AZ delivery system. Over the past 30+ years, we have seen health care change. There are many improvements, but we know provider shortages and fragmented care still persists. As such, we are committed to making life easier for our members, implementing innovative and meaningful solutions for S. AZ ACC members, and recognizing one size does *not* fit all.

SOUTH: UNIQUE ASPECTS TO SERVICE DELIVERY IN THE SOUTH GSA

According to the US Census Bureau, the South GSA spans 33,167 sq. mi., approximately 29% of AZ, with a land area greater than 11 states. Bordered by Mexico, S. AZ has inherent challenges of rugged geography including mountains and vast open desert. The population is culturally diverse with a large immigrant workforce driven by seasonal agricultural opportunities. The population density varies from the least populous county (Greenlee) to the second largest AZ city (Tucson), and this rural to urban dichotomy results in varied "access to care" barriers. The South GSA has the highest percent of Hispanic/Latinos (46.2%), with Santa Cruz County first (83.3%), and 33% of South GSA residents primarily speaking Spanish at home. Unemployment rates in the South GSA exceed national averages, with Yuma ranking as one of the highest in the nation. According to the US Department of HHS, every South GSA county contains areas considered Health Professional Shortage Areas (HPSAs) with shortages of primary care, dental care and/or mental health providers. There are multiple, distinct tribes with reservation lands in remote areas where community infrastructure is minimal. Given our years serving South and Central GSA members, we reviewed BUFC data and by using machine learning and artificial intelligence clustering analyses, three population clusters were identified with differences among their prevalence of chronic conditions. For example, children in Central Pima, North Pima and Pinal counties have significantly more asthma, mental illness and developmental disability than those in Southwestern AZ, South Pima County and Santa Cruz County. Adults in South Pima and Santa Cruz counties have higher prevalence of asthma, mental illness and substance abuse. We also analyzed 65 AZ Community Health Needs Assessments (CHNA) to validate South GSA service barriers and health care concerns. Challenges vary dependent on locale and residents, but in general include:

- Service barriers often cited: access to PCPs, dental, mental health, specialists, pediatric sub-specialists; transportation; rural/geographic isolation; knowledge of available programs/services; severe housing problems; food insecurity.
- Top health care concerns identified: alcohol and substance use; anxiety, depression spectrum; chronic physical health (PH) diseases, such as diabetes, asthma/respiratory and cancer; teen pregnancy, lack of family planning; obesity; traumatic injuries; Hispanic, AI, migrant and refugee population's underutilization of prevention services.

STRATEGIES FOR EFFECTIVE DELIVERY OF SERVICES

Monitoring/Managing Access: To address provider shortages, we are diligent about network adequacy. Our South GSA provider network meets or exceeds AHCCCS requirements for access to care in every case possible, including PCPs, dental, BH, specialists and facilities. We assess network adequacy at least quarterly and take immediate action if a provider change results in a gap. We use Quest Analytics software and tools, such as Medicare.gov, other health plan's provider directories, and Healthgrades.com, to identify new providers. We aggressively pursue contracts and timely authorize out-of-network services or Letters of Agreement. We mandate that our BH homes offer walk-in and after-hour appointments to improve access. We maintain an up-to-date provider database, McKesson, which feeds our printed/online provider directory and provider look-up, so accurate information is available to members and providers. Understanding members' health is affected by beliefs, culture and values, and given the high percentage of South GSA Hispanic/Latinos, our provider directory indicates languages spoken in provider offices. To support members with language barriers, we employ bilingual staff and use interpretive services at no cost, have in-house Spanish translation services to provide immediate written translation services, and schedule telephonic interpreters or in-person sign language services to help with an appointment. We supply health literacy booklets that member's can use when they visit providers and have printed materials in other languages, larger fonts or other formats. We also help members with any other belief systems, abiding by all AHCCCS non-discriminatory requirements.

Banner Delivery System: As a provider-based plan, there are unique synergies between BUFC and the Banner Delivery System, with the delivery system and health plan acting as a safety net in support of the AZ's Medicaid program. Banner recognizes the importance of providing affordable access points for AHCCCS members and is maximizing ambulatory service investments in the South GSA by adding 5 urgent care centers, maintaining and improving 35 provider practices, and engaging in significant PCP expansion in Pima County. These will address provider shortages and reduce an over-reliance on EDs. As an AZ anchor institution, we understand our responsibility to support and revitalize an aging, delivery system infrastructure through community re-investment as demonstrated by Tucson's new Banner-University Medical Center and Outpatient Health Center with projected budgets over $500M. BUFC works with our delivery system colleagues, as well as financially/technically supporting providers who offer integrated care models, or through our Healthy Together Care Partnership (HTCP). HTCP is staffed with Spanish-speaking interdisciplinary team members and began as a primary care at home program. It is funded and managed by BUFC to exclusively serve high-risk members, primarily in the South GSA who have co-morbid BH/PH disorders. To support PCPs in the collaborative care of high needs members, HTCP expanded to a co-management program and is evolving into a hub model to support provider groups statewide. The hub is BUMC and the spokes are strategically located in the South GSA with specific needs/lack of capacity. It provides clinical pharmacy, BH and service navigation to home-based care providers, such as geriatrician Monica Vandivort in Cochise County. This program has shown significant reductions in avoidable hospital services. HTCP also trains medical, pharmacy and nursing students in the art and value of home-based care visits. For continued innovation and collaboration, Banner has launched Affordability and Medicare Advantage Imaginariums, testing real solutions like HTCP-models in Central GSA AZ locales that, once proven successful, are scalable to improve service delivery effectiveness. We will give high-performing providers the flexibility to test theories to support integration.

Innovative Network Design: To address South GSA concerns, BUFC is creating a comprehensive provider network across the continuum that is aligned to bring cohesive *Neighborhood Networks* of care. Neighborhoods will be mapped to align where members reside and seek services to optimize member engagement while addressing the unique strengths, needs, cultural aspects and social determinants of each Neighborhood. Through Neighborhood Advisory Councils, representatives of each Neighborhood will set priorities and goals openly and transparently. Neighborhood Networks will make sure members have access to integrated Health Homes and providers are incentivized to take steps toward integration, such as through expansion of VBP agreements. We have incentives to improve access to care, such as annual PCP visits and 7-day post hospital follow-up. Each Neighborhood will focus on quality improvement and outcomes-driven service provision – participating in Health Current (Health Information Exchange) and gaining access to near real-time, member-specific and population-based data to guide service delivery and programmatic enhancements through our exclusive *Banner Navigation Accelerator* platform. We will contract with Centers of Excellence (COEs) and early adopters of integration models to develop integrated solutions for children and adults with specialized health care needs. We will also engage *Equality Health* to help small provider groups with infrastructure and population health support to participate in VBP arrangements. We will retain and expand these types of partnerships in the South GSA:

Community Health Centers (CHCs): We have strong VBP partnerships with CHCs, several in key border communities. Mariposa CHC exceeded most VBP quality measures and has a nationally recognized Community Health Worker (CHW) program, providing 18,000 CHW visits per year. This is noteworthy given the unique continuity challenges in border communities as members receive care across the border, such as dental and prenatal care. On the Nogales, AZ border, Mariposa acts as a community resource, outreaching and engaging members by attending their appointments with them and facilitating access to other resources. Chiricahua CHC in Cochise County is a top VBP performer and a pediatric COE. One of the most challenged border areas, Yuma, is home to Sunset CHC which, in its first year as a VBP partner, improved its adult wellness visits by 38% and retinal eye exams by 116%, exceeding its goal.

Intermountain Centers (IC): Considered a COE for serving AI members, IC provides culturally aligned services for tribes in the South GSA. For more than 10 years, IC's innovations promoted community-based services on the Tohono O'odham Nation with face-to-face interactions including mobile services and technology-supported access to care, as well as ongoing participation in cultural rituals and events. In addition, IC is a COE for Autism Spectrum Disorder (ASD) and has successfully implemented a demonstration project consistent with AHCCCS' ASD Taskforce recommendations, in partnership with El Rio. This model is being expanded in partnership between IC and SunLife FQHC.

Building BH Capacity: BUFC provides a continuum of BH services to meet members' needs in the least restrictive setting, through the use of intensive community-based services supported by strong partnerships with BH and Integrated Care providers in the South GSA, such as COPE, Marana and El Rio. In alignment with the Arizona Opioid State Targeted Response Grant, BUFC is working to increase Medication Assisted Treatment (MAT) capacity, especially in rural areas as well as specialized programs for pregnant women and justice involved individuals. For example, CODAC provides expert

care for pregnant women who need MAT, which includes routine assessment and monitoring for common medical complications. Other MAT providers include ConnectionsAZ, Community Medical Services and Community Partners, Inc./Assurance Wellness Center with planned expansion for Safford in 2018. Further, BUFC has established partnerships with Independent Peer and Family Run Organizations for employment and rehabilitation services, housing services, and peer and family support services. We will partner with Family Involvement Center (FIC) and MIKID to expand peer and family support services for parents of children with complex needs, such as diabetes or DCS involvement, as well as youth. In addition, to target increased capacity for BHPs and BHMPs, we will provide technical assistance to providers in obtaining the designation of a HPSA and assist with centralized recruitment strategies. Furthermore, we partner with OOH therapeutic providers and target strategies to build capacity and access to care with a focus on members with challenging behavior through intensified staffing patterns in lower levels of care, as there are no BH inpatient facilities (BHIFs) current in the South GSA that serve AHCCCS youth. BUFC will continue to assess the need for this level of care and will consider expansion to the South GSA if needed. We will also work with the 8 Public Housing Authorities who manage over 6,000 HUD housing vouchers regarding public housing options in the South GSA for our members experiencing challenges with securing permanent housing, which is a primary risk factor to overall health and wellness.

Workforce Development: Training medical professionals is key to driving complete care transformation, and we are involved in training many, including: 1) The Tucson/Phoenix Banner-University Medical Educational Complex is training the next generation of providers – such as doctors, nurses, pharmacists and others – to become an integral part of AZ's delivery system. We train more than 720 physicians and 890 nurses annually at our South GSA sites. 2) Banner partners with UA and ASU, and our training programs include innovative and transformation models, such as: Banner University's new pediatric fellowship program focused on serving children with ASD; UA's use of master's level students to increase capacity of BH specialty services, such as Dialectical Behavior Therapy (DBT); ASU's College of Health Innovation and Health Solutions student-run programs, such as the Student Health Outreach for Wellness clinic for the homeless and internship sites for the Doctor of Behavioral Health and Master of Health Innovation Students; and UA College of Public Health's Service Learning Extension Program, which identifies needs in rural communities and implements workforce development efforts. 3) Banner's Simulation Medical Center is a virtual hospital used to train statewide physicians and nurses before they treat actual patients; and 4) We partner with SunLife Home Care to train community health and direct care workers in rural communities and tribal lands.

Oral Health Capacity: Research indicates oral health has a direct impact on improving health, especially for members with Specialized Health Care Needs, such as ASD. To address dentist shortages and the lack of knowledge about available service barriers, we assure the efficient delivery of dental services in the South GSA, such as through mobile dental clinics. We are implementing VBP oral health initiatives to incentivize providers to educate pregnant teens on dental care for themselves and their infant and refer them for a dental well check and cleaning during pregnancy. The goal is to promote caries prevention through member education and fluoride varnish on emerging baby teeth. In CY 2018, we will launch 2 affiliated dental hygiene programs to connect hygienists with pediatric centers to provide oral health screenings and varnish in medical practices. One will be in Yuma and one will be in Pima County.

Transportation: Because each county in the South GSA has areas designated as HPSAs, there will be service gaps and members will need transport to obtain care. We arrange access to care by transporting members to the closest available services through our transportation broker, Veyo. When members call BUFC for transport, they are directly linked to Veyo's dispatch center for service arrangement. During our recent ALTCS implementation, Veyo supplied more than 1,800 ambulatory, 348 wheelchair and 86 stretcher vehicles to serve incoming members, exceeding needed vehicle capacity in most South GSA areas. For contracted BH providers offering transport services, we include same-day transport services in their contracts to address immediate BH needs. Also, when a child must receive critical care away from home, we arrange for a family member to lodge nearby, such as at Ronald McDonald Houses or in a local hotel.

Alternative Care Solutions: To address barriers due to geographic isolation, we will continue to provide PH/BH telemedicine alternatives to increase access to PCPs, BH providers and specialists. We will continue working with local providers to implement home-based care programs, such as our HTCP. Further, BUFC participates in statewide efforts to activate the Treat & Refer (T&R) program, which addresses non-emergent health needs through assessment and referral to a more appropriate level of care (e.g., PCP, urgent care or BH office). As efficient stewards of public funds through the appropriate use of limited resources, we will contract with T&R-recognized providers and, through community reinvestment, will assist others to become T&R certified. As most AI members do not live on reservation lands and, to honor their choice of where to receive services, we will coordinate their care with IHS, Tribes, Tribal Organizations and Urban Indian Organizations (I/T/U) services. We will partner with tribal organizations to support access to culturally relevant services, such as traditional healing.

17. DESCRIBE, IN DETAIL, THE STEPS THE OFFEROR WILL TAKE TO ENGAGE AND COLLABORATE WITH TRIBES FOR…

*"As a 6-year-old, I held a role within my family to act as my **huhhu'ul's** (grandmother's) medical interpreter and guide. My **huhhu'ul** was blind and often needed care from the Phoenix Indian Medical Center (PIMC). For our visits, we'd pack a lunch, leave at dawn and wait for the crowded PIMC shuttle at the Quijotoa Trading Post off of State Route 15. The medical visit was about 30 minutes, but it took all day. On the return trip, I recall praying that our ride back home would already be there for us because I was so afraid waiting in the dark."* Banner-University Health Plans (BUHP) knows similar stories of tribal members across AZ and understands the commitment, coordination and trust needed to become a tribe's and tribal member's valued health partner. We will expand our community resources and sensitivity training to respectfully serve AZ's tribal members. Our Tohono O'odham *storyteller*, Silvia Parra, is also BUHP's Chief Operations Officer. She teaches a master's level American Indian (AI) health policy course at the University of Arizona's (UA) College of Public Health for AI and non-AI students. At BUHP, she has led the Cultural Competency Committee for 7 years.

UNDERSTANDING THE NEEDS OF TRIBAL MEMBERS ON AND OFF RESERVATION

Before we can effectively engage tribes and tribal members, we first need to understand. According to the 2016 U.S. Census Bureau, 71% of AIs reside in urban areas, and 1 in 5 are below the federal poverty level. Since BUHP will serve both on- and off-reservation members, BUHP must engage tribal governments to assure traditional and legal requirements are in place to serve AI members. We understand the complexity of AI health care coverage, including: 1) AI members may choose the AHCCCS Indian Health Plan (AIHP) or an AHCCCS Complete Care (ACC) plan; 2) AI members frequently move on and off reservation due to health needs or/and employment; 3) CRS partially integrated acute AI members may receive acute and CRS-related services from BUHP and receive BH services from a TRBHA; 4) AI members with SMI may select AIHP or ACC, and opt to use a TRBHA or RBHA; and 5) AI members with reservation-based zip codes will be assigned to AIHP, while those living off-reservation will be assigned to an ACC plan unless a tribal member selects AIHP. AI members experience added complexity when moving for a job or living-related need because they must navigate multiple transition-points to access needed services. When relocating off of tribal land, AIs often lose access to Purchased Referred Care (PRC). Since PRC is the funding source for IHS care outside of IHS facilities, AI members may experience service barriers. We understand Urban Indian Center (UIC) offers AI members excellent support and respects the needs of different tribal populations. Support from UICs is especially important when urban AIs are far from home. As we develop programs and enhance our extensive network to improve care on reservations, BUHP will not lose sight of rural and urban AI members' care needs. Also, we understand the profound impact of historical and intergenerational trauma which contributes to risks associated with addiction and self-destructive behavior. As a result, we maintain a provider network that includes culturally relevant and responsive services, such as the White Bison Medicine Wheel and 12-steps. We will also offer alternative providers who incorporate traditional values, rituals and spirituality in healing to strengthen ties to the AI culture to support recovery, such as through our contracted provider Intermountain Centers. We provide high-touch training and technical assistance when an AI youth is moved from a reservation to participate in off-reservation residential treatment programs, helping develop residential treatment provider capacity to respond to unique cultural needs and create a smooth transition home. When services are far from home, we will arrange and provide transportation. Regardless of the situation or location, we stand ready to assist when AI members select BUHP.

ALIGNING TO TRIBAL PRIORITIES AND COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS

To meet AI member's needs, BUHP will align our provider network and care coordination processes. BUHP reviewed the 2017 AZ tribal consultation priorities identified in the annual IHS Budget Formulation process, which include multiple health concerns for AZ tribal members, such as chronic disease management; mental health; health promotion and disease prevention; maternal childhood health care and oral health. The Phoenix IHS Area Summary shares a similar perspective and identifies mental health, hospitals and clinics, continuation of PRC funding, dental, and alcohol and substance abuse as important focus areas. With our long-standing AHCCCS participation, BUHP has historically served AI members, with 2.9% of University Family Care (UFC) and 2.6% of 2016 Maricopa Health Plan (MHP) members identified as AI. Our AI members are, on average, 3-6 years younger than our non-AI members, likely due to migration to urban AZ for higher education or employment. In spite of this younger age, and consistent with tribal priorities and CHNA findings, our AI members have a prevalence of chronic physical (PH) and BH disorders, such as 11% with asthma, 6% with diabetes, 18% with a mental health disorder and 12% with substance abuse. For UFC AI members, there is a higher associated PMPM cost than historical MHP AI members, which may be attributable to lack of comprehensive facilities in the South GSA: The Sells Hospital is located on the Tohono O'odham Nation (TON), only provides primary care services, and is hard for urban or non-TON tribal members to reach; whereas, Maricopa County has the PIMC that receives

appropriations to serve all area AI and is located in an urban area. BUHP's proposed ACC strategies align with tribal priorities and we will proactively work with tribes to address health concerns and decrease service delivery barriers.

STEPS BUHP WILL TAKE TO ENGAGE FOR DELIVERY OF SERVICES TO AMERICAN INDIANS

To honorably serve AI members, we offer our comprehensive BUHP provider network and innovative programs focused on caring for those with higher needs or at higher risk, but we can do more. Due to the complexity of AI eligibility requirements and care coordination, BUHP will develop clinical and non-clinical AI-unique initiatives designed specifically for, and by, AZ tribal members. In addition to extending all BUHP services to support the AI community, BUHP will provide AI members with a unique tribal onboarding experience supported by policies and procedures to assure an appropriate and respectful transition to and from BUHP for ongoing treatment. This will include supplying AI members with a Tribal Resource Kit, which will initially be ready for distribution by 10/1/18. This kit will include: a personal safety checklist utilizing I/T/U best practice approaches; information on access to traditional medicine; tribal-specific 638 programs; IHS direct care, PRC notifications; UIC locations; a wallet-sized card with basic BUHP contact information and a toll-free number they can call to discuss provider billing concerns, especially since IHS is the payer of last resort; health literacy resources; and BUHP services available to all ACC members. Condition-specific health education information will be designed for our AI members to be more pertinent to their situation, thereby improving engagement. Further, by 10/1/19, and each year thereafter, BUHP will amend the Tribal Resource Kit and health education programs to incorporate knowledge gained from collaborative engagements and feedback gathered from listening sessions. As each tribe is considered a nation within the U.S. and retains sovereignty to rule over tribal members and lands, BUHP will support and foster a relationship to engage each tribal government based on tribal practices and as permitted by respective rules of law. Because of tribal sovereignty, we acknowledge the need to first engage that government's leadership. We will reach out and schedule meetings with tribal executives and legislators, anticipating tribal governments will refer us to tribal health programs and/or their Office of the Attorney General. It is also critical for BUHP to engage with Child Welfare Services, to align with the Indian Child Welfare Act. Respectful of each tribe's laws, we will seek Memorandums of Understanding (MOUs) or Tribal Resolutions that grant BUHP and our contracted providers, such as Intermountain (which already offers services on multiple tribal lands), with access to serve AI members on tribal lands. BUHP's goal will be to secure tribal support prior to 9/30/18. BUHP will introduce our Tribal Coordinator (TC), who will schedule listening sessions and assist in setting up service delivery.

Tribal Coordinator Position

The BUHP TC will be a valued team member who brings AZ tribal health care experience; acts as a liaison and interfaces with IHS, Tribes, Tribal Organizations, Urban Indian Organizations (I/T/U), other health plans' TCs and TRBHAs. Our TC will serve tribes in awarded GSAs where care coordination, meetings, relationship building and AI member data-sharing may occur, in accordance with 42 CFR Part 2. The TC will build and establish trusting relationships to facilitate health care conversations. The TC will participate in all AHCCCS Tribal Consultation Meetings, provide data and collaborate with AHCCCS and BUHP leadership to implement changes recommended at meetings. The TC in conjunction with Executive Leadership will hold semi-annual Community Forums with IHS and 638 Tribal Facilities to seek input and assure BUHP remains connected to broader AI issues. Coordination may include discussions with county and state delivery and legal systems. The TC will facilitate coordination of care to include face-to-face meetings with children in culturally appropriate residential facilities located off tribal lands. To broaden opportunity for alignment, the TC will communicate with required government and legal entities as well as IHS and 638 Tribal Facilities to coordinate involuntary commitments for AI members. BUHP will assure member care coordination and continuity for the duration of the Court-Ordered Treatment (COT) and when members transition to services on tribal lands. BUHP recognizes the importance of having processes in place and relationships formed before they are needed. We will maintain open communications with stakeholders, our Court Coordinator and other internal staff, and hold proactive meetings with county, state and tribal government officials, judges, lawyers, attorney generals, providers (Title 36 leads), and jail liaisons so the process works efficiently and tribal members receive timely services. As needed, BUHP will enter agreements with tribes to address BH needs and improve the care coordination for tribal members. BUHP will require providers to follow statute, contract and AHCCCS guidance to develop MOUs when converting orders to sovereign orders and transitioning to services on tribal lands. BUHP's TC will submit a TC Report annually to address all ACC-required components and sentinel events, including justice system deliverables. The TC will be fully supported by BUHP Executive Leadership and incorporated into BUHP operations, such as becoming a member of our Cultural Competency Committee.

Engagement through Training

In alignment with ACC requirements and to enhance engagement, BUHP will offer education and training courses for licensed and unlicensed PH/BH personnel working on tribal lands. The TC will help develop and provide in-service trainings for IHS, tribally operated facility/programs, tribal colleges and Urban Indian Health Program clinics on service utilization and BH resources for AI communities. BUHP will also offer innovative training to drive additional engagement.

Project ECHO: To address tribal priorities, such as mental health, substance abuse, diabetes and oral health, BUHP will tap into Banner's 30-year affiliation agreement with UA to offer **Project Echo** (Extension for Community Healthcare Outcomes) telemedicine training to licensed IHS staff, including Primary Care Providers (PCPs), dentists and prescribers, regarding pain management, use of opioids, co-prescribing of naloxone and evidence-based psychosocial interventions. To be launched before 10/1/18, this guided-practice model aims to increase workforce capacity by sharing knowledge. Specialists at the "hub" site meet with PCPs in local communities via videoconferencing and train PCPs in specialty care service delivery. The ECHO model provides front-line clinicians with the knowledge and support they need to manage patients with complex conditions – in their own communities – to increase access to specialty treatment in rural and underserved areas. BUHP will launch Project Echo with a Pain Management Training. As the tribal priority of substance abuse is highly correlated to chronic pain, we will also partner the UA Center for Integrative Medicine (UACIM), which recently launched a webinar series on Integrative Pain Management. We will offer cutting-edge educational materials to specifically address the opioid epidemic before 10/1/18, in preparation for the ACC launch.

Awareness Training/Resources: In coordination with Banner Health (Banner) and as a way to educate our future workforce on tribal priorities associated with mental health, BUHP will conduct at least 2 adjunct professional lectures per year at tribal colleges to introduce and/or enhance BH curriculum and promote the *12 Guiding Principles of Arizona's System of Care for Children* and *9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems*. The TC will host 2 lectures in non-college settings for Urban Centers and use SAMHSA's Tribal Affairs and Tribal Training and Technical Assistance Center to identify evidence-based practices and BH Toolkits. These will be available to unlicensed staff in suicide prevention, health and wellness, and other issues requested by tribes. BUHP will also develop and provide training and education for PH/BH personnel on multi-agency, government involvement in health and legal systems, including the COT/COE involuntary commitment process, using UA Health Sciences Library health literacy experts as a resource by 12/1/18. AHCCCS AIHP program staff experts will be consulted throughout the process.

Telehealth Technology Training: Telehealth services are a proven solution, but personnel need training at IHS sites to facilitate service delivery. By 9/30/19, BUHP will partner with contracted providers with expertise on tribal lands, such as SunLife, to provide AI PH/BH personnel with tele-paraprofessional training using technology, such as tribal attendant care services. These efforts will enable IHS sites to tap into 20+ years of experience from UA and BUHP collaboratively developing and delivering telehealth solutions. For example, UA psychiatrists have identified travel to tribal lands for in-person consultation combined with telemedicine visits as the best practice for optimal engagement and positive outcomes. In conjunction with UA and Banner, BUHP will support the expansion of AZ telemedicine from the current programs for mental health, childhood asthma and cardiology.

Other Engagement Activities

Provider Guide: Ms. Parra, in conjunction with an AI graduate student, Heidi Dugi, already developed a *Provider Guide* for coordination of care and benefits for AIs using a storytelling approach that has been disseminated to over 250 statewide providers in 2017. To respond to the upcoming system transformation, by 1/31/19, we will update this guide to reflect important tribal facility and BH information. The Guide will continue to be distributed to tribal and non-tribal providers, hospitals, ambulance companies and other stakeholders on and off tribal lands.

Pilot Programs to Facilitate AI Engagement: Through an **exclusive agreement with Equality Health**, a company driven to organize a better health care delivery system for cultures that have struggled integrating into the traditional one-size-fits- all system, BUHP will launch 2 innovative pilots aimed at expanding AI access to services. The first innovative engagement features a mobile app to support AI youth in residential placements off tribal lands. The app will contain AI-relevant BH information and, as these AI youth transition back into their communities, they can engage their mobile device to learn, in a culturally sensitive manner, about management of BH conditions, such as depression. The second innovative pilot will supply tablets and tele-communication to Community Health Representatives (CHRs) and Peers to connect high risk members with needed services, especially when they are unable to show-up for scheduled appointments. In coordination with I/T/Us, CHW/CHRs will visit tribal members in their home or local health clinic and via the tablet and Skype or telemedicine link, connect an AI member to providers. We will launch both pilots by 7/1/19.

Banner Delivery System Training: In collaboration with our Banner corporate education department, we will launch a Banner-AZ delivery system employee and provider training on cultural competency for special populations, including AI members, to go into effect by 4/1/20. During the first year of our ACC Contract, BUHP will also deploy a *Coordination of Care* learning module for Banner EDs so they better understand tribal care coordination, which includes critical steps to timely inform tribal members' payer systems and assure appropriate referrals and/or transitions are communicated to PCPs. It will be available to EDs as a segment of provider education. With the successful launch of these culturally sensitive Banner trainings, we will also distribute these trainings to our contracted providers by 12/31/20.

BUHP Employee Awareness/Understanding: BUHP trains all employees on cultural sensitivity; health care and traditional beliefs; barriers and risks in accessing health care; and social determinants of health (SDOH) that may impact optimal health outcomes. Incorporating and complying with all ACC Contract elements, such as "Collaboration with Tribal Nations and Providers," our expanded training will include: 1) the importance of traditional medicine in native communities; 2) How BUHP will not impose fees on AIs served by an AI health facility, IHS facility, a tribally operated 638 health program or I/T/U; 3) BH services will be offered to AI members on and off reservation; and 4) BUHP payment responsibilities for BH services provided to AI members by an IHS or 638 Tribal Facilities, unless the IHS facility is a contracted provider. Also, the TC will annually update training to reflect insights garnered in the prior year, changes in programs and new opportunities to serve AI members. The TC will present quarterly to BUHP's Operations Leadership so all leadership levels are engaged on issues and solutions related to tribal health care. Special training will be offered to employees in contact with AI members and providers, including Provider Relations, Contracting, Care Management and Customer Service, so they understand unique circumstances, such as AI members who live in traditional dwellings or remote locations (e.g., lack of plumbing). To increase understanding of transport barriers for member-facing employees, we will supply tribal land road maps to describe access to AI villages (e.g., roads have washes or are unpaved).

Health Information Exchange: To improve communication through use of **Health Current** (HIE), BUHP will collaborate with AHCCCS, IHS and 638 Tribal Facilities to improve care coordination, health outcomes and information sharing. Recognizing past data breaches may result in reluctance of some tribes to share health information with non-tribal entities; BUHP will form trusting relationships with tribes where data sharing may occur in the future.

Out-of-Home (OOH) Therapeutic BH Services: We prioritize community-based services, but when OOH services are needed, we utilize providers such as Intermountain Centers with specialized expertise in culturally aligned care that includes transition planning to support member's successful return to their communities. BUHP will enter into Letters of Agreement (LOA) when the need for a non-contracted provider is the best choice for the member.

Tribal Radio: The TC will coordinate outreach to tribal stations, such as KOHN on TON, to offer educational public service announcements. The TC will also offer various BUHP subject-matter experts to participate in radio interviews, who could discuss pertinent health topics – such as the opioid epidemic, fetal alcohol syndrome or diabetes – or could provide basic information on what a tribal member can do when they receive a bill from a provider.

PROCESS FOR IDENTIFICATION (ID), ESCALATION AND RESOLUTION OF SERVICE DELIVERY BARRIERS

Process to Identify Service Delivery Barriers On and Off Reservation

A primary process to identify (ID) AI service barriers will be through BUHP Tribal Community Forums (TCF) with the IHS and 638 Tribal Facilities to build trusting relationships and discuss barriers to service delivery on tribal lands. We will invite the 2 major urban centers in Phoenix and Tucson, providers, tribal members, family advocates and peers, all AHCCCS health plans, and tribal elders. We will have tribal translators' on-hand to assist. These will begin during the first year of the contract, be facilitated by our TC and PH/BH leadership in awarded GSAs, and will include access to and quality of care discussions. Jointly, we will develop methods to ID, report and track barriers. Our TC will attend AHCCCS Tribal Consultation meetings, ad hoc meetings and non-tribal meetings, and request standing agenda items on service delivery barriers on the Tucson Indian Center agenda and the Native American Connections agenda. Additional barrier ID may come from tribal and federal agencies, including law enforcement agencies, as well as via AHCCCS, governor's office, congressional office or advocacy organization complaints, concerns or notifications. BUHP will also utilize internal ID processes, including AHCCCS-required quarterly network adequacy analyses and appointment availability monitoring; tracking of out-of-network (OON) Prior Authorization requests; monitoring volumes of OON LOAs; tracking pharmacy utilization; monitoring member grievances; members reaching into the call center with concerns; our care managers/other employees identifying a service barrier as they interact with AI members; and providers or their case managers notifying us of service barrier concerns. We may identify service barriers via AHCCCS notification of providers closing or stopping needed services. We will also use data gathered by our Healthcare Analytics and Reporting Team (HART) to analyze data sources that can further ID service barriers. Working with Medical Management and Finance

Departments, BUHP closely monitors PMPM and service costs, and utilization trends, including monitoring AI member subpopulations. The TC and UM Finance Committee monitors AHCCCS enrollment, Blind Spot and PMMIS data, and Health Current to check other state agency involvement. The TC will also collect information from IHS, SAMHSA and other data sources to ID service gaps. Tribal participation in our advisory and advocacy councils will provide insights that may require analysis to ID solutions. Further, our partnership with AZ Center for Rural Health and UA College of Public Health will offer insight to PH, BH and access to care issues in Critical Access Hospitals, such as Parker Indian Health Center. We will research and review publications, such as tribal priorities documents, IHS reports, CHNAs, US Census Data, Robert Wood Johnson Foundation reports and other well-respected data sources to assist with barrier ID.

Processes to Escalate When Service Delivery Barriers are Identified On and Off Reservation

BUHP's process to escalate will vary, dependent on the service delivery barrier identified. If an AI member has a personal crisis or immediate care need, members and their families are able to immediately reach into BUHP via our customer care center or 24-hour nurse triage line, which includes access to BH providers around-the-clock. If there is a Quality of Care (QOC) immediate jeopardy concern, BUHP will deploy our 24-hour QOC team to investigate. If a service barrier is identified due to a community crisis, we will deploy teams to assess and respond. For community crises on tribal lands, it is unlikely the tribe will contact AHCCCS, rather they may contact IHS. Upon BUHP notification, we will immediately notify AHCCCS. Our TC will reach out to tribal officials to coordinate a timely response. We will also supply tribal leaders with a direct line to BUHP's TC, who will have a direct line to BUHP's Executive Leadership to facilitate rapid response. To support service barriers identified during routine operations, an AI Service Delivery Barrier Reports will be reviewed at QMPI and Network Strategy Committees. The TC Inventory developed during the course of engaging and collaborating with tribes will be a source of external information to help identify escalating problems on and off tribal lands.

Processes to Resolve When Service Delivery Barriers are Identified On and Off Reservations

Using the information gathered during escalation, we will formulate action steps and develop solutions with the tribal community and stakeholders to create longer-term solutions. To resolve an AI member's personal crisis or immediate care needs, around-the-clock, BUHP employees and clinicians will guide AI members. To resolve immediate jeopardy concerns, our 24-hour QOC team addresses immediate needs, such as transferring institutionalized members to other locations. To resolve community crises or unexpected events, we rapidly deploy teams to respond. For example, should a wildfire result in a barrier, BUHP will deploy our Continuity of Operations and Recovery Plan (COOP), with our well-trained employees implementing a COOP incident command and taking rapid steps to address the incident. During last year's Sawmill Wildfire, we reached out to members in affected areas to assure services (including critical prescriptions) were supplied. For community crises on tribal lands, upon notification, BUHP will notify AHCCCS and quickly reach out to affected members, providing support or guidance. Our TC will have a direct line to BUHP's Executive Leadership to facilitate a rapid response, including deploying our Los Bomberos team, which we successfully used during our ALTCS implementation. For barriers identified during routine operations, BUHP will seek out and timely contract with providers to resolve concerns. When contracted providers are not available, BUHP will make alternative arrangements, such as providing non-emergent transportation, authorizing OON services or entering into LOAs with non-contracted providers.

Long-Term AI Service Delivery Barrier Resolution

Our affiliations and continuous learning philosophy allows us the unique opportunity to form creative partnerships to resolve barriers, such as supporting the Graduate Medical Education (GME) program. Our relationship with Banner University Medical Group (BUMG) provides first-hand knowledge of newly relocated graduates, who rotate through the GME program annually to gain first-hand experience with vulnerable and complex patients needing more than typical primary care. BUHP offers provisional credentialing to new graduates and relocated providers working in underserved communities. We also offer training to providers so they may hire and train paraprofessional AI staff to help them gain expertise serving members on and off tribal communities. Finally, BUHP has been a long-standing signature sponsor of AZ Special Olympics (SO), contributing $35,000 in 2017, with our employees volunteering many hours at SO events. Through this significant community re-investment, we supported 1,298 AZ AI Special Olympic athletes in 2017 alone, thus demonstrating our deep commitment to Arizonans and directly benefitting AZ's AI community. Through these actions, we build AI community resources and remove service barriers for the long term, while respecting traditions and processes that already work well. As Silvia, our storyteller states: *As a mother with growing children, it's important to share that my children receive exemplary care through the San Xavier Clinic. My experience with tribal health reflects my dedication to the I/T/U and informs my interaction with my peers in regard to integrating BUHP and I/T/U."*

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

    Banner – University Family Care Plan is a category 1, current AHCCCS Contractor. As such, AHCCCS will review the most recent Acute Care Operational Review (CYE16). Therefore, no submission for number 18 is required.

Oral Presentations

The following Banner – University Family Care Plan individuals will be participating in the AHCCCS Complete Care Oral Presentations:

Kathleen Oestreich
Chief Executive Officer

Mary Consie
Chief Administrative Officer

Silvia Parra
Chief Operating Officer

Thomas Ball, M.D.
Chief Medical Officer

Sandra Stein, M.D.
Medical Director

Kristin Frounfelker
Behavioral Health Director

KATHLEEN OESTREICH

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PROFESSIONAL BACKGROUND

An executive leader with over 40 years of healthcare experience. Significant experience in managed care, AHCCCS and Medicare Advantage plan operations, population health, academic and private practice management, health care budget and reimbursement management, leadership and staff development. Unique experience in designing and leading a health care COOP in Arizona (starting an insurance company from the ground up). Leading organizational strategic planning and implementations, consultant to health systems and health plans across the U.S. Innovative leader who focuses on the person first, solving problems with realistic achievable solutions.

ACCOMPLISHMENTS

- Healthcare Heroes – Innovation Award, Phoenix Business Journal, October 2014
- AZ Business — Economic Engines of Arizona Award, October, 2006
- Inside Tucson Business —Woman of Influence Award, July 2005
- Quality, Performance, Incentive – The Keys to Staff Compensation Today's Healthcare, Sept/Oct 1995, In Focus Newsletter, MGMA 1995
- Creative Approaches to Human Resource Management Today's Healthcare, May 1995

EXPERIENCE

2017-Present Banner - University Health Plans Tucson, AZ

Vice President/Chief Executive Officer

- Leads B-UHP operations, fiscal performance, strategic growth and development.
- Serves as Member of Senior Management for the Banner Health Insurance Division and a member of Banner Health Senior Leadership.
- Reports to Banner - University Health Plan Board of Directors and Banner Health Network President.
- Provides leadership to the Banner Health system related to successful integration of Medicaid Health Plan operations within the clinical delivery system.
- Leads an organization with a strong member centric focus and value system ensuring all actions support a positive member experience.
- Leads a quality assurance and customer service culture ensuring all leaders and staff focus on "best possible performance", high member, provider, and employee satisfaction.

2016-2017 Banner Health Network Phoenix, AZ

Chief Operating Officer

- Oversees key third party administrator operations
- Leading development of an organizational process culture that will lead to predictable, sustainable outcomes that ensures strong strategic partner satisfaction, strong financial viability and member and employee satisfaction

- Leading the Operation Simplify and Standardize initiative to improve use of resources while improving overall work environment experience
- Oversees development and ongoing management of Banner ACO networks
- Ensures alignment of Banner Health Network Operations with Banner Corporate departments including dotted line reporting of Population Health Information Services leadership to the COO
- Leading the integration of acquired physician groups into Banner Health Network operations using a best practice approach to evaluating existing operations and integration of acquired operations.
- Works collaboratively across Banner Health with all levels of leadership as well as interacting with Banner Boards

2011-Present Eastwick Strategy Group

Partner

- Expertise in health plan and health care executive management.
- Expertise Medicaid, Medicare Special Needs, and Commercial Exchange Products
- Interim organizational leadership capabilities.
- Assistance in preparing for and responding to competitive Requests for Proposals to secure government contracting for small to medium size health plan organizations.
- Specific expertise in operating health plan organizations within an integrated delivery system and academic teaching organization.

2011-2014 Meritus Mutual Health Plan/Meritus Health Plan

Chief Executive Officer

- Authored the HHS FOA Application that resulted in a $93 million loan award to Compass Cooperative Health Network (Meritus). The Loan award provided $21 million in start-up funds and $73 million in solvency reserve funds allowing Meritus to start Arizona's newest insurance company.
- Meritus sold HMO and PPO individual and small group products on the Federal Marketplace as well as through non-exchange traditional commercial sales channels.
- Oversee the development, implementation, and initial operations of Meritus.

2003-2011 University Physicians Health Plans

Chief Executive Officer

- Led the Plan's growth from 20,000 lives in 2003, 44,000 lives in 2005, 52,000 lives in 2008, 132,000 lives in 2010.
- Served as Member of Senior Management Team of UA Healthcare (formerly University Physicians Healthcare).
- Reported to University Physicians Health and Maricopa Integrated Health System Board of Directors.
- Provided leadership to health system related to integration of Health Plan across hospitals and providers.
- Provided executive management of Maricopa Health Plan for Maricopa Integrated Health System.

- Provided Strategic Planning and Business Development for UA Healthcare and Maricopa Integrated Health System.
- Developed a customer service culture for members, providers, and colleagues.
- Developed an accountable, measured employee performance management planning structure.
- Promoted a continuous process improvement work environment and developed excellence in Plan performance through the use of cross functional leadership and teams.

EDUCATION AND TRAINING

1987 University of Wisconsin-Madison

- Graduate Studies
- Budgets/Budgetary Planning and Control in Health Care Institutions

1979-1983 Milwaukee Area Technical College

- Accounting and Personnel Management

1976 Milwaukee Area Technical College

- Associate Degree – Health Sciences

MARY CONSIE

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PROFESSIONAL BACKGROUND

Over 23 years' experience, including over 19 years' experience in Medicaid and Medicare managed care. Have held multiple leadership roles in strategic planning, business development, compliance, government programs oversight (Medicare and Medicaid), network development, contracting, and provider relations.

ACCOMPLISHMENTS

- Created and implemented an integrated health plan compliance program and compliance infrastructure to support compliant Medicare, Medicaid and Marketplace Government Programs.
- Led successful new award of Arizona long-term care Medicaid product for Banner-University Health Plan. Awarded contract for 10 Arizona Counties.
- Led successful re-award of Arizona Medicaid product for both University of Arizona Health Plans and Maricopa Integrated Health Systems. Awarded expansion to 11 Arizona Counties.
- On behalf of UAHP, led joint partnership venture between UAHP and Cenpatico Integrated Care (CI). Through this joint partnership, bid and won AHCCCS integrated bid for Southern Arizona.
- In support of Medicare D-SNP bids, led two successful Arizona provider network expansions in 2010 and 2014.

EXPERIENCE

2015-Present University of Arizona Health Plans Tucson, AZ

Chief Administrative Officer

- Leads and ensures the production of desired results associated with health plan-wide strategic goals, business development, government programs and regulatory compliance. For these areas, leads the development, implementation, and oversight of standards, systems, policies, and procedures.
- Advises the health plan's Board and senior management team on matters related to administrative operations and regulatory compliance. Serves as compliance advisor to the Banner Health Network and Banner Plan Administration Board and senior management team.
- Ensures successful business development outcomes, including retaining and expanding government program contracts, such as Medicaid and Medicare program contracts, as well as expanding government program opportunities into new markets and lines of business.
- Oversees contractual, operational and regulatory compliance initiatives, including promoting high compliance expectations and readiness for regulatory oversight as well as ensuring effective lines of communication are in place for employees.

- Promotes high performance expectations for the leadership and management teams consistent with the health plan's strategic and business plans, regulatory compliance, as well as with the triple aim of improving the experience of care, quality of care and efficiency of care. Sets clear expectations and holds team members accountable for producing desired outcomes. Motivates and develops team members and promotes teamwork.
- Develops and maintains positive relations with all health plan stakeholders and facilitates implementation of health plan cultural initiatives. Ensures and fosters a high level of collaboration within a highly matrixed team environment in order to coordinate activities, review work, exchange information and resolve problems.

2014-2015 University of AZ Health Network Tucson, AZ

Interim Chief Compliance Officer

- In addition to the University of Arizona Health Plan compliance responsibilities (detailed below), oversaw The University of Arizona Health Network's (UAHN's) compliance for the health care delivery system. This included creating, implementing and maintaining a compliance program that addressed the seven elements of the federal sentencing guidelines and ensuring a strong culture of compliance throughout UAHN.
- Developed and conducted an annual risk assessment to determine organizational risk and developed and implemented an auditing and monitoring work plan to oversee areas of identified risk.
- Built, implemented and maintained corporate compliance processes including: Annual Conflict of Interest Attestation, Non-Monetary Compensation, Intermediate Sanctions, Business Associate Agreements.

2013-2015 University of AZ Health Plans Tucson, AZ

Vice President, Compliance & Audit

- Oversaw UAHP's contractual, operational and regulatory compliance for Medicare, Medicaid and Marketplace.
- Acted as Compliance Officer and Privacy Officer for Medicare and Medicaid. Responsible for overall Health Plan compliance with all federal and state statutes, regulations and contract compliance. This included compliance with conflicts of interest prohibitions both financial and ethical, Medicare and AHCCCS fraud and abuse regulations, HIPAA and privacy compliance.
- Implemented an annual Health Plan Compliance Program to ensure compliance with federal and state law as well as CMS and Medicaid required compliance components. Create and foster a culture of compliance.
- Developed and conducted an annual Health Plan risk assessment to determine Health Plan risk and developed and implemented an auditing and monitoring work plan for areas of identified risk.

2011-2013 University of AZ Health Plans Tucson, AZ

Director, AHCCCS Programs & Compliance

- Acted as UAHP's Compliance Officer for Medicare and Medicaid, including compliance with all federal and state statutes, regulations and contract compliance.

- Oversight of the Health Plan's operational and contractual oversight of the Medicaid program including audit project management and assuring optimal contractual performance in all areas of the health plan, establishing and maintaining positive relationships with Medicaid regulators.

2008-2011 University of AZ Health Plans Tucson, AZ

Director, Network Development

- Overall responsibility for the Network Development Department, including budget preparation and management of contracting, provider relations staff and database employees.
- Oversaw contracting strategy and negotiation of all provider contracting, network analysis and maintenance, contractual rate analysis and goal setting.
- Participated with plan management in business strategy development and managed care operations.
- Facilitated consistent provider education. Acted as a liaison to other plan departments on behalf of contracted providers. Developed and implemented programs to improve provider satisfaction.

EDUCATION AND TRAINING

1998 University of Phoenix Phoenix, AZ

- Bachelor of Science, Business Administration
- Summa Cum Laude

2006 Arizona State University Phoenix, AZ

- Bachelor of Fine Arts, Sculpture
- Summa Cum Laude

CERTIFICATIONS

Certified, Healthcare Compliance (CHC), Health Care Compliance Association, 2012. Re-certified 2014 and 2016.

SILVIA L. PARRA

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PROFESSIONAL BACKGROUND

I have an extensive background in Health Care Operations including Health Plans, Public Health and Hospitals/Clinics.

ACCOMPLISHMENTS

I have consistently been promoted within my respective assignments based on my ability to engage work teams on improving production and service.

EXPERIENCE

06/16 - Present University of Arizona Health Plans Tucson, AZ

Chief Operations Officer

- Responsible for functions and deliverables of the Health Plan Call Center
- Oversight and responsibility of the Grievance and Appeals Department including regulatory deliverables
- Oversight and responsibility for the Marketing Department including websites, member and provider communications, regulatory approvals and distribution of materials
- Direct oversight and supervision of Member Outreach
- Oversight and Responsibility of the Claims Department
- Direct and facilitate organizational workgroups
- Responsible for ensuring facility, maintenance and upkeep of Elvira facility.

05/15 – 06/16 University of Arizona Health Plans Tucson, AZ

Director of Operations

- Responsible for functions and deliverables of the Health Plan Call Center
- Oversight and responsibility of the Grievance and Appeals Department including regulatory deliverables
- Oversight and responsibility for the Marketing Department including websites, member and provider communications, regulatory approvals and distribution of materials
- Direct oversight and supervision of Member Outreach
- Direct and facilitate organizational workgroups
- Responsible for ensuring maintenance and upkeep of Elvira facility.

10/11 – 05/15 University of Arizona Health Plans Tucson, AZ

Customer Care Director

- Responsible for Call Center and Enrollment Operations
- Chair the Cultural Competency Committee
- Develop and manage the departmental budget
- Develop education material for membership
- Write and develop the membership newsletter
- Create membership communication
- Responsible for development of the membership handbook
- Actively participate in inter-departmental workgroups
- Responsible for a multitude of contractual and compliance deliverables
- Maintain a high membership satisfaction rate 93% and above
- Rated as the highest performing customer service department by AHCCCS.

12/07 – 10/11 University of Arizona Health Plans Tucson, AZ

Member Services Manager

- Manage departmental hiring and training of staff
- Maintain and monitor quality measure required for Medicare/Medicaid/AHCCCS reports
- Maintain and develop internal and external communication and education material
- Develop and update policies and procedures
- Develop and manage departmental operational budget
- Provide continuing education to staff on member services and benefits
- Provide outreach resources and benefit advocacy for members
- Submit grievances on behalf of members
- Seek reimbursements for health care costs absorbed by members
- Research denied medical claims.

06/04 – 06/07 Tohono O'odham Nation Sells, AZ

Chief Administrative Officer

- Developed financial and budget projections for Government Operations and Districts
- Provided direct supervision to General and Administrative Services of Executive Branch
- Evaluated funding effectiveness
- Developed program standards and created policy
- Planned program staffing and financial growth for elected officials
- Responsible for grants and contract agreements with state and federal government
- Developed annual budget policies, budget proposals and presented for appropriation

- Provided technical and financial assistance to Tri-branch and local governments
- Presented the Governmental Single Audit to elected officials
- Provided financial education to districts and programs
- Provided financial oversight to the Tribal Emergency Response Committee
- Addressed constituency and programmatic service issues on behalf of the Chairwoman and the Budget & Finance Legislative Committee.

10/99 – 06/04 Tohono O'odham Nation Sells, AZ

Executive Director of Health and Human Services

- Directed the Health and Social Services Departments for the Tribe
- Coordinated services and programs between the distinct Internal Providers
- Developed relationships with County, State and Federal Agencies
- Researched and recommended Health and Social Initiatives to the Elected Officials
- Addressed program concerns and initiatives directly to the Districts
- Recommended and implemented budget proposal for the Department
- Established policies and procedures for the Department
- Enforced regulations applicable to Health and Human Services
- Developed accountable quality measures of programs and services
- Organized and completed a tribal health assessment
- Actively participated in Budget Consultation with the Indian Health Service
- Represented Southern Arizona Tribes in the Indian Health Service Business Plan
- Conducted a Health Needs Assessment in Sonora, Mexico with Tribal Members
- Coordinate Health Services with Mexican Healthcare Providers
- Actively Participated in events involving access to care in Border Communities
- Participated on the Tribal Emergency Response Committee
- Developed the Domestic Violence Program
- Implemented a criminal and background clearance program for staff working with children and vulnerable adults.

08/95 – 10/99 Northwest Medical Center Tucson, AZ

Hospitality Director

- Provided Leadership to non-clinical departments in the facility
- Maintained and controlled financial system utilizing cost accounting
- Developed cost savings measures
- Developed and facilitated patient centered care delivery systems
- Developed satisfaction surveys
- Developed an effective "Safety Management" plan for the facility
- Participated successfully in the JCAHO process

01/93 – 08/95 The ServiceMaster Company Irvine, CA

Education Manager

- Facilitated Education Workshops for Corporate Clients
- Developed Education Plans and Needs Assessments for Managers
- Developed Education Curriculum
- Provided Accreditation Training for Health Care Facilities
- Developed Data Driven Management Measurements with Health Care Facilities
- Facilitated Sessions in Communications Skills, Change Management, etc.
- Presented Sessions on an array of Safety Management Practices
- Coordinated the Corporate Training Academy
- Assisted in the Recruiting Process for Management Personnel

EDUCATION AND TRAINING

1999-2001 University of Phoenix Tucson, AZ

- Master's in Business Administration

1980-1985 University of Arizona Tucson, AZ

- Bachelors of Science in Business Administration

CERTIFICATIONS

1995-1996 University of Phoenix Los Angeles, CA

- Total Quality Management Certification

THOMAS M. BALL, M.D., M.P.H.

2701 EAST CALLE LOS ALTOS • TUCSON, ARIZONA 85718 •

520-874-3362

THOMAS.BALL@BANNERHEALTH.COM

PROFESSIONAL BACKGROUND

Executive level medical professional with over 25 years of clinical and program development/oversight experience in academic and private practice settings located in both urban and rural Southern Arizona. Administrative experience includes leading the medical management department of a rapidly growing Medicaid health plan, which includes overseeing and leading medical management and quality improvement programs, as well as chairing medical/clinical committees within a managed care setting. Innovations include building a collaborative value-based network of patient-centered medical homes serving over half our membership and creating an interprofessional care team for high risk patients within our integrated health system. Graduate training in Epidemiology and Biostatistics supports a new role in population health management for both Medicaid and Dual-Eligible Medicare health plans. Board certified in pediatrics, Spanish-speaking, and experienced in delivering cross-cultural healthcare in Latin America, Africa, and along the Arizona-Mexico border.

ACCOMPLISHMENTS

Publications (selected from over 30) as follows:

Ball TM, Serwint JR. Missed opportunities for vaccination and the delivery of preventive care. Archives of Pediatric and Adolescent Medicine. 1996;150:858-61.
Ball TM. Childhood immunizations: beyond HEDIS. American Journal Managed Care. 1996;2:1337-40.
Wahl RA, Sisk DJ, Ball TM. Clinic-based screening for domestic violence: use of a child safety questionnaire. BMC Medicine 2004, 2:25
Ball TM. Invited Review: Cortisol circadian rhythms and stress responses in infants at risk for allergies. Neuroimmunomodulation 2006; 13(5-6):294-300.
Ball TM, Castro-Rodriquez JA, Griffith KA, Holberg CJ, Martinez FD, Wright AL. Siblings, day care attendance, and the risk of asthma and wheezing during childhood. New England Journal of Medicine 2000;343:538-43.
Ball TM, Shapiro DE, Monheim CJ, Weydert JA. A pilot study of guided imagery for the treatment of recurrent abdominal pain in children. Clinical Pediatrics 2003;42:527-532.
Ball TM. Invited Commentary on *Comparison of racemic albuterol and levalbuterol for treatment of acute asthma*. Evidence-Based Medicine 2004; 9(3):76.
Ball TM. Invited Commentary on *The addition of peak expiratory flow monitoring to symptom-based self-management did not enhance outcome in children with asthma.* Evidence-Based Medicine 2005; 10:87.

EXPERIENCE

2007-2008, 2010-2015, 2018-Present University of Arizona Health Plans Tucson, Arizona

Chief Medical Officer
Included all responsibilities of CMO for two Medicaid health plans.

2015-2017 University of Arizona– Banner Health Plans Tucson, Arizona

Medical Director for Population Health
Includes all responsibilities of Medical Director for Population Health.

2005-2007, 2008-2010 University Physicians' Health Plans, Tucson, Arizona

Medical Director
Included all responsibilities of medical director for two AHCCCS health plans.

2006-2011 Casa de los Niños, Tucson, Arizona

Medical Director
Provided direct clinical care and administrative oversight for health clinic co-located in a shelter serving abused and neglected children in Southern Arizona.

1997-Present University of Arizona College of Medicine, Tucson, Arizona

Assistant, Associate, and Full Professor of Clinical Pediatrics
Provided direct clinical care, graduate level training, administrative oversight, and completed research within the Department of Pediatrics. Directed training curricula in evidence-based medicine and provided care within the Pima County Juvenile Detention Center.

1991-1996: Thomas-Davis Medical Centers, Tucson, Arizona;

Pediatrics
Provided direct clinical care and served as Director of Clinical Outcomes and Guidelines Committee, aimed at improving care protocols for chronic health conditions.

1990-1991: Blantyre Adventist Hospital, Blantyre, Malawi; East Africa

Pediatrician
Provided direct clinical care in hospital, clinic, and rural settings.

1986-1990: National Health Service Corps, Nogales, Arizona

Provided direct clinical care as a solo practitioner within private practice option of NHSC in hospital and clinic settings.

EDUCATION AND TRAINING

1994-1997 University of Arizona Tucson, Arizona

M.P.H., Epidemiology

1983-1986 Children's Hospital of Los Angeles Los Angeles, California

Pediatrics Internship and Residency

1979-1983 Tulane University School of Medicine New Orleans, LA

M.D.

1974-1978 Johns Hopkins University Baltimore, Maryland

B.A., Natural Sciences

CERTIFICATIONS

AZ #16198 since 1986

Pediatrics, Board Certified since 1987

PROFESSIONAL AFFILIATIONS

2009-Present: Board Member, Nurse Family Partnership-Pima County

2010-2011: Associate Residency Director, Department of Pediatrics, University of Arizona

2009-2012: Director, Department of Pediatrics Journal Club, University of Arizona

2008-2012: Member American Academy of Pediatrics Section on Epidemiology
2007-2010: AZ AAP Liaison for Child Care & Early Childhood Education

2000-Present: Instructor, University of Arizona College of Public Health

1994-2011: Recipient of grant funding from NIH, AAP, HRSA, & PCORI

1997-2010: Journal reviewer for multiple health care journals

SANDRA J. STEIN, M.D.

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SANDRA.STEIN@BANNERHEALTH.COM

PROFESSIONAL BACKGROUND

Executive level medical professional with over 20 years of experience including clinical and administrative responsibility at the Regional Behavioral Health Authority (RBHA), State of Arizona and provider level. Administrative experience includes psychiatric leadership roles in Quality Management (QM)/Performance Improvement (PI), Utilization Management (UM)/Utilization Review (UR), Care Management, implementation of Evidence-Based Practices (EBPs), Trauma Informed Care (TIC), collaboration with members, families and key stakeholders/state agencies and training. Innovations include leadership roles in developing programming to meet the behavioral health needs of members with complex conditions which lead to reduced psychiatric hospitalization and crisis utilization and development of an integrated care demonstration projects for youth with Autism Spectrum Disorders. Board Certified include General and Child and Adolescent Psychiatry. Selected for and successfully completed the National Council of Behavioral Health Psychiatric Leadership Program.

EXPERIENCE

October 2017-Present University of Arizona– Banner Health Plans Tucson, Arizona

Medical Director of Care Integration
Includes all responsibilities of Medical Director for Behavioral Health Services and Complete Care.

October 2015-September 2017 Intermountain Centers, Tucson, Arizona

Chief Medical Officer(CMO)
Included all responsibilities of CMO including psychiatric oversight of all psychiatric services, outpatient services and therapeutic out-of-home services including Home Care Training to Home Care Client (HCTC), Behavioral Health Residential Facilities(BHRF) and specialized programming for members with Substance Use Disorders, Autism Spectrum Disorders and complex needs.

March 2015-September 2015 Arizona Department of Child Safety(DCS), Comprehensive Medical Dental Program(CMDP)

Behavioral Medical Director
Included all responsibilities of medical director for psychiatric/behavioral health services with a focus on statewide implementation of TIC and collaboration with RBHAs, state and community agencies.

July 1997-March 2015 Community Partnership of Southern Arizona(CPSA)/Regional Behavioral Health Authority(RBHA)

Children's Medical Director/Associate Medical Director/Medical Director Project Match(SAMHSA Grant)

Included all responsibilities of medical director for psychiatric services with a focus on implementation of EBPS, collaboration with state agencies and key community stakeholders, and direct provision of services through Project Match to complex needs multi-state agency involved youth.

EDUCATION AND TRAINING

BA Psychology: 1988, Emory University, Atlanta Georgia

MD: 1992, Albany Medical College, Albany, New York

Psychiatry Internship, Residency and Child Psychiatry Fellowship: 1992-1997,

Universtiy Medical Center, Tucson, Arizona

American College of Physician Executives: Physicians in Management Seminar I and II

National Council of Behavioral Health: National Psychiatric Leadership Training Program: 2015

CERTIFICATIONS

American Board Of Psychiatry And Neurology: Certification In General Psychiatry, #45411,Certification in Child And Adolescent Psychiatry #4795

PROFESSIONAL AFFILIATIONS:

American Academy of Child and Adolescent Psychiatry

American Psychiatric Association

KRISTIN FROUNFELKER

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602-463-2838

KFROUNFELK@COX.NET

PROFESSIONAL BACKGROUND

Visionary healthcare administrator with 10+ years of management experience in managed healthcare, public and private sector operations, 25 years in behavioral health care, a proven ability to implement strategies to ensure compliance; operate within macro corporate level with focus on quality, accountability and outcomes. Serve as catalyst for a positive change through team building and provide leadership infusing organizations with internal and external collaboration, cooperation and communication. Highly organized professional with a self-directed approach to work.

ACCOMPLISHMENTS

- During time at AHCCCS was agency lead for the development of the Maricopa Integrated RBHA RFP and evaluation committee
- Speaker at three national conferences regarding integration of Arizona Behavioral health services
- Medical management lead for Cenpatico's greater Arizona RFP response and oral presentation.
- Part of Implementation team for California State Department of Mental Health's External Quality Review Organization

EXPERIENCE

02/2015-Present University Arizona Health Plan Tucson, Arizona

Director, Behavioral Health

Responsible for the oversight and the development of an integrated behavioral health department that conducts utilization review, prior authorization, case management, concurrent review and denials for Medicare and Medicaid lines of business. Develop internal processes to administer the Medicaid behavioral health services for Medicare/Medicaid members that are designated as general mental health/substance abuse "dual eligible", including coordination of benefits and the facilitation of services, court ordered treatment, crisis follow up and determination of SMI. Manage, train and clinically supervise clinicians and case managers responsible for the integrated care management of enrolled members. Work in collaboration with medical case management, UM and the organization matrix to ensure a regional integrated case management is applied to members with high cost/high needs and other disease management programs. Administer the Depression Disease Program for Medicare and Medicaid members. Currently, the lead Director for the Statewide Justice System Transition initiative. Submit reports and deliverables to regulatory agencies and ensure the organization is in compliance with State and Federal regulations. Serve as the lead subject matter expert on integrating specific populations and for all behavioral health Medicaid and Medicare lines of business including responding to RFP's. Represent UAHP at AHCCCS and RBHA meetings to ensure compliance. Conduct business functions according to the mission, values and goals of the organization and ensure that staff

implement strategic initiatives to achieve the organizational goals and metrics.

01/2014- 02/2015 Cenpatico of Arizona Tempe, Arizona

Medical Management Administrator

Responsible for the oversight of all licensed behavioral health staff that conduct authorization of medically necessary services for enrolled members for inpatient, outpatient, and out of network services, concurrent/retrospective reviews and denials of services. Monitor the prior authorization functions to confirm that decisions are made consistent with clinical criteria and required timelines. Conduct analysis of utilization data identifying over/under service utilization and determining appropriate interventions based on identified trends. Maintain implementation of URAC standards and National Accreditation. Participate in QM, UM, Peer Review and Risk and Fee for Service committees. Provide oversight and supervision of the Care Management Program and Integration activities. Ensured accurate and reliable data for financial planning and claims processing.

07/2013-12/2013 ADHS/DBHS Phoenix Arizona

Assistant Director of Quality and Integration

As member of the Senior Executive Team, responsible for oversight of the Bureau of Quality Integration which included Offices of Medical/Utilization Management, Quality Management/ Performance
Improvement, Information Management, Quality of Care, EPSDT and
Customer Services. Ensured the accuracy and timeliness of deliverables required under the AHCCCS/ADHS contract as well as the oversight of all contractor (RBHA) contract compliance and deliverables. Directed the readiness and implementation of the managed care functions related to the onboarding of an integrated care RBHA contract for Maricopa County in collaboration with AHCCCS.

09/2010-07/2013 AHCCCS Phoenix, Arizona

Administrator, Behavioral Health

As the behavioral health administrator and designated as the agency lead project manager, currently responsibilities include facilitating the collaboration with a state agency in the development, implementation and oversight of managed integrated behavioral health and physical health care services for persons with serious mental illness in Maricopa County, including the integration of dual eligibles. Prepare executive staff and content experts for oversight readiness of an integrated health plan with a Contractor. Lead an interagency work team to develop core concepts and operational requirements for integration activities including care management policies, cost sharing considerations, and opportunities under the Affordable Care Act and multiple other activities. Ensure that both agencies remain compliant with CMS regulations, state and federal regulations. Contract Oversight: Serve as the agency behavioral health content expert and provide clinical consultation for administrative law decisions on provider

appeals, quality management and medical management and consultation with compliance staff on behavioral health contract oversight functions including operations and claims and tribal related behavioral health issues.

EDUCATION AND TRAINING

1982-1985 Wright State University Dayton, Ohio

- Master's in Rehabilitation Counseling
- Bachelor of Arts, Sociology

CERTIFICATIONS

Arizona Licensed Professional Counselor (LPC) Active- #2437

Certified Professional in Healthcare Quality (CPHQ) Active

PROFESSIONAL AFFILIATIONS

Member of Arizona Association of Health Care Quality, previous Board Member

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.

Banner – University Family Care Plan	Kathleen Oestreich
Company Name	Signature of Person Authorized to Sign
2701 E. Elvira Road	Kathleen Oestreich
Address	Printed Name
Tucson Arizona 85756	Chief Executive Officer
City State Zip	Title

Exhibit E: Affiliated Organization Attestation

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

Offeror Name: Banner – University Family Care Plan

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.

Banner – University Family Care Plan			Signature of Person Authorized to Sign
Company Name			
2701 E. Elvira Road			Kathleen Oestreich
Address			Printed Name
Tucson	Arizona	85756	Chief Executive Officer
City	State	Zip	Title

Exhibit F: State Only Pregnancy Termination Agreement

THIS AGREEMENT is entered into by and between the Arizona Health Care Cost Containment System (AHCCCS), located at 701 E. Jefferson, Phoenix, Arizona 85034, and Banner – University Family Care Plan (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.

Banner - University Family Care Plan	Kathleen Oestreich
Offeror Name	Signature of Person Authorized to Sign
2701 E. Elvira Road	Kathleen Oestreich
Address	Printed Name
Tucson Arizona 85756	Chief Executive Officer
City State Zip	Title