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	4-6
Offeror's Signed Signature Page(s) for **each** Solicitation Amendment	Refer to Bidders' Library	7-8
Capitation Non-Benefit Costs Bid Submission		
Signed Agreement accepting capitation rates	RFP Section H, Instructions to Offerors	9
Non-Benefit Costs Bid Submission workbook	RFP Section H, Instructions to Offerors	10-15
Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	16-19
Executive Summary and Disclosure		
Executive Summary	RFP Section H, Instructions to Offerors	20-22
Moral or Religious Objections	RFP Section H, Instructions to Offerors	23
Narrative Submission Requirements		
1.	RFP Section I, Exhibit C	24-25
2.	RFP Section I, Exhibit C	26-32
3.	RFP Section I, Exhibit C	33-37
4.	RFP Section I, Exhibit C	38-44
5.	RFP Section I, Exhibit C	45-49
6.	RFP Section I, Exhibit C	50-54
7.	RFP Section I, Exhibit C	55-61
8.	RFP Section I, Exhibit C	62-66
9.	RFP Section I, Exhibit C	67-71
10.	RFP Section I, Exhibit C	72-76
11.	RFP Section I, Exhibit C	77-81
12.	RFP Section I, Exhibit C	82-86
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	87-91
14.	RFP Section I, Exhibit C	92-96
15.	RFP Section I, Exhibit C	97-101
16. A (North) *If applicable*	RFP Section I, Exhibit C	102-104
16. B (South) *If applicable*	RFP Section I, Exhibit C	105-107
17.	RFP Section I, Exhibit C	108-112
18.	RFP Section I, Exhibit C	113
Oral Presentations		
Names and Titles of Participating Individuals	RFP Section H, Instructions to Offerors	114
Resumes of Participating Individuals	RFP Section H, Instructions to Offerors	115-128
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit D Refer to Bidders' Library	129
Affiliated Organization Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	130
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	131-133

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

BID CHOICE FORM - PART 1

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

Authorized Signature — Date: 1/3/2018

Joseph G. Gaudio
Print Name

CEO, UnitedHealthcare Community Plan
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.**

UnitedHealthcare Community 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

Authorized Signature — Date: 1/3/2018

Joseph G. Gaudio
Print Name

CEO, UnitedHealthcare Community Plan
Title

SECTION A: SOLICITATION AND OFFER PAGE

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

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

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

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

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

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

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

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

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

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

Late Proposals shall not be considered.

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

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

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

OFFER

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

NPI No. (*optional*)

86-0813232
Federal Employer Identification No.:

161273495
Dun and Bradstreet (DUN) No.

E-Mail Address: jgaudio@uhc.com

UnitedHealthcare Community Plan
Company Name

1 East Washington, Suite 900
Address

Phoenix	AZ	85004
City	State	Zip

For clarification of this offer, contact:

Name: Joseph G. Gaudio

Title: CEO, UnitedHealthcare Community Plan

Phone: (602) 255-1717

Signature of Person Authorized to Sign Offer

Joseph G. Gaudio
Printed Name

CEO, UnitedHealthcare Community Plan
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: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 1/3/2018	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: Joseph G. Gaudio	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO, UnitedHealthcare Community Plan	TITLE: Chief Procurement Officer
DATE: 1/3/2018	DATE:

Signed Agreement Accepting Capitation Rates

As indicated in Section H, subsection 19 in the RFP for Contract/RFP NO YH19-0001:

"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 by the Offeror. The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and will follow generally accepted actuarial principles and practices."

Additionally, AHCCCS intends to include adjustments for contractor specific population risk to the rates published prior to October 1, 2018.

I, Joe Gaudio, Chief Executive Officer of UnitedHealthcare Community Plan of Arizona, understand that these actuarially-sound rates will be calculated by AHCCCS and will not be negotiated. UnitedHealthcare Community Plan of Arizona will accept these capitation rates developed by AHCCCS for the contract.

This agreement satisfies the submission requirement of signed agreement accepting capitation rates per RFP Section H, Instructions to Offerors.

Joseph G. Gaudio - CEO, UnitedHealthcare Community Plan of Arizona

1/16/2018

Date

North GSA

Member Months to Use for Bidding	990,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 28.89
% of Admin PMPM that is Fixed	42.56%
% of Admin PMPM that is Variable	57.44%
Detail Admin Break Out	
Compensation	$ 18.80
Occupancy	$ 0.83
Depreciation	$ 0.66
Care Management/Care Coordination	$ 3.72
Professional and Outside Services	$ 0.98
Office Supplies and Equipment	$ 0.73
Travel	$ 0.53
Repair and Maintenance	$ -
Bank Service Charge	$ 0.00
Insurance	$ 0.19
Marketing	$ 0.12
Interest	$ 0.12
Other Administrative	$ 2.21
Total Admin PMPM	$ 28.89

Underwriting Gain Component

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

Central GSA

Member Months to Use for Bidding	3,170,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 22.83
% of Admin PMPM that is Fixed	24.40%
% of Admin PMPM that is Variable	75.60%
Detail Admin Break Out	
Compensation	$ 15.92
Occupancy	$ 0.54
Depreciation	$ 0.15
Care Management/Care Coordination	$ 3.04
Professional and Outside Services	$ 1.04
Office Supplies and Equipment	$ 0.71
Travel	$ 0.13
Repair and Maintenance	$ -
Bank Service Charge	$ 0.00
Insurance	$ 0.20
Marketing	$ 0.13
Interest	$ 0.13
Other Administrative	$ 0.83
Total Admin PMPM	$ 22.83

Underwriting Gain Component

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

South GSA

Member Months to Use for Bidding	1,630,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 22.84
% of Admin PMPM that is Fixed	31.29%
% of Admin PMPM that is Variable	68.71%
Detail Admin Break Out	
Compensation	$ 15.06
Occupancy	$ 0.55
Depreciation	$ 0.24
Care Management/Care Coordination	$ 3.86
Professional and Outside Services	$ 0.89
Office Supplies and Equipment	$ 0.66
Travel	$ 0.19
Repair and Maintenance	$ -
Bank Service Charge	$ 0.00
Insurance	$ 0.17
Marketing	$ 0.11
Interest	$ 0.11
Other Administrative	$ 0.99
Total Admin PMPM	$ 22.84

Underwriting Gain Component

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

North and South GSAs

Member Months to Use for Bidding	2,620,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 26.17
% of Admin PMPM that is Fixed	26.76%
% of Admin PMPM that is Variable	73.24%
Detail Admin Break Out	
Compensation	$ 18.33
Occupancy	$ 0.63
Depreciation	$ 0.22
Care Management/Care Coordination	$ 3.34
Professional and Outside Services	$ 1.13
Office Supplies and Equipment	$ 0.80
Travel	$ 0.18
Repair and Maintenance	$ -
Bank Service Charge	$ 0.00
Insurance	$ 0.22
Marketing	$ 0.14
Interest	$ 0.14
Other Administrative	$ 1.03
Total Admin PMPM	$ 26.17

Underwriting Gain Component

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

North and Central GSAs

Member Months to Use for Bidding	4,160,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 25.54
% of Admin PMPM that is Fixed	20.02%
% of Admin PMPM that is Variable	79.98%
Detail Admin Break Out	
Compensation	$ 18.38
Occupancy	$ 0.62
Depreciation	$ 0.14
Care Management/Care Coordination	$ 2.86
Professional and Outside Services	$ 1.19
Office Supplies and Equipment	$ 0.84
Travel	$ 0.12
Repair and Maintenance	$ -
Bank Service Charge	$ 0.00
Insurance	$ 0.23
Marketing	$ 0.15
Interest	$ 0.15
Other Administrative	$ 0.85
Total Admin PMPM	$ 25.54

Underwriting Gain Component

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

Central and South GSAs

Member Months to Use for Bidding	4,800,000

Administrative Bid Component

Total Admin PMPM (All Admin Expenses)	$ 21.58
% of Admin PMPM that is Fixed	18.81%
% of Admin PMPM that is Variable	81.19%
Detail Admin Break Out	
Compensation	$ 15.20
Occupancy	$ 0.51
Depreciation	$ 0.10
Care Management/Care Coordination	$ 2.80
Professional and Outside Services	$ 1.04
Office Supplies and Equipment	$ 0.70
Travel	$ 0.08
Repair and Maintenance	$ -
Bank Service Charge	$ 0.00
Insurance	$ 0.20
Marketing	$ 0.13
Interest	$ 0.13
Other Administrative	$ 0.69
Total Admin PMPM	$ 21.58

Underwriting Gain Component

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

Actuarial Certification of the Non-Benefit Costs (Administrative and UW Gain Bids)

The 2018 Medicaid Managed Care Rate Development Guide (2018 Guide) issued by CMS describes the rate development standards and appropriate documentation to be include within Medicaid managed care rate certification. This certification has been organized to follow the 2018 Guide to help facilitate the review of this rate certification by CMS and AHCCCS. The following certification covers section 5 of the guide, Projected Non- Benefit Costs.

5. Projected Non-Benefit Cost Section

A. Rate Development Standards

i. Overview

The purpose of this document is to certify the non-benefit cost bid submission for UnitedHealthcare's response to Contract/RPF No. YH19-0001. In accordance with 42 CFR 438.5(e) the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the AZ Complete Care managed care program. The methodology described was applied to each of the 6 potential scenarios:

1. North
2. Central
3. South
4. North + South
5. North + Central
6. Central + South

ii. PMPM versus percentage basis

The non-benefit cost was developed as a PMPM amount for each of the six scenarios submitted. Each individual scenario bid stands alone.

iii. Basis for variation in assumptions

A PMPM cost has been developed for both fixed and variable costs for each scenario. Fixed costs are costs that do not change in relation to utilization or enrollment. At a minimum these costs include the salaries, employee related expenses, and related operating costs for all required key staff and additional required staff/positions listed in the contract. Variable costs are costs that change with utilization and/or enrollment changes.

Per Contract/RPF No. YH19-0001, Amendment 1, UnitedHealthcare will rely on AHCCCS to distribute the adjusted administrative PMPM by developing benefit cost relativities based on the projected member costs by risk group. We will also rely on AHCCCS to sufficiently adjust the variable administrative bid rate for each risk group and GSA using contractor specific relative cost ratios.

iv. Health insurance provider's fee.

The Health Insurance Providers Fee (HIPF) is not included in these rates. Per Contract/RPF No. YH19-0001 Section D, AHCCCHS shall make a capitation rate adjustment consistent with a methodology approved by CMS to approximate the cost associated with the HIPF.

B. Appropriate Documentation

i. Development of non-benefit costs

(a) Description of the data, assumptions and methodologies

Data

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

- Historical non-benefit expense loads
- A detailed survey of internal functional areas
- Non-benefit loads in comparable state Medicaid programs

Assumptions and methodology

In developing the non-benefit costs, we reviewed historical state specific managed care administrative costs loads for the Acute, CRS and RBHA contracts. For each GSA scenario we considered the anticipated membership and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the Arizona Complete Care population. We surveyed internal functional areas to determine appropriate staffing and other needs related to the contract.

Historic non-benefit expense assumptions were utilized, adjusted for additional administrative requirements since the development of the historical expenses. We have compared this load to actual administrative costs in Contract Year Ending 2018 Acute, CRS, and RBHA rates as well as administrative loads added to capitation rates in other comparable state Medicaid programs. Both of these comparisons lead us to believe that the non-benefit load rate developments are reasonable.

(b) Material Changes

Considerations in development were given for programmatic and administrative requirement changes since the development of the historical administrative rates. Additionally considerations were given for economies of scale and efficiencies gained through the integration of physical and behavioral health programs.

(c) Descriptions of other material adjustments

There were no other adjustments (material or non-material) to the projected non-benefit expenses bid in each GSA.

ii. Non-benefit costs, by cost category

(a) Administrative costs

Non-benefit costs were developed by GSA, utilizing historical applied non-benefit expenses and results of internal functional area survey. The non-benefit cost allowed was reviewed in aggregate by GSA scenario, with anticipated further actuarially sound adjustments to be applied by AHCCCS. The resulting non-benefit costs by GSA win scenario are illustrated in the table below.

Admin Component	North	Central	South	North + South	North + Central	Central + South
% of Admin PMPM that is fixed	42.56%	24.40%	31.29%	26.76%	20.02%	18.81%
% of Admin PMPM that is variable	57.44%	75.60%	68.71%	73.24%	79.98%	81.19%
Total Admin PMPM (All Admin Expenses)	$28.89	$22.83	$22.84	$26.17	$25.54	$21.58

(b) Taxes, licensing and regulatory fees, and other assessments and fees

As indicated in the RFP, AHCCCS will include a provision for premium tax and any other applicable taxes, fees, or assessments for this filing. UnitedHealthcare did not include any provisions for these fees.

(c) Contribution to reserves, risk margin, and cost of capital

A provision for risk margin, by GSA and contract year, as a percent of the gross medical component for each GSA is given in the table below.

UW Gain	North	Central	South	North + South	North + Central	Central + South
Year 1	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Year 2	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Year 3	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%

The Society of Actuaries (SOA) 2017 report, "Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting," indicates that most state's capitation rates include an explicit provision for margin in recent periods ranging from 0.5% to 2.5%. UnitedHealthcare's bid falls within this national range. UnitedHealthcare sets margins based on financial needs and expectations, in alignment with business strategies, including competitiveness of current bid. Population risk adjustment as described in Contract/RPF No. YH19-0001, risk corridors and other risk mitigation approaches alleviate some of the burden of unexpected claim volatility and other financial risks. For these reasons, UnitedHealthcare has no concerns with meeting the capitalization requirements with the underwriting gain bid above.

AHCCCS is awaiting CMS requirements of the actuarial certification for the underwriting gain if it is bid rather than developed by AHCCCS actuaries. If AHCCCS elects not to apply the conditions required by CMS for documentation, the underwriting gain bid above will not be used in the capitation rates. In the event the underwriting gain bids are

not utilized in the capitation rate development, AHCCCS will set the underwriting gain equal to one percent of the gross medical component.

(d) Other material non-benefit costs

The required submission document, "Section F-Non-Benefit Cost Bid Submission – amended.xlsx" includes a detail admin break out section for each component of the non-benefit cost submission.

iii. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

See section 5.A.iv. The Health Insurance Providers Fee (HIPF) is not included in these rates.

(b) Fee year or data year

See section 5.A.iv. The Health Insurance Providers Fee (HIPF) is not included in these rates.

(c) Fee impact to rates

See section 5.A.iv. The Health Insurance Providers Fee (HIPF) is not included in these rates.

(d) Timing of adjustment

See section 5.A.iv. The Health Insurance Providers Fee (HIPF) is not included in these rates.

(e) Identification of long-term care benefits

See section 5.A.iv. The Health Insurance Providers Fee (HIPF) is not included in these rates.

Actuarial Certification

I, Bonnie M. Punch, Actuary at UnitedHealthcare and Member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA), am certifying that the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the AZ Complete Care managed care program for the contract period. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board, specifically the guidance put forth in ASOP #49.

Bonnie M. Punch, ASA, MAAA – Director, Actuarial Services

1/18/2018
Date

Executive Summary and Disclosure

Executive Summary

UnitedHealthcare Community Plan (UHCCP) is more than a health care company — we build and maintain strong community partnerships in Arizona because strong communities are healthier communities. Our mission is helping people live healthier lives and to help make the health system work better. Core to our mission is addressing social, behavioral and medical needs of the whole person by supporting each person's individual goals and supporting care coordination within a fully integrated service delivery system to meet those goals. Impactful service integration requires system transformation to reduce fragmentation in service delivery, improve health outcomes, reduce costs and increase value. We have achieved these service integration and system transformation goals as sole Contractor for the Children's Rehabilitative Services (CRS) program, and we will apply our successful learnings to the integrated AHCCCS Complete Care Contract. To improve quality and drive integrated care, we collaborate and share data and analytics to connect AHCCCS stakeholders, members and providers. The critical components of our integrated service delivery approach include timely and enhanced care coordination and care management; improved access to preventive care and health screenings; a network of high-performing, experienced providers; provider support and training; and collaboration with members, providers, community organizations, AHCCCS and other AHCCCS Complete Care contractors.

Our strategy to delivering holistic, integrated care and meeting AHCCCS' contractual requirements centers on:

- Evidence-based, member-centered and provider-supported care management and coordination
- Enhancing provider capabilities and transforming networks through technology and incentives
- Driving system integration and modernization, coupled with continuous monitoring and improvement

We will carry out the mission for AHCCCS Complete Care, and maximize impact of its comprehensive benefit package.

Organization Overview

UnitedHealthcare Community Plan is within the UnitedHealth Group family of companies and one of several distinct UnitedHealthcare businesses operating in Arizona, including UnitedHealthcare Community & State (where UHCCP receives operational support and organizational governance), UnitedHealthcare Medicare & Retirement and UnitedHealthcare Employer & Individual. These entities manage health benefits for nearly 2 million Arizonans. UnitedHealth Group employs nearly 7,000 Arizonans, which includes UHCCP employees.

The financial strength and stability of UHCCP through UnitedHealth Group makes us a dependable partner to AHCCCS to serve its most vulnerable citizens. We are dedicated to the highest standards of fiscal and program integrity through ongoing fidelity monitoring and regulatory reporting. We continually work in partnership with AHCCCS as responsible stewards of the public resources entrusted to us. We invest over $700 million in Arizona's communities annually.

Relevant Experience

We have been an AHCCCS contractor for more than 35 years, since AHCCCS' inception in 1982. Evolving with AHCCCS, we bring value to Arizona's program through efficient administrative and clinical operations. Our experienced and local leadership team, led by chief executive officer Joseph Gaudio, is supported by and has access to UnitedHealth Group's corporate resources, knowledge, clinical care experience, evolving best practices, operational and cost containment experience and efforts, and integrated Medicaid experience in 22 other markets. We leverage our corporate resources to support and achieve AHCCCS' program goals for quality improvement and cost-efficient benefit management.

UnitedHealthcare Community Plan has active Medicaid contracts serving over 560,000 beneficiaries through AHCCCS' Acute Care, ALTCS/EPD, ALTCS/DDD and CRS programs. We have Arizona experience managing integrated services via the ALTCS/EPD contract and as sole contractor for CRS. We will apply our local integrated service delivery experience, along with the relevant integrated system experience and best practices of 22 of UnitedHealth Group's Medicaid plans,

to address the whole health needs of our AHCCCS Complete Care members and to align our network with an integrated delivery system.

Approach to Meeting Contract Requirements

We meet or exceed AHCCCS contract requirements and have sustainable strategies to bend the cost curve while improving health outcomes and in continuous pursuit of quality improvement. For AHCCCS Complete Care, we will build upon these successes to support integration through system transformation and application of new and emerging practices to reduce service fragmentation. We meet contract requirements through strong partnerships with Arizona's provider community, community investment and collaboration through myConnections, qualified and experienced local staff and advanced technology, which enables provider-led integrated care coordination and data sharing.

Strong Partnerships with Arizona's Provider Community

In 2007, our strong provider partnerships led to formation of Accountable Care Organizations (ACOs) throughout Arizona to improve member health outcomes and quality. We continually enhance our value-based purchasing (VBP) arrangements to align with AHCCCS' better health, quality and cost-saving goals. We exceed AHCCCS goals for VBP with 49.1 percent of AHCCCS Acute Care program expenditures within a VBP arrangement. As of December 2017, we have 30 ACOs serving 278,738 of our Acute and CRS membership. Our innovative population health management processes and increasingly sophisticated use of technology to share data and coordinate care helps our providers to proactively close gaps in care, promote prevention and wellness, and better manage members' acute and chronic conditions.

As with our CRS and ALTCS/EPD provider contracts, ***we will not use block purchasing*** for any behavioral health provider contracts. We link members with special health care needs to providers dedicated to delivering integrated service. We support our providers' evolution to integrated care by enhancing reimbursement for care coordination and offering incentives for quality and value, shared savings/risk, condition-specific and/or population-based payment for ACOs and partners capable of proactive, data-driven, holistic and integrated care.

To encourage all providers (not only those in ACOs or with a VBP arrangement) to deliver integrated care, we developed a strategy called ***Provider-led Integrated Care Coordination*** **(PLICC)**. We formed a Behavioral Health Provider Advisory Council to help develop our PLICC. The program allows physical and behavioral health providers to receive payment for leading care coordination efforts for members with higher levels of integrated care needs. PLICC is aligned with what we heard from providers: Support payment strategies to account for care coordination between providers.

Community Investment and Collaboration through myConnections

Through our myConnections program, we invested over $21 million in Arizona communities to build ***supportive housing, our Community Connect Center and a social services referral network.*** Our myConnections program is an initiative to organize social resources in a community to address individuals' social determinants of health (SDOH) to promote better member health outcomes and self-sufficiency. In Maricopa County, we partnered with Chicanos Por La Causa (CPLC) to acquire and refurbish nearly 500 new housing units, 100 of which are reserved for our members. To date, we have housed over 40 UHCCP members. Our Community Connect Center is a bricks-and-mortar hub created in partnership with CPLC. At the center, CPLC delivers behavioral health, dental and primary care services while community health workers conduct comprehensive social needs assessments. Our employment, housing and transportation navigators provide resources to help individuals obtain services. The center has a food pantry, which has *distributed nearly 260,000 pounds of healthy foods* since July 2016. Through myConnections, we organize community resources in a systematic inventory of organizations; then seek partnerships to share data, make referrals and coordinate care among providers and partners. We have ***more than 40 partnerships with Arizona community organizations, including CPLC, Nurse Family Partnership, Raising Special Kids Arizona, Southwest Autism Research & Resource Center and Circle the City.***

Qualified and Experienced Local Staff

Our locally based leadership team oversees all key operational functions and administrative activities of our AHCCCS

programs. Each member of our executive team not only has direct experience in successfully meeting contract requirements for our AHCCCS programs, but also has five or more years' experience administering the AHCCCS Acute Care and/or CRS programs. Our executive team is surrounded by qualified and experienced managerial and support staff who have in-depth knowledge and understanding of contract requirements and maintain contract compliance.

Advanced Technology Enabling Provider-led Integrated Care Coordination and Data Sharing

A key component of our population health management strategy is promoting care coordination among interdisciplinary care teams, including our PLICC approach with providers. We facilitate collaboration among providers through our CommunityCare care management platform, an interactive tool enabling two-way information sharing. We use Arizona's Health Information Exchange, Health Current, within our CommunityCare platform. As Health Current's functionality is enhanced, we will continue to promote provider adoption. CommunityCare gives providers a technical care coordination vehicle for accessing and sharing HIPAA compliant, secure, timely, actionable, value-added information about members' care. We teach providers how to use the tool and provide raw data and reports to providers who do not wish to use the full platform. We supply providers and care coordinators with our social service resource database to connect medical and behavioral providers with community-based organizations and to assist in making social services referrals.

To monitor and assess fidelity of care delivery to the member's service plan and to verify our members receive a high standard of care, we analyze information and key metrics related to quality of care, member experience, outcomes and costs. Our advanced technology enables us to closely monitor performance metrics, such as HEDIS and CAHPS, outcome metrics and utilization. We monitor provider performance against local and national benchmarks and use industry-accepted standard metrics. Throughout our proposal, we describe how we use technology to assemble and share information about the needs of the people we serve, to identify and manage trends, and to improve quality.

Bringing Added Value to AHCCCS Complete Care

Medicaid beneficiaries often face challenges accessing health care services or keeping appointments, exacerbated by food, housing and transportation insecurities, unemployment and/or technology access issues. These SDOH factors are key drivers to Medicaid health care costs and leaving them unaddressed diminishes people's ability to get and stay healthy. As an experienced AHCCCS health plan, we add value by helping our members to get services to address their unique challenges so they can achieve and maintain health and wellness. This includes the good work of myConnections.

Throughout our proposal, we describe how we continually refine our network to better serve our members' physical, behavioral and social needs. We gather feedback through many mechanisms (e.g., Joint Operating Committee meetings, governance committees, member and physical/behavioral health provider advisory councils, surveys) to inform our community investment, service integration, network and system transformation strategies.

We will continue to support system-wide change with investments, high-value innovations, social network development and community engagement. Key to momentum is engaging all providers in delivering quality, cost-efficient services to members and in steering members to services most impactful to their long-term health and wellness.

Meeting Medicare Advantage D-SNP Requirements

We began administering a Dual Special Needs Plan (D-SNP) in Arizona in 2005 and expanded our service area to Gila County on Jan. 1, 2018, becoming a statewide D-SNP covering all 15 counties in Arizona. We are a single entity with no Regional Behavioral Health Authority (RBHA) affiliation and therefore meet the requirements described in Paragraph 7, Affiliated Organization Requirements. We meet and abide by the requirements specified in Paragraph 9, Participation, as a Medicare Advantage Dual Special Needs Plan (D-SNP) and RFP Section D, Paragraph 70, Medicare Requirements. Our program covers 55 percent of the market with over 50,000 members, demonstrating we are the D-SNP of choice in Arizona.

Moral or Religious Objections

We do not restrict coverage for any services because of moral or religious objections, nor do we place any constraints on the coverage, reimbursement or delivery of services based upon moral or religious principles. We provide access to all Medicaid services covered under our contract with AHCCCS. All of our provider agreements contain a clause that allows the provider to refuse to provide any service they find objectionable because of moral or religious grounds. In that situation, we assist the member to access another provider who is willing to provide the service.

Exhibit C: Narrative Submission Requirements

Question 1

CONTRACTS WITH DELIVERY SYSTEMS SIMILAR TO AHCCCS COMPLETE CARE

AHCCCS Complete Care represents the next stage in Arizona's Medicaid managed care journey — and it is most ambitious. UnitedHealthcare Community Plan (UHCCP) recognizes that this complex change to a fully integrated model must be seamless and must support AHCCCS' long-term strategy to bend the cost curve while improving health care outcomes and service quality for members and providers. Since AHCCCS' founding in 1982, UHCCP has evolved with AHCCCS and has continually brought value to the AHCCCS program through innovative and efficient health care delivery systems. We have served AHCCCS for more than 35 years and want to continue expanding our service to AHCCCS through the AHCCCS Complete Care program and its other programs serving vulnerable and underserved populations.

In Arizona, UHCCP has active Medicaid contracts serving beneficiaries through AHCCCS' Acute Care, ALTCS/EPD, ALTCS/DDD and CRS programs. Being the sole contractor for the CRS program, we have extensive experience administering integrated behavioral health programs for individuals with special health care needs.

UnitedHealthcare Community Plan is part of UnitedHealth Group through its Medicaid managed care business segment, UnitedHealthcare Community & State. UnitedHealth Group has UnitedHealthcare Community & State health plans in 26 states plus Washington, D.C., serving nearly 6.4 million beneficiaries of acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP), Special Needs Plans and other federal and state health care programs. UnitedHealthcare Community & State's health plans — with integrated programs in 22 out of 26 states — and the care programs they manage are tailored to address the complex needs of the populations served, including the chronically ill, those with disabilities and persons with higher risk medical, behavioral and social conditions.

Acute, ALTCS, CRS and DDD Programs in Arizona

The table depicts key elements of our Arizona Medicaid contracts and programs.

Program Elements	Acute Care	ALTCS/EPD	ALTCS/DDD	CRS
Years in Program	**35 years (since 1982 via our legacy APIPA)**	**28 years (since 1989)**	**29 years (since 1988)**	**10 years (since 2008)**
Populations Served	**Adults and children with TANF coverage, CHIP, SSI, uninsured children**	**Adults and children who are chronically ill with LTSS coverage**	**Adults and children with chronic or congenital developmental disabilities**	**Children with special health care needs, including behavioral health, members with serious mental illness and intensive case management**
Geographic Service Area	**All counties except Gila and Pinal**	**Central and North GSAs**	**Statewide**	**Statewide**
Current Contract Status	**Active through September 2018**	**Active through September 2022**	**Active through September 2018**	**Active through September 2018**
Enrollment as of Jan. 1, 2018	**515,281**	**8,496**	**17,732**	**23,853**

Program Elements	Acute Care	ALTCS/EPD	ALTCS/DDD	CRS
Behavioral Health/Physical Health Integration Status	**Administer physical benefits for all members. Administer general mental health and substance abuse benefits for acute members eligible for Medicare. Care coordination with RBHAs for members with acute and behavioral health conditions**	**Administer physical and behavioral benefits; and integrated care management and service coordination, including use of community health workers**	**Administer physical benefits, but not behavioral benefits, which are carved out to DDD and managed by the RBHAs. For DDD members with acute behavioral health conditions, we coordinate care with the RBHAs and with the DDD. For DDD members also enrolled with CRS, we manage behavioral health services and coordinate with DDD and member's care team**	**There are four coverage types within CRS, of which we administer statewide integrated behavioral health benefits for two coverage types:** ▪ ***CRS Fully Integrated:*** Administer physical and behavioral benefits, integrated care management and service coordination ▪ ***CRS Partially Integrated Behavioral Health:*** Administer specialty care related to the CRS condition and behavioral benefits, care management and service coordination

Descriptions of Kansas and New Mexico Medicaid Programs

We administer integrated physical and behavioral health benefits in 22 of our 26 Medicaid markets. In addition to our Arizona Medicaid contracts, we selected our Kansas and New Mexico Medicaid health plans to illustrate our vast experience with integrated delivery systems. They align most closely with the AHCCCS Complete Care program in terms of integrated delivery system transformation, provider payment modernization and use of advanced models for population health management. Also, the scope of services our Kansas and New Mexico health plans administer, closely match the services provided and complex populations we anticipate serving through the AHCCCS Complete Care program. The table depicts key elements of our Kansas KanCare and New Mexico Centennial Care programs.

Program Elements	Kansas KanCare	New Mexico Centennial Care
Years in Program	**Five years (Since Jan. 1, 2013; State of Kansas extended all contract renewal options)**	**Medicaid LTSS: 10 years (since 2008); integrated Medicaid physical, behavioral and LTSS: four years (since 2014)**
Populations Served	**Adults and children with TANF, CHIP, ABD/SSI, LTSS and HCBS (includes frail elderly, physically disabled and DD/ID waivers)**	**Adults and children with TANF, CHIP, ABD/SSI, LTSS, Dual Eligible and HCBS (for frail elderly, physically disabled and brain injury waivers and excludes DD waiver)**
Geographic Service Area	**Statewide**	**Statewide**
Current Contract Status	**Active through December 2018**	**Active through December 2018**
Enrollment as of Jan. 1, 2018	**134,266**	**103,346**
Behavioral Health/Physical Health Integration Status	**Administer physical and behavioral benefits, integrated care management and service coordination**	**Administer physical and behavioral benefits, integrated care management and service coordination**

Question 2

System transformation is a fundamental principal of the AHCCCS program, and UHCCP has been a trusted partner to AHCCCS for 35 years. As AHCCCS pursues the next stage of transformation through integration, UHCCP is well positioned to maximize the impact of AHCCCS' comprehensive benefit package by reducing fragmentation in health care delivery, implementing alternative payment methods, and sharing data and analytics with AHCCCS, its contractors, providers and system partners. We recognize that simultaneously, the health care system must maintain and advance core organizational capacity, infrastructure and its workforce. We have numerous strategies that make AHCCCS' vision achievable, and we identify the following as the critical components of behavioral and physical health service delivery:

- ***Timely and coordinated care*** that is evidence-based and member-focused, strengths-oriented, family friendly, culturally appropriate and clinically supervised. This includes meeting members where they are in their health care journey and providing options that span the range of covered services.
- ***Enhanced care management and care coordination*** for members with complex behavioral, physical and social conditions who may experience high levels of costly, preventable utilization.
- ***Access to preventive care and health screenings*** that identify and treat potential health conditions in the earliest stages to help members achieve their highest level of wellness.
- ***A network of high-performing providers*** across the continuum of coordinated, collocated and integrated care.
- ***Support and training for providers*** looking to innovate, integrate and advance their scope of practice.
- ***Collaboration with members, providers, community organizations, AHCCCS and other AHCCCS Complete Care contractors*** to address the whole-health needs of Medicaid members and improve their health care experience.

Strategy for Implementing Critical Components and Principles of Service Delivery

We have successfully implemented integrated behavioral and physical benefits in 22 states. This includes Arizona CRS, dual-eligible GMH/SA and ALTCS, New Mexico and Kansas. Our experience informs our three-tiered implementation strategy for AHCCCS Complete Care. It is rooted in the pillars of managed care and reflects our vision to be more than a managed care company. Our approach (see Figure at right) addresses members' behavioral, physical and social needs while modernizing the health care system with more accountable and integrated participants:

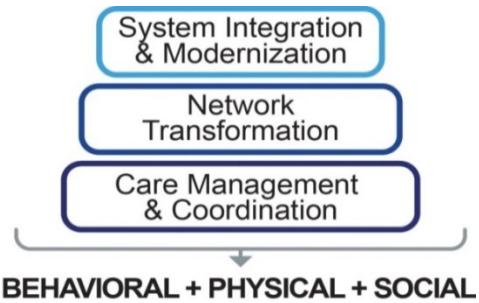

Figure 1. Our three-tiered approach is rooted in care management and coordination and it reflects our vision to be more than a managed care company.

1. ***Evidence-based care management and coordination*** to assist members in managing health conditions — including ensuring adherence to evidence-based medical standards, preventive care and chronic condition management — and improve communication across care teams.
2. ***Enhancing provider capabilities and transforming networks*** through innovative programs and payment models, experiential learning, continuous quality improvement programs, technology and data sharing.
3. ***Driving system integration and modernization*** by bringing together the services that low-income people receive with community reinvestments, grassroots innovation and partnerships that support sustainability.

Key to our approach is ***sophisticated information exchange*** through advanced technology to bring strategies to life.

Evidence-based Care Management and Coordination

Our goal is to deliver person-centered care for all AHCCCS Complete Care members. Clinical and administrative data, evidence-based models and consensus from the clinical and consumer communities inform our strategy. We follow a four-step process:

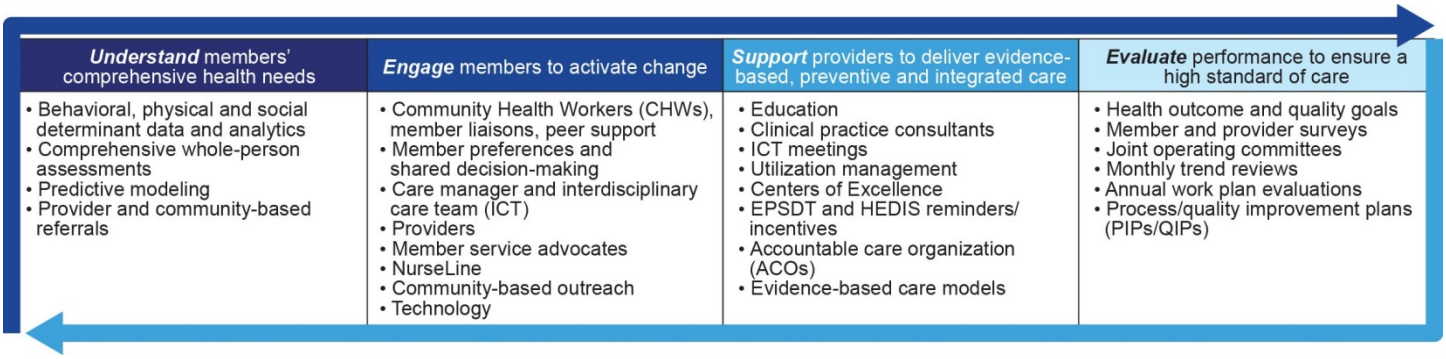

Figure 2. Four-step care management and coordination process.

Understanding Members' Comprehensive Health Needs

We recognize the populations served under the AHCCCS Complete Care contract face significant challenges, such as managing multiple behavioral and physical health conditions, food insecurity, unsafe housing, unemployment, under-employment and more. Studies and our own experience show that taking a holistic view of members' circumstances is important, given that social and economic factors affect 40 percent of health care outcomes. ***That is why we use behavioral, physical and social determinants of health data and analytics to help us understand member needs.***

Our identification and stratification (ID/stratification) process uses industry-leading technology, proprietary analytics and clinical expertise to segment members by demographics, diagnoses, utilization, and risk upon enrollment and daily thereafter. We leverage sophisticated predictive modeling to produce actionable information that reveals member-specific care opportunities and helps prioritize members for outreach. Data inputs include:

- ***Behavioral, physical and social determinant data***, including ICD-10 data; continuity of care documents; admit, discharge and transfer (ADT) notifications; historical claims; and behavioral health and other "blind spot" data (e.g., AHCCCS-provided supplemental data)
- ***Assessments***, including health risk assessments (HRAs), PHQ-9 for depression and readmission risk assessments for adverse events
- ***Referrals*** from providers, members, families and other natural supports, state and community service agencies

An integrated health profile is created for each member, which includes an overall risk score, physical and behavioral health diagnoses, assessment results, claims history, care team members, gaps in care and other key characteristics about the member. This information allows internal and external care managers, providers and other constituents of the care team to easily access each member's individualized needs.

We have learned from data analysis that a different mix of our members can represent the top 5 percent of cost and utilization from one year to the next, so we developed a proprietary algorithm to identify individuals most likely to be persistent high need, high cost (PHNHC) year-over-year. The PHNHC algorithm is based upon a member's demographics, Medicaid eligibility criteria, chronic morbidity and comorbidity, medical and pharmacy expense, utilization and trends. Data shows individuals identified through the algorithm have a 78 percent likelihood of repeated identification in the top 5 percent of spend in the next 12 months. These members represent one segment of the high need, high cost population referred into care management and coordination. The impact of our care management program can be seen in improved year-over-year utilization and quality trends for PHNHC members in the Arizona Acute population in 2016:

- PHNHC members, targeted by our care management and coordination program, experienced a reduction in inpatient admissions of ***10.6 percent*** and a reduction in ER visits of ***8.7 percent***
- PHNHC members enrolled in our transitional care management program experienced an ***11.1 percent*** decrease in 30-day readmissions

- PHNHC members receiving our care management and coordination were more likely to receive follow-up care with a PCP within seven days of an inpatient visit by ***10 percent*** and within seven days of an ER visit by ***5 percent***

In addition, members with specific chronic conditions (e.g., diabetes, asthma, sickle cell, depression), individuals with special health care needs (e.g., HIV), everyone with four or more ER visits in the past six months, those who are part of the justice reach-in and pharmacy lock-in programs, pregnant women and those transitioning out of an inpatient setting are referred to care management and coordination. The impact of these engagements includes:

- Decreasing ER visits by ***7.7 percent*** in 2017 compared to 2016
- Exceeding the minimum performance standard for PCP follow-up visits within seven days by ***12.2 percent***

Engaging Members to Activate Change

We engage members to take action on their health using a variety of strategies and tactics to ensure our outreach is culturally relevant, appropriate for the member's age and demographics and tailored to their health needs. We respect that individuals have varying health literacy levels and readiness to change. A key component of engaging members is establishing trust and understanding the goals and capabilities of members, their family and other natural supports. This is one reason we employ ***community health workers*** (CHWs) hired from communities where they work, cross-train ***care managers*** in physical and behavioral health and evidence-based approaches, such as motivational interviewing and trauma-informed care; and leverage staff members with shared knowledge and experience with members, such as our ***veteran advocate, court coordinator, obstetrics nurses, tribal coordinator*** and ***justice system liaison***.

Members with the highest level of risk are supported by an ***interdisciplinary care team (ICT) led by a care manager who serves as their primary navigator and point of contact***. The ICT includes the member, his/her PCP and a guardian or other family representative (if requested by the member). Care managers verify the right providers are engaged and establish a service plan for the member. For members with high behavioral health needs, care managers ensure a behavioral health home is functioning, a Child and Family Team (CFT) or Adult Recovery Team (ART) is engaged, a behavioral health professional and peer support specialist are selected or assigned, and a service plan is active and monitored. The ICT works together to inform and update the service plan, monitor progress toward achieving the member's goals and validate the member is experiencing improved health outcomes. This collaboration is enabled by our ***CommunityCare*** technology platform, which supports two-way data sharing and service plan collaboration.

In addition to our care management and coordination outreach, we can ***provide actionable information to our providers*** to support proactive engagement with their assigned or attributed patients. This includes a list of high-need, high-cost members, daily discharge notifications, up to 27 months past claims history and quality gaps-in-care. If providers need extra support in caring for members, they can make referrals to our care management team.

We have additional programs in place to provide support to all members. This includes appointment scheduling through our call center ***member service advocates (MSAs), our NurseLine***, which is available 24 hours a day, seven days a week, and our quality staff. We also reach members through ***community-based outreach***, such as health fairs, and through ***technology***, such as tailored digital communications, mobile and web-based tools. This multifaceted approach maximizes our ability to effectively engage with members and families ahead of and during the AHCCCS Complete Care contract launch to help them understand their benefits and how to access services.

Supporting Providers to Deliver Evidence-based, Preventive and Integrated Care

One way we ensure members receive a high standard of care is by partnering with providers to deliver evidence-based preventive, specialty and integrated care. We do this for the lifetime of our ACO partnerships through online and in-person ***education***; at ***Joint Operating Committee meetings (JOCs)*** with all ACO partners, which are generally held on a monthly basis and attended by UHCCP's chief medical officer Steve Chakmakian, D.O., or a designated medical director; and at ***ICT meetings*** to discuss care for individual members. We also deploy ***clinical practice consultants*** for quality and administrative support in provider practices, and ***utilization management (UM)*** staff to ensure high-quality care during

prior authorization and concurrent review. Our UM team ensures members receive care consistent with clinical guidelines and do not receive unnecessary services. We track this information and use it to direct members to providers with the highest level of adherence to evidence-based medicine through our ***Centers of Excellence*** and ***Provider Recommendation Engine (PRE)***. PRE is an intelligent tool that matches members with preferred providers demonstrating high quality scores and low costs, while respecting member choice and meeting access standards.

We reinforce the importance of preventive care with members and providers through ***reminders and incentives*** for closing gaps-in-care, and completing screenings and activities consistent with ***EPSDT and HEDIS measures***. For example, we offer incentives for quality and value, shared savings/risk, and/or condition-specific payment for ***ACOs*** and other provider partners who deliver proactive, data-driven, holistic and integrated care.

To further support the delivery of integrated care, our clinical team studies the latest ***evidence-based care models*** to develop innovative programs and inform our partnerships and investments. For example:

- ***The Collaborative Care Model*** is the basis for our ***new, innovative strategy called Provider-led Integrated Care Coordination*** (PLICC), to be implemented under the AHCCCS Complete Care contract. Collaborative Care is an evidence-based model for primary care screening and treatment of depression and anxiety, vetted by the clinical community through 79 randomized controlled trials, which cited improvement of depression and anxiety.
- We established a novel partnership with ***ConnectionsAZ***, who runs the *urgent psychiatric center (UPC)* model — an evidence-based alternative to costly (on average $2,264 per patient; (Nicks B., Manthey D. *Emerg Med Int.* 2012) boarding of psychiatric patients in emergency departments (ED). In partnership, we will combine the success of the urgent psychiatric center model and health care analytics to create an ***Integrated Health Transitional Care Program*** to address the comprehensive needs of members who frequently visit the urgent psychiatric center or ED, are high crisis resources utilizers, and lack strong connections with their PCP and behavioral health providers. This short-term, high-touch strategy will address acute conditions and reengage members with their providers for the longer term.
- We leveraged the evidence-based ***Housing First*** model, which combines permanent housing with wraparound services, for our ***myHousing supportive housing investment*** through myConnections in Arizona. This model stabilizes people experiencing homelessness and reduces health care, corrections and other social services costs. To date, we have housed more than 40 of our members in Arizona.

Evaluating Performance to Ensure a High Standard of Care

Ensuring a high standard of care is inherent in our processes, as described above. To further validate our performance, we closely monitor metrics that indicate the success of our clinical approach, such as leading indicator metrics (e.g., HEDIS), outcome metrics (e.g., symptom reduction), cost and utilization. We do this at an individual level through the ICT, by member segments and as a total population. Monthly, we review admission, readmission and ED data, analyzing how providers perform compared to national and local benchmarks. The data is reviewed at state and facility levels and includes metrics, such as admits/1,000, average length of stay and readmit rate. During these reviews, our teams analyze trends by facility, region and primary diagnosis. This data-driven clinical review is repeated monthly as a part of a continuous improvement process and is used to inform program enhancements and long-term strategic planning.

Network Transformation

Our goal is to expand access to integrated physical-behavioral practices and increase the utilization of preventive and evidence-based care to improve member care and health outcomes. Our strategy goes beyond meeting adequacy standards at all times (ACOM 436), and includes engaging more providers in value-based purchasing (VBP) models and partnering with providers to deliver integrated care.

We have decades of experience empowering providers and enabling a high-performing network. For example, in 2007 our clinical leaders identified unusually high utilization patterns in Yuma. In partnership with Yuma Regional Medical

Center, San Luis Walk-in Clinic and Sunset Community Health Center, we developed relationships between providers and established accountable care communities (ACCs). This included:

- Getting the local hospital partner to agree to provide the first ADT exchanges
- Establishing data sharing processes between UHCCP and the ACCs (later referred to as ACO partners)
- Building the ACC Registry web-based application tool to electronically exchange actionable data
- Providing predictive ID/stratification and building workflows to help ACCs manage member care in the following categories: access to care, avoidable ED and inpatient, and high-risk cohorts

These actions laid the groundwork for our first ACO VBP contract in Yuma in 2012. Today, we have 30 ACO partners in Arizona serving 278,738 members. Our ACO partners have VBP agreements in place to align payment and incentives, improve quality and bend the cost curve. These models align to AHCCCS VBP directives and the Health Care Payment Learning & Action Network (LAN) Alternative Payment Models (APM). We currently exceed all AHCCCS VBP targets for both the Acute and CRS populations. More than 49 percent of our total medical spend in the Acute contract and more than 41 percent of our medical spend in the CRS contract are covered under VBP contracts. We anticipate the percentage of medical spend under VBP contracts to consistently exceed AHCCCS' requirements. ***We are in contract discussions with additional partners that, upon execution in 2018, are predicted to raise the percentage of medical spend in the AHCCCS Acute contract to more than 67 percent and in the CRS contract to more than 90 percent.***

Experiential learning and information sharing is a critical element of our ACO partnerships that supports network transformation. We hold ACO Summits where partners from Arizona and across the nation convene to share experiences, results and best practices. ***Our ACO University and Integrated Care Institute is an innovative provider education strategy*** we will launch as an AHCCCS Complete Care contractor. The program will provide continuous learning through bi-annual provider summits, webinar modules and UHC On Air segments about evidence-based care models and best practices. We will provide seminars led by industry thought leaders, a training module on how and why to integrate behavioral and physical health care, and identification and sharing of best practices.

Where our members enter the delivery system and where they receive the majority of their health care varies widely based upon individual behavioral, physical and social needs. Because not all providers can deliver integrated care within their four walls, we have developed ***unique programs to support providers in delivering integrated care***.

For example, in Kansas, we piloted an ***innovative VBP strategy*** that addressed ***significant gaps in behavioral health services***. Our pilot linked FQHCs with peer support services and it holds the FQHCs accountable for behavioral health quality measures through integrated VBP agreements. As a result, one FQHC increased mental health follow-ups after hospitalization by ***150 percent. We will leverage this same approach with ACOs and VBP quality metrics under the AHCCCS Complete Care contract.***

To encourage **all** providers (not only ACOs or those with a VBP contract) to deliver integrated care, we developed a new, innovative strategy called ***Provider-led Integrated Care Coordination (PLICC)***. This program is based upon the Collaborative Care Model described above and allows providers to earn additional office visit reimbursement for leading care coordination efforts for members with higher levels of integrated care needs. Key components include:

- Members identified by UHCCP or the provider, with at least one physical and one behavioral health diagnosis.
- Providers complete a health risk assessment (HRA) and social determinants screening for targeted members. Results are documented in a service plan within CommunityCare to be shared with an ICT.
- Providers submit a designated non-covered CPT code with the E&M code on the claim.
- We confirm the claim is from a provider contracted for PLICC. In addition, we complete quarterly audits of CommunityCare for PLICC providers to confirm required documentation is present.

Our Behavioral Health Provider Advisory Council began in early 2017 to discuss integrated care for child/adult members with mental health and substance use conditions. Behavioral health providers from across Arizona participated and shared experiences and feedback with past integration activities, changes in provider payment methods and integration strategies. These insights informed our new PLICC program.

Primary care providers (PCPs), behavioral health providers and integrated providers are eligible. The program encourages providers to work to their highest capacity to deliver integrated care for members, with support from us. PLICC is aligned with what we heard providers ask for, support payment strategies that adequately account for care coordination efforts between providers and encourage PCPs and behavioral health providers to more effectively share data and collaborate.

PLICC is enabled by two-way information sharing via our CommunityCare care management platform, which is already used by our staff and our ACO provider partners. Our long-term goal is to leverage Arizona's Health Current as the underlying data exchange technology supporting CommunityCare. We commit to working with AHCCCS and providers to further develop and expand the adoption of Health Current. Today with CommunityCare, providers can communicate with us and with each other (including sending secure messaging) in member-consented service plan development. This is part of an interdisciplinary approach to improve data sharing, improve communication and virtually integrate care. In CommunityCare, the assigned PCP and attributed behavioral health provider can access timely, actionable data (HIPAA/state compliant), such as: ADT data, up to 27 months of member claims; member risk stratification, including special health care needs designation and diagnosis information; and quality gaps-in-care.

System Integration and Modernization

We believe achieving the best health outcomes for low-income individuals requires addressing the social challenges that underpin health. We do this at a member level through care managers who are trained to identify and address the social needs of our members and by supporting provider partners to do the same. However, to make a more meaningful, long-term impact for the Medicaid population, ***our goal is to integrate health and social services in the community***. Our strategy is to pioneer ways to use managed care technology and resources to align systems that serve Medicaid recipients. We are doing this today through myConnections in Arizona. There are three main components to this work — – the creation of nearly 500 permanent supportive housing units, 100 of which are reserved for UHCCP members; a first-of-its-kind one-stop health and human services Community Connect Center; and a social services network.

Supportive Housing

In Maricopa County, myConnections leveraged the evidence-based practice Housing First and partnered with Chicanos Por La Causa (CPLC) to create a first-of-its-kind permanent supportive housing model. Through our $21 million investment and coordination, nearly 500 refurbished housing units are available, 100 of which are set aside for our members at low or no cost. We identify members who can benefit from housing assistance through the ICD-10 code for homelessness on claims data, ED and inpatient data; claims history; and input from our CHWs, care managers and community partners. After placing members in a low- or no-cost unit, we provide clinical and social supports to help them achieve stability. Our model is informed by national permanent supportive housing models, which have been shown to stabilize people experiencing homelessness and reduce health care, corrections and other social services costs.

We see significant improvement in the health of members we place in housing, and reduced utilization and costs. Consider Anna (name changed to protect her identity), our 2-year-old CRS member who suffers from serious epileptic seizures and chronic respiratory failure. Because her family belongs to the Navajo Nation and resides on the reservation, Anna was frequently flown from the reservation to Phoenix for medical treatment. A UHCCP CHW working with the family arranged access to one of our 100 low or no cost housing units. With a stable place to live, Anna's parents could focus on their daughter's medical needs. They received respiratory care, nursing and CPR training. ***Before the housing intervention, Anna was admitted to the hospital 23 times, totaling 234 days inpatient. Her average monthly medical costs totaled approximately $53,000. After the housing intervention, she was admitted just 12 times for a total of 84***

days, and her average monthly medical costs were reduced by more than 50 percent.

Community Connect Center

Arizona Housing Investment
To extend the impact of what we have achieved in Maricopa County, we commit to use a portion of our available capital to invest in supportive housing services or facilities across all awarded geographic service areas for AHCCCS Complete Care.

Our myConnections Community Connect Center is a physical hub for system integration innovation in Maricopa County. Created in partnership with CPLC, this one-stop health and social services center delivers behavioral health services, dental and primary care while we provide CHWs and specialists in employment, housing and transportation. When an individual enters the center, a CHW conducts a comprehensive social needs assessment. As needed, our employment, housing and transportation navigators provide resources to help the individual achieve independence. The center includes a food pantry, which has distributed nearly 260,000 pounds of healthy foods since July 2016.

Social Supports Network

Through myConnections, we are working as a convener to better organize community resources and create healthier communities. We start with a systematic inventory of organizations serving a community and store them in the *Healthify* tool. We then seek partnerships through collaboration agreements in which we can share data and coordinate care across non-medical partners. ***We currently have more than 40 collaboration agreements with Arizona community organizations***, including CPLC, Nurse Family Partnership, St. Joseph the Worker, Raising Special Kids Arizona and Circle the City. Via *Healthify* and our myConnections social service network, providers make referrals to address social needs adversely affecting health outcomes. Data gathered from social service referrals identifies gaps in community capacity to address social issues. Joint Operating Committees discuss the data and inform investment and coordination strategies.

While myConnections has already achieved strong outcomes, it is just the beginning of the potential of using the reach of managed care to enable healthier communities. Continuing to develop these capabilities helps us understand what other systems our members are using so we know where coordination is needed most.

Technology to Enable Coordination, Alignment and Integration

Technology and information exchange are critical to implementing the components of behavioral and physical health service delivery. Short-term, our CommunityCare platform supports this by connecting members with all ICT participants, connecting UHCCP with providers, and connecting providers with each other to collaborate and enable a holistic and integrated care experience. Long term, we are committed to developing Health Current in partnership with AHCCCS and other stakeholders. We will invest in the technology and support the deployment and adoption of the tool with our network of providers, community organizations and our care managers.

Our three-tiered strategy of evidence-based care management and coordination, network transformation and system integration and modernization, supports providers and members through the transition to this transformative integrated service delivery model. The AHCCCS Complete Care contract represents the next stage of our 35-year partnership with AHCCCS, one that will bend the cost curve while improving quality health outcomes.

Question 3

The AHCCCS Complete Care program represents a pivotal change to the managed care delivery system that affects providers, the community and thousands of members, including children in CRS and Comprehensive Medical and Dental Program (CMDP), and those enrolled in RBHA services transitioning to an AHCCCS Complete Care contractor for behavioral health services. To achieve this transformation, we are gathering valuable input from members, families, providers and stakeholders to consider every perspective and carefully implement this integrated program. Through our extensive clinical and operational experience in seamlessly transitioning members to/from our health plan, we know network stability, proactive communication and continuity of care for members is vital to success.

Successful Member Transition Experience in Arizona
We carved behavioral health services into the CRS product for 23,000 members in 2013 and behavioral health services for 30,000 acute GMHSA members in 2015. AHCCCS asked us to present member transition best practices to other health plans after our transition of 65,000 members from the Maricopa Health Plan to our plan in early 2017.

Immediately following contract award, we begin our rigorous planning and self-monitoring processes, ensuring members' seamless access to quality services post implementation. We use a detailed self-monitoring plan refined through 22 unique state Medicaid integration initiatives to transition members without disruption. Our goals are continuity of care, no service delays, no missed appointments, the fewest possible member complaints, collaborative provider/UHCCP relationships and accurate and timely provider payments. We will apply best practices and lessons learned from other transitions to the AHCCCS Complete Care transition.

Network analysis shows our behavioral health network exceeds RBHA networks collectively by 400+ Medicaid providers; all UHCCP contracts are fee-for-service (FFS). Members have access to this robust network, and we expect minimal behavioral health provider gaps. However, we will monitor this transition carefully for gaps. Through successful structured practices, with an eye on strengthening the availability of behavioral health resources within an integrated delivery system model, our contracting and provider relations staff will educate providers regarding changes, like moving from block payment to FFS payments.

Self-monitoring is critical to the success of transitioning members. We monitor each member's transition using our robust data analysis and reporting, across clinical and operational areas, to confirm members have timely and convenient access to needed services. We identify and resolve negative trends, such as members not accessing expected care or not receiving needed services post-implementation, such as behavioral health and CRS services.

The transition to AHCCCS Complete Care requires a thoughtful multi-faceted approach, focused on:

- Monitoring the transition to confirm a successful implementation with continuous process improvement
- Transitioning both incoming and outgoing members to an integrated delivery system, with a focus on educating members regarding benefits and provider choice
- Incorporating strategies for education and information to promote a smooth pre- and post-transition for members, families, providers and community partners
- Providing special supports for members and providers to facilitate a seamless transition

Monitoring Transitions to Promote a Successful Implementation

As we have done with every transition, we will implement post-transition monitoring processes through our Command Center model, staffed with experienced clinical and operations staff on call 24 hours a day, seven days a week for at least 60 days, post go-live. This includes daily meetings with key leaders from all functional areas (e.g., call center, authorizations, claims, provider relations, care management) with a focus on performance metrics, barriers to success of the transition, information sharing by all teams and celebration of successes. This high-intensity approach focuses on all

feedback inputs (calls and data trends as well as member, provider and staff feedback) for clinical and operational success. Our approach continues daily until all areas agree to reduce the need, then we move into our standard operating models. Executive leaders monitor the transition with ultimate accountability at the CEO level.

Operations: We self-monitor for any barriers to access to care for quick resolution. Processes include:

- Using data trends from claims, call centers, network data, vendors, and grievances and claims disputes to identify any issues as well as assess need for additional education. Trends we monitor include:
  - Claims denial (e.g., focus on behavioral health diagnosis codes, education for provider billing patterns)
  - Repeat callers in call centers — screen pop-up will identify members for targeted action
  - Daily calls with key vendors (e.g., transportation, pharmacy) to monitor for issues
- Informing members, as needed, through member advocates, written communications and outreach teams
- Educating providers, as needed, through claims educator, training materials and provider relations staff
- Monitoring all levels of provider activity to make sure members can access the care they need

Clinical Operations: Our clinical operational monitoring includes using data trends from authorization waivers, appeals and quality of care concerns to identify issues and assess need for additional education focusing on the member for continuity of care. Some actions our transition coordinator will take during transition include:

- Using AHCCCS Data Exchange File (DEF) and blind spot data to measure similar claims before and after transition, watching for:
  - Non-utilization: members not receiving services as they were with RBHAs or not receiving services at all; with focus on specific diagnosis (e.g., opioid, autism)
  - Underutilization/overutilization, at member/provider level, or change in services provided to members
- Monitoring for negative trends in hospital admission, discharge and transfer (ADT) data
- Reviewing prescription fill data to identify any trend changes and monitor for non-network usage
- Monitoring service plans for activity to ensure integration is truly happening
- Reviewing any continuity of care needs beyond the initial 90 days, to determine best course of action

Transitioning systems that have been separate for decades to the best practice of whole person, integrated care can be complex. Our continued partnership with AHCCCS will meld physical and behavioral health systems into a cohesive, collaborative and easy-to-access program. As we have done in the integrated AHCCCS Long-Term Care and CRS programs, we will improve health outcomes and realize savings in overall costs to the program.

Transitioning Members to an Integrated System

It is important to engage members and their families quickly and at all system levels with this transition, particularly during the early days of transition. Our continuity of care focus will make sure members and providers do not experience a disruption in service, as expected per ACOM 401, 402, 403 and 520. Once available, we will quickly use AHCCCS DEF files to assess target provider areas for education and potential network gaps to comply with ACOM 436 network standards. Also from the DEF files, we will assess the most acute members in need of rapid service coordination to minimize care disruption, quickly setting up transition coordination activities.

Our transition coordinator, Lisa Davis, spearheads processes during a transition and oversees identified transitional staff, integrated cross training for medical and behavioral health providers, and provider monitoring to assess network needs. Our transition team analyzes the following data and reporting to proactively identify and mitigate potential issues:

- Clinical data to verify authorizations are in place for continuity of care during the transition, with focus on critical services such as durable medical equipment, oxygen and nutrition needs

- ADT data to identify trends and to transition members seamlessly to and from varying levels of care as needed and without disruption
- Member service plans (confirm members have a service plan where needed; 42CFR 438.208)
- Claims information (denied/pended claims, for example), including pharmacy claims
- Transportation challenges, such as member not getting to needed appointment
- Call center reports, including service levels, to make sure our staffing levels meet call volume demand
- Feedback from members, their families, peer and family run organizations, the community and providers (as the voice of those we serve is important as we improve the system of care)

Self-Monitoring Practices to Identify Operational Issues during Transition
Using data analytics, we self-monitor to proactively and quickly identify trends and opportunities across claims, vendors, provider activity and call centers. We quickly take action on findings. For example, in our recent transitions, we monitored every member with recurring transportation needs, such as dialysis, to be sure they were getting to appointments.

We will provide additional navigational assistance to members with special or unique needs during this transition. We will begin transferring information up to four weeks before go live to allow ample time to transition all prior authorizations and services. We will waive authorizations for members not seeing a network provider for the first 90 days for physical health and up to six months to cover the duration of treatment of behavioral health services. This gives us time to determine if a contract with this provider is the appropriate option, or if transition to an in-network provider will meet the member's needs. When needed for members in the middle of treatment (e.g., post-surgery, pregnancy, etc.), we will issue an authorization for longer than 90 days until the completion of the episode of care. Daily reporting informs us of any access or timeliness issues, and our member and provider advocates act immediately to address problems identified. As with the recent Maricopa Health Plan Acute AHCCCS member transition, we will outreach to all non-network PCPs to discuss member transition and call members impacted by potential network changes.

Through our call center, we act quickly to resolve member issues through a single phone line for both medical and behavioral health calls. Our member services advocates (MSAs) have key member data available to engage members well beyond their initial reason for interaction with us. The MSAs can see if members have any gaps in care, such as an annual well visit. They can access the PCP and behavioral health provider on record for the member, demographic data and historical calls. MSAs help members with next-day appointments for priority services such as initial engagement with a provider for Medication Assisted Therapy. MSAs also connect members to providers participating in our Express Access Program, where network behavioral health providers have agreed to offer members a routine appointment within five business days of a member's request. Our nurse triage line will be available 24 hours a day, seven days a week for all members for physical health and behavioral health questions. Our call center Interactive Voice Response (IVR) uses natural language, which identifies 70,000 utterances such as "transportation," to route members to the right help quickly. We will use a dedicated IVR prompt for the AHCCCS Complete Care transition to get members or providers to a person who can quickly resolve their transition issue.

Educational Strategies to Promote a Smooth Transition

Our comprehensive, multi-pronged plan educates members, families, providers, our staff and other key stakeholders of the changes that will affect them upon the transition to AHCCCS Complete Care. Our educational strategies focus on ***helping members and providers understand the delivery system and changes to that system***. Our plan addresses the following changes: children in CMDP moving out of the CRS program, change in CRS program for state only and partially integrated behavioral health, children in the CRS program moving to new contractors, RBHA members moving to AHCCCS Complete Care contractors, CRS/DD dual members remaining with UHCCP, transportation vendor changes, and technology changes, including shared service plans. We know how critical the family is in the education process, so we

inform both members and their families. We will use the peer and family supports available in the community and at our provider offices to engage members and their families in the educational programs we offer. Our new member advocacy positions (e.g., member advocate, transition coordinator, adult and child health care administrators, adult and child behavioral health member advocates, veteran advocate, individual and family affairs administrator, court coordinator, employment/vocational administrator and care management staff) will help members transition and gather feedback from the members. Recognizing that providers will vary in their knowledge of AHCCCS Complete Care and the changes that are a result of the new system, we will incorporate both broad and targeted education as needed.

We will seek feedback from our existing ***Behavioral Health Provider Advisory Council*** and ***CRS Member Advisory Council***, as well as the newly formed quarterly ***Member Advocacy Council*** *and the* ***Governance Committee*** (to begin within 30 days of award) for input on educational approaches for new/enhanced materials. Feedback will also be incorporated into our training materials, creating targeted education, by population or provider type, as necessary.

We understand that members, families and member-focused community organizations may face challenges with the transformation to AHCCCS Complete Care. We consider providers a key partner in developing and distributing educational materials, since they are a trusted source of information for members. We will create and seek AHCCCS approval for educational materials about AHCCCS Complete Care that informs members how to access services and benefits, based upon provider input. Additionally, we will engage community organizations, members and their families to educate and support their readiness for this change.

Members can better navigate the health care system when they are aware of their assigned PCP, dental home and behavioral health providers. Based upon our comprehensive network, we will keep members with their assigned providers, whenever possible, to minimize confusion. Some members will move to new health plans (e.g., foster children currently enrolled in the CRS program). We will work with ACOs and other specialty providers to ensure members receive continuous, seamless care.

Self-Monitoring: We use feedback, from all stakeholders and our robust data tools, throughout the transition to create targeted educational strategies for members and providers. During a recent transition, pharmacy data highlighted the need for targeted outreach to members using non-contracted pharmacies.

We will use transition experience and lessons learned for the AHCCCS Complete Care transition. Educational strategies will include at a minimum:

- Community forums and community organizations; NAMI, peer and family run community service agencies (CSAs), Raising Special Kids and Keogh Health Connection
- Educational materials (e.g., *Member Handbook* in easily understood language, *Care Provider Manual*, explanation of system integration change) distributed via mail, website and direct staff interactions
- Informing members of the our advocate, liaison and coordinator roles and how they can be reached for help
- Member outreach by both our staff and contracted providers
- Identification and engagement of members in active treatment, and their providers, so that they are aware of changes that may impact care planning and delivery
- Workforce management tools, such as Learning Management System training modules for contracted providers
- Provider organizations (e.g., Arizona Academy of Family Physicians)
- Provider forums, webinar, bulletins, one-on-one visits from our provider relations team and UHC On Air live and on-demand video-based training
- Targeted education focus for all PCPs
- Provider technical help around FFS payments (e.g., billing guides, use of clearinghouses, benefit coordination)
- Staff education and readiness monitoring

Special Supports for Providers to Promote a Smooth Transition

In early 2017, we created our Behavioral Health Provider Advisory Council, meeting with a diverse group of behavioral health providers often to understand their concerns and develop solutions to enable mutual success. Their key concerns include implementing new processes and payment models for each AHCCCS Complete Care contractor, implications integration has on members' access to services, potential for complicating internal operations and processes, data sharing requirements with AHCCCS Complete Care contractors and among providers engaged in members' care and how these changes will impact financial viability.

We recognize providers, particularly those delivering behavioral health services, may have challenges dealing with multiple AHCCCS Complete Care contractors as opposed to a single RBHA. We commit to leading efforts with other contractors, and in concert with AHCCCS where necessary, to minimize variations and administrative burdens for providers, where possible.

We are particularly sensitive to the behavioral health providers who may end up moving to an integrated model as well as a new payment model. We have 49.1 percent of spend in acute care value-based models and we are well poised to design payment options to meet providers where they are and support their transition to AHCCCS Complete Care. Our executive team, including our CEO Joe Gaudio, has met with key providers to educate them on the new contract expectations, address their concerns and discuss how we can best support them.

CommunityCare Platform
Includes member's assigned providers, ADT and 27 months of claims data. It allows providers to share member service plans and secure messages, get alerts for members in EDs or hospitals, enter assessments and create referrals to social services — all for improved and coordinated care.

Providers will be in varying states of readiness and financial stability, prior to implementation, affecting ability to move from block funding to transaction-based reimbursement. We are committed to moving providers from block funding to FFS and value-based purchasing (VBP) models. Working with providers, we will use tailored approaches to determine the best fit for each provider and offer incentive options tied to integration activities and improved member outcomes. We will consider cash advances as an interim solution to support providers through transition. For those providers new to FFS claims processes, we will deliver special education around billing and will commit to a dedicated provider claims and billing testing process well before the transition.

In discussions with our behavioral health provider advisory council, they identified the lack of data sharing, poor member health-literacy education, and lack of collaboration among providers as improvement priorities. We address these concerns through enhanced clinical systems for sharing comprehensive member treatment information, focused and targeted member education and incentive-based models to encourage collaboration. Our goals are reduced fragmentation and increased sharing of data across the delivery system. Our CommunityCare platform, anchored by a collaborative workflow technology tool called HealthBI, includes comprehensive historical claims data, open quality gaps in care, physical and behavioral health diagnoses, lab results and pharmacy data, which allow providers to see a holistic picture of a member's needs and enables virtual integration of care teams and service providers. When providers use the CommunityCare platform to share information with other providers involved in a member's care, they will receive a payment incentive, beyond their fee schedule payment, for the interaction. We will use all functions of the Health Current HIE, and encourage providers to do so as well, to create more data flow in the health care delivery system. As Health Current's functionality expands, we will incorporate functionality into our systems and encourage provider adoption. Provider feedback is used to gauge our success and to make system improvements.

Question 4

Our organizational alignment through a single entity allows us to administer integrated benefits seamlessly, ensuring members experience one system of care without fragmentation or duplication.

We administer integrated behavioral and physical health benefits for Medicaid beneficiaries in 22 states, resulting in comprehensive experience developing, implementing, managing and monitoring integrated benefit programs. Our successful experience includes Arizona's integrated care programs—CRS, ALTCS/EPD, and GMH/SA. This strong operational infrastructure serves as a solid foundation for delivering AHCCCS Complete Care. Our proven organizational practices include:

- Incorporating primary and behavioral health care needs in network development, provider contracting, care coordination and management
- Offering integrated settings that serve members' primary care and behavioral health needs and encourage member utilization of those settings
- Reducing duplication of services, consistent with the integrated care guidance AHCCCS provides

To improve individual health outcomes, enhance care coordination and increase member satisfaction, we constantly evaluate health plan performance locally. We review innovative programs and processes/policies in place at a national level that support integrated benefit administration and can be leveraged locally. We also leverage feedback from providers and members to help direct strategic planning, process improvement and decision making. One way we do this is through our local Governance Committee, made up of at least 25 percent peers and family members who will be or have been participants in the behavioral health community in our assigned geographic service areas (GSAs).

Organizational Practices to Successfully Administer Integrated Benefits

Our organizational practices that enable successful administration of integrated benefits can be summarized in alignment with the three-tiered implementation strategy outlined in our response to RFP Question 2. These practices are rooted in managed care fundamentals but go beyond to drive and support transformation. Our approach (see Figure) addresses members' behavioral, physical and social needs while modernizing the health care system with more accountable and integrated participants. The tiers include: ***Evidence-Based Care Management and Coordination, Network Transformation*** and ***System Integration and Modernization.***

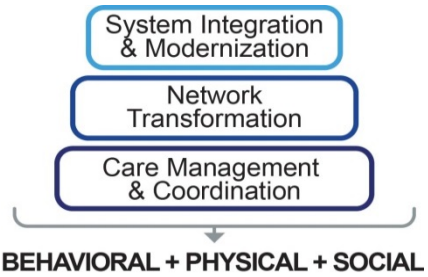

Figure 3. Our organizational practices align with our three-tiered strategy, which is rooted in care management and coordination, and reflects our vision to be more than a managed care company.

Evidence-based Care Management and Coordination

We have decades of care management and care coordination expertise and maintain responsibility for these functions even as care management activities increase at the provider level. The following integrated practices improve health outcomes, enhance care coordination and increase member satisfaction:

- ***Integrated Care and Special Healthcare Needs (SHCN) Expertise*:** Throughout our organization, committed staff work together to ensure members' whole-health needs — and provider needs — are consistently represented and considered. Our health plan leaders bring unique expertise and very special backgrounds. For example, Dr. Leslie Paulus our CRS and SHCN medical director, provided direct physician care to patients at the Phoenix CRS multi-specialty, interdisciplinary clinic (MSIC) and has nine years of experience managing our CRS statewide program. Judy Walker, our ombudsman member advocate, has worked extensively with CRS and with organizations representing members with SHCNs since 1986. Our in-house expertise is enhanced through strong local relationships with community organizations and leading behavioral, physical and integrated care providers — many of which participate in our Member Advocacy and Behavioral Health Provider Advisory Councils — and

our exclusive national partnership with the Camden Coalition of Healthcare Providers, an industry leader in delivering integrated services to low-income individuals.

- ***Care Managers and Coordinators with Physical and Behavioral Health Experience:*** Our local care management and coordination teams comprise experienced behavioral health professionals, RNs, social workers and community health workers (CHWs). Care managers are cross-trained to identify and address members' physical, behavioral and social needs through high-touch, personalized interactions. They receive advanced, evidence-based training to improve health outcomes, such as Mental Health First Aid, trauma-informed care, motivational interviewing and crisis intervention. As part of an interdisciplinary care team (ICT), including psychiatrists and medical directors, they focus on holistically evaluating a member's situation to identify issues and solve them.
- ***Comprehensive Health Risk Identification:*** Effective care management and coordination requires identifying health risks in our members. Our integrated member ID/stratification process incorporates behavioral, physical and social determinants of health and recognizes that comorbid individuals have total expenditures almost twice that of those without comorbid medical and behavioral diagnoses. We leverage predictive modeling to produce actionable information that reveals member-specific care opportunities. The results show every member's circumstances and needs, their level of health risk, and the driving factors (behavioral, physical or social) of their needs. Each member is assigned an overall integrated risk score and additional, targeted risk scores (e.g., behavioral risk, future risk of inpatient care). The risk scores allow us, and provider partners, to identify and prioritize members for outreach and intervention.
- ***Integrated Service Plans and Technology-enabled Coordination:*** Our clinical technology platform, CommunityCare, allows us to capture and share a holistic view of members' needs — physical, behavioral and social — which are incorporated into an integrated service plan. CommunityCare is a key component of ensuring coordination, integration and communication among our staff, behavioral and physical health providers and members. Within the system, providers and care managers can send email messages or appointment reminders directly to members, and members can respond. ***CommunityCare has its own mobile app***, allowing members to view and sign their service plan. CommunityCare tracks health risk assessments (HRA), information related to members' behavioral, physical and social needs, and provider treatment plans, allowing our staff to run reports to electronically monitor and audit provider performance.
- ***Matching Members with the Right Provider for their Needs:*** We help members connect with providers who meet their needs, through our Provider Recommendation Engine (PRE). PRE is an intelligent rules engine that systematically matches members with preferred providers while respecting member choice and distance standards. Preferred providers include integrated providers, those who demonstrate higher quality scores and lower costs, have value-based purchasing (VBP) agreements with us, or may be recognized as a Center of Excellence. PRE is leveraged for preferential auto-assignment for members in need of a PCP and is used by our call center staff when members seek a new PCP. This is one way we guide members to integrated care settings.

Network Transformation

AHCCCS Complete Care contractors are encouraged to develop specific strategies to promote care integration activities, such as establishing integrated settings, which serve members' primary care and behavioral health needs. ***We will expand access to integrated practices and increase the utilization of preventive and evidence-based care to improve member care and health outcomes.*** We recognize not all providers can deliver integrated care within their four walls. This is why we assess providers for their level of integration and sophistication, understand their ability to take on risk and accountability for population health activities and if they participate with integration activities, like the Targeted Investments Program. We tailor our support to meet providers where they are, help them grow their capabilities and advance along the continuum of integration, defined by the SAMHSA-HRSA Center for Integrated Health Solutions.

Meeting Providers Where They Are

To know how to best support providers in delivering integrated care for our members, we assess and segment providers based upon multiple inputs, including provider type (e.g., primary care, behavioral or specialty care), size of assigned/

attributed member panel, amount of financial risk they are able to accept and level of integration. Our evidence-based integration assessment tool places practices on the SAMHSA-HRSA continuum. The following chart, reflecting this continuum, shows the level of integration for select providers in our Arizona ACO network, including the CRS MSICs.

	Coordinated **Key Element: Communications**		**Co-located** **Key Element: Physical Proximity**		**Integrated** **Key Element: Practice Change**	
	Level 1 – Minimal Collaboration	Level 2 – Basic Collaboration at a Distance	Level 3 – Basic Collaboration On-site	Level 4 – Close Collaboration On-site with Some System Integrations	Level 5 – Close Collaboration Approaching an Integrated Practice	Level 6 – Full Collaboration in Transformed/ Merged Integrated Practice
Central GSA	Common-wealth Phoenix Pediatrics	Phoenix Children's Care Network	Mountain Park Health Center Adelante Healthcare	Equality Health Maricopa Integrated	Bayless Healthcare Phoenix MSIC	
South GSA	Yuma Priority IPA Yuma Valley Family Medical	Children's Medical Center Tucson Arizona Community Physicians Sunset Community Health Center (CHC)	Mariposa CHC El Rio CHC – CODAC site Chiricahua CHC – Southeastern AZ Behavioral Health Service	San Luis Walk-in Clinic	COPE Community Services El Rio CHC (at eight PCP Clinic Sites)	Tucson MSIC Marana El Rio CHC-SIA (Special Immunology Associates)
North GSA	Kingman Regional	North Country CHC		Yavapai CHC Canyonlands		Spectrum Healthcare

We use the integration assessment results in combination with detailed practice-level information to determine the right support for each provider. **We offer support through innovative financial models, education and technology, which helps providers build capacity and treat members more holistically; strengthens service delivery by connecting providers and community organizations; and fills delivery system gaps for specific member needs.** For example, we offer integrated incentives to our ACO partners based upon total cost of care for the members assigned to them and additional office visit reimbursement to providers (PCPs, behavioral health providers and integrated providers) who lead care coordination efforts for defined members through our Provider-led Integrated Care Coordination (PLICC) program. Both of these organizational level practices encourage the delivery system to collaborate and integrate care to improve health outcomes. Additional practice-specific examples of tailored support we provide to encourage integration include:

- Phoenix Pediatrics, a Level 1 practice, cares for a large group of children with special health care needs. We support them through on-site behavioral health and dental professionals to achieve a higher level of integration. We provide technical guidance, data (e.g. identifying members' co-occurring behavioral health conditions and treatment location), connections with behavioral health partners and innovative contracting strategies.
- San Luis Walk-In Clinic is a Level 4 practice. When we learned of their interest in adding behavioral health support on-site, we provided immediate contracting assistance to assure a smooth integration.
- We do not stop supporting practices even if they are fully integrated. We are supporting Spectrum Healthcare (Level 6) in its effort to integrate Genoa Pharmacy, which provides high-risk, high-needs pharmacy model to improve outcomes measures and compliance.

Supporting Behavioral Health Homes

Behavioral health homes (BHHs) and Integrated Contractors (ICs) are key to successful implementation of integrated care under the AHCCCS Complete Care contract and the Targeted Investment Program. We contract with BHHs and ICs to serve as the behavioral health intake, assessment, service planning and case management agency. BHHs span the

range of integrated care levels, and we offer them the same assessment and support to encourage integration as described above. We confirm assessments are completed and service plans are updated regularly as member needs change. Through our care managers, ICT meetings and Joint Operating Committees (JOCs), we assure coordination between the BHHs and the member's PCP, specialty providers and others involved in care or treatment.

System Integration and Modernization

Clinical evidence and our own experience show that better behavioral and physical health outcomes are achieved when the social factors contributing to an individual's health are addressed. We do this at a member level through care managers who are trained to identify and address the social needs of our members and by supporting provider partners to do the same. However, to make a more meaningful, long-term impact for the Medicaid population, ***our goal is to integrate health and social services in the community***. To do this, we pioneer ways to use managed care technology and resources to align systems that serve Medicaid members. These efforts align with the nine guiding principles for the Adult Service Delivery System, such as focusing on the individual as a whole person; empowering the individual to take steps toward independence; and integration, collaboration and participation with the community of one's choice.

In early 2016, we launched myConnections in Maricopa County. MyConnections is an initiative to organize social resources in a community to reflect their impact on health care costs and outcomes. There are three main components to this strategy in Arizona — the creation of nearly 500 permanent supportive housing units, 100 of which are reserved for our members, a first-of-its-kind one-stop health and human services center, and a social services network.

- ***Supportive Housing:*** We use our integrated ID/stratification and predictive modeling algorithm in combination with other data and referrals to identify members who would benefit most from stable housing, then connect them with a low- or no-rent apartment. After we place members in a stable home, we provide supportive wraparound services to treat their physical and behavioral health conditions. This supportive housing intervention is based upon the evidence-based Housing First model.
- ***Community Connect Center:*** At our Community Connect Center in Maryvale, we partner with Chicanos Por La Causa to provide behavioral, dental and primary care services. We provide assistance with employment, housing, transportation, food and clothing.
- ***Social Supports Network:*** We have developed a distinctive social services network in Arizona, in which over 40 community organizations currently participate. These organizations take referrals and share data through a collaboration agreement, which enhances organization and coordination of resources for members with social needs. Using the data we gather from social service referrals, we perform gap analyses to better understand community capacity to address social issues. This information informs coordination and investment strategies.

Past Experience Administering Integrated Contracts, Improved Quality Outcomes and How We Will Apply this Experience and New Strategies

Arizona Experience

Reducing CRS Emergency Department Utilization

We have been the sole statewide contractor serving CRS members with integrated benefits since 2013. We deployed a multifaceted approach to effectively manage care for this population with special health care needs, including:

- Sharing actionable data (behavioral and physical) with ACO partners
- Building our ACO strategy around key delivery service partners, namely MSICs, to serve as the medical home for CRS members
- Integrating key care management teams within the health plan, including utilization management (UM) and high-risk care management

The impact of these strategies is demonstrated in the ***9 percent reduction in Emergency Department (ED) use*** during the three-year period from July 2014 to June 2017 for our CRS members assigned to a PCP in an ACO.

Improving Quality for ALTCS

We achieved improved quality outcomes while administering integrated benefits for the ALTCS population. Our long-term care quality improvement strategy includes an integrated case manager who works individually with each member to coordinate care and close gaps in care. This focused case management assures care is coordinated and integrated across physical and behavioral health and produces improvements in our outcome measurements. For example, over a three-year period (2014-2016), quality scores improved for the following measures:

HEDIS Measure	2014 Results	2015 Results	2016 Results	3-Year Percent Improvement
Follow Up After Hospitalization for Mental Illness – 30 Days	44.68%	68.09%	68.00%	**23.32%**
Adult Body Mass Index (BMI) Assessment	30.44%	36.75%	47.48%	**17.04%**
Comprehensive Diabetes Care (CDC) – Nephropathy	78.59%	88.08%	92.46%	**13.87%**
CDC – Eye Exams	68.37%	81.75%	81.27%	**12.90%**
CDC – HbA1c	70.80%	78.59%	79.08%	**8.28%**
CDC – HbA1c Control (<8.0%)	43.31%	47.20%	46.96%	**3.65%**

New Mexico Centennial Care Experience

Since the initiation of integrated behavioral and physical health in New Mexico in 2014, our New Mexico health plan has achieved significant improvement in quality scores. This is due in part to the effective use of the integrated care coordination and management strategies and network transformation initiatives, including:

- Implementing an integrated care team model, which facilitates a comprehensive approach to assessing our members' physical health, behavioral health and social needs, such as housing and employment
- Shifting to value-based, population-oriented care, which encourages providers to collaborate
- Using population-specific strategies to engage a wider range of members in care coordination and management programs. For example, some members with behavioral health conditions may be reluctant to engage due, in part, to ongoing societal stigma of mental health and substance use issues, and lack of readiness for change. To address this, our New Mexico health plan employs care managers who have training in behavioral health; connects members with peer support or CHWs; or refers members to trusted providers for care coordination.

The impact of these strategies can be seen in the following quality improvements from 2014-2017:

HEDIS Measure	3-Year Percent Improvement
Annual Dental Visit (ADV) Total	**12.41%**
CDC – Nephropathy	**7.78%**
Frequency of Ongoing Prenatal Care (FPC)	**12.41%**
Follow Up After Hospitalization for Mental Illness (FUH) – Seven Days	**2.78%**
FUH – 30 Days	**3.61%**
Prenatal and Postpartum Care (PPC) – Prenatal	**10.46%**
PPC – Postpartum	**10.94%**

Applying Past Experience and New Strategies

We bring to the AHCCCS Complete Care contract, lessons learned through successfully administering integrated benefits and improving quality outcomes for CRS and long-term care (LTC) members in Arizona and Medicaid members in New Mexico. For example, both states benefited from multifaceted member engagement strategies with heavy focus on integrated care management, provider partnerships, data sharing and incentives. This insight informed several

innovative strategies we will deliver under the AHCCCS Complete Care contract, including our ACO strategies and the new PLICC program. Additionally, peer support in New Mexico is not a stand-alone covered service, but our commitment to the consumer voice and choice is so important that we hired peer and family support partners on our care coordination and outreach teams. In Arizona, peers and family members enrich members' health care experience by engaging members in their own care. Our experience confirms leveraging an integrated care team model is effective.

Engaging Members through Technology and Social Media

Member engagement strategies, including through use of technology, are an important element of our approach to care management and coordination. Our goal is to educate and empower members to take an active role in their health — both behavioral and physical. Our innovative capabilities include tailored digital communications, mobile and web-based tools that enable engagement wherever and whenever needed. To continually improve our engagement platforms and develop new tools, we measure member use and analyze feedback received through our Member Advisory Committee, surveys, focus groups, call centers and other stakeholder input. We engage members through personalized tools in two categories: self-directed tools and tools that connect members and care teams. Examples follow.

Self-directed Tools

Baby Blocks: This web-based incentive program rewards members for attending appointments during pregnancy and the first 15 months of their baby's life. Since the program's launch in Arizona in 2012, over 9,440 AHCCCS members have enrolled. This program is available in English and Spanish and members can earn up to eight incentives, which are specifically designed to promote babies' cognitive development and physical safety, including books, educational toys, home safety kits, digital thermometers and more. Baby Blocks provides helpful and evidence-based advice to parents. For example, expectant mothers receive messages like, "*It can be hard to wait for your baby to be born. It's best to give birth after at least 39 weeks. Your baby's brain and lungs are still growing!*" Baby Blocks users have ***lower utilization and costs*** than non-Baby Blocks users across several important measures:

- ***Admits/1,000 are 8 percent lower*** for Baby Blocks babies vs. non-Baby Blocks babies, and ***average length of stay (ALOS) is reduced by 1.6 days***
- ***Admits/1,000 are 2 percent lower*** for Baby Blocks moms vs. non-Baby Blocks moms
- ***Readmissions are reduced by 2 percent*** for Baby Blocks babies and ***0.4 percent*** for moms

KidsHealth®: This web-based educational resource provides health and wellness information in English and Spanish for children, teens and parents. It includes more than 200 videos and 10,000 articles on a wide range of health and wellness topics. *KidsHealth* demonstrates strong results, including:

- ***92 percent*** of users report learning something new
- Results show ***up to a 91 percent drop in 30-day hospital readmission rates*** when *KidsHealth* asthma videos are included in discharge instructions

Websites: Through a single member sign-on, we offer secure member portals with the following:

- Medication reminders and personalized health reminders (e.g., gaps in care)
- Confidential access to professional behavioral health care, self-help programs, interactive tools and educational resources, such as:
  - *Three Recovery Toolkits:* One for mental health, one for addiction recovery and one for family members. The toolkits contain resources members can use to support their wellness between visits.
  - *QPR (Question, Persuade, Refer) for Suicide Prevention:* This training program helps family and friends learn how to ask and what to do if someone is thinking about suicide.
  - *Peer Videos:* 75+ short videos of people in recovery talking about stories of hope.

Social Media: We use social media to deliver targeted local health information and invite members to community events. For example, we recently used Facebook to bring awareness to a 2017 back-to-school health fair that we held in partnership with Isaac School District. It featured a lineup of services to get children and families ready for school. ***More than 2,000 people participated*** and received 800 backpacks for young students, 40 medical screenings, 160 dental screenings, and 170 vaccinations.

Figure 4. More than 2,000 people attended our back-to-school event.

Other self-directed technology tools include:

- ***Health4Me:*** Free mobile app (available through the Apple iTunes App Store and Android Market), which provides education and easy ways to contact UHCCP, and sends alerts about needed preventive services and sends push notifications.
- ***A-CHESS:*** A smartphone-based system (downloadable through the Apple iTunes App Store and Android Market) for preventing relapse and increasing engagement and activation in substance-use disorder services.
- ***Whole Health Tracker:*** Free mobile app available through our member website that is used to address a variety of physical, behavioral health and life situations.

Tools Connecting Members and Care Teams

Telemedicine: We were pleased to support AHCCCS' 2017 effort to revise AMPM Chapter 300, Policy 320-I, Telehealth and Telemedicine. We offer multiple telemedicine options (e.g., dermatology and telepsychiatry), which extend service delivery and allow members to access services in the most effective way for them. We have seen annual utilization of telemedicine ***increase by 50 percent*** in Arizona over the past year. A new opportunity we have identified for telemedicine is to ***enhance screening across Arizona for at-risk children***, especially those with developmental delays. In support of this, we executed a Memorandum of Understanding (MOU) with Southwest Autism Research & Resource Center (SARRC). As part of this agreement, SARRC uses store-and-forward video and Autism Spectrum Disorder (ASD) screening tools, combined with clinical review, to reduce the time to assess a child with a potential developmental delay.

MyHealthLine: Nearly two-thirds of low-income individuals use their phone to obtain health information and 79 percent text to communicate. *MyHealthLine* aligns with this preferred method for engagement. It is a program that extends the national Lifeline benefit and offers a smartphone, data plan, secure 1:1 texting with a care manager, and condition-specific text campaigns to members, plus free calls to UHCCP. ***Eighty-five percent*** of participants would recommend the program to a friend, and it helps us reduce the number of members we are unable to reach by ***5 percent***. Text campaigns help members control diabetes and quit smoking. Early results look positive, including:

- ***50 percent*** increase in smoking abstinence at six months; ***1.3 percent*** reduction in HbA1c levels

Video conferencing: Use of video conferencing in our Justice Reach-In program allows our justice system liaison to increase member touchpoints and engagement, which enhances our ability to connect members to physical and behavioral health providers prior to release, improves member education, reduces ED visits/inpatient admissions and lowers the recidivism rate post release. The first year of our Justice Reach-In program, CYE 2017, we worked with 241 individuals. Our analysis found an ***ED reduction of 30 percent, inpatient admission reduction of 53 percent, and an overall member cost reduction of 68 percent*** post release once engaged by the justice system liaison and a care manager. Coordination with justice partners, natural supports and community resources resulted in a 97 percent success rate of members remaining stable in the community, thereby reducing member recidivism.

Question 5

Our new member, Maria, presents with a complex clinical scenario, including a diagnosis of schizophrenia, an opioid use disorder (OUD) with use of IV heroin, significant health issues (diabetes, chronic pain) and social needs (homeless, food insecurity). Based upon what we know, it is likely that her stabilization in the Emergency Department (ED) was required primarily due to her mental health status, and her length of stay in the ED was impacted by having arrived on a Friday. With notification that Maria is in the ED, information gathering and planning must begin immediately so that when readiness for discharge is verified, we can quickly complete the process of coordinating services to move her safely from the ED to a setting where she can continue to receive behavioral health and primary care services and further stabilize post discharge. We have robust processes for managing the types of transitions represented by this scenario (e.g., an individual with complex needs moving from one Offeror to another), facilitating ED discharge to a respite setting, then orchestrating long-range provisions for primary care management and care coordination, which may involve a transfer of Maria's care to a Regional Behavioral Health Authority (RBHA) if warranted. Our overarching goal is to facilitate the most appropriate primary health home setting, relationships and services that optimize Maria's stability and positive health outcomes. This requires an integrated approach to address her behavioral health, physical and social needs — beginning before she arrived in the ED, continuing during the ED visit and after discharge — to empower Maria with the supports she needs and desires to make progress toward her goals. Core principles guide our engagement with Maria, aligning with those of AHCCCS — our efforts are grounded in respect for cultural difference and the need for strength-based solutions that foster hope and resiliency and recognize individual choices.

Our Steps Prior to Emergency Department Admission

According to our protocol for transferring members from another Offeror, prior to Oct. 1, 2018, our transition team would have analyzed data about Maria provided to us via a Data Exchange File (DEF) from the relinquishing plan. The DEF includes information, such as diagnoses, pharmacy claims, providers, and if there is active behavioral health care. Based upon these data, Maria would have been flagged as a high-need/high-cost incoming new member. Additional data gathering about Maria's health history and current status would then be collected during a series of our pre-transition meetings with the relinquishing Offeror prior to the October 1 enrollment date. We assume that Maria would most likely qualify as an adult having special health care needs (SHCN) [42 CFR 438.208(c)(1)/AMPM Chapter 500, Policy 520] and our high-risk care management staff would plan for the process of outreach to her immediately upon her enrollment date. This proactive approach with high-need/high-cost new members allows for rapid identification, targeting and starting the engagement process as soon as possible. We do not know this based upon the facts in this scenario, but we assume that our attempts to contact Maria as our new member began on October 1, but were unsuccessful prior to her ED admission, given the challenges to immediately locate and engage individuals who are experiencing homelessness.

Emergency Department Admission and Treatment Phase

Maria was admitted to the ED on Friday, Oct. 12, 2018. Notification would be sent to us in real time via a daily admit, discharge and transfer (ADT) alert from Health Current, the Health Information Exchange (HIE). Receipt of this alert flags members with SHCNs in CommunityCare, our care management platform. Upon receiving this notification, an RN care manager with assistance from a community health worker (CHW) would immediately outreach to Maria and the ED staff to begin the discharge planning and placement process. The care manager's thorough and rapid assessment of this new member is extremely important based upon the numerous factors to consider and the urgent need to transfer Maria to a more appropriate setting as quickly and safely as possible. When the final notification that she is stable enough both physically and psychiatrically to be released comes on Oct. 15, all plans can be smoothly executed for a successful care transition to a new location where she can continue to further stabilize. The immediate task in the ED is to find an appropriate next setting to meet Maria's continued needs for physical and behavioral health stabilization, with an understanding that longer range planning can occur after she is released from the ED.

In preparation for contacting the ED and member, the care manager gathers collateral information from data sent by the incumbent Offeror and the State (e.g., DEF files), including the list of general medical and psychiatric providers, the diagnoses she has currently along with all medications by prescriber. Combined with information gathered by the ED staff, the care manager can begin to assemble a description of events that led up to the ED admission and how the member is responding to treatment in the ED and begin to evaluate discharge alternatives. This data may help fill in gaps for the ED team who may have trouble getting an adequate history from Maria and who would be grateful for the input.

During Maria's time in the ED, the care manager starts process of engagement with her, a crucial first step that must be done intentionally with everyone considering Maria's schizophrenia. Many factors can be present that make this more difficult, including disorganized behavior in addition to the presence of cognitive deficits — particularly in someone in their 50s living with schizophrenia. It is important for the care manager to discuss information gathered with the ED discharge planner, nursing staff and medical providers and to read information in the electronic medical record (EMR), as the care team needs all data sources to make an initial assessment and discharge plan. Although it is stated she is "medically and psychiatrically stabilized" enough to be discharged, our care manager must verify this using evidence-based *MCG Care Guidelines* and American Society of Addiction Medicine (ASAM) criteria because three days is a very limited time to truly stabilize someone with schizophrenia, OUD and active symptoms of brittle diabetes. Information gathered during this ED assessment is entered into CommunityCare to begin creating a shared service plan for Maria. Results can be used by subsequent caregivers to reduce repeating assessments and to help better coordinate her care.

Problem List to Guide Discharge Decisions

Behavioral Health Concerns

First are Maria's diagnosis of schizophrenia and a history of inconsistently taking her psychotropic medications. It is important we coordinate assessment with the ED staff so she does not get overwhelmed with repeat questioning. Important elements that should be asked include what medications Maria takes, when she last picked them up at the pharmacy and who prescribes them. This information can be crosschecked by looking at her psychotropic prescribing history from the DEF files and running a check of her prescriptions using Health Current, including its link to Controlled Substances Prescription Monitoring Program data. Medication bottles she may have in her belongings can be checked for names of prescribers. The care manager asks if Maria has been taking her psychotropic medications prior to her ED stay and ensures she has an adequate supply until she can be evaluated again after discharge — important because running out of psychotropic medications before she can be evaluated next can lead to decompensation and a return to the ED. It is important to ask who Maria is currently seeing for psychiatric care and if she is a member of a behavioral health home where she has a treatment plan and may be working with a psychiatric provider, adult recovery team, case manager, peer specialist and therapist. The care manager evaluates any safety concerns; prior or current reports of suicidal ideation or trauma are important and could affect placement decisions.

Maria's second behavioral health concern is the use of opioids then IV heroin, presumably related to managing her diabetic neuropathy pain. The care manager can assess Maria's use of opiates using a tool, such as the DAST 10, to gain more understanding of use patterns, as it is important to determine the extent of opioid misuse or dependency. The results of a urine drug screen during the ED stay and any signs of withdrawal over the three days are helpful in assessing any recent heroin use. During the ED stay, the care manager and ED providers can explore temporary alternative ways to manage her pain so that Maria knows she can have some relief at discharge. In addition, understanding her use and dependency on opioids informs the care team's approach to discharge options, including a placement where Medication Assisted Treatment (MAT) is a treatment option, if Maria chooses this intervention, including MAT from a qualified PCP. If it is determined that Maria needs opioids as an element of her treatment, our care manager promotes adherence to the CDC and Arizona Department of Health Services (ADHS) Opioid guidelines, including co-prescribing Naloxone to reduce risk of overdose.

Physical Health Concerns

Maria has been identified as having "brittle" diabetes that is, by definition, very difficult to control and marked by high and low swings in blood sugar that can be dangerous and life threatening. Although not stated in the scenario, Maria's PCP may have prescribed insulin for this condition, which we can help verify using data from the DEF file or the Health Current, and asking Maria about insulin in her possession. If so, Maria may be having difficulty with regular use of this medication that is also facilitating her access to needles for heroin use. Being homeless can contribute to her inability to coordinate insulin self-administration with access to regular meals and inconsistencies with storing her insulin and monitoring her blood sugars. Obtaining and using heroin creates even more impediments to managing her diabetes with insulin injections. Addressing diabetic complications is important for Maria; in addition to her chronic pain from peripheral neuropathy, further complications, including blindness, heart and kidney disease, are likely developing and represent high-cost conditions and much potential suffering for Maria. It is important for the care manager to address this high-risk condition in the discharge planning process so appropriate placement and ongoing care integrating her psychiatric and physical health needs can be considered, including the need for ongoing preventive care tied to HEDIS goals (e.g., diabetic retinal exams and HbA1c monitoring) and insulin administration.

Social Needs

Maria is currently homeless, estranged from her family and challenged to find regular meals that are important for managing her diabetes. It is unlikely that a homeless individual, even with access to sources of food support, would have access to an American Diabetes Association diet plan. This factor requires an even more comprehensive approach to her discharge plan. Assessment of disability status and her current preferences for living arrangements are important factors to consider in guiding placement considerations. The care manager is motivated to find a rapid solution now that discharge is imminent and her housing and living situation is paramount to address.

OPTIONS UPON DISCHARGE

Our care manager engages with Maria to solicit her agreement on plans for her care after she leaves the ED. At a minimum, the care manager discusses with Maria a relationship with a PCP, either her former PCP who is now not in-network, or a different source of primary care. Also, there is a question as to whether Maria was ever assessed and determined to meet seriously mentally ill (SMI) criteria and whether her current circumstances potentially make her eligible for and amenable to accept the services offered to members with a SMI provided through a T/RHBA. However, as a first step, based upon her complex needs and the importance of leaving the ED as soon as possible, Maria can benefit from a post-ED, facility-based solution offering a safe place to further stabilize management of her comorbid psychiatric, OUD and physical conditions. Our care manager will discuss with Maria transferring to a setting that provides a stable environment for a short period to address her multiple issues and form a solid long-term solution guided by her input and desires. Options to consider include a skilled nursing facility, residential treatment or a medical respite stay in conjunction with an arrangement for housing.

Arrangements for Short-term Respite Care and Housing

Different scenarios are possible for Maria immediately post-ED discharge, depending upon her willingness to remain engaged with care coordination and her preferences and choices among alternatives. One excellent discharge option for Maria is placement with Circle the City (CTC), which offers an innovative approach to holistic, integrated care for individuals living with homelessness. CTC provides a 50-bed short-term medical respite resource, in a clean and respectful environment, for individuals who are experiencing homelessness and are ready for discharge from ED or inpatient care. CTC coordinates a safe and sober place to stay with primary care and behavioral health services while also collaborating with us through our myConnections program to further evaluate and plan for addressing members' social needs. To address physical and behavioral health needs, PCPs on staff at CTC can provide close follow up for Maria's unstable diabetes and assist with a plan for managing her insulin use, diet and chronic pain. A psychiatrist provides medication consultation to the PCPs and psychiatric treatment. Medication changes (e.g., use of long-acting injectable antipsychotics), can be considered to address medication adherence if Maria agrees to this regimen. The

continuation of evaluation and planning by on-site behavioral health staff meets the HEDIS measures of seven- and 30-day follow up from ED discharge for behavioral health and substance use reasons. If MAT is determined as a viable option to address Maria's use of opioids, and if she is willing to pursue it, our care manager will work with CTC to initiate it.

Addressing Maria's social needs is a critical component of planning that must occur during the respite stay. CTC works with myConnections — our specialized program that organizes resources to address safe living environment, food insecurity and socialization — all critical elements that maximize impact on health care costs and outcomes. Launched in 2016 in Maricopa County, myConnections includes myHousing, 100 permanent supportive housing units, and a one-of-a-kind one-stop health and human services Community Connect Center in Maryvale. It is a network of social service organizations sharing data and referrals and wraparound services (e.g., embedded staff, peer supports, on-site nurse practitioner and/or physician support contracted through TeamMD, and MAT and counseling services). As a critical first step in planning for Maria's longer-term needs, CTC staff works with our care manager and housing specialist to coordinate Maria's referral and qualification for a myHousing open unit. Our CHW shows Maria the unit to gain her approval and support Maria when relocating to this residence. If Maria chooses not to engage in the housing option, CTC has a mobile van, which could provide services to her if she chooses to return to the street.

Circle the City can work with us to plan to address Maria's other social needs. During her CTC stay, CTC staff, assisted by our care manager and CHW, can connect Maria with our myConnections Community Connect Center for practical guidance on specific foods that are appropriate given her diabetes, including sources for food. Our Healthy Savings program will offer access to healthier food through a discount program being arranged for our members through a UnitedHealthcare partnership with food manufacturers and local grocery retailers, such as Bashas. Using *Healthify*, a statewide, validated community resource tool, CTC and our CHW will help to identify and coordinate referrals and plans for the broad range of services from our community partners that will be most helpful to Maria, including provisions for healthy meals.

Should Maria decline the respite option provided by CTC, another option to assure Maria receives the intensive, high-touch care management and care coordination that will benefit her immediately post ED stay would be fostering her engagement with a transition team through ConnectionsAZ. ConnectionsAZ is being established as a center of excellence offering a novel approach to supporting high touch transition care for individuals with high risk/high need. Upon referral, ConnectionsAZ can provide a comprehensive approach to immediate short-term behavioral health treatment while helping Maria to engage with an outpatient interdisciplinary care team (ICT) for longer-term care management. Our care manager, working as a team with a CHW and housing specialist, would continue to provide important care coordination activities, such as working with the staff at CTC or ConnectionsAZ to secure a myHousing bed, finding transportation options required by Maria, facilitating information sharing between the ED and receiving providers, including updating all information in CommunityCare, and educating and preparing Maria for the transitions from the ED to respite care and then to a longer-term plan of treatment and services. The care manager would make sure medication orders are written and filled so there is no break in the care transition process assisting with medication reconciliation, as needed.

Longer-term Options for Ongoing Care Management

Long term, the integration of care for her behavioral health, primary care and social needs is extremely important for Maria. A close connection to providers and services with monitoring and support by a care manager are important components of her treatment and service plan. Plans must include access to medication monitoring services, given Maria's history of inconsistent medication use, as well as use of advanced therapies, such as long-acting antipsychotics and clozapine. Her primary care must include oversight and supports related to her diabetes and observation for any evidence of IV drug use, including opioid intoxication.

There are several options and scenarios that Maria could choose as part of her ongoing primary care management and care coordination once ED discharge and initial stabilization have occurred. Maria's PCP prior to her joining UHCCP, is

not in our network. Should Maria want to remain with this PCP, we have a continuity of care prior authorization process to approve ongoing care from this PCP for a period prior to a transfer to an in-network provider. Our care manager would work with this PCP on care planning, and potentially this PCP could be added to our network. Our care manager can explore other options for primary care management and coordination, considering Maria's location and choices. One option is to assign her to one of our contracted, integrated accountable care organization (ACO) practices offering enhanced care management and care coordination for complex individuals with behavioral health needs.

A team-based behavioral health home (BHH) would be ideal for the co-management of medical needs (diabetes, chronic pain) with her behavioral health conditions (schizophrenia, opioids/heroin use) while social needs are addressed (food, housing, peer supports, employment) as part of her long-range recovery. Peer support, an evidence-based practice, is uniquely effective at building trust and will be critically important to foster Maria's engagement in ongoing care management. Our network includes several ACO partners who are qualified to function as BHHs and/or participate in our Provider-led Integrated Care Coordination (PLICC) program. These practices have the advantage of using our CommunityCare platform for information sharing among a member's ICT, including peer supports that would play important roles as part of Maria's care team. One example of an ACO is Equality Health, which includes some practices with co-located and fully integrated primary care and behavioral health providers who work actively with peer providers and other community-based services. Should Maria affiliate with this type of practice, she would engage with a practice-based case manager. However, in any case, our care manager will follow up with Maria's providers, which could include an endocrinologist, and Maria at regular intervals to monitor her progress and confirm services and supports continue to meet her needs. Joint care planning and information sharing with the behavioral health staff in the BHH are a crucial role for the care manager to support the ongoing success and recovery given Maria's complex needs. Technology options can provide valuable support for Maria and her ICT. Through a federal cellphone program, we can facilitate Maria obtaining a smartphone. Providing Maria with a smartphone would promote contact with ICT members and allow her participation in our texting program for reminders of appointments, health/wellness messages and access to other online wellness and prevention tools. This phone can be used to keep Maria aware of the location of urgent care centers in her area and how to reach crisis support personnel as part of her crisis plan. The peer support specialist on Maria's ICT would help Maria develop personalized crisis and recovery plans. These plans would be maintained on our member portal, including a Whole Health Tracker self-management tool that allows Maria to track her health and recovery goals and identify triggers that could lead to relapse.

Pursuing Additional Benefits for Maria

We provide Maria the full range of covered benefits, care management and care coordination as described. She may already receive or be eligible for additional benefits, including SSI or, depending upon past work history, SSDI. SSI or SSDI would provide her a source of revenue; members of her care team would assist with needed applications, if needed. If Maria qualifies for SSDI, she may also be Medicare-eligible or already have Medicare, in which case she would be a dual eligible GMH/SA member or qualified to choose a Dual Special Needs (D-SNP) plan. If a D-SNP plan were chosen (e.g., UHC Dual Complete), benefits include $3,250 in additional annual dental care or a Personal Emergency Response System safety device. It is also possible that Maria may have been evaluated for an SMI determination at an earlier time and either was not eligible, or she declined to accept the designation. Based upon Maria's current behavioral health and related functional status, pursuing an SMI determination might now be in Maria's best interest; if she remains difficult to engage and cycles in and out of homelessness, she would have access to the Assertive Community Treatment team services consisting of mobile outreach to individuals wherever they may be. During the post-ED period, the process of completing the SMI Assessment Packet for review by the Crisis Recovery Network for eligibility can be initiated. Should an SMI designation be affirmed and Maria willing to accept it, we initiate a transition process with the T/RBHA and ensure a smooth transfer of care. Where Maria ultimately decides to receive her care is a personal choice supported by her care manager and treatment team. Exploring SMI determination, disability qualifications, additional benefits (e.g., housing and utility assistance if determined SMI) and interest in employment options are all components of a well-rounded, long-term recovery plan, which will be tracked and supported by her care manager on an ongoing basis.

Question 6

Donita is at a critical crossroads in her life, requiring immediate medical stabilization due to the potential complications of being pregnant with sickle cell disease (SCD) in addition to depression and intermittent use of opioid medications during the first two trimesters of her pregnancy. Donita faces significant unmet social needs upon jail release. We assume Donita's SCD was largely stable prior to incarceration through her past connection to our integrated CRS program for her SCD, a CRS-qualifying special health care needs (SHCN) condition. As a returning CRS member, we support her transition from jail to the community and her transition to the adult system of care. Post release, using a team-based approach with Donita's special needs care manager (SNCM), Pamela Ray, as the team lead, an ICT provides assistance navigating the adult system of care — physical and behavioral health care, parole and social services. We define roles, coordinate handoffs, hold team meetings and use our care management platform, CommunityCare, to facilitate coordination of care and efficient information sharing between interdisciplinary care team (ICT) members. Donita's ICT encourages her to define her own recovery, build resiliency skills, care for herself during pregnancy and after, and care for her newborn or make a decision to allow for adoption. The priority is to stabilize Donita in the community as quickly as possible post release by supporting appropriate service utilization and offering Donita informed choices to meet her needs. With early, coordinated, holistic prenatal care, women like Donita who live with SCD can have healthy pregnancies and positive health outcomes for both mom and baby. The ICT leverages the critical components of behavioral and physical health service delivery to address Donita's mental health needs like depression and anxiety, her sickle cell condition, including pain medication needs. The ICT carefully monitors and adjusts service delivery, includes interventions for social needs, and tracks Donita's outcomes throughout her pregnancy and beyond.

Sickle cell disease in pregnancy trend and pregnancy outcomes: Our data analysis (May 2014 – April 2017; 25 deliveries) shows outcomes trend positive for our pregnant AHCCCS members with SCD who received evidence-based prenatal care management and coordination. The average gestational age for these women at delivery was 37 weeks. Further, 64 percent of the time delivery occurred no earlier than 37 weeks gestational age and their newborns did not need neonatal intensive care unit (NICU) services. In addition, 32 percent of deliveries occurred at greater than 39 weeks gestation (eight of 25 births). Only one infant out of 25 newborns had neonatal abstinence syndrome, and 12 percent of newborns were diagnosed with sickle cell disease.

Complex physical and behavioral health and the social determinants of health (SDOH) have a significant impact on individual health and well-being and on population health. We pay careful attention to member-directed recovery, offering community supports and resources and access to coordinated health homes (primary care, specialty care and behavioral health) thus offering an interdisciplinary approach for our members with SHCN. In Donita's case, the integrated health home resides at the Multispecialty Interdisciplinary Clinic (MSIC). We adhere to AHCCCS' Adult Nine Guiding Principles for member and family-centric care. We have formed MSIC accountable care organizations (ACO) with value-based purchasing (VBP) agreements, which include enhanced data-exchange. This network transformation approach facilitates improved outcomes for member and population goals. For example, in our CRS experience for the 12 months prior to July 2017, our members in CRS ACOs demonstrated a ***9 percent decrease in Emergency Department (ED) utilization/1,000 and a 20 percent decrease in inpatient utilization/1,000***. These positive results demonstrate practice transformation, incentivized with VBP programs, is a strategy that measurably improves care.

Transition from Jail and Re-engagement in High-risk Care Management Phase

Donita was recently released from jail. Prior to her release, our justice system liaison, Mary Krawczyk, assists Donita with the transition from jail to the community by providing support for her physical, behavioral and social needs. The justice system liaison was alerted to Donita's incarceration via the 834 file, which showed suspended AHCCCS eligibility. Although the state of Arizona suspends Medicaid eligibility during incarceration, it makes Medicaid benefits immediately available upon release from jail. During CYE 2017, our justice system liaison and her team worked with 241 individuals who were transitioning from jail or prison settings. She meets with individuals prior to release to provide intensive, wraparound services in a holistic, person-centered approach in coordination with probation/parole, thus reducing re-

arrests, hospitalizations, ED utilization, homelessness and more. Our justice system liaison establishes trust through empathy and respect, and understands health disparities and the need to treat individuals in this population with respect and cultural sensitivity. Upon receiving notification of Donita's incarceration, the justice system liaison:

- Reviewed Donita's previous integrated service plan in CommunityCare and notified Donita's previous SNCM of Donita's pending jail release via CommunityCare alert, re-establishing the SNCM as lead for the ICT. Dr. Paulus, our special needs medical director, provides clinical/administrative support for our SNCMs. She was a CRS pediatrician/internist for four years and has nine years of experience managing our CRS statewide program.
- Contacted Donita while she was in jail to identify her post-release physical, behavioral health and social needs, advising Donita that her previous SNCM will continue to lead her ICT while the jail liaison assists with the jail transition. The SNCM, Pamela Ray, has nine years of experience with sickle cell disease management and was Donita's SNCM prior to her jail stay. Maintaining this relationship facilitates Donita's continuity of care.
- Called jail staff to get jail-related background information. Jail staff reported Donita had been receiving care for her SCD and depression and attending monthly pregnancy checkups while in jail. Jail staff conducted a pregnancy test, which confirmed Donita's pregnancy.
- Scheduled an initial face-to-face meeting with Donita using video-conferencing technology, a best practice and important tool our justice system liaison uses to increase member touchpoints and engagement. The justice system liaison used an empathy and recovery approach to gain trust while exploring Donita's perspective of her incarceration and gain more insight into her pregnancy and intermittent opioid use. During this meeting, the justice system liaison assessed Donita for physical and behavioral needs and any social barriers in the way of a successful reintegration with the health care system post release. The justice system liaison also:
  - Verified Donita's family availability and other natural supports to help her immediately post release with housing and offered family counseling to improve Donita's relationship with her family/natural supports.
  - Reviewed with Donita choices related to becoming a parent or creating an adoption plan and determined the availability of family or other natural supports to assist with childcare, if parenting was chosen.
- Received County Detention and Prison Release Reports confirming Donita's release date, then coordinated the necessary urgent treatment referrals and scheduled the MSIC appointments with Donita's PCP, a behavioral health professional (for depression and possible trauma treatment), her hematologist and OB specializing in high-risk pregnancies (pregnancy and pain management). Specialists not providing care at Donita's MSIC participate in ICT meetings (in-person or virtual).
- Focused on Donita's immediate connection upon jail release back to her health home at the MSIC and formation of an adult recovery team (ART), including a peer support specialist, to support her recovery.
- Notified our maternal child health program manager to enroll Donita in our Healthy First Steps (HFS) high-risk OB program and assign an HFS high-risk OB care manager (with consent) to the ICT during the pregnancy.

The week of jail release, the justice system liaison called Donita to reiterate the availability of post-release care team support and the time/place of the ICT meeting. She verified Donita had contact information for ICT members and knew how, when and where to seek local urgent care, if needed. She confirmed Donita had stable housing arrangements, maternity clothes donated by a community-based organization, a supply of prenatal vitamins, medications for pain, and a plan for getting refills, transportation from jail to her chosen community-based housing, and transportation to and from provider appointments scheduled pre-release by the justice system liaison.

Steps to Ensure Continuity of Care in the Community Post Jail Release

A woman living with SCD is more likely than other pregnant women to have problems (e.g., infections, pulmonary complications, blood clots, pain crisis more frequent, more preterm labor and low birth weight infants) during pregnancy. These issues can affect the health of mom and the unborn baby. Post release, throughout the pregnancy and 30 days postpartum, the HFS high-risk OB care manager assists and coordinates activities with Donita's SNCM related to

managing services for the high-risk pregnancy and delivery. The SNCM explains to Donita the HFS high-risk OB care manager's role on the ICT. The first week post jail release, the SNCM:

- Establishes Donita's initial post-release ICT, which includes Donita, the SNCM, the justice system liaison, a representative from a team-based behavioral health home, an HFS high-risk OB care manager, an MSIC SCD clinic nurse and a peer support specialist to assist during the re-entry transition and stabilization period. The ICT flexes depending upon Donita's needs and her desired ICT attendees. The ICT provides seamless, coordinated support without duplicating work.
- Contacts Donita, administers a health risk assessment and evaluates success of Donita's transition to the community. Donita confirms depression, and with her agreement, the SNCM conducts the PHQ-9 assessment for depression and a supplemental suicide risk assessment to further identify severity and risks, entering assessment results in CommunityCare.
- Discusses, reviews and coaches on the importance of preventive care opportunities, such as those we promote as part of her EPSDT eligibility. Donita's MSIC PCP will perform her EPSDT wellness visit, or if she desired it can be coordinated with her obstetrician as another option. At this visit, it is important to assess care any gaps, such as reviewing her vaccination history and/or service needs like a dental visit with her assigned dental home. Dental care and good oral health education are important issues, particularly during pregnancy with some studies showing a link between periodontitis and premature birth and low birth weight.
- Verifies Donita still plans to attend and has transportation to physical, dental and behavioral health appointments, including an appointment for Cognitive Behavioral Therapy for pain management, an evidence-based practice shown to improve outcomes for pain management.
- Ensures Donita has prescriptions for treatment of depression and medical needs and a plan for getting refills.
- Discusses Donita's goals and possible interventions, including how Donita might be able to get a high school diploma while attending to the demands of her depression, pregnancy and SCD.
- Helps Donita with her transition to the adult system of care in both physical and behavioral health — a process the CRS MSIC would have completed due to her age.

As part of the ICT, the HFS high-risk OB care manager reaches out to Donita to:

- Verify Donita's appointment date with a high-risk obstetrician and explores for barriers for attendance.
- Educate Donita about healthy behaviors during pregnancy (e.g., the importance of proper nutrition); about neonatal abstinence syndrome; and about options for pain management and depression, including alternative treatment options like meditation.
- Verify the obstetrician performs the ACOG screening for the presence of other conditions.
- Assist Donita with completing the applications for the Women, Infants and Children (WIC) program and Supplemental Nutrition Program (SNAP) for nutritional needs.

Donita's hematologist from the MSIC and high-risk obstetrician coordinated Donita's care by teleconference to discuss the risks and benefits of narcotics and effects on the unborn child in the context of Donita's preferences for pain control. Donita's hematologist agrees to manage, track and monitor Donita's use of opioid for pain and use either the Arizona State Board of Pharmacy Controlled Substances Prescription Monitoring Program (CSPMP) or Health Current, the HIE.

Ongoing Care Planning — The Power of a Locally Integrated, Member-driven Approach

Post jail release, evidence-based practices, such as the 2014 *Sickle Cell National Heart, Lung, and Blood Institute's (NHLBI) Guideline* and *CDC Opioid Prescribing Guideline*, direct Donita's care and services. The ICT continually monitors and documents Donita's progress toward meeting goals and recommends adjustments, as needed, or ways to address identified barriers. The SNCM oversees Donita's care management and coordination:

Physical Health Concerns

- ***High-risk pregnancy care and SCD*** – Coordinate a comprehensive health examination at the MSIC to help Donita's ICT and ART understand her total care needs. The most suitable services for Donita are integrated services with expertise in blood diseases, those offering same-day/walk-in availability and those easily accessed by public transportation or by Medical Transportation Brokerage of Arizona. Donita maintains choice of where her care is provided, although she uses the MSIC as her health home.
- ***Medication reconciliation/SCD pain management*** – Due to Donita's need for opioid pain management, she is at risk for opioid dependency/abuse, as well as transition reconciliation errors from ED or hospitalizations. Donita chooses who on her team has access to substance use information. The SNCM monitors that the physician is updating her medication regimen and checking CSPMP. In addition, she will be referred to a pain management specialist if Donita has a positive psychosocial screen using a standardized measurement tool (NSDUH identifies elevated risk for abuse; NIDA and SAMHSA for elevated risk for accidental overdosing) or greater than20 morphine equivalent daily dose. Referrals for pain management with adjunctive treatment, cognitive behavioral therapy, biofeedback or other alternative therapy is closely coordinated with hematologist and high-risk obstetrician input.
- ***Self-sufficiency*** – The SNCM educates Donita about ED alternatives, including 1) using key assigned nurse contact at the SCD clinic at the MSIC for increasing symptoms; 2) calling Banner University Medical Center adult SCD Center for a same-day appointment for uncontrolled pain if Donita needs IV fluids or a transfusion. The SNCM reviews the *Member Handbook* when discussing ED use and provides SCD disease management information and education, if needed.
- ***Wellness*** – The SNCM helps Donita sign up for *Health4Me* for mobile access to *myuhc.com*, *Text4baby (educational text program)* and the *Baby Blocks* app, which provides health and wellness rewards for attending prenatal and postpartum visits and well checkups for babies up to 15 months.
- ***Newborn preparations*** – The HFS high-risk OB care manager helps Donita prepare for the baby's arrival, making sure Donita has breastfeeding support/access to formula, baby clothes and a safe sleep setting for the baby. The HFS care manager helps Donita complete the newborn enrollment paperwork. The baby can go to the same MSIC as Donita for primary care if she chooses and her newborn will be tested for SCD with the newborn screenings.

Behavioral Health Concerns

- ***Trauma/depression*** – Depression is a high priority and safety concern. A behavioral health home (BHH) conducts an assessment for management of depression and trauma history. The BHH recommends careful monitoring of depression throughout Donita's pregnancy and postpartum period when Donita is at risk for worsening depression. The SNCM confirms behavioral health appointment completion and services are in place for treatment and documented in Donita's service plan in CommunityCare. Treatment offered for pain management should include Cognitive Behavioral Therapy.
- ***Crisis and transition plan*** – The ICT works with Donita and her BHH to create an integrated crisis/safety plan and educates Donita to reach out to her BHH or crisis line immediately if she experiences worsening symptoms of depression. A youth transition plan is developed and the plan is reviewed and updated.
- ***Peer support*** – A culturally and age-appropriate BHH peer support specialist will continue to help Donita stay focused on her recovery goals and help her to mitigate the stigma of a criminal conviction.

Social Needs and Removing Barriers to Care and Achievement of Member Goals

- ***Transportation*** – Arrange transportation to appointments, as needed.
- ***Housing*** – Donita's recovery begins with safe housing, allowing her to live, work, learn and participate fully in her community. Safe, stable and familiar living arrangements are critical to a Donita's ability to benefit from treatment/support services to achieve positive health outcomes. Donita has a choice of living with her family,

seeking a UHCCP myConnections/myHousing unit or requesting other housing options. MyHousing is a Housing First permanent supportive housing model in Maricopa County where we invested in nearly 500 refurbished housing units, 100 of which are set aside for our members. The SNCM engages a housing specialist on Donita's ICT if/when she asks for housing options outside of the family home. The care manager assigns a community health worker if additional support in this area is needed.

- ***Food*** – Confirm Donita is receiving WIC and SNAP nutritional benefits.
- ***Communication*** – Referral to the federal Lifeline benefit for a free smartphone, which allows Donita to communicate with her ICT members and to participate in our Baby Blocks member incentive program — at 18 years old, the ability to earn rewards appeals to Donita. When the phone arrives, the SNCM can help her program important contacts, including doctors, care manager, peer, member services, NurseLine and crisis line.
- ***Parenting skills*** – We connect Donita to Teen Outreach Pregnancy Services (locations in Glendale, Tucson, Phoenix and Mesa) for healthy pregnancy education, childbirth classes for teenagers, parenting classes for teen mom and dads, baby goods, clothing, diapers and Parents of Teens programs.
- ***Legal*** – Referral to community-based legal assistance to pursue child support or for adoption, if Donita's choice.
- ***Education*** – The SNCM refers Donita to Linda Abril Educational Academy, an alternative program designed to help students like Donita complete their high school education in a small learning environment with specialized classes and schedules. The SNCM also presents Donita with the choice of completing her high school education by enrolling in an Arizona Workforce Innovation and Opportunity Act program through the Department of Economic Security to complete her GED and for career exploration/training, mentoring, counseling and books.

Care Management Monitoring and Follow Up

At the end of 30 days post birth, the HFS high-risk OB care manager transitions unfinished support issues to the SNCM who continues to follow up with Donita at regular intervals to monitor her progress, confirm completion of appointments and verify services and supports continue to meet Donita's needs. Together, the SNCM and Donita update the service plan. The SNCM keeps Donita's physicians abreast of Donita's progress toward goals, making sure ICT members can access and update Donita's information in CommunityCare and including them in case conferences.

Postpartum depression is a concern because one in six women experiences it after giving birth. Donita's BHH closely monitors her for worsening depression. Interventions may include a change of medications or intensified counseling and supports. Post pregnancy, the SNCM makes sure Donita attends a postpartum visit and well-child visits for her baby. She connects Donita to community-based family planning resources. The SNCM continues outreach based upon updated service plan goals and interventions, at minimum, based upon Donita's needs, exploring Donita's progress toward achieving a high school diploma and her long-term goal of employment. When Donita is ready for employment resources, the SNCM will refer Donita to a myConnections employment coordinator for assistance with bus passes, finding job training, local employment opportunities and childcare resources. The SNCM continually monitors claims and Donita's service plan to verify provider updates and that care and treatment are completed and shared in accordance with evidence-based practices and CDC and Arizona prescribing guidance. The SNCM uses outcomes data to analyze results, including recidivism, ED and inpatient events, and coordination with Donita's providers and community partners. UHCCP leadership reviews metrics indicating the success of our care management and coordination approach, such as leading indicator metrics (e.g., HEDIS for mom, such as timeliness of prenatal and postpartum care and well-baby checkups), outcome metrics (e.g., cost), inpatient admissions, ED and pharmacy utilization.

Question 7

These special populations represent a diverse group of members with complex and significant medical, behavioral health and social needs — often presenting simultaneously. Member engagement and activation are the first steps to achieving improved health status. Members are more engaged and activated in treatment when they define their recovery goals with their providers; are engaged with treatment providers in shared decision making about treatment planning; and use self-care tools that identify, strengthen and support the member's own motivation for change. For adults, member preferences are supported by the formation and facilitation of an Adult Recovery Team (ART). For young members, family engagement is a collaborative relationship where families and legal guardians are partners in their child's treatment, usually as part of a Child and Family Team (CFT).

Employing population-specific strategies — not a one-size-fits-all approach — allows us to reach a wide range of members to participate in care coordination and management programs. We establish trusting relationships with members by supporting and empowering them to improve their health and well-being through individualized, compassionate, whole-person care. Our strategies evolve through continuous quality improvement efforts and are refined through Plan-Do-Study-Act monitoring of expected impact on health outcomes and developing best practices.

Justice-involved Population

The prevalence rates of major health conditions among the jail and prison population when compared to the general population are considerably higher. The rate of chronic conditions (e.g., high blood pressure, heart-related problems and asthma) is 44.7 percent among the jail population versus 26.9 percent for the general population. Prevalence studies suggest up to 64 percent of the jail population has a mental health condition, two of three jail inmates meet criteria for substance use disorder (SUD) and 56 percent of state correctional populations have mental health conditions (MAC Learning Collaborative 2017).

To ensure timely connection to health services, our all-GSA jail transition process focuses on immediate post-release connection to primary and behavioral health providers and an assessment of social barriers to successful reintegration with the health care system. Our justice system liaison, Mary Krawczyk, uses the AHCCCS 834 eligibility file and the County Detention and Prison Release Reports to identify members scheduled for release. Prior to release, Ms. Krawczyk meets with the member using video conferencing to complete a comprehensive assessment, reviews correctional health records, documents member goals, social needs and barriers to care. She communicates regularly with the member and jail/prison/parole/probation staff, ensures the creation of a service plan, and makes referrals for post-release support leveraging our myConnections program with available supportive housing units and our *Healthify* resource referral tool. We will expand our care management capacity, assign members to a behavioral health home and expand peer support options for the increased number of justice-involved members with behavioral health needs on the new contract.

Member engagement: For members identified with physical and behavioral conditions, Ms. Krawczyk offers members and families the choice of an integrated clinic to increase member engagement with physical, behavioral and safety net services during the re-entry phase of care. The Department of Correction (DOC) liaisons provide us with timely exchange of medical history and services provided in the institution. This information expedites discovery of health care needs and improves member engagement. Our Resiliency Empowerment and Activation Choices (REACH) tool identifies a member's level of activation based upon their personal preferences and willingness to change, directing them to appropriate wellness tools.

Develop and implement best practices: Best practices help us identify members' needs and connect them with services and supports to prevent further justice system involvement. This requires multi-system collaboration to be successful:

- We contract with crisis organizations, such as ConnectionsAZ, with specialized criminogenic and health risk assessment experience in helping this population with urgent behavioral health needs.

- Our strategy aligns with the Sequential Intercept Model, which emphasizes diversion from the justice system into alternative services at each stage of the law-enforcement/justice system continuum. Each intercept is an opportunity for linkage to integrated services and prevents further involvement with the justice system.
- Peer support helps improve member outcomes by promoting recovery. Employing people in recovery as peer specialists or in other qualified roles is an SAMHSA best practice with proven member engagement results. ***Based upon our experience from 2014–2016, peers contributed to a 22 percent decrease in behavioral health inpatient admissions/readmissions and close to a 20 percent decrease in total inpatient admissions.***
- Video conferencing is an important tool used by Ms. Krawczyk to increase member engagement pre-release. Early engagement and intervention results in reduced Emergency Department (ED) visits, inpatient admissions and lower recidivism rates post release. Member self-empowerment is encouraged via the Whole Health Tracker self-management tool on our member portal. Individuals set and actively work on goals in 10 domains of wellness.
- Our team identifies pregnant members who are at extremely high risk for negative pregnancy outcomes, have prior substance use and connect them to immediate services post release.

Track, monitor and continuously improve: We analyze recidivism rates, ED and inpatient admissions, seven-day appointment follow-up and crisis services interactions for all justice-involved members. Monitoring volumes and type of services members receive, we adjust service plans when interventions are not meeting member needs. Our quality management staff review metrics that indicate the success of our strategies and clinical approach. Our justice system liaison staff surveys members regarding the resources they need to remain in the community and monitors member reassessment data to connect members with additional services. This tracking identifies opportunities to enhance our community-based organization partnerships and it informs and expands the *Healthify* database so that providers, care managers and community health workers (CHWs) can offer more choices to members and families.

Prison Transition and Recidivism Prevention

The first year of our Justice Reach-In Program, CYE 2017, we worked with 241 individuals. Analysis found an ***ED reduction of 30 percent, inpatient admission reduction of 53 percent, and an overall member cost reduction of 68 percent*** post release once engaged by Ms. Krawczyk and a care manager. Coordination with justice partners, natural supports and community resources resulted in a ***97 percent success rate of members remaining stable in the community,*** thereby reducing member recidivism.

COURT-ORDERED EVALUATION/COURT-ORDERED TREATMENT

In our ***ALTCS, CRS and dual-GMH/SA integrated programs, we identify*** individuals at risk of court-ordered evaluation/court-ordered treatment (COE/COT) early and engage them to voluntarily seek treatment. Our court coordinator is the single point of contact for monitoring the court's disposition for COE/COT involved members. A court field worker is assigned to each member involved in COE/COT inpatient or outpatient treatment and:

- Engages the member, family and behavioral health providers to mitigate potential crisis to support the member in following the treatment plan recommended by the treating psychiatrist.
- Monitors member contact with providers; documents provider feedback about member adherence with outpatient appointments, medications and need for renewal of 60-day judicial review notice.
- Convenes an interdisciplinary case review to discuss changes in health or socioeconomic status. Once a member completes a COT and is discharged from it, the court coordinator maintains contact with the member's treatment team for a minimum of three months to determine additional services or support.

Member engagement: During the COE/COT process, our court coordinator conducts regular status meetings with the interdisciplinary care team (ICT) and behavioral providers to confirm member motivation and progress toward treatment goals and willingness to engage in voluntary treatment. The care manager engages providers and attempts re-engagement with members who withdraw from participation in treatment prior to successful completion, those who

refused services or those who miss scheduled services. The provider documents all re-engagement attempts in the member service plan.

Involuntary to Voluntary Treatment – Member, Family, PCP and Psychiatric Nurse Practitioner Form Clinical Alliance

An AHCCCS member suffered from severe depression, kidney and heart disease and a recent diagnosis of brain cancer. He became so overwhelmed with his medical and psychiatric conditions that he was placed on COT due to suicidal statements and a plan to take his own life. Our care manager rapidly engaged the member's wife and a psychiatric nurse practitioner (PNP). The PNP had frequent consultations with the member's PCP, the member and his wife, and by the second judicial review, the member chose to engage in voluntary treatment and since his needs were being met, the COT was terminated. The member no longer exhibits episodes of anger, depression or irritability, feels empowered and engaged in his health care, and stays connected with his treatment team.

Best practices: We inform members of their choices and guide them to voluntary treatment, a preferable disposition because it promotes recovery, personal responsibility and self-care. Many of our best practices focus on prevention:

- At every stage of the pre-petition screening and COE/COT process, a member can change their status to voluntary allowing the member to direct their own recovery based upon their treatment preferences. Engagement or reengagement of a member's ART is completed as quickly as possible.
- When notified that a member presents at the ED or other settings, our care management team engages Crisis Preparation and Recovery (CPR), Terros or La Frontera EMPACT staff to provide an on-site assessment to determine if a member meets the criteria for emergency or nonemergency petition. We regularly consult with ED physicians and staff to bring the latest evidence-based practices to this specialized field.
- Our diversion-first approach includes collaboration with the crisis response teams, police and paramedicine/EMT units to improve early identification and engagement of members, to facilitate enrollment into services that support the member's return to the community and divert the need for court intervention.
- Tribal coordinator, Joetta Goldtooth, and our care managers engage tribal providers to ensure we comply with State-recognized tribal court orders and to support continuity of care services within the COT.

Track, monitor and continuously improve: With our county and provider partners, we track, trend and monitor our members' disposition and care at all stages of the Title 36 process. This includes monitoring emergency and non-emergent petitions, sources of application, COE volume and member legal disposition (dropped, voluntary or COT). We track and monitor outcomes for COE/COT at the member and population levels and review metrics that indicate the success of our strategies and clinical approach, such as inpatient admissions, ED utilization and PCP visits. The care manager or court liaison documents court-related activities in the member's clinical record, CommunityCare, promoting a complete view of the member and follow-up activities. We are actively engaged with the health care community to help improve COE/COT care processes.

Members with High Needs and High Costs

The implications of behavioral health comorbidities on annual per capita costs for members are uniquely connected to and rise significantly for members with COPD, heart failure, heart disease and diabetes. ***Our high need, high cost (HNHC) strategies demonstrate results. For example in CYE 2016, HNHC care managers coordinated physical and behavioral health and social services during an HNHC UHCCP/RBHA 150-member joint pilot. This pilot reduced PMPM costs by 67 percent, ED visits by 51 percent, inpatient admits by 62 percent and became our strategy going forward.***

Our health analytics team uses Impact Pro™ and a proprietary persistent HNHC (PHNHC) algorithm developed from our experience managing Medicaid populations to prospectively identify HNHC members. Our analytics approach identifies:

- Members at risk for readmission based upon a medical or behavioral health inpatient stay

- High-risk members and members at emerging risk for high claim costs in the next 12 months, by using our PHNHC algorithm based upon integrated physical, behavioral health, demographic and pharmacy data
- Members with chronic conditions with high costs and a likelihood of future inpatient admissions

Our HNHC Claimant Report identifies the top 5 percent of HNHC members by annual total health care costs and by specific clinical, pharmacy, dental and blind spot utilization data. Members identified via any of the algorithms above are flagged on the HNHC Cost Claimant Report. The care management team uses this information to prioritize members with high emerging risk scores and outreach for further assessment and intervention.

Member engagement: Many HNHC members are disenfranchised by the health care system. Our HNHC care managers use persistent outreach efforts to contact and remain in touch with members, including involvement by behavioral health member advocates, CHWs and peer support specialists. We have specialized relationships with Community Medicine paramedics and behavioral health providers, which help us engage hard-to-reach members using the ED for non-emergency care. Member outreach is initiated at the time of facility admission to begin care planning. The member-centered service plan includes interventions and creation of measurable goals to close identified gaps. Our care managers continue to support the member/provider relationship by identifying health and community resources. The following illustrates an HNHC member success story:

Prioritizing High Needs, High Cost Members for Outreach, Assessment and Intervention

In 2017, our HNHC Cost Claimant Report identified a member with more than four ED visits within a six-month period. The care manager discovered this member used the ED for non-emergent visits, had high annual service costs and was not seeing a PCP or specialist. The care manager engaged a CHW who educated the member on appropriate use of the ED and the importance of seeing a PCP and needed specialists. The care manager helped the member find a behavioral health therapist for reported depression and provided the member with dental care resources. As a result, this member no longer used the ED, completed PCP and specialist visits and had claims for biweekly behavioral health therapist visits, which the member reported improved her depressive symptoms.

Best practices: We deploy several strategies to help members with HNHC receive the right care at the right time:

- Care managers connect members with peer support specialists and CHWs to engage members who are resistant to participating in care management services. Other engagement strategies include the use of the REACH assessment tool, motivational interviewing and online cognitive behavioral therapy to help individuals overcome their fear, anxiety, lack of self-confidence or hesitancy about participating in care management activities.
- Our myConnections/myHousing supportive housing program provides a safe environment where free or subsidized housing units with embedded clinical and non-clinical support services are set aside for our members to address their integrated care needs. Care managers and CHWs use the *Healthify* tool for community referrals.
- We address family needs through Mental Health First Aid training, refer to the National Alliance on Mental Illness (NAMI) national and Arizona chapters, and connect families with community-based family supports.
- Through our HNHC DDD program, our staff identifies Acute/DD members who have a CRS condition. They submit applications with medical records to AHCCCS for possible enrollment into the CRS specialty program.

Track, monitor and continuously improve: Care management leadership uses HNHC report data to analyze reductions in ED and inpatient and improve coordination with providers. We review HEDIS and outcome metrics (e.g. cost) pharmacy utilization and ED utilization to measure the success of our strategies and clinical approach. We identify common barriers to care and services, including a lack of healthy family supports, like childcare, so parents can attend treatment. To mitigate these barriers, we expand partnerships with community-based programs and enhance our provider network and staff training. We share this information with provider partners to collectively address HNHC members.

Members with Substance Use Disorders

Substance use is a critical public health issue in Arizona, which ranks 41st in drug deaths (*America's Health Rankings*,

2016). We use American Society of Addiction Medicine (ASAM) criteria to determine the most appropriate level of care when assessing a member's SUD treatment needs. Our company's opioid strategy focuses on prevention and early intervention, increasing adherence to CDC guidelines, encouraging cultural competence and sensitivity, reducing stigma, connecting people to community-based supports and promoting evidence-based treatment practices for addiction.

Member engagement: Trauma-informed care, a recognized SAMHSA evidence-based practice, is a basis of our SUD care approach. We require care management and CHW staff to complete training in motivational interviewing to more fully engage with members needing SUD services. A behavioral health advocate assists the member and their family/natural supports to improve their interactions with care team members and the delivery system. Our health risk assessment (HRA) tools include questions to identify trauma backgrounds and SUD behaviors and we use supplemental assessments to fully assess SUD. The REACH assessment helps members enrolled in our behavioral health programs identify their level of activation and provides resources in which to increase their activation.

Best practices: To address the needs of members with alcohol, tobacco, opioids and other SUD, best practices include:

- We encourage people with personal experiences in the mental health system to become peer and recovery support specialists to provide a key service to individuals during their recovery journey.
- We make psychometrically sound screening tools and clinical guidelines widely available to providers in our CommunityCare portal and *Care Provider Manual*. Our *Behavioral Health Toolkit for the Health Care Professional* offers behavioral health information to PCPs and encourages SUD screening. Our *Pain Management Toolkit* educates prescribers of the need to assess for comorbid conditions leading to abuse.
- We encourage use of *Arizona Opioid Prescribing Guidelines* in primary care and specialty outpatient settings for providers managing acute and chronic pain not related to cancer and/or palliative care. We improve prescriber adherence to the CDC Guideline for Prescribing Opioids for Chronic Pain through education and pharmacy edits at the point of sale. We direct members to medication-assisted treatment (MAT).
- We encourage use of A-CHESS, a smartphone app designed to improve competence, social relatedness and motivation, using the three tenets of self-determination theory.
- Medical Director Dr. Copeland and our pharmacy director meet with the top opioid prescribers to review prescribing patterns, educate them on CDC prescribing guidelines, our *Behavioral Health Toolkit*, MAT, and Naloxone dispensing and coverage to prevent overdose. Our established peer review process manages provider-specific quality of care concerns.

Our ***Pharmacy Restriction Program*** identifies members with high opioid utilization. Today, 373 members are locked into one pharmacy based upon their pharmacy over utilization. We implemented long-acting opioid authorization criteria on Jan. 1, 2017 and ***decreased national utilization per 1,000 members by 25 percent.***

- Pregnant women and mothers face unique challenges and hardships (e.g., worries about removal of children from the home) as they seek SUD treatment. They benefit most from gender-specific, integrated programs that address the families' need for safety, food, transportation and childcare.
- Seeking Safety is an evidence-based counseling program that helps members achieve safety in managing the effects of trauma, health concerns or SUD. Peers and care managers broadly disseminate the training materials.
- We partner with White Bison Wellbriety Training Institute, a national organization providing trauma and SUD resources, trainings and supports. They target the unique SUD needs of American Indians using traditional healing practices aligned with their cultural values.
- We refer members to ASHLINE for tobacco cessation and use *Healthify* for alcohol support program referrals.

Track, monitor and continously improve: As an enterprise, we invest in reducing opioid use while ensuring safe and effective treatment of pain. We track neonatal abstinence syndrome babies and moms, monitoring progress and outcomes. Our pharmacy team uses an opioid utilization data tool to compare AHCCCS member opioid utilization to CDC

benchmarks and shares outcomes with the community for problem solving. The data alerts us to members using opioid medications in combination with benzodiazepines, putting members at significant clinical risk. Opioid prevention includes prospective drug utilization review (DUR), retrospective DUR, utilization management (prior authorization and quality limits), and prescriber and member surveillance. Community engagement is crucial in solving SUD/the opioid epidemic. To enhance our efforts we are mapping actual ***member journeys*** and meeting with community partners in February 2018, to share this critical work. We will compare our end-to-end programs and resources available for members with SUD and together, find system delivery gaps and opportunities to take further actions to address them.

Children at Risk of Removal by the Department of Child Safety (DCS)

In Arizona, 50 percent of children removed by DCS are age five or under. Our priority is to prevent removal of children from their homes and support the family unit. We identify at-risk children and families and help parents to secure safe treatment in lieu of placing children in out-of-home settings or the foster care system. We believe the most desirable place for a child to grow up is with their own families, in school and in their communities where families and caregivers can provide safe, nurturing and stable homes.

Member engagement: We identify at-risk children through multiple channels. For example, when a child is in crisis, the crisis provider is notified by the crisis call line and visits the home, assesses the situation, engages the child/family and notifies us via a rapid response form. This communication describes the crisis visit and immediate next steps. As clinically and legally indicated, we outreach to the family to assure child and family involvement in the planning process and that immediate stabilization services are in place. Our DCS liaison schedules a PCP visit for additional evaluation and support to the child/family. Our care manager engages the behavioral health home to ensure a CFT is convened to address the critical issues and needs placing the child/family in jeopardy. We establish trust and positive relationships with everyone involved as it takes many community professionals to address the health, welfare, legal, nutritional, educational and social needs of a child at risk of removal.

Best practices: Child safety, prevention and well-being are our top priorities. The following practices guide us:

- Use incremental steps to move children and families from where they are to a better level of functioning. Assess circumstances and resources and communicate the necessary activities to assure ongoing safety and stability in the home. Crisis and transition plans are in place for children transitioning to adulthood.
- Ensure assignment of a provider-based high-needs case manager and convene interdisciplinary team meetings and CFTs, including teachers and other school staff when agreed to by the child and parent/guardian, to develop a child and family specific service plan and align goals.
- Promote PCP screening for risk during EPSDT well-child visits to assess the home environment for the presence of domestic violence, SUD, economic insecurity, food uncertainty, stable housing and other health and safety barriers. We ensure child welfare concerns are reported to the proper authority.
- Implement Family Access to Stabilization and Treatment (FAST) program for youth 12-18 years old at risk of being removed from home or inpatient hospitalization due to issues with their mental health or behaviors. FAST provides diversionary options from crisis intervention to follow-up care that includes in-home counseling.
- Connect families to services, including home visiting services, respite, peer support, living skills training, family counseling, parenting skill support through Triple P, Love and Logic, or Circle of Security and community organizations that support families and children (e.g., Family Involvement Center and Raising Special Kids).
- Address stable housing needs, employment and food insecurity by connecting families to the ARIZONA@WORK Program and myConnections/myHousing.
- Build relationships with foster, adoptive and kinship families through the Member Advocacy Council.
- Identify children and youth whose development has been disrupted by trauma, increase their access to effective interventions, and strengthen linkages between systems that serve vulnerable children and families.

- Ensure care coordination with providers and families in the Families F.I.R.S.T program to help families overcome the barrier of substance use to preserve permanency and maintain employment.

Track, monitor and continuously improve: We track, monitor and measure the success of our strategies and clinical approach using changes in levels of care as measured by the CASII; HEDIS measures (inpatient and ED); the number of children who remain in the home, who are successful in school and who avoid delinquency; and utilization of case management services and provider-based high needs case manager-to-child ratios. We adjust strategies to make sure they lead to safety, permanency and well-being for children.

Children Transitioning to Us from the Comprehensive Medical and Dental Program

Transitioning from foster care to home is exciting and stressful for the child and their family. ***In CYE 2017, our transition coordinator and team transitioned 446 children in foster care Comprehensive Medical and Dental Program (CMDP) to UHCCP with no member or family complaints.*** During the reunification process, we take extra precaution to assure the child and family are equipped to deal with the differences between home and the foster home. New rules, schedules and continued engagement in health care affect the success of the transition. We identify children through the 834 AHCCCS file and Enrollment Transition Information documents from the relinquishing program, which enables us to coordinate services and prevent care gaps. We approve non-participating providers to prevent service delays. All children transitioning from CMDP have an assigned provider-based high needs case manager to help the family maintain stability and coordinate care for one year from the date of closure with CMDP. If a child remains AHCCCS eligible, the provider-based high needs case manager continues to support and coordinate services for the child and family.

Member engagement: Our transition coordinator prioritizes children with complex care needs and refers them to a care manager who connects children/families to our network of pediatricians, behavioral health and specialty providers, mobile crisis services and family/peer supports. Our staff and providers perform welcome calls and complete an HRA, which guides member-specific interventions. We enhance member engagement through NurseLine, natural language IVR, *myuhc.com*, *MyHealthLine* wellness text programs, Whole Person Tracker, *KidsHealth.org* and social media.

Best practices: We apply the following actions and best practices to improve family situations and improve outcomes:

- Coordinate with the behavioral health home and provider-based care manager to ensure the CFT reflects the strengths, needs and preferences of the reunited family and to support the updates to the service plan, working toward the same goals. One year following the transition, the last meeting confirms stabilization and verifies service plan completion or recommendations for follow-up care if the child is no longer AHCCCS eligible. If eligibility remains intact, the case manager continues to support and coordinate services for the child and family.
- Minimize disruption by allowing a child to continue to see their provider(s), if out of network.
- Meet the child and family in their community and encourage consistency with the service plan.
- Partner with providers, CFTs, schools and community-based organizations to support, strengthen and help families avoid re-engagement with DCS. We conduct monthly outreach calls to check on the child and family and to offer services (e.g., school supplies through a community agency) and address unmet needs.

Track, monitor and continuously improve: We monitor services and outcomes through claims data, CFTs and care manager involvement to confirm that the child is receiving ongoing health services and verify progress toward child and family-defined goals. We review metrics to assess the success of our strategies and clinical approach by measuring reunification success, school success, delinquency prevention, utilization of case management services and provider-based high needs case manager-to-child ratios.

Question 8

The heart of our solution is keeping pregnant women and their families engaged, educated and empowered to ensure healthy outcomes for moms and babies. We foster high standards of care to improve outcomes, add value and improve the experience of pregnant women and their families through our care management and coordination approach to implementing critical components and principles of behavioral and physical health service delivery. Network transformation and system integration and modernization enhance our ability to achieve optimal outcomes.

New and Enhanced Strategies for Pregnant Members and Their Families

With approximately 35,000 pregnancies and births over the last three years, our Healthy First Steps (HFS) maternity program focuses on early identification of pregnant members, increased access to services that are culturally and socially relevant to Arizona women and their families, and ensuring our members receive the care and services necessary to promote a healthy pregnancy and achieve positive health outcomes. We use sophisticated analytics to understand members' unique physical, behavioral, and social circumstances, and their level of health risk. Health risk assessments, OB assessments, behavioral health screeners (e.g., PHQ-9 depression and AUDIT-C alcohol screeners), claims data and referrals help us identify members with specific conditions, such as high-risk pregnancy and members with special health care needs (SHCN). We assign high-risk pregnant women, including those with SHCN, to an experienced OB high-risk care manager who provides education, additional risk screening, coordination and outreach to OB practitioners. They work with our HFS, program community health workers (CHWs) to address a member's social issues and verify member engagement with a behavioral health home, Child and Family Team or Adult Recovery Team and peer support specialist, as needed. They help members remove barriers to accessing and getting to care. For providers, we support initiatives to reinforce evidence-based OB care, develop innovative new approaches to support practice transformation and reward providers for high quality health outcomes.

Pregnant members receive HFS health promotion activities, including education regarding healthy behaviors during pregnancy, and assistance connecting to OB care. Our maternal child health coordinator oversees all aspects of our HFS program while developing, implementing and measuring the effectiveness of strategies designed to improve pregnancy and neonatal outcomes. She empowers member/families to make good decisions, and reduces costs associated with hospitalizations and prolonged neonatal stays. ***Our HFS program met 100 percent of the 2017 AHCCCS Operational Review goals demonstrating our program strategies improve outcomes through high quality care and service delivery.***

Care Management and Coordination-Related Strategies

We design our population health strategies to reduce the risk of maternal and infant mortality and pregnancy-related complications by facilitating member access to quality preconception, prenatal/postpartum and inter-conception care.

Enhanced Strategy to Increase Timeliness of Prenatal and Postpartum Care

Key priorities:

- Assure early identification of pregnant members' holistic needs and coordinate timely and effective services
- Connect pregnant members to community service providers, medical home and/or behavioral health home
- Continually improve HEDIS measures for timeliness of prenatal and postpartum care

Prenatal care is vital in preventing complications that can adversely affect a woman's health during pregnancy and delivery of a healthy baby. Postpartum care is essential to screen for depression, assessing physical and mental health after delivery, providing family planning guidance, breast-feeding support and nutrition counseling. We review our strategies continually to ensure they meet the required goals, modifying them as necessary.

Our statewide HFS maternity program leverages field-based CHWs. Our HEDIS scores have trended positive year over year since implementing this CHW strategy in 2015. The CHWs are local, member-facing staff who are trusted members of the community and provide face-to-face outreach in rural, frontier, tribal and urban area where they share ethnicity,

language, social and life experiences. Our CHWs help locate and engage pregnant members we cannot reach by telephone. They direct women with at-risk pregnancies to our HFS high-risk OB care management program; provide health education; and assist members in finding an OB provider, setting up appointments, and arranging transportation. They assess member's social needs using their local knowledge of resources and the *Healthify* community resource tool to connect members to food banks, housing, breastfeeding support and other maternity/newborn supports. They support families by connecting them to employment and supportive housing resources through myConnections/myHousing and to community supports through Healthy Families, Nurse Family Partnership, Parent Partner Plus Alliance, and Family Spirit in the White Mountain Apache Tribe for pregnancy support through home visits and parent education. They help women enroll in our Baby Blocks member incentive program and the *Text4baby* educational text program. They help families complete the applications for the WIC and SNAP nutrition programs.

Enhanced Neonatal Abstinence Syndrome Prevention and Care Management Strategy

Key priorities:

- Improve mom/baby health outcomes and reduce substance use/misuse by pregnant members
- Increase provider use of evidence-based practices and clinical practice guidelines
- Increase cost savings through prevention, care management/coordination and innovative programs

Newborns are the tiniest victims of the drug-use epidemic, particularly opioids. Our neonatal abstinence syndrome (NAS) prevention and intervention activities to improve health outcomes spanning the continuum of care from preconception, pregnancy, birth and postpartum, extending through a baby's first year or as clinically indicated. Skyrocketing rates of NAS in Arizona parallel the rise in prescription and illicit drug use, with associated increases in hospitalization and costs. From 2008 to 2014, Arizona's rate of NAS increased by 235 percent with AHCCCS as the payer in 79 percent of those cases. We have been an active participant in the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs, which promotes updated *Substance Exposed Newborn (SEN) Guidelines* for provider screening, referrals to treatment and follow-up care management supports and services for moms with SUD and their newborns. We connect members to and keep them engaged with medical and behavioral health providers and community supports. In addition to the alert for members with SHCN, we set a CommunityCare alert to separately track pregnant women with opioid use disorder and pregnant women with co-occurring pain and opioid use.

To prevent and address early in-utero opioid and other addictive substance exposure, identification of members at risk of delivering a baby with NAS is key to getting them into treatment. In CYE 2017, we identified 131 babies diagnosed at birth with NAS and will use this data for future baseline outcome tracking. Risk identification occurs through:

- Family/provider/community referrals or members who self-report prescription opioid or illicit substance use
- Data analytics using opioid pharmacy reports, analysis of pharmacy claims with opioid medications and review of prior pregnancy history to identify moms of babies born with NAS
- Use of Controlled Substances Prescription Monitoring Program and Arizona's health information exchange, Health Current, to identify pregnant members with a history of prescription opioid use
- Our HRA questions targeting substance use and social determinants that present barriers to positive health outcomes and use of evidence-based screeners to further assess substance use and the need for treatment

We established a comprehensive approach to engaging members with physical and behavioral health providers and community-based agencies. Upon identifying pregnant members at risk for NAS, we assign an Arizona-based high-risk OB care manager who educates members/families and connects the member to behavioral health clinicians, SUD treatment providers or integrated clinic providers, including evidence-based Medication Assisted Treatment, if appropriate. The high-risk OB care manager links at-risk pregnant members to an Arizona-based peer support specialist with relevant life and recovery experience and who is a support resource for members with addiction issues. Peer support is an evidence-based practice that is uniquely effective at building trust, reducing stigma, promoting inclusion

and engaging members in care and treatment. In numerous states, including Kansas and New Mexico, where we have a peer support specialist on staff, they increased member engagement in outpatient behavioral health services by 41.1 percent while reducing inpatient utilization by 13.7 percent from June 2014 to November 2015. Our HFS CHWs remove barriers to NAS-related care and services by helping members schedule appointments and arrange transportation.

Hushabye Nursery is an innovative approach to filling a critical gap in care for families and children. We established a MOU with Hushabye, expected to be the first licensed and credentialed NAS freestanding facility in Arizona. Hushabye will provide a therapeutic and inviting setting for post-NICU integrated care for infants and moms. For many, having a baby with NAS is a turning point in their own lives and Hushabye will offer non-judgmental support, education, counseling and addiction support. Caring for babies with NAS at Hushabye and not in the NICU may reduce the cost of care by as much as 50 percent. Further, this model better meets families' social needs.

Enhanced Strategy to Decrease Prematurity Rates

Key priorities:

- Improve birth experiences and pregnancy outcomes and decrease prematurity rates with optimum care
- Adopt best practices in pregnancy care management
- Educate about 17P best practice benefits to promote treatment compliance

National data shows 17P (progesterone) administration decreases risk of preterm birth by 34 percent. Our HFS 17P OB Home Care Program offers a targeted strategy to achieve key priorities. Early and continuing identification of high-risk pregnancies occurs during the risk stratification process, during a member's visit with her OB practitioner, and via our OB assessment tool at initial HFS program enrollment. With authorization from the pregnant mom's OB, members receive care management, education and coordinated delivery of 17P treatments at home. Each step of our HFS 17P authorization process—from intake to care management—has checks and balances to assure members receive the right care at the right time in the right setting. With this process, providers spend less time procuring the medication and more time with our members. The unique benefits associated with 17P home care services include:

- Dedicated OB RN staff to address any service delivery issues and to conduct weekly, in-person risk assessments
- Telephonic access to an OB nurse any time of day or night
- Member education materials and encouragement to complete 17P therapy of scheduled injections
- On-demand and weekly reports to the prescribing physician; documentation in CommunityCare

Enhanced Strategy to Improve Member/Provider Engagement and Service Delivery

Key priorities:

- Incentivize member engagement, completion of physician appointments and reduce hospital and ED use
- Improve HEDIS quality measures for timeliness of prenatal and postpartum care and baby well checkups
- Increase member, family and provider engagement and satisfaction

Our staff (e.g., HFS CHWs, clinical practice consultants [CPCs] and ACO transformation consultants) implement new programs, to engage members and providers and enhance service delivery. One example is our ***OB Homecare Nausea and Vomiting of Pregnancy Program,*** a program designed to help pregnant members avoid a hospital or ED when they face severe morning sickness or hyperemesis gravidarum, occurring in up to 3 percent of pregnancies. Nationally, this program showed a 55.5 percent reduction in antepartum hospital admissions and a 91.9 percent reduction in antepartum ED visits. This program uses a multi-interventional approach that includes

Member Quote: "One of my Baby Blocks rewards was the book Goodnight Moon. It's now my daughter's favorite. Every time she sees it, she brings it to me and we read it. The rewards are great. But I also love how the program reminds me about my appointments."

dieticians, psychosocial support, nursing support and home care (e.g., medication delivered continuously via micro infusion pump).

Our Baby Blocks program, available in English and Spanish, is a smartphone and web-based incentive program that reminds parents to keep their doctor appointments — from prenatal visits through the baby's age of 15 months. ***Since the Baby Blocks launch in Arizona in 2012, more than 9,440 women have enrolled in the proram.*** Members get a reward for signing up and can earn up to eight incentives as they complete physician visits. Pregnancy and well-baby incentives promote babies' cognitive development and physical safety and include books, educational toys, home safety kits, digital thermometers and more. Baby Blocks users have lower utilization and costs in key measures than non-Baby Blocks users. For example, national data shows admits/1,000 are 8 percent lower for Baby Blocks babies vs. non-Baby Blocks babies, and average length of stay is reduced by 1.6 days.

Our provider-facing staff (e.g., field based RN CPCs) engage with and provide data and tools to providers to improve quality outcomes and close gaps in care. They work with high volume OB practitioners to identify members, manage high-risk cases, engage members in care, and close prenatal/postpartum care gaps. Practice support for OB practitioners includes data flagging newly identified pregnant members and communicating the results of the stratification process. This helps providers proactively identify high-risk members needing additional complex care management and engagement. Our staff offers toolkits and educational sessions about current or updated clinical practice guidelines, including 17P (progesterone) treatment, post-partum depression screening, medical record documentation standards, appropriate coding, electronic medical record maximization and real-time gap in care notifications.

Enhanced Family Planning Strategy to Decrease Unplanned Pregnancies

Key priorities:

- Reduce unplanned pregnancies, delayed prenatal care, premature birth and low birth weight
- Improve health outcomes through targeted member and provider training on family planning options
- Promote long-acting reversible contraceptive (LARC) options to prevent unplanned pregnancies

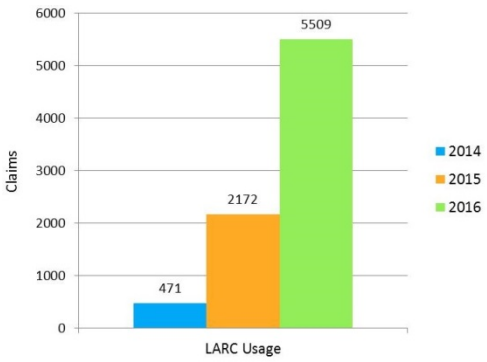

Figure 5. LARC claims/usage trend.

AHCCCS bears a significant burden for the complications accompanying unplanned births as it pays for more than 50 percent of all births in Arizona. In 2016, 51 percent of all pregnancies in Arizona were unplanned compared to the national average of 45 percent. Women with the highest rates of unplanned pregnancy have low income and are between the ages of 18 and 24. A CDC targeted study found increased LARC utilization by teens in one state resulted in a 45 percent decrease in repeat births over four years. Despite its effectiveness, LARC is underutilized by our female membership. Members request flexible choices for family planning methods during care planning. Member feedback indicates barriers to LARC use is the belief that it causes infections, infertility or increased susceptibility to sexually transmitted diseases. Provider confusion about the reimbursement system also makes it challenging to increase LARC utilization. To overcome member barriers, we initiated a targeted strategy where member-facing staff educate women/families of the outcomes of unplanned pregnancies, contraception options and the benefits of LARC. We provide LARC-related information via member newsletters. To overcome provider barriers and to further boost LARC utilization, we educate providers around LARC via our *Care Provider Manual*, LARC-related informational website bulletins and deliver targeted training (e.g. provider reimbursement, clinical practice guidelines) during provider forums and our web-based *UHC On Air* videos. We continually enhance member and provider education, promoting sensitivity to members' cultural, spiritual and individual beliefs. We will continue to leverage partnerships with my Connections community-based partners (e.g., Teen Outreach Pregnancy Services in Glendale, Tucson, Mesa and Phoenix; Hope Women's Center; and Southwest Human Development in Maricopa County - Birth to 5 Helpline and

Nurse Family Partnership) to promote family planning. From 2014-2016, LARC utilization grew from 471 to 5,509 inpatient and outpatient claims per year.

Network Transformation-Related Strategy

Our VBP models consider how we reimburse integrated, physical and behavioral provider types for care rendered and what incentive strategies (based upon data) drive cost-effective and quality outcomes.

New Specialist-Obstetrics Professional Incentive Program

Key priorities:

- Incentivize OB providers to provide high quality care and improve HEDIS measures
- Increase provider engagement and satisfaction
- Improve member engagement in preventive care and quality health outcomes for pregnant women

Our OB Community Plan Primary Care Professional Incentive program will start in Arizona in January 2018 for selected practices. Taking the place of our earlier OB Pay-for-Performance model effort, it offers dollar incentives to providers based upon quality metrics achieved (e.g. timeliness of prenatal, post-partum care visit, low birth weight rate, C-section rate, full-term delivery rate ≥ 37 weeks). We launched a similar pilot program in mid-2017 in New Mexico to facilitate member access to comprehensive health, wellness, prevention and care coordination services.

System Integration and Modernization-Related Strategy

We invest in high-value innovations, social network development and community engagement. We pioneer ways to use technology and resources to align all of the systems that serve AHCCCS members to deliver healthier communities.

New March of Dimes Supportive Pregnancy Care Program

Key priorities:

- Provide social support, health education and skill-building in a group setting
- Improve quality, outcomes and the member, family and provider experience
- Provide a support system to help pregnant women achieve healthy pregnancies/births

In partnership with March of Dimes, we will launch their innovative Supportive Pregnancy Care (SPC) model to help improve Arizona's "B" grade (9.1 percent) on the 2017 March of Dimes Premature Birth Report Card. The SPC model is scalable and offers the core components of traditional group prenatal care but with more flexibility and support for providers and individuals. An earlier iteration of a group prenatal care model led to a 33 percent reduction in preterm births, with greater results for African American women (who experience a 37 percent higher preterm birth rate in Arizona) and a 50 percent reduction in rapid-repeat pregnancies. Published research indicates group prenatal care benefits include improved psychological outcomes and readiness for labor and delivery, increased rate of breastfeeding initiation, increased member/provider satisfaction and reduced health care costs. To test and ultimately scale and expand this model in clinical practices, we will build our local capacity through a train-the-trainer program conducted by March of Dimes staff. We will identify OB practices in communities with higher rates of preterm birth and significant disparities for future SPC implementation target locations.

Question 9

The early years of a child's life are critical to health and the time to identify signs of developmental delay through child/family/provider engagement, access to care and screening diagnosis and referral, plus follow up and monitoring. Our goal is to ensure developmental concerns are addressed by kindergarten so children can attain positive health outcomes and meet full potential. Many factors impact a family's ability to successfully care for a child with special health care needs (SHCN), including physical, behavioral, social, cultural and environmental factors. Our approach to the developmental needs care continuum aligns with the Arizona Vision-12 Principles of the Children's System of Care and promotes choices for individuals and their families through flexible, quality-driven, member-defined services and supports within their communities. Our culturally sensitive, person-centered, integrated system of care delivers treatment and services based upon a child's identified needs and goals, clinical guidelines, and evidence-based and promising practices. We strengthen community connections and make sure care planning activities emphasize each child's unique abilities, strengths and gifts, with most care and services occurring in the family's home or community. The member's care manager leads the care team; verifies services are authorized; and monitors the provision of care and services, outcomes and the achievement of family goals.

Early Identification and Diagnosis
"UnitedHealthcare and SARRC are partnering on unique methods to improve the capacity for early detection of developmental delays and diagnosis of Autism Spectrum Disorder. Our Center of Excellence will significantly improve the treatment capacity in our state through education and training of providers. Our efforts will create a stronger primary network that will better meet the needs of children with autism in Arizona."

Daniel Openden, Ph.D., BCBA-D, President/CEO, Southwest Autism Research & Resource Center (SARRC), Center of Excellence

Promoting Identification and Referrals for Developmental Needs of Young Children

The ideal time to address developmental conditions is between birth and age 5. An estimated 15 percent of U.S. children have at least one developmental delay, yet less than one-fifth of them receive early intervention services before age 3 (*aafp.org* 2017). To overcome barriers to initial screening and referral, we regularly educate providers to incorporate screening tools into workflow of primary care practices; will add new quality incentives to encourage screening; and will work with SARRC, a center of excellence, to expedite diagnosis and treatment. Use of a validated screening tool at regular, repeated intervals, in addition to PCP surveillance at well-child visits, improves early detection. The short time it takes a provider to conduct a screening can change the trajectory of a child's life. We identify children needing assessment through direct referrals from families, providers and community agencies; claims-based risk stratification; pediatric health risk assessment (HRA); and our innovative Special Needs Initiative (SNI).

Developmental Observation and Screening

Target: All children from birth to age 5.

Well-Child Visits. We encourage and assist new parents to connect with a PCP for their child's health care needs. Well-child visits occur at a regular frequency aligning with the EPSDT periodicity schedule. During these visits the child's physician evaluates a child's general health, growth and development, often being the first chance to identify a child with developmental needs. Through our Community Plan Primary Care Professional Incentive (CP-PCPi) program, we will offer new quality payments to AHCCCS-certified providers for completing the AHCCCS-approved developmental screenings at 9, 18 and 24 months EPSDT visits. For members, our ***Baby Blocks*** prenatal and postnatal web-based program provides information to pregnant members on fetal development and childhood milestones through the first 15 months of a baby's life and incentivizes parents to complete each milestone.

Provider Support and Tools. We require providers to use one of the three AHCCCS-approved screening tools: PEDS tool, M-CHAT or Ages & Stages Questionnaire. Through our provider portal, providers can access the Children with Special Health Care Needs (CSHCN) Screener, a CAHMI best-practice screening tool for a variety of biopsychosocial concerns,

inclusive of developmental delay *(cahmi.org).* We offer providers our *Behavioral Health Toolkit for the Healthcare Professional*, which contains validated screening tools and information on clinical practice guidelines. Our clinical practice consultants (CPCs) meet face-to-face with over 300 provider groups each month, who have Medicaid members under age 21 on their panel, to review EPSDT-related requirements. CPCs encourage providers to schedule a well-child visit and complete a developmental screening assessment with member's parents/guardians. As a best practice, we align CPCs with PCPs to assist in closing targeted member gaps in care (e.g. developmental screening), resulting in ***95.5 percent*** of our birth-to-5 population assigned to these PCPs. ***For members ages 0-5 years, 95.3 percent of EPSDT forms reflected developmental surveillance for CYE16 with the rate increasing to 98.3 percent in CYE17.***

Parent-completed screening tool. Parents who have concerns about developmental delay appreciate the convenience of a parent-completed tool available on *myuhc.com*, our member portal. This tool empowers parents to use screening results to prompt discussion between parent and physician regarding developmental delay concerns and the need for further investigation. Children develop very quickly; therefore, we discourage a "wait-and-see" approach.

New member screening. We receive Enrollment Transition Information forms for members transitioning to us from another health plan. During member welcome calls, our staff uses a pediatric HRA tool that incorporates the CSHCN screener to obtain information like psychosocial and environmental risk factors not captured through claims data, such as cultural influences on health outcomes, well-child exams (EPSDT) or trauma; this prompts further investigation into a child's health needs or concerns. Depending upon HRA results, our staff may make an electronic internal referral through CommunityCare, our care management platform, to a care manager for urgent outreach to a family to identify a preferred provider to conduct a developmental screening. Care managers coordinate referrals to other system agencies, including Arizona Early Intervention Program for members age 0-3, or application submission to DDD for members age 4+, and we notify AHCCCS of a CRS-qualifying diagnosis identified per ACOM Policy 426, and refer families to community-based resources to remove social barriers to health (e.g., food insecurity). ***Between 2016 and 2017, we referred/submitted applications for over 3,100 members for enrollment into targeted programs.***

Healthy First Steps. Our Maternal Child Health Program identifies moms at high risk of delivering newborns with special health care needs due to exposure to harmful agents like medications, alcohol or tobacco before/after birth, infections, prematurity, severe poverty, poor nutrition, lack of care, trauma during pregnancy, previous high-risk pregnancy or siblings with developmental needs. Our high-risk OB care managers coordinate care and services pre/post-delivery and follow up to ensure a provider regularly screens the child for developmental delay, and mom is receiving necessary substance use disorder interventions, parenting skills training and referral to myConnections for social support.

Referral, Evaluation and Assessment

Target: Families with young children birth to age 5 who are at risk of developmental delay.

Our member services and care management staff collaborate with providers to facilitate referrals and assist with appointment scheduling, transportation, language or physical needs. Initial screening results may facilitate a referral for a comprehensive evaluation to a developmental pediatrician, neurologist, psychologist, geneticist, physical therapist, occupational therapist, speech language pathologist, audiologist or other provider. A comprehensive medical evaluation may identify gaps in care, including members determined to have a developmental delay requiring continuous and proactive services, including behavioral health services. Sharing a concern about a child's development with a parent is never easy, but can be the way a provider ensures a child receives the early intervention he/she needs, such as a referral to a specialist for an accurate autism or other developmental delay diagnosis.

Once a child receives a positive screening for a potential autism spectrum disorder (ASD) diagnosis, our ***partnership with SARRC*** decreases the wait for formal diagnosis and subsequent ASD treatment. SARRC staff uses their specialized proprietary Naturalistic Observation Diagnostic Assessment (NODA) technology. Developed and tested by SARRC research, NODA is an accurate, remote diagnostic service that uses smartphone technology and specific feedback from a team of SARRC clinicians to early diagnose — or rule out — autism. An accurate diagnosis is the first step on a path to

earlier intervention and treatment.

Early and Specialized Intervention Services

Target: Families with young children birth to age 5 who have identified developmental issues.

Care Management/Member Services. Field-based staff is cross-trained to provide integrated care coordination services. Members with SHCN require a specialized course of treatment or regular care monitoring, and the care manager connects members to a physical and/or behavioral health specialist and, as needed, a behavioral health home, Child and Family Team (CFT) and community-based social services. Our community health workers and provider family peer support specialists work directly with families to connect them to the services they need by making appointments and helping to ease a parent's unease about a child's transition from a developmental center to kindergarten and transition from an Individual Family Service Plan to an Individual Education Plan. Our *Advocate4Me* member services model empowers member services advocates to help members/families resolve a wide range of issues in a single call.

Provider Services. Our extensive statewide provider network helps to remove barriers to care for members needing early intensive behavioral intervention and includes providers specializing in infant mental health (age 0–3) and preschool (age 2–5). Our network includes Applied Behavior Analysis (ABA)-certified network, behavioral health network, physical health network, access to field clinics and virtual clinics (telemedicine/tele-psychiatry), respite services in the home, and access to formal and informal supports. We develop standardized, and offer validated, assessment tools and training to help providers better serve children with SHCN and developmental delays. Strategies include:

- Use of the children/youth clinical practice guidelines (e.g., autism, reactive attachment disorder and disinhibited social engagement disorder) from the American Academy of Child & Adolescent Psychiatry, accessible to providers on our provider portal and highlighted during our provider trainings.
- Workforce development through our relationships with the CRS MSICs, SARRC and Valley of the Sun to increase the number of individuals qualified to perform screenings and identify developmental delays.
- Provider website access to tools, such as AHCCCS-approved behavioral health assessment tools, evidence-based practices, clinical practice guidelines, and the *Care Provider Manual*
- Provider training available through the provider portal, UHC On Air, for easy access to recorded online provider training modules, Arizona-based staff resources (e.g., provider advocates and claims educators), and statewide integrated provider forums held multiple times throughout the year in person or via webinar.
- Aligned care management as close to the point of service as possible; requiring providers to perform assessments, report assessment outcomes timely, and use/update a service plan, reinforced through value-based payments (VBP).

Technology. We provide care team members with digitally enabled technology that presents timely, relevant and actionable information about members and their interactions with the health care system through:

- ***Impact Pro*** is a multidimensional, episode-based predictive modeling and care management analytics solution that enables care managers and care teams to use clinical, risk and administrative profile information to coordinate targeted, integrated health care interventions for our members and reduce gaps in care.
- ***CommunityCare*** functionality allows sharing of member-level data, progress notes and treatment plans (with member consent), and auto-generates alerts to direct and support care management. Providers can view and provide feedback on assessments/service plans and submit attachments for prior authorization. CommunityCare flags members designated as having a developmental delay or SHCN.
- ***Link,*** our secure provider portal, offers a central access point where enrolled providers have real-time access to eligibility/benefits, claims management and reconsiderations, enhanced online authorizations and gaps in care.

- ***Baby Blocks*** engages care managers for outreach to moms who have completed the developmental assessment activity, along with the PCP to verify further referrals to specialists are completed, and assist if necessary.
- Use of ***Arizona's Health Current (HIE) and electronic medical records*** to integrate data and improve communication among interdisciplinary care teams (ICT), including care managers and providers.
- Expanded use of our current ***telemedicine/telepsychiatry*** program for diagnosis, treatment and training to improve care and treatment in underserved areas. In Arizona, we have 67 tele-psychiatry providers.
- Enhanced member/family ***engagement:*** *Health4Me* text application; secure member portal (*myuhc.com*) with downloadable educational materials, searchable list of providers, service plan, service history/claims; benefits and coverage; member rights/responsibilities; health literacy material; link to *KidsHealth.org*; and link to Partnership with Autism Sesame Street online learning tool for children ages 2 to 5; Facebook and YouTube.

Promoting Public Awareness of Child Development and Special Initiatives

Target: Families and communities

Special Needs Initiative (SNI) is an innovative best practice member-engagement model for high-touch complex issues for families identifying at-risk SHCN members or those identified with a developmental delay and who have difficulties managing the system of care. The program assigns a *family navigator* (telephonic, single point of contact) to the family for issue resolution, and coordination of care providers, including specialty care, behavioral health home and social supports. ***Because key performance indicators for a recent eight-month period (January to August 2017) show a significant increase in families assigned (+3,061), a 225 percent increase in clinical engagement, 9 percent increase in social support, and a 45 percent decrease in the appeal rate, we will continue to expand this initiative.***

- ***Community Relationships.*** We build formal/informal relationships with child-specific community organizations (e.g., Children's Action Alliance and March of Dimes). We participate on advisory councils and sponsor community events and trainings for provider organizations and member stakeholder groups.
- ***Valley of the Sun United Way (VSUW)*** will partner with us to support early detection and intervention in Maryvale and Central City South. VSUW will conduct a train-the-community event, with a strong emphasis on training CHWs.
- ***Developmental Delay Parent Education*** is available via providers, care managers and SARRC, which offers the JumpStart program for parents of children newly diagnosed with an ASD. Online and in-person training teaches parents about ASD, behaviors, evidence-based treatment; and how to navigate State services. SARRC trains other providers to deliver JumpStart at their facilities. Our webinar, ***Family Ages and Stages Training,*** held monthly, provides family/child educational resources and will be recorded and uploaded to our website.
- ***Member Advisory Council*** offers opportunities for parent participation. We hold other focus groups quarterly where we seek key stakeholder/parent input. Participants represent all Arizona member populations we serve.
- ***MedicAlert*** partnership provides a member diagnosed with an ASD or cognitive disability a free MedicAlert ID bracelet with the child's name, address and/or phone number and all-day, all-night access to a support service team.

How We Monitor Member Identification and Provision of Services

In pursuit of continuous quality improvement, our care management team reports and trends member health outcomes from service plans at the member and population levels. As part of monitoring and tracking per AMPM 1000, Impact Pro analyzes claims and authorization data in our SMART data warehouse to identify members (ages 0–5) to verify completion of appropriate assessments and EPSDT referral compliance to confirm services are in place. Our tools provide a detailed, holistic understanding of our members. Care management leadership monitors behavioral health agency caseloads through monthly roster updates to ensure we meet AHCCCS requirements. They monitor outcomes at the member and population levels and through follow-up outreach efforts by integrated care teams and our child

behavioral health member advocate. We confirm assignment of a provider high-needs case manager. We confirm use of an Individualized Family Service Plan for children age 0–3 years and semi-annual or annual updates. As a child approaches 2.5 years of age, the care manager verifies the child/family and intervention team prepares the transition to services with a focus on the child's needs. To ensure providers identify and treat children, we use:

- Population Registry to identify actionable HEDIS and evidence-based medicine gaps in care for each member
- Provider chart audits completed by our quality team
- The CFT meetings confirm service plan adherence, member goals identified and obtainable, and family supports
- Integrated service plan monitoring, quarterly auditing and reporting to verify the ICT is using the care system to track member care, interactions, interventions and coordination of services
- Outcomes measures and incentives for providers caring for children with ASD in a VBP model focus on standards of care, quality of life indicators, use of best practices, member/family-centered care and satisfaction rates

Managing the Early Intensive Behavioral Intervention Benefit

The increased diagnosis of ASDs presents a unique challenge for MCOs and states. In response, we created a national ABA-focused team in 2011 to support families facing high therapy costs and, in some cases, poorly managed services. Our ABA team of psychologists and board-certified behavior analysts provide specialized management of intensive behavioral interventions and focus provider care on evidence-based treatment through clinical reviews. For AHCCCS Complete Care, we will incorporate the expertise of this nationally based ABA team, trained in evidence-based practices aligned with AHCCCS' ASD Advisory Committee recommendations, to manage the early intensive behavioral intervention for members from birth to age 22. The team supports families by coordinating evaluation/preauthorization services, specialized network referrals, providers' development of individualized treatment plans, clinical oversight/benefit coverage review and family support and empowerment.

Intensive behavioral interventions average $40,000 to $60,000 and can exceed more than $71,000 per year based upon national research from the Centers for Disease Control and Prevention and Autism Speaks. ***Our ABA team has a comparable average cost of $22,000 per child per year*** — not based upon restriction of critical benefits, but rather a focus on the appropriate intensity of evidence-based services, specialized management and coordinated care. To support our ABA team, we established a specialized ABA network team. Our network team has a strong national network of over 2,600 ABA providers, which offer multi-county/statewide BCBA access (SARRC). Where gaps exist, our dedicated ABA team negotiates single-case agreements with qualified providers meeting credentialing criteria.

Managing Utilization: While early behavioral intervention brings great value, many states grapple with costs, underutilization/overutilization of benefits and variations among provider practices. To manage the autism benefits, we:

- Review for underutilization/overutilization of services or potential fraud, waste and abuse and have integrated medical and behavioral claims algorithms and dashboard reporting that identify aggregate information across providers.
- Identify care needs for high-needs, high-cost (HNHC) members not receiving adequate ancillary services; verify HNHC members receiving adequate ancillary services get continued monitoring, but less outreach.
- Provide our support via Arizona-based outpatient practice managers to providers identified as having outlier practice patterns to improve their overall delivery of the early behavioral intervention.
- Provide a locally based ABA network manager to provide face-to-face provider support and education, monitor providers with non-utilization, and coordinate with our ABA clinical and network teams to manage referrals.

Question 10

Minimizing Emergency Department Holds for Behavioral Health Conditions

Growing Emergency Department (ED) utilization for behavioral health reasons is a problem we recognize and are developing new strategies to address. We found 38,322 visits with primary diagnoses of anxiety, substance use disorder (SUD) or major depression, during review of all ED visits with behavioral health primary or secondary diagnoses from July 1, 2016, to June 30, 2017. Members frequently have comorbidities, such as chronic pain or diabetes and social determinants, such as homelessness (66 members). Across Arizona, behavioral health reasons for ED use range from 7 percent to 17 percent of all ED visits. Individuals may be boarded in the ED for days, until inpatient psychiatric beds become available or alternate discharge services are arranged. In Maricopa County delayed hospital-based examinations, a backlog in transferring members from pre-petition screening to court-ordered evaluation (COE) and lengthy COE detainments prior to court-ordered treatment (COT) hearings further contribute to prolonged ED holds. Reliance on a singular hospital to perform all COEs and indifference toward encouraging voluntary evaluation and treatment contribute to the backlog. Other Arizona counties experience ED holds, which are due to post-ED stabilization placement issues, not due to COE backlog. ED holds for all counties strain Arizona resources, resulting in overcrowding, extended wait times, diversion of ED resources from time-sensitive and life-threatening situations (e.g., stroke or major trauma), and costly use of ED in place of non-hospital-based behavioral health services.

We reduce need for ED visits and in/out-of-state inpatient admissions by providing alternate service settings to manage the behavioral health care needs of our members. We align with State goals by offering a strategy of multiple interventions to reduce ED utilization and conduct a systematic review of the individual elements of our strategy to verify its effectiveness in achieving better outcomes. As the sole CRS contractor serving CRS members in an integrated service delivery system, we identified and reversed an upward trend in ED use via our ACO model of providers more actively engaged in managing an individual's care. Because of increased collaboration, data sharing, incentives and alignment with our ACO partners, ***from 2014 through 2017, ED utilization decreased by 9 percent for our CRS members assigned to an ACO PCP.*** We expect even more intense results based upon further rollout of additional strategies.

Pre-emergency Department and Psychiatric Hospital Diversion Strategies

Individualized service plan, interdisciplinary care team (ICT) and care management. Evidence shows that preventive and coordinated care helps individuals manage health conditions, avoiding unnecessary ED and inpatient utilization. We encourage members to establish a strong relationship with an ACO, integrated care provider or a behavioral health home, which delivers and coordinates the evidence-based care they need. A peer support specialist or community health worker (CHW) assists members in accessing services. When members receive help navigating the system of care, they get support and encouragement they need to succeed in developing and implementing a recovery plan. ***Our national experience in rendering peer support services from June 2014 through November 2015 to members increased utilization of outpatient behavioral health services by 41.2 percent, and reduced behavioral health inpatient services during the same time period by 13.7 percent.*** Because multiple providers can be involved in caring for our members, we engage the right individuals on the member's ICT, including family and natural supports, a behavioral health professional and care manager. We flex ICT participant involvement as a member's needs change. Early engagement of a member with special health care needs (SHCN) in care management and collaboration with a Child and Family Team (CFT) or Adult Recovery Team (ART) team assures a connection to the member/family's choice of needed services before they seek care in the ED. The care manager facilitates ICT meetings to implement a care strategy for emerging risk or high-risk members. The care manager reaches out to members with SUD and mental health issues, using peer support specialists and CHWs, if needed, to assist a member with getting a behavioral health or medication-assisted treatment (MAT) appointment and with arranging transportation. Planned follow up by care managers allows for continued support and updated service plans for improved member outcomes.

Member education. We identify members at risk for ED use by our monthly analytical data or during an ICT, CFT or ART

meeting. The care manager educates these members/families about appropriate use of the ED and calling 911 versus other alternative resources (e.g., hotlines, urgent care and mobile crisis). A peer support specialist or CHW can help a member develop personalized crisis and recovery plans using forms available on our member portal, inclusive of the Whole Health Tracker, which allows a member to track and focus on health and recovery goals and identify triggers that could lead to relapse and ED or inpatient visit. A-CHESS is a smartphone-based system for preventing relapse and increasing engagement and activation in SUD services. It improves competence, social relatedness and motivation.

Information sharing. We promote collaboration and information sharing among a member's ICT. CommunityCare, our shared care management platform with two-way data sharing of the service plan, gives providers timely notification regarding members who are in the ED, based upon data feeds received from Health Current. This facilitates scheduling follow-up appointments within seven days — a best practice for prevention of further ED use or inpatient readmissions. We monitor member ED use for misuse or overuse of opioid prescriptions using the Controlled Substance Pain Management Program database.

Early identification of the highest users: We use data analytics to identify ED utilization to target our efforts to the highest risk individuals. We act upon a variety of data sources, including a differentiated combination of industry-leading technology, analytics and clinical expertise. Predictive modeling produces actionable data and analytics that reveal member-specific care opportunities. The results show every member's circumstances and needs, their level of health risk, and the driving factors (behavioral, physical or social) of their needs. With our Impact Pro tool, each member is assigned an overall integrated risk score and additional, targeted risk scores (e.g., future risk of cost, behavioral risk and future risk of inpatient care). In addition, we are developing a new ED-specific predictive utilization model that allows proactive outreach to create awareness of alternatives to ED usage with points of contact. Identification of high and emerging risk members allows care managers to engage the member's behavioral health home, CFT or ART.

Diversion: We use evidence-based programs and alternative community-based services, the residential treatment center (RTC) Diversion and Family Access to Stabilization and Treatment (FAST) programs or crisis stabilization centers to divert children, adolescents and adults with behavioral health issues from the ED, inpatient psychiatric facilities and justice settings to less restrictive, medically necessary treatment settings. We operate in collaboration with hospitals, correctional facilities and other systems. We collaborate with law enforcement and other emergency services personnel to establish diversion processes and expand training on models, such as Crisis Intervention Teams, where local law enforcement personnel receive training in de-escalation tactics and non-lethal management of a member in crisis.

Coordination with crisis providers. The ED is not the optimal setting for individuals experiencing a mental health crisis. Individuals need the right care in the right place at the right time. Deploying crisis providers or crisis response teams to meet an individual where they are is an alternative to using the ED and we coordinate with crisis providers and the RBHAs to do just that. Notification from crisis providers is key to timely follow up with members to connect them to care and services they need to avert future crisis and need for ED. Our care managers review daily reports from the crisis response team and then contact members for follow-up appointments within seven days to address behavioral health needs. The crisis response team can recommend members be taken to urgent psychiatric care (UPC) centers operated by Community Bridges, Inc., RI International or ConnectionsAZ. The UPCs are also incorporated into member crisis plans as alternatives to ED use.

On-demand services. Our *Advocate4Me* member services model allows member services advocates to help members and families resolve a wide range of issues in a single call finding alternatives to ED use. They connect NurseLine or their care manager. NurseLine effectively reduces unnecessary ED use by providing RNs who help members access other medical and behavioral health services 24 hours a day, seven days a week. RNs help members choose appropriate medical care, find a physician or service. RNs reinforce education about appropriate ED use. The *Health4Me* app with GPS technology gives members a convenient way to find an urgent care facility.

Mobile options. We use innovative care delivery models, like Community Medicine (paramedicine) teams comprising

nurse practitioners, ambulance/fire EMTs and other paraprofessionals, to proactively visit selected members (including those actively experiencing homelessness) who are identified through data and risk stratification models in their natural setting to reduce ED use and improve outcomes. Our work with Healthcare Innovations (currently operating ambulance services in the North and South GSAs) informs us that community-based partnerships bring trusted, "blue-shirt credibility," well-trained field-based clinicians directly to our members. Mobile options increase access to care when we have providers and sites, but too few local behavioral health specialists. We work with home health agencies, behavioral health case managers, care managers and CHWs who meet the member where they are to provide needed services. We continually seek new partnerships. We are finalizing a contract with Mobile Health, which offers mobile urgent care in the Central GSA and it is expanding to Pima County.

Telepsychiatry. The psychiatrist shortage contributes to ED holds if there is not a psychiatrist on staff to evaluate and treat the member in the ED. To bridge this gap, we will work with hospitals to increase use of tele-psychiatry services when they do not have a psychiatrist or child/adolescent psychiatrist to address immediate needs, such as starting medications to stabilize the member. In Arizona, we have 67 tele-psychiatry providers, comprising 32 provider groups, six MDs, two MSWs and 27 RNs. From January 2016 to September 2017, providers completed 313 Medicaid tele-psychiatry virtual visits — with 275 or 88 percent of the 313 visits delivered by an MD or RN with prescriptive ability.

Improve access. We actively seek and contract with providers who can conduct in-home visits or telemedicine to avert crisis and address medication changes. For example, the integrated Southwest Behavioral Health Services, one of the autism centers of excellence, offers provider management for medication needs 24 hours a day, seven days a week. Our broad, direct referral, behavioral health network improves member access to behavioral health care post ED and hospital stabilization thus avoiding return visits. The broad network also helps us prevent out-of-state admissions for hospital or residential treatment centers level 1 (RTC 1). Incentivizing development of integrated clinics that can manage members with complex needs improves behavioral health home assignments for this subgroup of members.

Post-emergency Department and Psychiatric Hospital Admission Strategies

Streamline the process once a behavioral health ED hold has been initiated. There may be unnecessary admissions to an inpatient psychiatric unit when safe discharge from ED is delayed to an alternative setting due to a lack of child and adolescent psychiatrist availability to evaluate and treat the member in the ED. We can promote a member's quicker ED discharge by facilitating ED staff access to a psychiatrist or tele-psychiatrist consultation to expedite appropriate diagnosis and treatment recommendations, including medications needed post ED release. We will analyze data to work with high-volume hospitals where we station case managers. Phone consultations by our utilization managers recommend alternative placement and lower levels of care, as appropriate.

Special circumstances for youth/adolescents ED diversion. For youth/adolescents with SHCN who go to the ED for behavioral health issues, ED staff notify a special needs care manager (SNCM). The SNCM convenes a CFT working with the behavioral health high needs case manager to review alternatives, such as wraparound services for the member and family, mobile crisis intervention with in-home follow-up supports, parent-peer support, therapies, behavioral coaches and CHWs to help the family navigate the system. Offering integrated clinics for members, PCPs share information with child psychiatrists allowing for improved family/member-centered, culturally sensitive treatment plans.

Population-tailored strategies – COE and COT. A single hospital providing COE in Maricopa County for adults creates delays in discharge from ED and other hospitals. A collaborative effort of all MCOs and the county judiciary to influence more than a single hospital providing COE might be a solution. When a member has a crisis, our clinical team engages Crisis Preparation and Recovery staff to provide an on-site assessment whether in or out of ED to determine if a member meets criteria for emergency or nonemergency petition. For individuals already involved in the COE/COT process, our court coordinator assigns a court field worker to each member discharged from COT inpatient to outpatient treatment. Their goals are to mitigate potential crises by ensuring the member follows the outpatient treatment plan, by monitoring progress toward goals and by convening an ICT to discuss complex situations needed from a behavioral health home or ART.

Reducing the Number of Out-of-State Psychiatric Admissions

Analysis of reasons for out-of-state psychiatric admissions shows the common causes for these hospitalizations include inability to place members due to complex medical needs (e.g., hearing loss; having a G tube), severe aggression, autism and cognitive impairment. Hospital discharge planning begins on the day of admission, and hospital discharge staff, care managers and ICTs consider the most appropriate placement for each individual needing a psychiatric admission. We avoid out-of-state behavioral health inpatient or RTC 1 use with evidence-based practices, such as intensity of services tools and then put the right services in place at the right time. Other ways for reduction include:

- Use hospital/ED utilization data analysis to develop programming and services designed to keep members in a community setting (e.g., additional providers who can perform an in-home functional applied behavior assessment) using applied behavioral analysis then provide appropriate staff for behavioral coaching.
- Cultivate an outpatient and inpatient integrated network and innovative solutions to support families/members with complex physical health comorbidities, intellectual developmental disability (I/DD), autism and aggression.
- Use RTC diversion strategies, alternative care settings, mobile options and community-based treatment options.
- Contact parent/guardian while the member is still in the ED for consent for comprehensive planning by a behavioral health-home case manager who coordinates the member's care/services, making sure services are in place to help the individual transition to outpatient services; verifying medications are obtained and reconciled.
- Develop a discharge plan to a more appropriate setting in collaboration with providers, member and CFT or ART.

Increasing Alternative Community-Based Services

Admissions to the ED for behavioral health conditions may reflect severity of a psychiatric illness, ineffective inpatient care, lack of community-based treatment or lack of adherence with outpatient care. In some cases, an admission or readmission may be related to a community resource issue, such as employment and residential status. Our approach to increasing alternative community-based services includes:

Increase utilization of alternative community-based services, including RTC Diversion and FAST programs. The RTC Diversion program is an innovative use of independent, objective assessors who see youth or adults face-to-face within 48 hours of request to determine the least restrictive, most clinically appropriate care for the member. ConnectionsAZ and Community Bridges will conduct the assessments. If a member (12 to 18 years old) is diverted, the member is then referred to the evidence-based FAST program for youth 12 to 18 years old who are at risk of being removed from their home for inpatient hospitalization due to behavioral health concerns. FAST keeps a youth at home by providing appropriate diversionary options, enabling clinicians to identify supports and services needed to allow a child to remain in home. FAST services range from parent support to crisis intervention. When a youth is ready to return home from necessary out-of-home placement, FAST transitions them back to the family with careful monitoring through gradual home visits and family therapy. Follow-up care includes any combination of in-home counseling, parent modeling and other indicated clinical interventions. FAST contributes to a significant decrease in inpatient and residential utilization, allowing children to avoid out-of-home placement. In addition, we are increasing efforts to ensure behavioral health respite services are available. Respite programs provide many individuals and families with a needed transition into permanent housing options and permanent supportive housing.

Peer support. For high-risk members, peer support specialists help reduce ED utilization and hospitalizations when engaged with members in the community. Peers work with members to create their own wellness and crisis plans, indicating the personalized triggers and interventions that can mitigate crisis episodes and maintain members in the community. We leverage peer support specialists and peer support groups to assist members with mental health, SUD, co-occurring and comorbid conditions. Members can access peers via behavioral health home referrals. Peers promote recovery via their living testimony that emphasizes recovery is possible and reinforce resilience and self-management while boosting access to needed physical, behavioral and social services. Peer support specialists engage members who resist care management services due to their behavioral health symptoms. In our Yuma Jail Outreach Program, 62

percent of justice-involved members who received peer support were more likely to live independently and to remain out of jail than those without peer support.

Housing stabilization. Safe, secure, long-term housing is one of the best treatments for individuals experiencing homelessness and suffering from behavioral health conditions. It helps to facilitate recovery and is critical to a person's ability to benefit from treatment and support services to achieve positive health outcomes. In Arizona, in 2016, we launched myConnections/myHousing solution, with three main components: the creation of 500 permanent supportive housing units (100 of which are reserved for our members); first-of-its-kind one-stop health and human services Community Connect Center in Maryvale; and a social services network. It is an example of a community-based, innovative collaborative care model, with partnerships between first responders, such as police, fire and EMTs who have training in physical and behavioral health conditions. Part of the program facilitates early notification when a member in a myHousing unit has a crisis event. Based upon recent experience, we anticipate improving member outcomes by earlier behavioral health treatment and saving ED costs. For example, one member in a myHousing unit thought he was having a heart attack and called 911. Instead of taking this individual directly to the ED, fire department and EMT staff collaborated, allowing time for the EMT on the scene to determine he was having an anxiety attack, not a heart attack. The EMT transported him to an integrated community clinic for assessment treatment versus taking him to the ED.

We are committed to use a portion of our available capital that is aligned with this contract to invest in the relevant services or facilities in support of the members we serve across all awarded geographic service areas. This holistic, member-centered program addresses the connection between social/economic factors, poor health, increased health care utilization and rising health care costs by identifying non-Medicaid social services for which an individual member is eligible. MyConnections staff actively links members through referrals and follow-up care and connects individuals to appropriate housing to reduce health care costs and improve outcomes. The myConnections program demonstrates our leadership in integrated health and social services by helping people achieve their goals, not just manage their care.

Ensuring the Provision of Follow-up Care

To ensure timely and appropriate follow-up care and improve outcomes with reduced further ED or hospitalization use, we focus attention on transitions, when there is a high-risk for members to fall through the cracks and end up in crisis. Many high-risk members are in continual crisis and they are not getting their needs met in the outpatient system. As part of the CFTs, ARTs or discharge planning, the behavioral health provider's high-needs case manager is instrumental in ensuring coordination of care identified by member and team to address post-crisis, recovery, ensuring warm handoff and troubleshooting for behavioral health barriers to care (e.g., help them get their meds, get to appointments and make sure they have basic needs like food and transportation). Our care manager monitors completion of services. Our care manager also verifies the ICT makes timely changes to a member's service plan, with focus on member choice, fully supporting the recovery model. Our care manager involvement in ICTs and discharge planning meetings confirms appropriate follow-up care is arranged prior to leaving ED or hospital. We track and monitor seven- and 30-day follow-up appointments, post ED and hospitalization. Care managers conduct rounds with providers for high-needs, high-cost members. The care manager monitors member claims and provider updates and confirms care and treatment are completed. The care manager monitors for outcomes of interventions, including reductions in ED and inpatient events, and coordinates with providers and community partners. UHCCP leadership reviews metrics indicating the success of our care management strategies and clinical approach, such as leading indicator metrics (e.g., the HEDIS measure for antidepressant medication management), and outcome metrics, such as cost, pharmacy utilization and ED utilization.

Question 11

We have a long history of creating and managing strong and diverse provider networks in Arizona and providing integrated services to members through long-term care (since 1989), CRS (since October 2013), and Acute General Mental Health Substance Abuse benefit (since October 2015). Our comprehensive, compliant, culturally diverse physical, dental and behavioral network for adults and children covers all Arizona counties and spans across state lines to border communities to meet member access to care requirements and maximize their choices. We have extensive specialty networks to serve Arizona's population. While our network strategies include all providers, we focus on special health care need populations, such as children with autism spectrum disorder, and specialty and behavioral health providers for children and adults. Strategies include reducing fragmentation in the system through provider collaboration, including those chosen for the Targeted Investments Program, member and family engagement, data sharing and incentives designed to reward integration.

Our statewide, integrated network, expands across state lines to serve members in border communities, and exceeds AHCCCS network adequacy standards. Network analysis shows our behavioral health network ***exceeds RBHA networks by 400+ Medicaid providers***; all contracts are fee-for-service.

We support AHCCCS in transforming the system to eliminate fragmentation and accessibility challenges. Our existing network serves culturally and linguistically diverse members regardless of their physical health, behavioral health and functional care needs, within easy access for members. As detailed later, we recognize access challenges exist, particularly when it comes to access to care for mental health and substance use disorders (SUD). As active, thoughtful purchasers of the Medicaid system, we collaborate with providers to be mutually efficient and effective. For example, we review our network quarterly to verify quality and cost-effectiveness. We evaluate providers with deficient areas to determine if they should remain contracted. We encourage and guide members to obtain primary care services from high quality, cost-efficient providers.

Comprehensive Network Development

Our Network

Our network knowledge and data analytics tools help us maintain a high-quality network of primary care and specialty providers with a knowledgeable workforce, focused on adults and children, to meet service needs. Per ACOM Policy 436, our network administrator, Briana Agnew, uses GeoAccess to confirm we consistently meet or exceed AHCCCS network adequacy requirements and takes immediate action on identified gaps. For example, in 2017, we resolved a gap in Gila County for an allergist, by working with community providers to find a part-time location for a Maricopa-based provider to practice in Gila County.

Our Network Development and Management Plan outlines strategies to maintain a network of providers sufficient in number, mix and geographic distribution to meet the needs of the members and make sure they receive the highest quality of service. Our collaboration to create accountable care organizations (ACOs) represents one such strategy. Phoenix Pediatrics was our first ACO in 2008, and now we have 278,738 members across 30 primary care practices, ACOs and FQHCs. We support ACOs with the Accountable Care Population Registry, UnitedHealthcare Transitions platform, clinical outcomes measurement and analysis, care coordination management and support. Each practice works in partnership with us to improve member access to primary care, close quality gaps in care, reduce avoidable Emergency Department (ED) visits and inpatient events, and address opportunities to provide care for their highest risk patients (our members).

We contract providers simultaneously for Medicaid, commercial and Medicare, thereby providing members equal access to providers and community norms for all members in Arizona.

Specialty Providers

Our full array of contracted specialty providers (e.g., dental, dermatology, immunology, neurology, pulmonology, community-based family support providers, psychosocial rehabilitation and homeless clinics) provide care and services in the community. We meet AHCCCS and CMS network standards in all geographic service areas (GSAs) and additionally provide alternate service delivery mechanisms to enhance our specialty network, such as field and mobile clinics and telemedicine. We hold contracts with 100 percent of the Multispecialty Interdisciplinary Clinics (MSICs), which include specialists who treat individuals with qualifying medical conditions under A.A.C. R9-22-1303, such as CRS members. In these MSICs, specialists offer interdisciplinary services to treat members' complex health care needs. We have expanded our partnership with MSICs with effective value-based purchasing (VBP) agreements and moved beyond the CRS population, offering these unique services to our broader membership and will do so with the AHCCCS Complete Care population.

Behavioral Health Providers

Our network supports the provision of covered behavioral health services. We do not delegate or subcontract delivery of behavioral health services. We have a comprehensive behavioral health network, comprising community-based, family support providers in urban, suburban and rural areas; locally established, Arizona-based, independent peer and family-run organizations; and specialty service providers who deliver services to children, adolescents and adults with developmental or cognitive disabilities and meet the needs of adults and children and all AHCCCS requirements.

We leverage our extensive commercial behavioral health network of fee-for-service contracts to fill any gaps identified in our Medicaid network, and will do so to fill any new gap as a result of additional members and benefits in AHCCCS Complete Care. We have contracts with all FQHCs in Arizona. Because the majority of FQHCs provide behavioral health services in integrated centers and are not labeled behavioral health, they aid in removing the potential stigma members may feel in going to a traditional behavioral health provider.

We are committed to a philosophy of care that is both member- and family-driven, and we understand the importance of having peers and family members involved in all aspects of care. In our Yuma Jail Outreach Program, 62 percent of individuals who received peer support were more likely to live independently and remain out of jail compared to those who do not receive peer support. In addition, families with children in the behavioral health system have better coping strategies when they have resource referral help and a family support partner to talk to about issues and challenges they face. We contract with, or provide financial support to, provider-agency support services and peer- and family-run organizations, such as NAZCARE, Raising Special Kids, NAMI and Family Involvement Center. To support the unique needs of peer- and family-operated organizations, we assign a provider advocate with experience working with peers and/or peer-operated organizations as a single point of contact. We continue to expand availability and choice by contracting with these organizations in service areas where they are available to members. We use our Sustainability Institute to train peer- and family-operated organizations regarding how to become Medicaid providers. Our technical assistance helps them become self-sustaining Medicaid providers not so reliant on grant funds or donations.

Maximizing Access to Care through Collaboration

Per the *Evolving Models of Behavioral Health Integration* report, supported by the Milbank Memorial Fund, "People with mental disorders are frequently seen in primary care, but are often underdiagnosed and undertreated. Similarly, individuals with serious mental illness and SUD seen in mental health settings lack adequate general medical care." Our network development plan and provider incentive structure seeks to improve primary care and behavioral health provider relationships with each other, to positively affect member health outcomes. Our approach uses input from our providers, promotes data sharing, pays incentives for integration, creates community collaboration and promotes evidence-based practices through our innovative comprehensive care management system, CommunityCare and payment model. We provide toolkits to all providers, especially helpful when members are referred to an outside specialist. Our holistic integrated approach begins with the PCP at the hub and connects all providers involved in the member's care through real-time electronic communication and collaboration.

We commit to maximizing access to care for all members, noting special focus in rural areas and for members with complex health care needs, because rural areas have unique challenges causing potential access to care issues. We design our network around partnerships, recognizing the value each provider brings to helping members achieve their health goals. Our provider network and community outreach teams leverage their knowledge of the local area and actively engage stakeholders and individuals across communities to explore potential partnerships to fill gaps and expand our reach of existing services. Examples of our partnerships include:

- ***Social Determinants of Health (SDOH):***
  - UnitedHealthcare partnered with Chicanos Por La Causa (CPLC) in 2016 to create the first social service-contracted provider network with whole-person member approach to tackle SDOH barriers. The resulting community center, myCommunity Connect™ Center, located in Maryvale, has direct electronic referrals to over 30 local social service providers.
  - We began a pilot with Health Current and CPLC to collect SDOH for future use by providers. Such data can highlight key information to members' providers who can then quickly get members into needed care or refer them to resources.

Housing is an important SDOH. We invested $21 million in nearly 500 units of affordable housing in Central GSA, with CPLC. One hundred units are set aside for our members. We will use a portion of our available capital, aligned with this contract, to invest in relevant services or facilities to support members served across all awarded GSAs.

- ***Centers of Excellence (COE):*** Using our data to identify a need for early diagnosis of childhood developmental delays, we partnered with Southwest Autism Research & Resource Center to get them to become an AHCCCS provider. They offer a COE to provide best-in-class capabilities, specialized clinical expertise and care management to support members and families affected by an autism spectrum disorder.
- ***Integrated Practices:*** We launched a program with Equality Health, an integrated delivery system specializing in serving the Hispanic population, to improve the quality of health care for our members. Through Equality Health's integrated network of physical, behavioral and community-based care providers, our members have access to culturally effective, coordinated health care. This collaboration helps improve our ability to identify social and cultural factors that put members at high risk and help reduce avoidable ED visits and readmissions, manage chronic conditions and take their needed medications. We are currently expanding our integrated care network to meet and exceed the AHCCCS goal of 50 percent contracted integrated care clinics.
- ***Medication-assisted Therapy (MAT) and Substance Abuse Providers:*** We create partnerships that enhance the integrated delivery system, such as our national contract with CleanSlate Addiction Treatment Centers, at the forefront of science- and medicine-based addiction treatment since 2009. A pioneer and leader in outpatient addiction medicine, CleanSlate is a multi-state medical group providing effective treatment for the chronic disease of addiction, primarily alcohol and opioid use disorders, and provides MAT services for our members.
- ***Value-based Contracts:*** We encourage providers to deliver high-quality care to meet the goals of both the Adult System of Care Principles and the Children's System of Care Vision and Principles by offering VBP contracts. We do not offer any block payment contracts. We believe VBP contracts improve member outcomes and bend the cost curve to provide higher quality, effective and efficient care for the populations we serve. Our 2017 quality metrics show greater improvement in many metrics for providers in VBP contracts. Incentives encourage physical and behavioral health providers to actively communicate with each other on mutual members' care, via our CommunityCare tool. Currently, ***49.1 percent of acute spend is in a VBP contract***, and we will exceed AHCCCS' target expectation in Learning and Action Network Alternate Payment Models by 2020.
- We have ***telemedicine options*** (e.g., dermatology, behavioral health) to extend service delivery; and we will expand use of these options as well as evolve policies. We received over 18,700 telemedicine claims in 2016.

Maintaining and Managing a Highly Qualified Network

To continue to maintain and expand our network of providers who can serve all members covered through AHCCCS Complete Care, we will incorporate any new members into our robust process for provider trends, provider profiling, member accessibility issues and provider feedback, such as:

- ***Ongoing Review:*** We conduct ongoing reviews of the provider network to verify compliance with network standards. We use our network development team, GeoAccess, Quality Management Committee, the Service Quality Improvement Subcommittee and our compliance team to identify gaps.
- ***Active Monitoring:*** We continuously monitor the provider network to identify provider additions and terminations, as well as issues or trends with individual providers identified through our provider relations outreach. To inform contracting decisions, we use AHCCCS and member feedback per ACOM 417 and appointment and availability data per our independent vendor, Alltran; appeals and grievances; network referral report identifying gaps in the network; and out-of-network referrals when an in-network provider is available.
- ***Single Case Agreements:*** We will review single case agreements monthly to identify patterns for authorized out-of-network care and to monitor specific member care needs.
- ***Workforce Management and Learning Management System (LMS):*** We will conduct network reviews to identify gaps in provider workforce and potential barriers to integration. Our workforce development specialist coordinates and oversees workforce development activities to validate our network has a sufficient number of qualified workers who serve members in the most interpersonally, clinically, culturally and technically capable manner possible. We will implement tools for providers to use to enable training of their workforce, where needed, and tracking of progress. The LMS tool, in conjunction with the Arizona Health Plan Association, will enable providers to share licensing and certification information across contractors.

Health care providers serve as essential partners in the delivery of physical and behavioral health care services. Some key components of monitoring for a high-quality network and compliance with AHCCCS requirements include:

- Reviewing PCP panel size, to make sure no panel is more than 1,800 AHCCCS members
- Monitoring appointment and availability standards, through Alltran, who performs quarterly telephonic appointment and availability surveys, taking action on any provider not in compliance
- Helping PCPs expand skills and services to manage members with GMH/SA disorders and educating them regarding referrals to behavioral health providers as per Policy 320e including ADHD, depression and anxiety
- Verifying members are seeking services from their assigned behavioral health professional, behavioral health home or PCP and, when finding discrepancies, working with members to reassign them to the best providers for needed care. Our customer service teams guide members to quality providers, via our Provider Recommendation Engine (PRE) tool. Providers in PRE are ranked by quality, cost efficiencies and VBP contracting. New members are auto-assigned PCPs via PRE, although they can choose other PCPs, as desired.

AREAS OF CONCERN AND MITIGATION STRATEGIES

Our network team accepts feedback through many purposeful mechanisms (e.g., surveys, meetings), identifying concerns for resolution. In early 2017, we targeted feedback from behavioral health providers, knowing the transition to AHCCCS Complete Care could affect them. We created a Behavioral Health Provider Advisory Council and through multiple meetings identified challenges and concerns affecting member access to integrated care. The table below notes top concerns from the council, with gaps/challenges from across our network, and then highlights mitigation strategies.

Area of Concern	Mitigation Strategy
Data sharing between PCPs and behavioral health providers could be more effective. The perception exists that PCPs do not show interest in behavioral health needs of their members	▪ Offer CommunityCare tool, which includes a secure messaging system from provider to provider; shared member service plan; assessments; hospital admit, discharge and transfer alerts; integrated clinical and claims data; and performance reporting ▪ Offer incentives to physical and behavioral health providers to use our CommunityCare platform to measurably increase data sharing among providers treating our members ▪ Evaluate PCP engagement in behavioral health service plans and act when PCPs are not engaged ▪ Use our ACO University and Integrated Care Institute to promote integration via continuous learning, data sharing, performance monitoring, continuous quality improvement, identifying and sharing best practices, reducing barriers and partnering with local/national organizations
Transition from child to adulthood is not always effective	▪ Identify/resolve barriers for transition-aged members moving from pediatricians to PCPs ▪ Make sure special needs and behavioral health transitions begin well before the age of 18, by reviewing provider capabilities and incentivizing them to manage complex members
Provider challenges in moving from block payments: ▪ Payment for case management, care coordination and in integrated settings for more than one service per day	One hundred percent of our current behavioral health network is paid via fee-for-service payments. Our flexible contracting approach includes use of cash advances to minimize a provider's cash flow issues. In addition, we will: ▪ Use our established Behavioral Health Provider Advisory Council to give behavioral health providers a voice in our programs and processes for AHCCCS Complete Care ▪ Educate PCPs and pediatricians to understand behavioral health and the incentive we offer through our Provider-led Integrated Care Coordination program, which reimburses them for time spent sharing information with the member's behavioral health provider ▪ Offer incentives for closing quality gaps in care and for high-value providers (Centers of Excellence); expand ACO model to behavioral health homes; enhance fee-for-service reimbursements for completing additional coordination of care activities ▪ Provide training to help providers bill and receive timely payment for integrated services, including how to bill for multiple evaluation and management services on same day
High no-show rates (Providers we met with indicated up to a 40 percent no-show rate)	National data indicates expanding access to care services through extended hours and offering same-day appointments improves no-show rates. Our MSIC model touts a 14 percent no-show rate. We will educate non-MSIC providers on this impact and ask them to offer extended hours and weekend appointments, same-day appointments and integrated services at their existing clinics.
Access to specialists, particularly in rural areas	▪ Use processes to make sure members have direct access to specialists, without barriers ▪ Expand statewide telemedicine program, focusing on behavioral health access to care ▪ Extend statewide CRS mobile/field clinics to all our AHCCCS Complete Care members
Insufficient Residential Treatment Center (RTC) Capabilities	▪ Currently hold contracts with 100 percent of the RTCs in Arizona ▪ Divert members to community-based services and reduce need for RTCs via existing level of review for alternate placements/treatments for behavioral health and complex medical needs ▪ Divert or step down option from inpatient or RTC services, through our Family Access to Stabilization and Treatment (FAST) program for Medicaid youth ages 12 to 18 at risk for inpatient hospitalization or RTC
The need for improved access to MAT and SUD providers	▪ Contract with Equality Health, who specializes in engagement and treatment of Hispanic members and expand partnerships, like CleanSlate, to create access to these critical providers ▪ Use ConnectionsAZ hubs around the valley to divert members with SUD from EDs ▪ Develop additional COEs for MAT and pain management through provider partnerships ▪ Secure collaborative agreements with Indian Health Services for their SUD treatment
Access to care for American Indians	Our tribal liaison, Joetta Goldtooth, works with each of the tribes and T/RBHAs to hold educational forums on health literacy and accessing services and to execute MOUs with providers to deliver services to members living on tribal lands.
Provider education on Integrated Care	We will offer training for the provider workforce and expand our network of 68 integrated clinics by identifying and encouraging other providers billing integrated care to become integrated clinics.

Question 12

Effectively Managing Provider Relations and Communications

AHCCCS Complete Care represents a complex change to integrated service delivery for providers, and we understand it is critically important to AHCCCS that contractors serve and interact with providers throughout the transition process and beyond. We have clearly defined strategies to work with providers collaboratively to collect feedback and use data to resolve issues and improve processes. In keeping with our corporate pillars (Integrity, Compassion, Relationships, Innovation, Performance), our provider services teams quickly resolve issues in a transparent manner whether we identify them or the member or provider brings them to our attention. Our strategies emphasize identification of possible emerging trends through sustainable processes to gain understanding about and address provider concerns.

We will build upon AHCCCS' System Values and Guiding Principles and integrated services expectations to maintain successful interactions with providers and the service we give to providers to support them in delivering quality, comprehensive and cost-efficient integrated services to members.

Serving Providers Locally through Ongoing Outreach, Education and Data Sharing

We invest in people, processes and information sharing tools to serve providers quickly and efficiently. We add value to providers by bringing innovative solutions, meaningful data and information to our providers to reduce their administrative burdens, minimize complaints and to anticipate and address provider concerns before they arise or adversely affect any portion of our network.

We treat all providers as essential partners in the delivery of an integrated service system. We view a well-served provider network as the fourth component of the State's Triple Aim because the provider experience is critical to optimizing value for the State, members and providers. We take our role seriously in adding value to the AHCCCS Complete Care program through our provider relations activities. For the AHCCCS Complete Care program, our current provider relations and communication activities will extend to all provider types, including tribal providers, clinical and non-clinical providers, and providers in subcontractor networks. Our integrated provider relations and communication processes and initiatives are driven by our interactions with providers through:

- Provider forums held at least quarterly for behavioral health and physical health care providers the first year of the contract and at least semi-annually thereafter for all provider types (which we call Town Hall meetings)
- Behavioral Health Provider Advisory Council recommendations (we formed this council in early 2017)
- Recurrent Joint Operating Committee (JOC) meetings for all provider types, including our subcontractor networks (e.g., dental, vision, transportation), to discuss performance and provider relations concerns
- Integrated medical and behavioral health meetings with providers
- Routine and ad hoc provider meetings (via onboarding orientations and ongoing provider training through on-site meetings and webinars)
- Feedback we obtain from community partnerships, provider advisory and member advocacy committees
- Provider satisfaction survey results, including a survey of interactions with the provider advocate

We collect, track, trend and use the information we receive from member and provider interactions to augment our ongoing provider outreach, education and information sharing. We incorporate feedback into our Network Development and Management Plan (NDMP), and use it to improve clinical and operational processes. In addition to our NDMP, our written policies and procedures regarding network adequacy and network quality guide our provider services and communication activities. Our comprehensive approach to effectively and efficiently serving providers translates into our goals to increase provider satisfaction, reduce administrative burden for providers and promote continuous performance improvement among our network providers and within our provider services, utilization management, quality and performance improvement and claims management operations.

Anticipating Provider Needs to Navigate the AHCCCS Complete Care System

Like AHCCCS stakeholders, we anticipate behavioral health providers will most acutely feel the change to the AHCCCS Complete Care program particularly in the areas of claims submission practices, authorization requirements, value-based contracting and performance metrics. We orient and train all providers to make sure they understand contract requirements, plan benefits, authorization, claims submission and payment processes. We modify training topics to align with program requirements and use technologies to simplify providers' ability to receive training at times and locations most convenient to them, seeking to reduce provider administrative burden where possible. We survey training session participants and use survey results to improve our training programs. We will use best practices created during transitions to integrated behavioral health models in 2013 for CRS and in 2015 for GMH/SA. These include provider forums targeted by provider type, video-enhanced online training offered via *UHC On Air* and webinars, direct outreach to providers with high-volume members, emails, newsletters, outreach calls and frequent follow up with providers most impacted by the change.

Link Provider Portal. A primary source of information with easy accessibility — both during and after business hours — is our secure provider portal, *Link*. It gives providers secure access to interactive features such as claims submission, eligibility verification, prior authorizations and training materials. *Link* gives providers quick and easy access to a wide variety of critical information, including our *Care Provider Manual*, *Provider Directory* and instructional materials.

An Experienced Provider Relations Team

We serve providers through our locally led leadership team including Wendella Howell-Bell, our provider relations manager accountable for escalated provider issues; Briana Agnew, our network administrator; and Karen Saelens, our chief operating officer. All serve on our quarterly governance committee, to review provider metrics (e.g., contract loading timeliness, denial trends and recurring issues) for process improvement. Ms. Howell-Bell leads provider issue resolution with our local provider call center team, adult and children's health care administrators, credentialing coordinator, tribal coordinator, provider claims educator and provider advocates serving all provider types.

One Face of UnitedHealthcare. We anticipate the transition to AHCCCS Complete Care may be confusing for providers, particularly behavioral health care providers accustomed to alternate claims and payment processes and prior authorization requirements in place with RBHAs and T/RBHAs for many years. To ease transitions to new programs and to eliminate confusion among providers regarding who to contact for assistance, our provider advocates serve as the "One Face of UnitedHealthcare" — a single point of contact for high-volume provider groups participating in any one of our lines of business (e.g., employer groups, retirees, military, Medicaid, Medicare).

Our provider advocates visit physician offices routinely to educate our provider network, establishing relationships with providers and their staff to foster collaboration in service delivery to our members. They share information via multiple tools with our providers, such as the *Care Provider Manual*, our care collaboration platform (CommunityCare), e-alerts, faxes, webinars and our provider portal, *Link*, and teach providers how to use these tools when coordinating care for our members. Our provider relations staff receives support in these activities from our IT team as they introduce providers to and teach providers how to use our IT tools and information sharing venues.

Provider Services Call Center in Phoenix

Our provider services call center in Phoenix is a single phone line for community-based, medical and behavioral health services providers. A live resolution specialist available 24 hours a day, seven days a week, answers calls Monday through Friday from 8:00 a.m. to 6:00 p.m. local time. An interactive voice response (IVR) system answers calls received after-hours and on State-approved holidays, enabling providers to perform key administrative functions such as automated eligibility verification and benefits information.

We currently meet or exceed AHCCCS requirements for provider call-center performance. We provide intensive training to our call center staff on call handling based upon State requirements and our policies, procedures and corporate

values. We use advanced IT tools and applications to enable our call center staff to see member and provider data on their screen while they are on the phone to support first call resolution.

First Call Resolution. Our goal is to resolve all provider inquiries upon first call. Our IT system enables tracking of first call resolution metrics. To date, provider satisfaction exceeds 95 percent based upon an end of call survey. If an end of call survey indicates dissatisfaction, we follow up with providers to resolve the issue.

Ongoing Provider Call Center Process Improvement Initiatives

To assess and promote continuous quality improvement, call center supervisors and provider advocates participate in meetings to discuss updates, issues, concerns, upcoming network changes, AHCCCS and regulatory changes impacting how our resolution specialists respond to provider calls going forward.

Workforce Management and Forecasting. To ensure providers receive quality services from our call center, we use a dynamic workforce management and forecasting IT tool that factors hours of operation, call volumes, average handle times and specific contract requirements. We staff our provider services center in Phoenix with dedicated resolution specialists. Our provider services center functionality is integrated with our centralized National Operations Center to facilitate business continuity and to manage unexpected high call volumes when needed.

Positive Reinforcement Coaching. In 2017, we introduced new core competency metrics for call center staff focused on behavioral components rather than purely metrics. The new coaching approach, based upon provider survey feedback, motivates and empowers our resolution specialists to resolve provider issues with greater focus on quality and first call resolution versus speed.

Minimizing Provider Complaints through Active Listening and Prompt Response

We use continuous feedback from providers, provider advocates, and through data to self-monitor and self-correct as necessary to improve both clinical and operational performance. Improvements include simple system changes, such as enhancing our *Care Provider Manual* to make it easier to find information or transformational changes for the health care delivery system. For example, in 2017 we created our Behavioral Health Provider Advisory Council in anticipation of the AHCCCS Complete Care initiative. The recommendations we received from council members over the course of several meetings helped to shape our integrated medical and behavioral system of care that addresses key concerns of behavioral health providers, such as payment model changes, data sharing and increased PCP engagement.

To address potential increase in provider needs during transition, our Command Center will open Oct. 1, 2018 — staffed with experienced clinical, provider relations and operations staff on call 24 hours a day, seven days a week — to quickly address provider issues. It will remain open for least 60 days after the transition, tapering off based upon needs, with handoff to provider relations for ongoing support.

Using feedback from providers, our provider claims educators and provider relations team augmented or introduced a host of outreach and education programs; toolkits tailored for specific provider types and populations, such as a Quick Reference Guide of UHCCP contacts; web-based and provider services center communication applications. For example, *UHC On Air* is a web-based video library resource to aid providers in education on relevant topics, such as claims billing.

We comply with AHCCCS' Grievance and Appeal System (G&A) requirements, and inform providers of their right to file appeals, grievances and claims disputes, including how to request a State fair hearing, via our *Care Provider Manual*, website and remits. Our dispute and appeals manager, Martha Fuentes, uses feedback from all G&A data collected to inform changes leading to process improvement, provider education needs and staff education.

Reducing Administrative Burdens and Improving the Provider Experience

We reduce administrative burdens and improve the provider experience in many areas, and will focus here on four:

timely resolution of provider concerns, minimizing contracting issues, minimizing prior authorization concerns and minimizing claims concerns.

Timely Resolution of Provider Concerns

Through our Provider Relationship, Insight and Service Model (PRISM), we quickly resolve escalated issues for providers. Separate from our G&A mechanisms, PRISM is a single-point tracking and monitoring tool on our provider portal that gives our provider services staff visibility into complex provider issues, enabling rapid response and resolution. As a single intake portal, PRISM streamlines and integrates information from claims, enrollment, clinical episodes of care and utilization history, and provides an all-inclusive picture of provider concerns. Our provider services staff cannot close issues until the provider indicates satisfaction with the solution to the issue at hand. Since introducing PRISM in April 2015, the average days an issue (not G&A-related) was open decreased from more than 90 days to an average of 10 days or less. This has held steady since mid-2016. We attribute our improved provider satisfaction rates since 2015 (shown through provider surveys) to the PRISM issue escalation and resolution process.

Minimizing Contracting Issues

As part of our continuous quality and performance improvement efforts relating to provider contracting, we use a combination of internal and external resources to minimize provider burden with the application process, source verification and contract completion activities. For example, we participate in the Arizona Association of Health Plans Credentialing Alliance, which eliminates duplication of application efforts among providers.

Contracting Accuracy. Our contract analysts use our PREDICT tool to perform quality checks on contracts prior to uploading contract details into our provider data systems. We implemented PREDICT in early 2017 to catch errors during provider contract data entry. It has significantly reduced provider complaints and inquiries related to claims and coding errors tied to contract data entry. We audit our provider contracts for accuracy through multiple processes, such as end-to-end review of claims to the contract, random sample audits, and provider roster comparison to contract setup.

Our locally based credentialing coordinator confirms provider contracts are loaded accurately and timely into our system. We meet or exceed AHCCCS timely credentialing requirements and load at least 90 percent of executed provider contracts into our system within 30 days of Credentialing Committee approval. Provider advocates closely monitor the contracting process and are poised to quickly resolve issues that may arise during transition.

Minimizing Prior Authorization Concerns

Relaxing Authorization Requirements during Transition. Partnering with providers to coordinate access to quality services has been instrumental in securing continuity of care for members and our development and implementation of our prior authorization requirements. For all providers, we will waive authorizations during the transition to AHCCCS Complete Care for a minimum of 90 days to maintain proper continuity of care for members.

Relaxing Authorization Requirements when Quality is Achieved. As a steward of publicly funded programs, we work with providers to balance administrative burden with benefit administration to confirm appropriate provision of Medicaid covered services. We continually review utilization data to find correlations between members' health care outcomes and the effectiveness of our authorization processes. Through our continuous quality improvement goals and associated initiatives, we have implemented several methods to streamline or reduce prior authorization requirements for providers without compromising quality or as a reward for providers meeting or exceeding quality goals.

Relaxing Authorization Requirements for Behavioral Health Services. To remove barriers to access to the right care when needed, we seek to streamline and minimize authorization processes. A few examples include:

- ***ACE (Achieving Clinical Excellence):*** The ACE program rewards network clinicians and facilities for reaching certain quality metrics and performance benchmarks. Waiving prior authorization requirements for certain services are perks that ACE preferred providers enjoy and it keeps them motivated to improve performance.

- ***Behavioral Health Outpatient Management Program:*** Removing potential barriers to accessing routine services aligns our model of care with requirements of Federal Mental Health Parity. We assess service delivery through claims analytics determining if care being delivered aligns with evidence-based guidelines. As a result, services, such as therapy and behavioral health outpatient visits, do not require a referral or prior authorization.
- ***Behavioral Health Treatment Milestone Authorization Program:*** Via a recurring authorization historical data quality review process, we determine if there are behavioral health diagnoses that do not require full clinical review. We introduced this process in early 2016 and identified 12 diagnosis categories that do not require initial clinical review, which significantly reduces administrative burden for our behavioral health providers. Prior to this process, 100 percent of diagnoses required initial clinical review; whereas about 40 percent of cases now require initial clinical review. Only cases needing care beyond the authorized treatment milestone require a review to determine clinical need and medical justification for continued care.

Streamlined Prescription Authorization. We introduced PreCheck MyScript to reduce the need to fax or call for prescription coverage information. PreCheck MyScript is available to providers via our *Link* provider portal and enables providers to offer prescription alternatives not requiring prior authorization and lower-cost alternatives with members during the appointment. PreCheck MyScript reduces frustration and delays at the pharmacy when prior authorization is needed and quickly provides members with information about the prescription.

Minimizing Claims Concerns

Prompt and accurate claims payment is a key concern among providers. We exceed AHCCCS claims payment timeliness metrics through prevention and swiftly addressing post payment issues. In 2017, we significantly reduced the amount of claims rework and provider claims complaints with our Claims Processing Early Warning System (CP-EWS) process. CP-EWS enables us to catch changes in claims denial patterns and to assist providers immediately if denials reveal the provider needs additional claim filing education. This effectively reduces claims denials going forward. For example, in October 2017, one provider had a spike of 17 duplicate denials due to not submitting claims as corrections. We reached out to the provider to discuss accurate billing, quickly stopping additional denials.

Other claims management activities aimed at improving the provider experience, reducing administrative burden and minimizing complaints include:

- ***Using post payment trend monitoring*** for denials, change in payment trends and population-based changes to derive policy and system change, such as reducing the need for authorizations or optimizing edits.
- ***Encouraging providers to use electronic data interchange (EDI) and electronic fund transfer (EFT)*** by educating them regarding the benefits of EDI and EFT over paper filing and payment methods, such as reducing common submission errors and faster claims turnaround. In November 2017, the denial rate for the EDI claims was only 15 percent; but for the paper claims, the denial rate was 32 percent.
- ***Removal of diagnosis related group (DRG) coding audits*** when a provider has 95 percent quality rating or higher in a quarter, which reduces administrative burden among providers with high quality ratings.

With every provider-specific claims issue, our claims educator works directly with contracted and non-contracted providers to quickly resolve issues and to give focused attention and education to providers, based upon results of claim payment trends. Our claims system auditors verify provider contracts are loaded correctly. This ongoing collaboration helps to keep our claims payment accuracy rates high and in compliance with the contract.

Question 13

Using Feedback to Improve the Member and Provider Service Experience

Transforming the current health care system in Arizona to an integrated system requires collaboration, relationships, eliminating barriers to care and data-driven decision making. Use of feedback, whether direct or indirect, in a continuous quality improvement process is the key to a high quality system of care that puts the member in the center and understands the member's experience. UHCCP has strong customer service processes, tools and systems aimed at continuously improving service through the incorporation of direct feedback from members, families, providers and community stakeholders. Indirect feedback comes in the form of each member and provider interaction (e.g., claim, authorization, grievance, call) captured in databases to identify trends at global and population-specific levels. We dissect all data gathered, searching for patterns and trends to improve member health outcomes, and to improve the member and provider service experience — bringing our customer's voice to life.

Surveys provide feedback tied directly to health outcomes and quality of services provided to members. Through formal and informal surveys, member and provider advisory councils and committees, and operational audits, we analyze and systematically use data in our clinical and quality improvement programs, policies, operations and performance improvement initiatives — with a view toward continually and measurably improving the service experience of our members and providers and improving health outcomes.

Obtaining and Using Feedback to Improve the Member Experience

For AHCCCS Complete Care members, moving to an integrated delivery system may alter their usual way of seeking services. We are highly sensitive to this change and the impact on members. Our staff is poised to use member feedback to ensure we provide the highest possible service to members. We use compassion, one of our core values, when interacting with members and when incorporating feedback into process improvements. We recognize achieving high member satisfaction with services and removing barriers to access to those services is our responsibility.

With every interaction, we ask our members and their families how we can help them, seeking to understand their needs and concerns, especially prior to and during times of transition. We continually assess, reassess, test, implement, streamline and improve processes to meet the ongoing and ever-changing needs of the members we serve. We use information we gather from formal and informal surveys conducted through our call center, claims and utilization data, complaints, grievance and appeals, governance committee and councils, member advocates, peer support, call center representatives (i.e., member services advocates and others). We collaborate with community partners, such as Raising Special Kids, to obtain feedback on all member materials targeted for CRS members who are also enrolled in DDD. Young adults, who are our former CRS members, review our website for accessibility and recommendations on changes. We are continually expanding these community partnerships to tailor feedback mechanisms to specific populations, such as conducting tribal consultations with tribal and tribal clinic leadership, to ensure we respect the traditions and customs of American Indians and all communities we serve.

Figure 6: Net Promoter System continually measures member and provider satisfaction.

Net Promoter Score (NPS) Measures Member Satisfaction. NPS is one way we understand how the people we serve are affected by the services we deliver. In simplest terms, NPS is a customer loyalty metric measuring likelihood of a member to refer UHCCP to another person. Among U.S. corporations using the NPS metric, the national average is around 50 points on a scale of negative 100 to positive 100. We are pleased our Arizona NPS score among members for 2017 is 64 and continues to climb.

Member and Provider Feedback Obtained through Our Phoenix Call Center

Monthly, we randomly select 50 recorded calls per supervisor and four calls per agent to evaluate quality and compliance with customer care guidelines and our performance

improvement initiatives. Using this data, our quality analysts assess and evaluate outcomes, acting on data in a number of ways including coaching member service advocates (MSAs) on first call resolution techniques, making a positive connection with callers, and compliance with regulatory and business requirements. We use feedback collected from callers to improve the member and provider experience, such as:

- ***Call Feedback:*** Using behavioral analytics, a language-based algorithm in our call system, we identify caller dissatisfaction (rating of caller's level of distress or satisfaction). All recorded calls are available to review and analyze through our behavioral analytics capabilities. Results provide ongoing training for our staff, such as identifying verbal cues and the best way to respond to behavioral signals.
- ***End of Call Survey:*** We invite callers to participate in a brief end of call survey - our United Experience Survey (UES). Those who opt to take the three-question survey, provide comments and ratings on service-related questions. We use UES information to trend call center satisfaction and assess members' experiences (2017 results averaged 90 percent satisfaction), evaluate the performance of member services staff and identify opportunities for training.
- ***Repeat Caller Data:*** The "Conversation Manager" feature within our phone system captures and collates caller frequency. Using repeat caller data and feedback, we apply our continuous quality improvement initiatives to better serve members and accelerate the resolution of their specific needs.

Member Feedback Obtained through Other Initiatives

We have broad reaching programs to obtain member feedback including:

- ***Member CAHPS Satisfaction Survey:*** At least annually, our Quality Improvement Committee oversees the conduction of CAHPS surveys, including an accountable care organization (ACO)-specific survey we conduct to tell us how well ACOs are performing. The committee shares results with the State and regulatory agencies, as required, and with ACOs and UHCCP staff for process and quality improvement initiatives.
- ***Key Member Indicator Survey (KMI):*** The KMI is a monthly random phone survey of a statistically significant number of members, for feedback on our service performance.
- ***Grievances and Appeals:*** We monitor member appeals and grievances for trends requiring action, such as indicators of access to care issues or providers who are billing members inappropriately. We take swift and appropriate action to mitigate issues found in data trends.
- ***Service Quality Improvement Subcommittee (SQIS):*** We seek feedback through staff interactions with specific member populations through SQIS, which is part of our Quality Improvement Committee, to include the member's voice in our strategies for improvement. The SQIS discusses member feedback gathered from key staff interacting with members, such as our member services and call management, dispute and appeal manager, tribal coordinator, Veteran advocate, member advocates, pharmacy director, justice system liaison, and housing and education staff.
- ***Member Advocacy Council:*** Our Member Advisory Council will comprise our existing Member Advocacy and Foster Adoptive Kinship Councils, with membership including adult members receiving integrated behavioral and physical health services, parents/guardians of children with special health care needs including adoptive, kinship families, and a member of our executive management team. We seek members who reflect our population and communities, including professionals and advocacy groups, with meetings starting prior to the Oct. 1, 2018, transition date. We will use feedback from this council to improve the member experience.

KMI Survey Results
Comparing November 2016 to November 2017, our member loyalty metrics increased by 10 or more points in the areas of likelihood to recommend our plan to family and friends; overall satisfaction with our service; and earning the member's trust. These results are key components of our overall NPS score and these high scores from our members let us know we are on the right track.

- We will use ***peer and family delivered support*** services/specialists as peer/family voices at all levels of the system. Information gathered will inform decisions for system and process improvements.

Transforming Member Feedback into Processes that Resulted in Improvements

Through daily meetings and use of early warning tools, our call center uses a rapid cycle improvement process, enabling us to flex in adjusting processes and quickly respond to member needs. Our goal with each call we receive is to quickly identify a member, understand their situation, history and needs, then connect them to the advocate best suited to support them. To support our goal and better serve members, we implemented natural language technology so callers can verbally state the reason for their call. This capability recognizes more than 70,000 keywords and utterances to route the call based upon the member's statement to the right help. The Interactive Voice Response (IVR) feature of our phone system includes 24 hours a day, seven days a week access to our nurse triage line (NurseLine), which includes behavioral health clinicians. Member services advocates are able to access information about gaps in care, health risk assessments, chronic conditions, past complaints, PCP assignment and prior calls — all aimed at using direct and indirect feedback to improve the member's experience and to assist the member in receiving services.

UnitedHealthcare Community Plan First Call Resolution Rates
Our monthly first call resolution rate exceeds the 70 percent AHCCCS standard, per ACOM 435, averaging 93 percent in 2017.

Improving our processes has been instrumental in improving our first call resolution rates. Our monthly first contact call resolution rate exceeds the 70 percent AHCCCS standard, per ACOM 435, averaging 93 percent in 2017. In addition to our call center initiatives, below are examples of our process improvements resulting from member feedback — some changes were simple and others truly transformational.

Special Needs Initiative. This initiative was created out of family feedback and is a member engagement model for high touch, complex issues for CRS/DDD families with behavioral health benefits and/or with commercial UnitedHealthcare insurance. We assign dedicated representatives who serve as a single point of contact for the family to resolve their unique issues and assist in minimizing the burden of health system navigation unique to their circumstances.

MyConnections. The UnitedHealthcare myConnections™ program links members with benefits and services to address social and economic factors contributing to poor health, increased health care utilization and higher health care costs. We use member feedback about myConnections to continually improve the process of identifying community resources to address social determinants that can lead to improved health outcomes.

Health Disparity Action Plan: Using data analytics, in 2017, we identified 15 ZIP codes in Maricopa County where quality measures were lower for children ages 3 to 6 and adolescents. Based upon the data, we developed a health disparity action plan tailored to the members in these ZIP codes to address unique needs, access barriers and to understand what was driving the lower quality ratings, such as culture dynamics. Actions we take to improve results include targeted member and provider outreach and education to schedule appointments and close care gaps.

IVR System Simplification. Based upon member feedback, we simplified our IVR call system. Changes included identifying a member prior to live-person greeting so the member or provider services advocate is prepared for the call; adding a callback option; adding an option to get eligibility information to members via text messaging.

Affiliated Practice Dental Hygienists (APDH). From member feedback, our staff recognized a need for access to dental care and proposed we integrate APDH into medical PCP teams to help improve access to care. Now, instead of waiting for members to go to the dentist, we are actively bringing a dental team member to their medical PCP office. In 2017, Medicaid Health Plans of America recognized the APDH program as a best practice.

Transition Processes. With each experience in transitioning members between plans, we use member outcomes to improve our tools and processes. After our 2017 transition of 65,000 members from Maricopa Health Plan to our plan, we AHCCCS recognized us as having strong processes and we were asked to present our best practices to other plans.

Handwritten Notes. Call center staff and member advocates use feedback from member interactions to write and send notes to members to let them know they are appreciated and we care about their wellness. The 2,000 handwritten notes they sent in 2017 demonstrate heartfelt compassion and are well received by our members.

Technology. Through feedback, we know members seek interaction with us apart from the call center. As a result, we use technology to facilitate greater member engagement in their health care, resulting in better health outcomes. For example, members can access our website through a mobile phone application called Health4Me.

Figure 7. Patient-centered health care starts with understanding the patient's viewpoint.

Providers. We also educate providers performing case management services about capturing member feedback, and using the feedback in decision-making, development and enhancement of customer service. For example, the Tucson Multispecialty Interdisciplinary Clinic (MSIC) surveys members for feedback on services the MSIC provides. At monthly meetings with the MSIC, member feedback is discussed, for action by either the MSIC or UHCCP.

Obtaining and Using Feedback to Improve the Provider Experience

For AHCCCS Complete Care providers, an integrated delivery system means changes to how they bill for services and coordinate care for their patients — our members. Throughout our health plan operations, health plan leaders and administrators emphasize compassion, integrity, relationships, innovation and performance in interacting with providers and incorporating their feedback into our process improvements. We recognize how critical our role is in gaining provider trust and satisfaction with our services as they serve our members and reform the health care system.

With every face-to-face and telephonic contact, we ask our providers how we can help them, seeking to understand their needs and concerns, especially prior to and during times of change. Provider relations and communication processes improve based upon feedback received from providers every day. Using information we gather from formal and informal surveys conducted through our call center, claims and utilization trends, complaints, grievance and appeals reports, provider councils and forums, our provider advocates, MSAs and others, we continually assess, reassess, test, implement, streamline and improve processes to meet the ongoing and ever-changing needs of providers we serve.

Our open-door policy for providers is a disciplined, routine approach offering providers many means to give us feedback. Examples of the ways we obtain and use feedback from providers includes, but is not limited to:

- ***PRISM:*** A single-point tracking and monitoring tool gives us visibility into critical provider issues (separate from grievance and appeals), enabling rapid response and resolution. PRISM integrates information from providers, claims, enrollment, clinical episodes of care and utilization history, and provides an all-inclusive picture of a provider's concerns. Our provider advocates and claims educators use data collected in PRISM to escalate and resolve issues, to the provider's satisfaction. Positive provider feedback around PRISM includes "…very quick, precise and detailed" and "Understood what needed to be done to reprocess the claim…."
- ***Surveys indicating provider satisfaction:*** Our annual provider satisfaction survey, conducted by the Center for the Study of Services, asks questions related to the utilization review process, claims process, appeal and grievance process, care management, coordination of care, provider services, provider materials and the health plan website. We separately survey providers regarding interactions with their provider advocates.
- ***Provider Forum Surveys:*** Our provider relations team conducts surveys of those who attend forums and use the feedback collected to adjust agenda topics and augment how we conduct future meetings.
- ***Grievance and Appeal System:*** We track and trend provider grievance, appeal and claim dispute data through our Enterprise Tracking System, from receipt to State Fair Hearing and final decisions. Trends help us find and resolve systemic issues, such as provider billing issues or prior authorization processes.

- ***Provider Input Regarding Claims:*** Our claims educator takes provider feedback from training sessions and from individual providers with whom she interacts. She uses the input to simplify processes and to offer additional training to providers regarding claims submission processes.
- ***Joint Operating Committees (JOCs):*** Our provider advocates host recurring JOCs with our providers (e.g., behavioral health, ACOs, MSICs) to discuss health care trends, appointment availability, program updates and contract changes. Results and feedback from meetings are used to improve processes.
- ***Provider Administrative Advisory Council (AAC):*** AAC consists of FQHCs, large provider groups, ACOs and hospital representatives who meet quarterly to enhance the relationship between providers and us. Presenters at AAC meetings are required to describe how AAC feedback influenced changes made to products, services and processes.
- ***Behavioral Health Provider Advisory Council:*** Through multiple and ongoing meetings with behavioral health providers, we captured frustration with the current system to enhance our clinical model around behavioral health integration, data sharing, care coordination and incentive payments for producing outcomes.
- ***Our Governance Committee:*** Comprises UHCCP leadership and at least 25 percent peers and family members, equally divided, who are/were participants in the behavioral health community, within each contracted GSA. This committee will meet at least twice a year and committee feedback will inform strategic planning, process improvements and decision making related to integrated service delivery.

Transforming Provider Feedback into Processes that Resulted in Improvements

When we identify key indicators not meeting performance expectations, our operations, clinical and local provider relations teams employ a variety of methods to drive improvement, such as educational material changes, clinical program adjustments, call center changes, website updates, communications and process changes. Examples of improvements we made that were simple or truly affected transformation of the health care system include:

- ***Care Provider Manual:*** We use provider feedback from various sources, such as provider advisory councils, survey results and PRISM, to continually improve the layout and ease of use of our provider manual. For example, overall provider satisfaction with UHCCP has increased 6 percent since 2014 and provider satisfaction with the helpfulness of our *Care Provider Manual* has increased 11 percent during this same period.
- ***Veterans:*** In 2017, we hosted a community meeting with more than 20 organizations serving Veterans and their families to gain insight into Veterans' needs. As a result, we created a Community Grants RFP and awarded grants to deserving organizations with funds to provide wraparound services for homeless Veterans.
- ***Early Warning System:*** From provider complaints, we learned we needed to detect sudden changes in claims denials to avert ensuing claims issues. This led to building our Claims Processing – Early Warning System (CP-EWS) tool, which monitors claims denials for abnormal trends. CP-EWS allows us to quickly notify providers and inform them of actions we are taking for resolution. Recently, a provider billed ancillary services incorrectly causing 661 denials in one day. Education outreach occurred immediately with the provider.
- ***Advancing alternative payment models:*** Through provider collaboration, our value-based contracting approach includes key outcome metrics and best practices resulting in sustainable value-based payment models intended to improve member outcomes and satisfaction; and drive savings and high quality into the health care system.
- ***PreCheck MyScript:*** Provides physicians real-time access to member information — eligibility, medication history, formulary data and out-of-pocket costs — to reduce member surprises at the pharmacy.

Question 14

We are at the forefront of national payment reform and we have used value-based purchasing (VBP) models in our Arizona Medicaid and Medicare D-SNP plans since 2012. These VBP models align to AHCCCS VBP directives and the Health Care Payment Learning & Action Network (LAN) Alternative Payment Models (APM). All of our organizational experiences and continuous learning actively inform ongoing strategic advancement of purpose-driven VBP models. When we consider partners for APMs (e.g., incentive models, shared savings and full-risk contracts), we evaluate them using a survey tool that assesses quantitative and qualitative readiness across the clinical and reimbursement risk continuum. This survey reviews organizational structure, operational sophistication and population health experience. Consistent with our experience integrating CRS, ***we will not use block purchasing*** for behavioral health provider contracts. We will offer traditional fee-for-service (FFS) models, enhanced reimbursement for care coordination, and incentives for quality and value (APM Category 2), quality with shared savings/shared risk (APM Category 3) and/or condition-specific or population-based payment (APM Category 4) for Accountable Care Organizations (ACOs) and similar partners capable of proactive, data-driven, holistic and integrated care, such as those that sought and received Targeted Investment Program funding.

Our VBP approach considers both ***how we reimburse*** integrated, physical and behavioral provider types for care rendered and ***what incentive strategies*** will drive cost-effective, aligned, quality outcomes. Our flexible approach includes a variety of payment and incentive options for different provider types, as demonstrated below:

Reimbursement Options and VBP Incentive Models	Integrated and Non-integrated ACO Providers	Integrated Non-ACO Providers	Physical Health Only Providers	Behavioral Health Only Providers
Shared Savings incentives: Savings achieved below agreed upon goal creates a pool that is paid based upon quality goals met	✓			
Clinical Integration Payments (CIP): Providers earn payments for specific actions that transform care delivery	✓			
Quality-based PMPM incentives: Providers earn payments across a population when achieving agreed upon quality goals	✓			
Quality-based Gap in Care incentives: Providers earn payments for addressing specific gaps in care per member	✓	✓	✓	✓
Enhanced FFS reimbursements: Provider-led Integrated Care Coordination (PLICC) for completing additional assessments, screenings, service plans and care coordination	✓	✓	✓	✓
Incentives for high-value providers (centers of excellence)	✓	✓	✓	✓

Our more advanced shared savings/risk incentive models focus on partnerships where payment transformation is sustained by larger membership panels, dedicated resources, evidence-based/proven clinical transformation models and the adoption/use of actionable data and health information technology. These fundamentals accelerate population health management, process improvement and continuous outcomes measurement — key elements for VBP success. For smaller network partners, our flexible VBP models address targeted quality gaps in care, defined by standard HEDIS/CMS Adult-Child Core Set Measure methodology. We develop customized reimbursement/incentive approaches for special programs, such as centers of excellence. Currently, we exceed AHCCCS VBP goals:

	2017 (% VBP Spend)	2018 (% VBP Projected Spend)	AHCCCS Goals: 2017/2018
Acute	49.1% (233,637 members)	67.6% (302,029 members)	35%/50%
CRS	41.9% (10,557 members)	90.8% (21,965 members)	35%/50%

Given that providers differ in levels of membership, size, organizational design and operational capacity, VBP must be a customized rather than a one-size-fits-all approach. Beginning in early 2017, we convened a ***Behavioral Health Provider Advisory Council*** and met over 30 times with key behavioral groups to *understand* where they exist on the integration continuum, *listen* to suggestions for payment/incentive models and *learn* how we should apply VBP effectively to reduce fragmentation and improve outcomes. We discussed their preferences for VBP models that better account for their service delivery efforts, value their role in case management/care coordination, align incentives and reward success in meeting outcome, quality and efficiency targets. We discussed their levels of practice readiness, aligning contractual terms and operational supports to meet providers where they are, flexing our level of support to allow them more responsibility for performance consistent with their capabilities. Our long-term goal is to help providers advance along the care delivery spectrum, with increasing accountability for cost, quality and outcomes.

Drawing from our Arizona experience, Behavioral Health Provider Advisory Council and ACO/VBP partner feedback and by implementing a comprehensive transition plan, we will support our network through these proposed reimbursement changes. In 2013, we successfully transitioned the CRS contract from block purchasing to FFS with VBP models. Moving away from block purchasing is critical to align payments with needed services, while mitigating the barriers and risks associated with block payments to improve performance and better monitor service provision. As AHCCCS Complete Care's fully integrated system design creates new opportunities to align payment and incentive models for ***integrated, behavioral only and physical only*** providers, our proactive collaboration will mitigate transition issues.

VBP Strategies: Integrated, Behavioral Only and Physical Only

For ***ALL*** these provider types, at a ***minimum,*** we will reimburse market-competitive FFS rates or the FQHC/RHC prospective payment system rates, pass through AHCCCS-differential payments (e.g., added 10 percent Evaluation and Management code payment to Integrated Clinics; targeted investment funds) and adhere to AHCCCS payment policies (e.g., AMPM Chapter 300, Policy 320-E). With these provider types, we will use two additional key strategies: our ***Provider-led Integrated Care Coordination*** and ***guiding members to high-value providers.***

Provider-led Integrated Care Coordination (PLICC): Our Behavioral Health Provider Advisory Council and VBP partner feedback indicates we must support payment strategies to adequately account for care coordination efforts and encourage behavioral health only and physical health only providers to share data and collaborate more effectively. These objectives helped guide development of our PLICC program, where our providers can earn additional office visit reimbursement when treating members with medical and behavioral complexities, in need of enhanced care coordination. Under PLICC, we link added reimbursement to completing or updating approved health risk assessments, conducting evidence-based, integrated screenings (e.g., depression, anxiety), assessing/referring for social determinants of health (SDOH) and developing integrated service plans. Members and authorized family can view their service plans through our member portal. Providers can view this data via our *CommunityCare* platform. Our resource database, *Healthify,* and our myConnections social service network will support provider referrals to address SDOH adversely impacting outcomes.

Our CommunityCare platform, containing integrated health care data, is used collaboratively by our staff and providers engaged in members' care. We ultimately want to leverage the health information exchange (HIE), Health Current, as the underlying technology for our CommunityCare platform. We remain committed to developing the HIE in partnership with AHCCCS and other stakeholders and encourage the adoption of the HIE with our network of providers, community-based organizations and our care managers. Today with CommunityCare, providers can participate with each other, and us in member-consented service plan development (including sending secure messaging), to improve data sharing, communication and virtually integrate care. In CommunityCare, the assigned PCP and/or attributed behavioral health provider can access timely, actionable data (HIPAA/state compliant), such as:

- Admit/Discharge/Transfer (ADT) data (fed today directly via Health Current/HIE)
- Up to 27 months of members claims data (e.g., last PCP visit, specialist, lab, imaging)

- Member risk stratification, special health care needs designation and diagnosis information
- Quality Gaps in Care (Medicaid HEDIS/CMS core measures, Medicare D-SNP Star ratings)

Guiding members to high-value providers. Using our *Provider Recommendation Engine* (PRE), we categorize our network based upon quality and cost data at the practice level. Additionally, providers who participate in one of our VBP/centers of excellence models receive additional credits as a high-value provider. PRE auto-assigns members who need a PCP to providers with a higher PRE ranking. Our member services and care management staff also use PRE to help members select a PCP, respecting that member choice is always the ultimate selection criteria. For the 12 months ending October 2017, we used PRE to assign 98 percent of new members to Tier 1 and 2 providers (higher quality, lower cost, VBP). Specifically, in October 2017 we assigned 89.5 percent of new members to Tier 1 and 8.6 percent to Tier 2 providers. As an AHCCCS Complete Care contractor, we will add new criteria to the PRE algorithm, including providers enrolled in PLICC, act as an Integrated Clinic and enrolled in the Targeted Investment Program. Via a separate process, we review members not seeing their assigned PCP or seeing a different PCP than the one assigned. Where possible, we realign members to high-value providers when the members appear disengaged from primary care altogether.

VBP Approach for Integrated Providers

ACO Providers

To meet AHCCCS' objective for integrating the medical, behavioral and social needs of members, we have collaborated with providers to develop an ACO model over 10 years that promotes accountable provider-led care. We make sure providers have the data, analytics and support to better identify and address those needs. By working together to enhance access to care, improve quality and treat the whole person, we encourage team-based, collaborative care that is member-centered and outcomes-driven.

> "We have been accountable care partners with UHCCP since 2012, adding a value-based agreement in 2014. Our clinical collaboration and the added incentive model has been a positive learning process, mutually beneficial and produced positive results for our shared patients. We are excited to continue and expand our clinical and value-based relationship with UHCCP with an integrated benefit design."
>
> MARANA Community Health Center
> Clint Kuntz, CEO

We have 30 ACO partnerships caring for 278,738 Acute and CRS members. These ever-expanding partnerships include independent practices, ICs, FQHCs and MSICs. We will expand to Behavioral Health Home ACOs under the AHCCCS Complete Care contract. These partnerships offer a range of medical/behavioral integration, ranging from partially to fully integrated. We deploy our CommunityCare tool with each ACO and hold regular Joint Operating Committee (JOC) meetings to share data/results and discuss effective clinical approaches to drive continuous improvement. In addition to offering the ***minimum*** payments noted above, we pay for appropriate behavioral case management services as defined by the AHCCCS Covered Behavioral Health Services Guide. We offer a Total Cost of Care (TCC) VBP model (APM Category 3) with ***shared savings*** (upside/downside), ***quality incentives*** and/or ***clinical integration payment*** support. The shared savings opportunity is based upon improvement of the benefit cost ratio (BCR) from an established baseline, inclusive of all benefit spend for the practice membership. Driven by ACO efforts, savings generated below the BCR target creates a shared savings opportunity "pool." The ACO is then eligible for a percentage of this pool, based upon physical and behavioral quality targets achieved. In addition, this VBP is structured to pay direct incentives for the quality achievements, either as population-based per member per month (PMPM) payment, or as a defined dollar amount per each gap in care addressed. The ACO may optionally choose a ***Clinical Integration Payment*** (CIP) that distributes a PMPM payment for successful completion of process improvement activities (e.g., access to care; seven-day Emergency Department (ED)/inpatient follow up; seeing high-need, high-cost members every 90 days). CIP payments support infrastructure and transformation efforts that accompany integrated, accountable activities.

Results: In collaborating with ACO partners from July 2015 to June 2017, our ***Acute membership*** showed a 21 percent reduction in hospital admissions and 12 percent reduction in ED visits. In this same period, our ***CRS membership*** showed 20 percent reduction in hospital admissions and 9 percent reduction in ED visits. A review of our longest tenured ACOs

with implementation dates ranging from Jan. 1, 2014, to Jan. 1, 2015, collectively shows BCR improvement (excluding catastrophic costs) of 0.7 percent from 2015 to 2016 calendar year. At the same time, multiple quality metrics have improved over each measurement period over the past three years. For example, El Rio and Marana Health Community Health Centers improved in ED visits/1,000, adolescent well-care (AWC) visits; Your Neighborhood Healthcare Center improved in annual dental visits (ADV), AWC, diabetes HbA1c control and ED visits/1,000; Children's Clinic for Rehab Services improved in all quality metrics (ADV, AWC, ED visits/1,000, well-child 3 to 6 years and well-child 0 to 15 months). As demonstrated by the results outlined above, our ACO program linked with VBP models has been successful in supporting organizations to partner with us to lead accountable models of high-quality, cost-effective care.

Non-ACO Providers

Where possible, we connect providers who are interested in ACO participation with our current partnerships to help accelerate integration and system transformation, while respecting any providers who choose to remain independent. In addition to offering all the ***minimum*** payments we noted earlier, we extend VBP contracts that pay providers for ***quality-based incentives.*** We base incentives upon improving HEDIS/CMS Adult-Child Core Set measures, both physical and behavioral health, with payments made for addressing individual gaps in care (APM Category 2). We customize contracts per provider type with metrics that include, but are not limited to: EPSDT measures, including developmental screening; ED or inpatient rates per 1,000 members; antidepressant medication management; seven- and 30-day follow-up post psychiatric hospitalization; follow up after discharge from ED for mental health; psychiatric hospital readmission rates.

VBP Approach for Behavioral and Physical Health

Behavioral Health Only Providers

In addition to offering all the ***minimum*** payments noted above and appropriate Behavioral Health Case Management services, we will offer our quality-based, gap-in-care incentive model tied to improving behavioral and medical HEDIS/CMS Adult-Child Core Set measures (APM Category 2). Being collaborative and flexible with providers, we will assess other goals and metrics they suggest as potential quality measures. To promote improvement and provider cooperation, we will align selected quality measures with those offered to physical health providers under the same VBP model. We will not duplicate incentives; rather, we will divide incentives between these providers, incentivizing each to improve the quality goal together. We are also in discussions with several Behavioral Health Homes interested in a comprehensive population-based payment model (APM Category 4). We will implement a reimbursement strategy commensurate with full claims experience for behavioral services rendered, assessing each interested partner and moving forward together in developing the strategy.

Kansas Quality Gap in Care VBP
Example: In 2017, we paid PMPM incentives to 26 Kansas community mental health centers (CMHCs) to focus on standard quality measures. As a result, these CMHCs realized positive results in all service categories, with the largest in inpatient (-18.1 percent); outpatient (-11.6 percent); dental (-10.4 percent); ED (-4.5 percent).

Physical Health Only Providers and Primary Care Obstetricians

In addition to offering the **minimum** payments we noted earlier, we will offer physical health only providers and primary care obstetricians our quality-based gap in care incentive model with metrics appropriate to the specific care needs of their membership. As noted above, we base these incentives upon improving HEDIS/CMS Adult-Child Core Set measures, both physical and behavioral health, with payment made for addressing individual gaps in care. As noted above, we will encourage provider collaboration by finding alignment where appropriate in the quality measures selected with those offered to behavioral health providers under the same VBP model. This alignment of incentives will further encourage providers to improve the quality metrics together. We will provide primary care obstetricians with OB-specific quality gap care incentives focused on achievement of metrics such as early entry into prenatal care and postpartum care. We are adding future metrics to this VBP model (e.g., early elective deliveries; low birth weight rate; C-section rate).

Centers of Excellence

We use data to guide us toward centers of excellence partnerships that can benefit our system of care and consider how VBP models can be integrated in our approach. Some e*xamples* are*,* we formed several centers of excellence partnerships: Integrated Clinic ACOs like Spectrum, COPE, Marana Community Health Center and Bayless Healthcare. These models are an extension of our core ACO program, and we incent through quality gaps in care and Total Cost of Care (TCC) incentive VBP models. We contracted with Southwest Autism Research & Resource Center for applied behavioral analysis clinical services and retain a MOU to create a novel, value-based autism center of excellence that expedites assessment and service delivery to those with autism or at risk, helps address workforce shortages in this field and leverages telehealth technologies. We partnered with ConnectionsAZ to establish an Integrated Health Transitional Care program with bundled payments, VBP and performance measurements. This program supports high-risk/high-needs complex members to engage in meaningful integrated care settings and reverse a cycle of repeated adverse events, crisis interventions, or costly, less effective care delivery. Another exciting new center of excellence partnership we have is with CleanSlate, an award winning (2012 Science and Service Award for Office-based Opioid Treatment by SAMHSA), person-centered network of physician-led outpatient addiction treatment-centers that deliver focused, outcome-based treatment of Medication-Assisted Therapy related disorders. Our VBP model promotes quality outcomes while reducing high-level inpatient and lengthy residential admissions that can be associated with opioid/substance use disorders. Our quarterly retrospective reviews compare FFS payments against all-inclusive case rates, which includes individual, group and family therapy as well as labs, urine/drug analysis and case management services. If the FFS payments are below the value of the case rate, the provider receives additional payment up to the case rate value. However, this payment is not made if the member is admitted to an inpatient or residential facility (admission to intensive outpatient treatment does not disqualify the value-based payment).

> "We have been ACO partners with UHCCP since 2016, including a value-based agreement. The level of sophistication and timeliness of the data we are given has been extremely helpful and the incentive model has been a positive addition. We look forward to evolving the clinical and value-based relationship with UHCCP once patients' benefits are integrated."
>
> April Rhodes, LAMFT: CEO, Spectrum

Our Comprehensive Transition Plan

We recognize the significance of shifting from block payment toward a combination of competitive FFS payments, reimbursement for care coordination activities, and financial and/or quality-defined value incentives. A comprehensive ***Transition Plan*** is critical, and we will work closely with providers to make sure the transition to new payment models does not financially disable them. We engage providers via ACO/VBP meetings, provider advocate visits, the Advisory Council and provider forums along with close monitoring of encounter trends. We will offer individual providers a test claim environment, claim educators and case-by-case financial support, including, but not limited to, cash advances, while working toward long-term, sustainable solutions. We will prioritize non-participating behavioral health providers for contracting based upon strategic assessment. We also will prioritize participating providers in our statewide network, which overlaps with the current RBHAs by 81 percent, for early transition. Our transition plan includes key activities for successful implementation and monitoring:

- Weekly virtual forums within 30 days after award with stakeholders and key organizations
- Reports that include a claims dashboard, call volumes/tracking and issue log tracking

We are well prepared to support AHCCCS' efforts in making major advances to integrate care at the member, provider and payer level. Our culture of continuous learning and provider feedback informs our innovative value-based strategies, which will reduce fragmentation and improve outcomes and the overall provider and member experience.

Question 15

Approach to Monitoring and Controlling Cost Trends

Controlling health care costs is paramount to the longevity and success of any publicly funded program. Because a model of care focusing on payment for procedures versus results does not effectively add value, it is clear why AHCCCS has formed AHCCCS Complete Care. Optimizing the physical and behavioral wellness of members, along with addressing social factors to drive evidence-based measurable improvements will result in better health outcomes, member satisfaction and systemic cost containment. AHCCCS requires its contractors to proactively predict and mine for upward cost trends and minimize or control unfavorable trends while improving quality and health outcomes for members.

We bring to the AHCCCS Complete Care program a strong financial management approach, a well-managed operational infrastructure and effective quality oversight programs working in synchronicity to enable the provision of highest quality accessible health care delivered to members for greatest cost value to Arizona. We use a multitude of approaches and methods to troubleshoot and identify cost trends — not limited only to health care costs, but including administrative and operational costs — to quickly make adjustments and bring any errant cost trends under control.

Our overarching strategy to control cost trends seeks first to prevent waste and promote cost containment and efficiency by directing members to receiving the right services in the right setting. Herein, we describe our processes for finding and addressing upward cost trends and successfully controlling or reversing upward cost trends.

Methods Used to Identify, Monitor and Control Cost Trends

Our global approach entails controlling health care cost trends at the population level. We look at our health care cost and utilization trends overall and by population. We seek opportunities in our AHCCCS programs to control costs and improve outcomes and satisfaction by reducing system fragmentation, payment modernization, structuring provider reimbursement to incentivize quality outcomes and leveraging health information technology and innovation. Our cross-functional teams, consisting of senior leadership and subject matter experts at all levels in our organization, meet regularly to discuss strategies to mitigate risks, trend upticks and emerging trends.

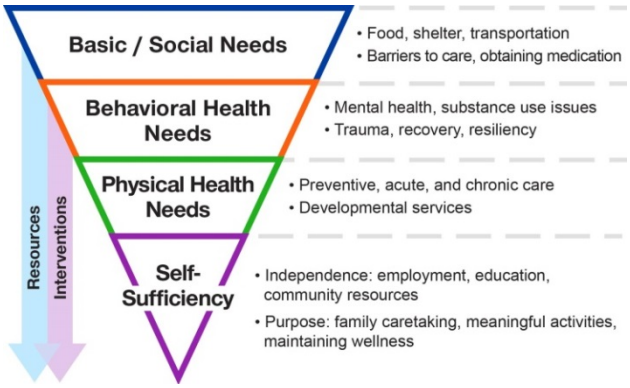

Figure 8. Cost drivers: Addressing a person's social, behavioral and medical needs together leads to more self-sufficiency, improved health, better quality and increased value.

Population Health Management

Research reveals the cause of intense utilization of services is often not due to the severity of medical illness, but due to social barriers to accessing care. Social determinants — such as financial resources, employment status, living situation, caregiver support, risks related to housing and food insecurity, community and personal safety, awareness of available community resources, transportation concerns and health literacy — are significant drivers of an individual's health and wellness. The figure shows it is critical to implement a comprehensive approach to identifying and addressing members' unique life circumstances to get to the heart of their need, add value, improve quality and bend the cost curve.

Our comprehensive approach to understanding and controlling cost trends starts with population health management techniques and comprises the following core elements:

- ***Identify:*** We collect myriad population data and dissect the data by line of business, population demographics, Medicaid categories, geographic regions, providers, members, utilization, costs and other elements to discover trends, gaps and overlaps in service needs according to members' social, medical, behavioral health and quality of life determinants. We review best practices from Medicaid health plans across the country for use in Arizona.

- ***Analyze:*** When we find a trend, decisions are made as a team including advisory committee input. We ask ourselves "Does it tie to our value system?" and "How will this impact the overall program and our customers?"
- ***Remediate:*** Using data, we follow a disciplined road to deployment before rolling out affordability initiatives, ensuring State, federal and plan guidelines, values, goals and initiatives are reviewed, are understood and can be achieved. Regulatory approval and legal sign-off are part of this process.
- ***Implement:*** With every initiative, we make sure the implementation methods and management processes tie directly to our values (Integrity, Compassion, Relationships, Innovation and Performance). We continuously ask ourselves not only can we do this, but also should we do this? Is it the right thing to do for the greater good?
- ***Monitor/Measure:*** Before, during and after deployment of programs aimed at bending the cost curve, we survey and obtain feedback from those impacted by the program to monitor satisfaction levels and program effectiveness. We gather feedback from members via our call center surveys and Net Promoter Score (NPS) program performed by an independent third party to gain the truest sense of member satisfaction with our services. We gather provider advocate and provider input from surveys, meetings, forums and our website. We measure continuous quality improvement and to determine program effectiveness.

Payment Alignment Strategies

To align provider payment with quality outcomes, we offer value-based purchasing (VBP) arrangements for providers as a strategy to control health care cost trends. We meet these goals through strategic VBP deployment based upon quantitative and qualitative evaluations of each provider's clinical integration continuum. Our survey tool assesses provider's readiness, when considered for shared savings/risk models, in areas, such as, organizational structure, operational sophistication and cost of care/population health experience with other payers. Key components of our payment alignment strategies include, but are not limited to:

- ***Accountable Care Organizations (ACOs):*** We formed several outcomes and performance-based ACO/VBP contracting arrangements that have effectively reversed unfavorable hospital admission and readmission trends and have reduced inappropriate Emergency Department (ED) use. We currently exceed AHCCCS goals for VBP contracting, with 49.1 percent of acute program expenditures occurring through a VBP arrangement.
- ***Centers of Excellence:*** We use data to determine the best and most appropriate providers and centers of excellence for members with special health care needs or chronic conditions. In early 2017, our data identified a need for earlier detection of autism, which led to our partnership with Southwest Autism Research & Resource Center as a center of excellence to accelerate access to services for those diagnosed with autism.
- ***PCP Alignment:*** We regularly review misalignments between the member's assigned PCP and the PCP from whom they are seeking care. Upon finding discrepancies, we align members to the new PCP, notifying members appropriately. The intent is to ensure providers, focused on total cost of care, have the right members in their panel. Quarterly, we review our network for quality and cost-effectiveness, taking action with low performers.
- ***Provider Participation on Our Committees:*** Network providers are committee members on our clinical, pharmacy and other committees. They provide valuable insight and useful recommendations and input through our Medical and Therapeutics Advisory Committee and Pharmacy & Therapeutics Committee, among others, who help us to augment our provider payment alignment strategies.

Programs and Processes Designed to Predict and Prevent Unnecessary Costs

Total cost of care for members is our overall strategy to control costs. For our providers in VBP arrangements, such as ACOs, we share data and analytic capabilities and integrate them with our provider community to give them unique insight into our membership and success of our care models. Our capabilities enable providers and us to determine common drivers and predictors of health to target members most in need with the greatest opportunities. It also enables provider intervention with our members in advance of acute care episodes, thus avoiding unnecessary post-episodic based costs to the system. This level of information sharing enables PCPs in VBP arrangements to have insight into members' total cost of care — incurred inside and outside of the PCP's practice — to address the continuum of care

in relationship to quality outcomes and overall expenditures.

We monitor our utilization management (UM) program through our Quality Management Committee (QMC) structure. Under the auspices of our QMC — chaired by our chief medical officer Steve Chakmakian, D.O. — our Healthcare Quality and Utilization Management (HQUM) Committee and our Arizona Provider Advisory Committee provide oversight of our UM program. Together, they review, edit and make recommends for adoption of updated clinical guidelines and utilization review policies and practices based upon input and recommendations from various sources, including our national clinical resources. Programs and processes align with our UM programs and effectively prevent inappropriate use of services, thus adding value and controlling costs. These include:

- ***CommunityCare:*** Platform includes a population registry and is a collaborative, information-sharing tool to share the service plan with interdisciplinary care team (ICT) members. This includes Automated Care Transitions (an HIPAA-compliant, secure, cloud-based automated care transition system that notifies care coordinators and clinics of ED visits and inpatient discharges). It automates appointment scheduling, documents discharge assessments, assists in medication review, performs reminders via phone, text or email and tracks event completions post discharge. Key tools within CommunityCare used to identify and manage costs include:
  - ***ALERT*** emphasizes early identification and monitoring of high-risk cases among members in outpatient behavioral health treatment, allowing us to focus our clinical resources to add the most value. ALERT is specifically configured to address the needs of children and adults through Wellness Assessments.
  - ***Clinical data sharing*** with and among providers to reduce unnecessary service duplication and enable proactive care delivery to special health care need populations reducing avoidable post-episodic costs.
  - ***Population-specific care management referrals*** ensure members are surrounded by supports to reduce unnecessary ED use, recidivism and opioid use. For example, through our Yuma jail outreach program, 62 percent of individuals who received peer support were more likely to live independently and remain out of jail compared to those who did not receive peer support.
- ***Prior Authorization:*** Our QMC reviews requirements quarterly to determine the effectiveness of our prior authorization protocol, making changes as needed. We quickly respond to changes recommended by AHCCCS and State legislators, such as the Governor's Opioid Executive Order.
- ***Predictive Modeling:*** Aligning with our whole-person care approach to service delivery, we integrate and assess medical, behavioral and pharmacy claims, and lab test results using Impact Pro™, our multidimensional, episode-based predictive modeling tool, and our SMART data warehouse. These tools allow us to develop and produce reports, dashboards and scorecards and conduct clinical, quality and utilization analyses to monitor and evaluate medical and behavioral utilization patterns.
- ***Claims Management:*** Our claims administrator, Debra Alix, oversees the claims management system, focusing on paying claims in accordance with AHCCCS, State and federal requirements, developing processes for cost containment, minimizing claims recoupments and ensuring accurate and timely claims processing. Our system contains a number of edits designed to efficiently and effectively examine claims at the point of submission to control cost, prevent claims denials and correct any errors before the claims goes through adjudication, such as:
  - ***Claims accuracy tools:*** We use Smart Audit Master to audit claims for specific edits before payment, correct coding via Ingenix Claims Editing System, and DRG pricing accuracy and cost outlier coding review
  - ***Early warning system*** of claims denial spikes via our early warning tool, CP-EWS
  - ***Coordination of Benefits (COB)*** capture third party liability from claims, authorizations, CMS, state 834 data
  - ***Pre-payment reviews*** for aberrant data, such as unexpected high-dollar claims
  - ***Policies*** for reimbursement, medical, drug and payment based

Pharmaceutical Costs. Adding value and controlling pharmacy costs is factored into all of our UM and claims programs through our prospective DUR (ProDUR) program, to improve appropriate use of medications and the pharmacy benefit. Our ProDUR, also called concurrent DUR (cDUR) program, uses multiple algorithms for comparing submitted prescription data with predetermined evidence-based guidelines to identify any potential drug issues or critical medication interactions. The system handles step therapy; opioid management, poly-pharmacy for children, COB, formulary list, prior authorization list and reinsurance as means to prevent unnecessary pharmacy expenditures.

Controlling Trends and Controlling Costs

As the sole CRS contractor serving CRS members in an integrated service delivery system, we identified and reversed an upward trend in ED use, which we attribute to our ACO model where providers are more actively engaged in managing patient care. Because of increased collaboration, data sharing and alignment with our ACO partners, from 2014 through 2017 we have seen ED utilization decrease by 9 percent for our CRS members assigned to a PCP in an ACO.

Programs to Address and Recover Unnecessary Cost

Each month, we analyze the previous month's claims data, for all claim types, with an eye on trends, incorrect payments and potential billing issues. Once issues are identified, actions are documented, solutions created and implementation and monitoring occur. This is a continuous and evolutionary process. Examples of this work include:

- Fraud, waste and abuse processes, built in accordance with ACOM 103, include claims monitoring looking for duplicate claims, billing anomalies and unusual patterns, Tip Hotline, medical record audits
- Medical Expenditure Trend Report includes projected and retrospective analysis of cost and utilization for inpatient, outpatient, ED and physicians, including physical and behavioral health care providers
- Pharmacy Expenditure Trend Report includes prospective, concurrent and retrospective costs; and trends about utilization, authorizations, reinsurance, Preferred Drug Lists and drug interactions
- Other trending reports to monitor and control costs associated with growth, process changes, market trends
- End-to-end claims analyses are completed comparing claim payment to the source of truth (e.g., benefits, provider contract, COB review per ACOM 434, member retro terminations eligibility, reimbursement policy adherence). Processes for any recoupments identified align with State requirements. We monitor encounter responses from AHCCCS for potential underlying claims issues

EXAMPLES OF ACTIONS IMPLEMENTED TO CONTROL EXPENDITURES

Herein we provide an example from our AHCCCS Acute Care program and our Kansas KanCare program demonstrating how we identified a cost issue and implemented specific actions to cause the trend to reverse or come under control.

AHCCCS Acute Care Example: Controlling Outpatient Chemotherapy Expenditures

Catastrophic illness, such as cancer, is expensive. With any health plan, medications for cancer treatment rank among the top cost drivers. Our program analysts continually mine cost data to seek opportunities for better cost management. The example below is just one of many processes we deploy as conscientious stewards of health care expenditures.

Background: In 2015, as part of our routine utilization review activities, we identified providers whose cancer treatment practices deviated from evidence-based medication management practices as defined by the National Comprehensive Cancer Network (NCCN). NCCN is recognized by the health care industry nationally as an expert in these treatment matters. To address this unfavorable trend, we introduced prior authorization for outpatient injectable chemotherapy. The process included deployment of a new online decision support solution directing physicians to all NCCN recommended therapies based upon the member's clinical information.

Strategy to Control Expenditures: To gain provider cooperation with the new prior authorization requirement, we:

- ***Communicated with providers.*** We sent letters to impacted oncologists announcing the program and made similar announcements to the broader provider community through our provider portal and bulletin.
- ***Trained providers and internal staff.*** Providers received training about the process change via face-to-face meetings and telephonically. Internal staff received classroom-style training on the process change.
- ***Worked closely with the American Society of Clinical Oncologists and other medical associations*** to extend communications with the provider community and to gain quicker buy-in to the new process among peers. The messaging was clear: When providers follow the NCCN recommendation, they receive immediate approval.
- ***Monitored utilization*** to ensure high quality of care was maintained.

Results: Costs were measured based upon a per-member-per-therapy-month (PMPTM). In 2016, the PMPTM costs for chemotherapy services were 15 percent lower than those in the control group, where costs rose by 18.2 percent during the same time frame. While *maintaining high quality*, savings translated into a $0.44 per member per month savings for UHCCP. Without this intervention, we calculate we would have experienced an 18 percent rise in costs for chemotherapy services.

Kansas KanCare Example: Controlling Psychosocial Rehabilitation Expenditures

Background: Between 2013 and 2015, utilization data indicated a steep increase in psychosocial rehabilitation services followed by a steep decrease among the same population over the summer months. A root cause analysis revealed providers were ordering day-long psychosocial services during the summer months to supplement after-school psychosocial services members (primarily teen and pre-teen children) received while school was in session. The providers felt these services were necessary to provide stability and prevent regression. Further analysis and research performed by our clinical care team found no evidence-based information or outcomes data supporting this practice.

To address this unfavorable trend, our Kansas affiliate implemented a three-pronged approach:

- ***Information Sharing:*** Our KanCare behavioral health director launched a communication campaign with the executive directors of the summer psychosocial rehabilitative service providers to include review of providers' data and the health plan's clinical approach. This communication helped the program providers and administrators within each facility to facilitate alignment of member care with evidence-based guidelines.
- ***Targeted Education:*** Our KanCare clinical director conducted one-on-one educational meetings with the psychosocial providers' clinical teams to review past utilization trend and clinical guideline expectations. Our clinical director reviewed each provider's psychosocial curriculum and made recommendations to modify and improve the curriculum (using evidence-based guidelines) to achieve better outcomes for our members.
- ***Intervention:*** In spring 2016, our clinical director requested a list of members whom the summer psychosocial providers expected to treat during the summer of 2016. This enabled our clinical team to review members' clinical needs and provide input on treatment options along with a list of members (generated from a predictive modeling tool) who could benefit from services over the summer to avoid a higher level of services. At meetings, providers and our clinical team agreed upon a plan for appropriate use of summer psychosocial services.

Post-implementation Data Review: The health plan clinical team reviewed data from 2015 through the summer of 2017 and saw a 15 percent reduction in summer psychosocial services, as well as a 4 percent reduction in acute psychiatric admission rate and an 8 percent reduction in residential admission rate, during summer months. The clinical team continues to monitor this program and will do so indefinitely to maintain quality and cost control of these services.

Question 16 - GSA Specific Submission Requirement

NORTH GEOGRAPHIC SERVICE AREA (GSA)

We have been an AHCCCS contractor for more than 35 years and have had the long-standing privilege of serving counties in the North GSA. We understand the unique features affecting service delivery, not only by county, but by communities within these urban, rural and frontier counties. Although Flagstaff is considered the only urban area, it looks and feels more rural than urban, especially when it comes to health care service delivery. As an AHCCCS Complete Care program contractor, our targeted strategies account for distinct factors, including topography and weather, time and distance between communities, tribal lands with sovereign governance and borders, key social needs like housing and food insecurity, religious and cultural considerations and provider availability. Our dedicated staff cares deeply about serving every individual in this GSA with compassion, integrity and effective strategies and personalized efforts.

Social, Cultural, Religious and Geographic Considerations

Social determinants of health (SDOH) have a profound impact on health outcomes, driving up to 40 percent of health care costs. O*ur goal to be more than a health care company* includes identifying members with SDOH needs and bringing communities closer together, to better address health disparities. We developed *myConnections* — our transformative statewide program designed to help *ANY* individual with barriers to improved health outcomes resulting from social needs, such as housing, food, employment or clothing. We proactively developed a social determinants provider network that is categorized and searchable, in the *Healthify* community resource database, by member need, community organization and location. A closely linked initiative called *myCommunity Tool Box*, in partnership with the United Way, will collect data to measure the impact of social services, further guiding our targeted efforts. This data will afford us opportunities to provide meaningful data to state and local partners for policy decisions to better of State.

Housing insecurity is the most impactful SDOH. Findings from Housing First initiatives show stable housing improves recovery of substance use disorders, and physical and behavioral health outcomes. Safe housing is one of the four major dimensions SAMHSA identifies to support a life in recovery. Currently, a gap of approximately 30,000 housing units exists across tribal lands, which disproportionally affects Arizona side of Navajo Nation due to Bennett Freeze land dispute. Similar to our housing development partnership in Maricopa County with Chicanos Por La Causa (CPLC), we will use a portion of our available capital from this contract to invest in services or housing in all awarded GSAs. Our housing coordinator manages our housing program, collaborating with care managers who connect members with additional resources, such as employment assistance, non-covered transportation, utility support and clothing. These non-clinical factors have direct and indirect impact on member health outcomes, and on the well-being of communities we serve. Exposure from lack of shelter, altitude and wood burning fires can all exacerbate certain conditions, especially for members with more complex conditions or special health care needs (SHCN).

Housing Intervention Reduces Emergency Department Visits

David is a 24-year-old male with diabetes, homeless and using the Emergency Department (ED) as a safe place to help manage his meds and get healthy meals. He was in the hospital in Kingman a few days every other week until our local community health worker (CHW), Melanie, connected with him, got him reconnected to his family and helped him understand his medication and healthy meal plans. He is now working, has not been in the hospital for months, and is feeling and looking healthy.

Food and water insecurity affects many of our communities. A number of Navajo Nation and Hopi communities do not have safe drinking ***water*** resulting from springs located near uranium mines. There are towns within the Hopi Nation (within the Navajo Nation) that transport drinking water from other sources because well water may be unsafe due to high fluoride, arsenic and toxins from past mining efforts. MyConnections can help link individuals in need with food bank partners who can help with water needs, while continually seeking new community partners, like the University of Arizona who runs a water purification program. There is also *food insecurity* and “food deserts” diversely affecting member health conditions. *Healthify* contains information on food banks and food assistance programs. Care managers

use this tool and offer it to providers and community partners. *Healthify "Coordinate"* is now being tested with providers, where members are electronically referred to an organization, and the resolution is sent back via the tool to close the loop.

Cultural: Our service delivery approach must be respectful of American Indian members' unique *cultural beliefs*. Our tribal liaison and the tribal community outreach workers at our provider agencies, engage tribal members in their health, wellness and treatment on and off tribal lands. Contracted tribal providers such as *Tribal Diagnostics* help meet the members' needs. Tribal Diagnostics, an American Indian owned and operated diagnostics lab, provides members living in tribal and rural communities greater access to laboratory testing services. Testing for drug or alcohol abuse issues is needed on tribal lands; our claims data shows that opioid abuse is overall highest across the North GSA. Tribal Diagnostics provides blood and urine drug testing using the most current technology, monitors their patients' medications to prevent opioid abuse in tribal/rural areas and for local providers who specialize in pain management. We will link our Medication-Assisted Therapy (MAT) network with Tribal Diagnostics. This testing access will also support our Phoenix-based MAT providers, ConnectionsAZ UPC for tele-psychiatry capability and 24-hour medical prescribing providers; Community Medical Services (CMS), who assist for medication delivery; Southwest Behavioral Health for outpatient treatment and methadone services in Kingman, Flagstaff and Prescott. Our partners and staff help refer members to White Bison Wellbriety Circles, similar to AA/NA meetings. Wellbriety Circles are currently held in Sanders.

Religious: In areas like Colorado City with special community needs, we support member engagement in care with providers who meet their *religious belief system*. In 2015, the Hilldale Health Service Center, a key provider, suddenly closed. We responded quickly by adding new contracted independent Arizona family nurse practitioners and more providers in Utah. We strategically recruited female OB/GYNs, PCPs and pediatricians to serve these individuals and with whom the Colorado City members would be comfortable receiving care. Then we helped safely transition our members to new providers, ensuring their continuity of care and demonstrating respect for their needs.

Geographic: The time and travel distances are important to consider for emergencies or crisis, specialty or routine care. Harsh weather, topography and infrastructure result in safety concerns. With our transportation vendor, we make sure four-wheel drive vehicles are available and in-state lodging when services are provided out of the GSA. Members with complex conditions requiring more assistance have access to our network capable of these transports, including ground/air evacuation providers that cover the entire United States. We have added specialty travel services for members with end-stage renal disease, or those undergoing cancer treatments, to have priority travel arrangements and those with autism spectrum disorder can travel for appointments with trusted case managers. We also have telemedicine options, home-based, mobile and novel care approaches available with details listed below. Based upon our experience data, we know that transportation cost trends are higher in the North GSA when compared to Central and South GSAs, due to utilization, distances traveled and operational costs. This GSA has the highest transport per member per month cost (PMPM) at $10.03 compared to $3.27 PMPM in the South GSA or $6.37 PMPM in Central GSA. This knowledge influences network, technology and member engagement strategies we develop and prioritize.

Provider Network Strategies

Our network is influenced by ***terrain, weather and distance*****,** particularly where ***provider shortages*** exist. We expand service delivery through key partners and new approaches (e.g., ***telemedicine options*** increasing utilization by 53 percent from January to June 2017, over prior year). We expand use types, as we did for congestive heart failure telemonitoring by piloting a successful program and then seeking AHCCCS approval to open codes and develop supporting policies. We promote greater adoption as policies evolve. A new opportunity for at-risk youth is based upon our Southwest Autism Research & Resource Centers MOU to use store video, autism spectrum disorder screening tools and virtual assessments, to reduce the time child developmental concerns are assessed. Because members with SHCNs are more impacted by network limitations, we developed our ***Special Needs Initiative (SNI)***, which assigns dedicated staff to members with specialized needs to help navigate to needed care.

We use ***Mobile clinical care*** in rural areas with too few providers for the number of delivery sites. Specialists see

members in our field-based, Multispecialty Interdisciplinary Clinics (MSIC). We use contracted mobile providers to create solutions like our first-of-its-kind ***Community Medicine*** (Paramedicine) bundled payment incentive model comprising nurse practitioners, ambulance, fire, EMT and paraprofessionals. Healthcare Innovations, our innovation partner who operates ambulance services in the North and South GSAs, will bring trusted, "blue-shirt credibility," well-trained, field-based clinicians, directly to our members. We led efforts with AHCCCS to have the ***Affiliated Practice Dental Hygienist*** (APDH) provider type added to extend dental services to those most in need or those who might not seek preventive and basic dental services. APDHs are now in 21 UHCCP accountable care organization (ACO) partners, including Yavapai CHC. Medicaid Health Plans of America recognized our program as a 2017 Best Practice.

Member Engagement through New and Existing Technologies

Data confirms that many members have smartphones, receive text messages, emails and have access to the internet. We use ***technology to engage*** members and help navigate the system of care particularly where resources are limited:

- With ***MyHealthLine***, members gain access to a free government smartphone; get access to mobile apps, such as ***Health4Me***; and we can direct message with them.
- ***Advocate4Me*** connects members, through a single toll-free number, to member services advocates (MSAs) with all the data required to address member questions.
- Pregnant members/new moms have ***Baby Blocks***, a smartphone/web-based member reward program providing incentives for prenatal and postnatal health and well checkups with email/text reminders for each appointment.

Crisis Services and Natural Disasters

For ***Crisis Services***, providers often must direct members to go to the ED where a crisis team meets them; sometimes causing long delays. Our claims data indicates the ED utilization rate in the North GSA of 639 visits/1,000 members is our highest statewide. Our predictive modeling confirms behavioral health risk score of our population in the North GSA is our highest at 1.24 times the average population. Upon award, we will convene a meeting with the crisis line provider and the RBHA to lead regional planning meetings with counties, tribes, law enforcement, FQHCs, Indian Health Services (IHS) and hospitals to create strategies to remove barriers to care, such as offering next-day appointments to members. We also will leverage the information and training we provided to AHCCCS to inform their 2018 statewide suicide prevention plan. Coupled with our Health Disparities Action Plan process and initiatives, like training all member-facing staff in suicide prevention, we will provide solutions for members in crisis and prevention strategies to address prevalent disparities in North GSA counties, such as the higher than statewide average suicide rate in Yavapai (32.8), Mohave (30.3) and Navajo (28.2); median rate is 18.3]. Kingman and Prescott Valley also have some of the highest statewide suspected opioid overdose-related events; therefore, we have prescriber and member monitoring reports, drug utilization review (DUR), and exclusive pharmacy program for at risk members and our medical directors meet with top opioid prescribers.

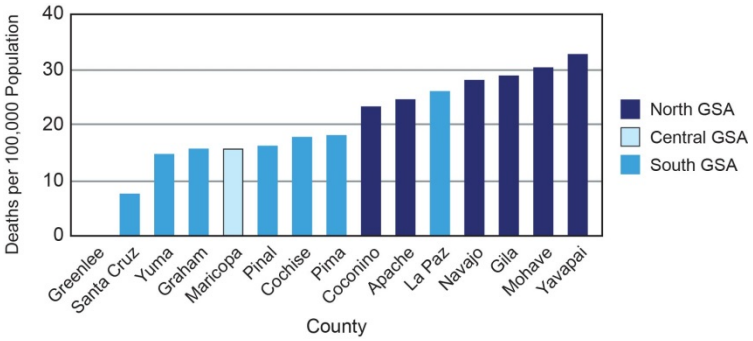

Figure 9. Suicide rates by county. ***HealthyAZ.org***

Natural disasters, like severe snowstorms or large-scale forest fires, have shut down entire communities. Our Business Continuity Plan (BCP) and requirement for all our vendor partners to have a BCP ensures we continue our work, even in the event a natural disaster affects our operations. It details how members can reach us, strategies we use to monitor member impact, AHCCCS notifications, and how to engage members in special settings or with SHCN. We have experience working closely with First Responders and providers across state lines to immediately transport our members to safer locations, including those who are hospitalized or in skilled nursing facility placements, working with the crisis support line during such emergencies.

SOUTH GSA

We have been an AHCCCS contractor for more than 35 years and have had the long-standing privilege of serving counties in the South GSA. We understand the unique needs affecting service delivery not only by county, but by communities within these urban, rural and frontier counties. As an AHCCCS Complete Care contractor, our targeted strategies will account for these distinct factors, which include border communities, tribal lands, special individual groups, social determinants of health, and provider availability. Our dedicated and qualified staff cares deeply about serving every individual in this GSA with compassion, integrity and effective strategies and personalized efforts.

Social and Cultural Considerations

Social determinants of health (SDOH) have a profound impact on health outcomes, driving up to 40 percent of health care costs. Part of *our goal to be more than a health care company* is identifying members with these social needs and bringing communities closer together to better address health disparities. *MyConnections*, our transformative statewide program, is designed to help *ANY* individual with barriers to improved health outcomes resulting from social needs, such as housing, food, employment or clothing. We proactively developed a social determinants provider network that is categorized and searchable, in the *Healthify* community resource database, by member need, community organization and location. A closely linked initiative called *myCommunity Tool Box*, in partnership with the United Way, will collect data to measure the impact of social services, guiding our targeted efforts. This data will afford us new opportunities to provide meaningful data to state and local partners for policy decisions to better our state.

Housing insecurity, as evidenced by findings from Housing First initiatives, is the most impactful SDOH and thus a key strategic consideration. As with our housing development partnership in Phoenix with Chicanos Por La Causa, we are committed to using a portion of our available capital from this contract to invest in the services or housing in the South GSA. Our housing coordinator manages the housing program, collaborating with care managers who connect members with needed employment assistance, non-covered transportation and utility support. In Tucson, we have committed to a plan for a new Medical Respite Center, with Catholic Charities, El Rio and other partners, similar to well-recognized Circle the City in Maricopa County. Through our community reinvestment dollars, we will help fund initial development and start-up costs for this innovative resource.

Food insecurity affects many communities in the South GSA. The *Healthify* community resource database includes 157 different resources in the South GSA to help address this need. Since July 2015, our partnership with 4-H has reached over 8,000 youth and family members in Pima, Cochise, and Santa Cruz who participated in 4-H Food Smart Families programming. 4-H Food Smart Families addresses hunger and obesity, engaging teens to empower their peers/families to establish lifelong healthy nutrition habits, food budgeting and meal-preparation programming. 4-H and UHCCP have reached over 40,000 Arizona youth/families with Healthy Living programs, investing over $260,000 since 2012, including a $60,000 University of Arizona 4-H Youth Development grant in 2017. As a result, 93 percent of participating youth know what makes up a balanced diet, 84 percent say their family prepares healthier foods and 80 percent eat together. In 2018, we will launch our Healthy Savings pilot in 5,000 households with specific conditions, such as diabetes. Using partnerships with food manufacturers and grocers, we provide an easier way for members to save on healthier foods.

Education, employment and clothing cannot be overlooked as key, non-clinical SDOH. Through myConnections and the *Healthify* support tool, we will continue to partner with St. Joseph's the Worker and Dress for Success to support any individual seeking job opportunities, including resume building, interview coaching and new professional attire. We are the sole, statewide health care sponsor of Playworks, a program that brings structured play to at-risk youth in Title IX schools, reducing bullying and absenteeism, while raising self-esteem. Through support offered by Amanda Aguirre, Regional Center for Border Health and local officials, Playworks is now active in Yuma with more sites planned.

Cultural and Religious: Our strategies reflect the unique characteristics represented by those we serve. There are many American Indian tribes in this region, the largest being the Tohono O'odham tribe. We respect all tribes and their *cultural beliefs* in our approaches to improve service delivery. Our tribal liaison and provider agency tribal community

outreach workers engage members in their health, wellness and treatment on and off tribal lands. We contract with tribal providers, like Tribal Diagnostics, an American Indian owned and operated diagnostics lab, to give those in tribal and rural communities greater access to laboratory testing services. They also monitor patients' medications to prevent opioid abuse in tribal/rural communities. We will link our Medication-Assisted Therapy (MAT) network with Tribal Diagnostics services to enhance this care delivery for our tribal members. Our partners and staff refer members to White Bison Wellbriety Circles, similar to AA/NA meetings. Wellbriety Circles are currently held in three Tucson locations.

The South GSA has a larger Hispanic/Latino population, including more mono-lingual Spanish speakers with *cultural beliefs* impacting health care engagement, and a larger population of migrant workers. We will engage these members into care by hiring bilingual staff and field-based community health workers (CHWs), plus community-based Promotoras (Hispanic/Latino CHWs). Providers and UHCCP use CHWs/Promotoras to *meet members where they are,* give information and answer questions. We partnered with Promotoras at San Luis Walk-In Clinic (SLWIC) to do field-based visits to close gaps in care. Some members may be undocumented immigrants. We train staff to be culturally sensitive and to have appropriate resources. ***Mentesana-Cuerposano*** is the Spanish language version of ***liveandworkwell***, accessible through *myuhc.com*, with targeted health information for Hispanic/Latino population. We developed ACO/VBP partnerships with Equality Health, El Rio Community Health Center, SLWIC and similar organizations with cultural diversity programs, support ACO efforts that transform practices and promote advanced care delivery methods. We also offer culturally sensitive **Fotonovela** booklets to organizations and school-based health centers to educate Hispanic/Latino youth, adults and families on asthma, depression, immunizations, obesity and diabetes. Our claims data shows a higher diabetic rate in the South GSA compared to our statewide rate. The booklets have shown increased knowledge and decreased stigma, positively affecting health disparity.

The South GSA has a large ***veteran population*** of approximately 135,000 individuals (almost two times the North GSA); this is a unique culture in itself. On Aug. 10, 2017, UHCCP leaders and 23 participants from local nonprofits, government agencies and medical facilities, discussed key veterans' health issues, determined goals for improving veteran's health and devised strategies for collaboration. Our veterans' liaison will monitor execution of the strategies, interact closely with military bases and in smaller communities with limited Veteran Support Centers and educate staff and providers regarding veterans and their needs. Following the August 10 meeting, we awarded $15,000 grants to U.S. Vets-Phoenix and Catholic Charities Community Services, Inc. to provide homeless veterans with housing and support services.

Refugee communities are prevalent in Pima County with two refugee centers in the Tucson area. We work closely with these centers to train providers on cultural differences and preferences to consider when serving this sensitive and traumatized population. We offer free Trauma-Informed Care trainings via our provider portal and recommended to all our providers. We also offer interpretation services, for members' natural language, to support providers in their holistic care efforts of the member. As enhanced technologies emerge, such as Pixel Buds, we will pilot use with providers.

Tucson has a strong ***LGBTQ community;*** therefore, we collaborate with ACOs, community organizations and offer peer support resources, groups and engagement with individuals with common life experiences. Our website lists many online and community-based support groups and our *liveandworkwell.com* site offers a variety of resources. The *Provider Directory* aids members in finding a selection of providers who can best address their clinical needs, such as lesbian and gay identified clinicians and providers, sensitive to LGBTQ issues. In December 2015, our ACO partner of 10 years, El Rio CHC was named "Leader in LGBT Healthcare Equality" by National Health Survey, the first such honor serving southern Arizona.

Clear proof we connect: Members choose us more than any other plan in the South (see Figure), a clear indicator as to the quality of services provided by our health plan and our efforts to support them.

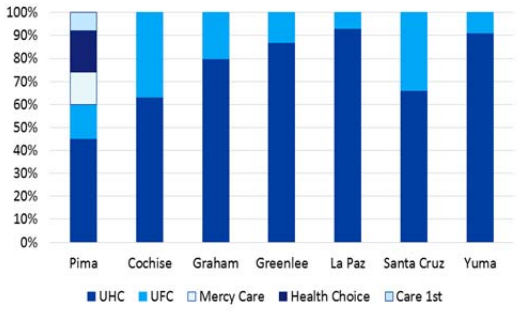

Figure 10. Member health plan choice by county.

Provider Network Strategies

Our network is influenced by the factors above, as well as *terrain, weather and distance*, particularly where *provider shortages* exist. We expand service delivery options through key partners and new approaches — ***Telemedicine options*** extend our service delivery and show increasing utilization, 53 percent increase from January to -June 2017, over prior year. We promote evolving AHCCCS policies and expand use types such as congestive heart failure telemonitoring by piloting a successful program, seeking AHCCCS approval to open codes and develop supporting policies for the Yuma CHF Telemonitoring pilot reducing readmissions from 36 percent to less than 10 percent. We have a MOU with Southwest Autism Research & Resource Centers to use video, autism spectrum disorder screening tools and virtual assessments, to reduce assessment timing of child developmental concerns. Because members with SHCNs are more impacted by network limitations, we developed a ***Special Needs Initiative that*** assigns dedicated staff to members with specialized needs to navigate to needed care. We use ***mobile clinical care*** in areas when we have delivery sites, but too few providers. Specialists see members in our field-based, CRS MSICs. We are contracting with Dispatch Health mobile Urgent Care to expand to Pima County. We contract with mobile providers and create solutions like our first-of-its-kind Community Medicine (Paramedicine) bundled payment/incentive model comprising nurse practitioners, ambulance, fire EMT and paraprofessionals. We are working with Healthcare Innovations and Golder Ranch Fire District. These innovative partnerships will bring trusted, "blue-shirt credibility," well-trained, field-based clinicians, directly to our members. We also led efforts to have the ***Affiliated Practice Dental Hygienist*** (APDH) provider type added, and created a credentialing process and contract options. We piloted APDHs with the SLWIC, *one of two ACO partnerships we first developed* in Yuma in 2007. APDHs are now in 21 UHCCP ACO partners, extending dental services to those in need. ***Medicaid Health Plans of America recognized this program as a 2017 Best Practice***.

Engagement through Technology

Data confirms many members have smartphones, receive text messages and emails and have access to the internet. *We use **technology to engage** members and help navigate the system of care particularly where resources* are limited:

- With ***MyHealthLine***, members get a free smartphone, with access to mobile apps, such as Health4Me, and can receive our direct messages.
- ***Advocate4Me*** connects members, through a single toll-free number, to member services advocates with all the data required to address member needs.
- Pregnant members/new moms have ***Baby Blocks***, a smartphone and web-based prenatal member reward program providing incentives to expecting mothers for prenatal care and postnatal health care for 15 months with email/text reminders for each appointment.
- ***Our Wellpass Platform*** has message features: welcomes, incentive program notices, appointment/medication reminders and NurseLine. Text reminders are sent based upon anticipated gaps in care identified by claims data***.***

Crisis Services and Natural Disasters

For ***Crisis Services***, southern counties have overwhelmed hospital EDs, law enforcement and jails. We are in discussions with providers to find solutions and we will lead regional collaboration meetings with counties, tribes, law enforcement, the RBHA, FQHCs, IHS and hospitals to strategize and remove barriers to care. Through our Justice Reach-in program, we work closely with impacted entities to ensure communications, protocols and relationships are in place. We have an MOU with ConnectionsAZ to develop a value-based member transitional program to fully support members with complex integrated health needs not engaged in care, to reduce their repeated urgent medical and behavioral care needs, which present greater risk to the community, law enforcement and to themselves.

Natural disasters, flooding and fire impact entire communities. Our Business Continuity Plan and requirement for all our vendor partners to have a BCP, ensures we continue our work even if a natural disaster affects our operations. It details how we ensure members can reach us, strategies to proactively monitor member impact, notifying AHCCCS, engaging members with SHCN and details how we work with the crisis line provider.

Question 17

Engaging and Collaborating to Improve Tribal Service Delivery

Sensitivity to and understanding of Arizona's sovereign nations and each tribe's unique health disparities, access barriers and cultural values are critical to the successful integration of service delivery for American Indian members. The key to our success in serving our American Indian members in Arizona is our purposeful approach to building meaningful relationships with tribal leaders and tribal providers bolstering our ability to work together to expand the delivery of quality service and support tribal members on or off tribal lands. Our holistic clinical approach respects the traditions of individuals and tribes and aligns with the beliefs and customs of the approximately 19,000 American Indian members we currently serve in Arizona through our AHCCCS contracts. Our experience serving Arizona's American Indian communities tells us that health outcomes for American Indians are usually worse than the general population. We will work directly with tribal leaders and providers to overcome system fragmentation and lack of coordinated care to improve health outcomes. Our main goal is to enhance the coordinated delivery of services among providers and empower American Indian members to be efficient users of the health care system by emphasizing behaviors essential to whole person well-being, preventive care and management of chronic, complex, social, physical and behavioral conditions. These principles align with and draw parallels to the AHCCCS American Indian Medical Home Program.

Respecting the unique fact that the tribes themselves lead health care for American Indians, we collaborate with tribal leadership to understand and address the needs of each tribe. Our engagement is led by the highest leadership levels including our chief executive officer Joseph Gaudio. Since 2008, through our CRS program, we coordinated care on and off tribal lands for many of Arizona's American Indian children with critical and complex health care needs. We are building upon the best practices we have in place with the CRS program.

Our Arizona-based tribal coordinator, Joetta Goldtooth, has served her community as a member of the Tuba City Council. She is experienced at working with Arizona's tribal communities and understands the importance of a relationship with each tribe that is sensitive to their needs and priorities. Since her hire, she has performed extensive outreach to tribal nations, including training in health education, local assistance programs and connection to essential social needs, such as food and housing. She works closely with and is supported by key staff and health plan leadership, including, but not limited to:

- Adult and child health care administrators
- Chief medical officer, clinical care staff
- Individual and family affairs administrator
- Member services staff
- Housing and education staff
- Cultural competency coordinator
- Employment administrator, workforce specialist
- Justice system liaison and court coordinator
- Provider services manager and provider advocates
- Transition coordinator

Key Steps for Engagement and Collaboration with Tribal Populations

Key to improving health outcomes of the American Indian members we serve is early engagement with tribal leaders and IHS and Tribal 638 providers (hereinafter, tribal providers) to enhance our existing partnerships and actively coordinate care using mutually developed approaches. To address each tribe's unique barriers to service delivery and health disparities, our outreach, collaboration and integration plan is tailored to each tribe and comprises key steps:

1. Establish Memorandums of Understanding (MOUs)
2. Support service delivery infrastructure and facilitate relationships between tribal and non-tribal providers
3. Dedicate staff to identify, escalate and resolve each tribe's unique service delivery barriers

Step 1: Establish Memorandums of Understanding

To help tribal providers increase care coordination and expand social support services to members on tribal lands, we

will create MOUs to compensate tribal providers for expanding services to reduce fragmentation, improve care coordination and reduce barriers unique to each tribe. The anticipated benefits of the MOUs include: 1) greater trust and a formal relationship with the tribe; 2) increased collaboration in assisting and advocating for tribal members; and 3) enhanced ability to pursue future initiatives aimed at closing gaps in care and increased use of shared data to improve member health. Our goal is to have MOUs in place with every Arizona tribe in our awarded GSAs no later than the October 2018 transition date.

Led by the need of each tribe, we will customize our MOUs. Examples of the scope of work in the MOUs may include:

- Payment for completion of health risk assessments (HRA) and translation assistance
- Payment for community health representatives (CHR) to do in-home visits to educate members about their newly diagnosed condition and to assess the home to address any concerns that could inhibit the member's ability to adhere to the plan of care or access services (e.g., transportation, medication refrigeration)
- Payment for CHRs to provide resource and social services referral coordination

Best Practices in New Mexico to be applied in Arizona via MOUs

In New Mexico, our UnitedHealthcare Medicaid MCO has MOUs with 11 tribes to support processes aimed at increasing care coordination activities and access to services. The MOUs are customized to address each tribe's unique health care disparity or service need. In Zuni Pueblo, for example, a high number of members had not completed an HRA. The New Mexico plan created an MOU to compensate tribal providers to translate and complete HRAs with their tribal members. Once the HRAs are completed, the health plan can create service plans specific to each member's needs. In Arizona, only 18 percent of American Indians have a completed HRA. This MOU should improve HRA completion rates and increase care coordination opportunities.

MOUs Enable Quicker Identification of Social Determinants of Health (SDOH). With higher levels of poverty, homelessness and limited English proficiency, American Indians often have difficulty accessing health care and suffer from significant health disparities. We will enhance our care coordination efforts to ensure the most appropriate level of assistance or provision of resources for each tribe. For example, in November 2017, we partnered with the office of the Navajo Nation President to deliver turkeys as part of their food drive, helping to address food disparities. Within the Navajo Nation, traditional families/elders may have a winter camp and a summer camp without running water, electricity or access to phone and other services. Our clinical staff prepares for these scenarios when considering outreach activities, such as temporary address changes in member home settings associated with traditions.

MOUs Enable Continued Collaboration to Resolve New Barriers. Tribal coordinator Ms. Goldtooth will leverage our tribal advisory councils and our community coordinators to identify new or emerging barriers. We proactively address barriers through the development and implementation of educational opportunities. We introduced and we will continue to deliver in collaboration with our tribal partners, educational opportunities, such as Member Days. These are in-person events our tribal coordinator hosts at walk-in sites on reservation lands to answer questions; share information and help members understand and effectively use their benefits.

Figure 11. Turkeys from UHCCP in support of the Navajo Nation's recent food drive.

Step 2. Support Service Delivery Infrastructure and Facilitate Relationships between Tribal and Non-tribal Providers

To facilitate stronger relationships between tribal and non-tribal providers, increase data sharing, reduce fragmentation, and support service delivery infrastructure, we will drive system integration and modernization to the extent possible on and off tribal lands.

Data Sharing to Reduce Fragmentation. Health care service delivery among American Indians is fragmented because members can seek covered services on and off tribal lands that often is not coordinated. Fragmentation occurs when providers are not aware of members who have received services elsewhere or members who need services, but have not received them. It inhibits the ability of providers to effectively coordinate care, which often results in poorer health outcomes, relapse, readmission, medication contraindications, inappropriate ED use and gaps in care. To address this chronic service delivery barrier, we will create data sharing links with tribal providers through our CommunityCare care coordination platform, which is connected to Health Current, the Arizona health information exchange.

Addressing SDOH to Improve Health - The Tohono O'odham Nation has a high rate of adult onset diabetes. In Southern Arizona, we partnered with 4-H, which has an effective education program — Food Smart Families — to help tribe members make lifestyle changes to prevent this disease. We will support 4-H in expanding education among tribes through our community investment initiatives.

Extending CommunityCare to contracted and non-contracted tribal providers, enables sharing of members' care coordination needs and activities between tribal providers, community providers and our clinical care coordination team. This mirrors accountable care organizations (ACOs), where data sharing is instrumental in enabling providers to actively outreach to members and effectively coordinate care. CommunityCare gives providers the ability to view member history, such as medications, prior treatment (such as ED visits) and inpatient care received.

CommunityCare enables providers on and off tribal lands to focus on access, quality and cost through physical, behavioral and social integration in a secure and HIPAA-compliant environment. Our tribal coordinator collaborates with our provider advocates to educate tribal providers on how CommunityCare fits into their care coordination activities.

We have a pilot with Health Current and the FQHC, Native Health, to collect SDOH data to share with other providers, to assist members in getting the help they need to maintain independence.

Support Care Coordination between Tribal Providers and Non-Tribal Providers. Per the Federal Policy on Tribal Medicaid Reimbursement as outlined in the CMS State Health Official Letter #16-002, dated Feb. 26, 2016, when care coordination agreements are in place between tribal and non-tribal health providers, states can receive 100 percent federal medical assistance percentages (FMAP) for Medicaid covered services delivered by non-tribal providers or facilities to American Indian members covered by Medicaid. We will facilitate relationships between tribal and non-tribal providers, such as Canyonlands ACO, to support care coordination that meets CMS requirements for 100 percent FMAP, maximizing federal funds for Arizona and improving the health and well-being of American Indians and their communities.

Improving Service Delivery Infrastructure. To supplement services that tribal providers deliver, where possible, our network administration team will bring additional services to tribal communities — such as mobile clinics, telemedicine and tele-psychiatry services — to enhance each tribal nation's ability to deliver integrated services within tribal lands. We are adding to our existing telemedicine provider network by entering into agreements with Arizona State University, Northern Arizona University and the University of Arizona to provide telemedicine services. We are contracted with Tribal Diagnostics, which provides tribal and rural communities with greater access to laboratory testing services. Tribal Diagnostics monitors patient medications to prevent opioid abuse.

Non-tribal Providers Delivering Services at Field Clinics on Tribal Lands. Through our CRS program, we have long-standing relationships with tribes at local clinics, expanding access to services for American Indians with special needs. Our non-tribal providers travel to the 40 clinics, 28 of which are located on tribal lands and provide specialized services in orthopedics, orthotics, physical therapy, neurology, cardiac care and genetics.

Ms. Goldtooth uses every opportunity to communicate with tribal providers about the availability of care coordination tools and network providers for referral purposes. She will educate tribal providers regarding available services for tribal

members through provider forums, standing meetings with key providers, Tribal Consultation meetings and ongoing communication mechanisms we establish with each tribe.

Customized Services for Tribal Nations. Examples of services and programs that we will support to strengthen or expand access to services for our American Indian members include, but are not limited to:

- ***UnitedHealthcare Health Equity Services (HES):*** HES is a predictive modeling tool that goes beyond looking at clinical data to identify health care disparities among American Indians. We use this toolkit in New Mexico and we are bringing it to Arizona. HES helps us to understand the unique needs and cultural characteristics of our American Indian membership so that our clinical team can better:
  - Identify care gaps and develop interventions to improve quality, reduce disparities, prevent avoidable costs
  - Refine patient-centered approach based upon tribe demographics (e.g., tribe, age, gender, ethnicity, location and language)
  - Improve the member experience through culturally relevant service delivery
- ***White Bison Wellbriety Training Institute:*** To expand access to support group programs for American Indians — known as Wellbriety Circles — UHCCP partnered with White Bison, a national organization that provides trauma and substance use disorders resources, trainings and supports to American Indians. In 2017, Wellbriety Circles were held in Sanders, Tucson and Whiteriver. We will offer at least one White Bison training in each of the GSAs in year one. Training is tailored to tribal providers, staff, community leaders and others.
- ***American Indian and Alaska Natives Clinical Toolkit:*** Developed to help clinical teams identify, understand and respect unique beliefs, values, customs, languages and traditions of American Indians. Our clinical teams use this toolkit to develop culturally relevant programs to address unique aspects of tribal life, such as:
  - ***Health Sovereignty:*** Empowering American Indians with access to culturally appropriate medical, behavioral health, and long-term care and services; focused on traditional practices and beliefs on and off tribal lands.
  - ***Historical Trauma:*** A strategy for outreach and engagement of tribal members focused on understanding and acknowledging historical traumas and the influence it still has on American Indians today.
  - ***Peer Support:*** The care team can proactively implement and promote peer support services among our American Indian membership who have behavioral health conditions.

Data Sharing through CommunityCare: Canyonlands ACO in the North GSA

Canyonlands ACO in the North GSA borders the Navajo Nation and serves American Indians in Northern Arizona. This ACO improves outcomes for our members by maximizing use of the data shared through CommunityCare. Since 2016, Canyonlands reduced ED use by 15 percent; reduced 30-day hospital readmission rates by 6 percent; and lowered inpatient admissions by 18.5 percent per 1,000 members in comparison to our entire AHCCCS population. Most importantly, quality of care improved. Via CommunityCare they receive and upload documentation to close care gaps, manage care transitions, receive alerts to outreach for seven-day follow-up appointments, monitor medication adherence, view current member demographics, view services received out of area, view top brand drug prescribers, and view flagged members with 30-day readmissions or non-emergent visits. Canyonlands uses CommunityCare reports (e.g., Member Registry) for ongoing member outreach, which has improved adherence to service plans.

Step 3. Dedicate Staff to Identify, Escalate and Resolve Unique Service Delivery Barriers

To support our tribal coordinator in her ongoing tribal engagement and collaboration efforts, we will introduce a team of specialists, including clinical technology support staff and a staff of interns to create a cohesive and supportive partnership with tribal providers. Ms. Goldtooth will have overall responsibility for the coordination of the team, reporting to the communications administrator.

Tribal Coordinator's Liaison Role in Helping to Understand and Address Service Delivery Barriers

Among tribal populations, funding and income disparity within individual tribal nations trickle down to tribal members,

impacting and often magnifying SDOH, such as people's ability to have affordable housing, receive proper nutrition, pay utilities or have reliable transportation. Disparities and system infrastructure varies from tribe to tribe, which requires us to tailor our approach and have a clear understanding of needs to address each community's service delivery priorities. Continuing to form relationships with tribal nations and providers and helping to link our members who are American Indians to services are the core responsibilities of our tribal coordinator. Our tribal coordinator, Ms. Goldtooth, with support of health plan leadership and local key staff, will perform key responsibilities including:

- Collaborating and establishing relationships with tribal providers and Indian Health Care Providers, AHCCCS, and our internal care coordination and network management staff to promote and facilitate care coordination and access to services. For our American Indian members, this collaboration includes facilitating communication and collaboration with specific American Indian populations, such as:
  - Tribal communities for American Indian children who are in residential facilities located outside tribal lands
  - Tribal providers and local governments (including legal systems) regarding involuntary commitment processes for American Indian members
- Actively participating in AHCCCS Tribal Consultation meetings and coordinating the implementation of any process changes the committee recommends.
- Ms. Goldtooth, in coordination with our adult and children health care administrators, AHCCCS and tribal providers, will close communication gaps through better use of Health Current to promote stronger care coordination and better health outcomes for American Indians.
- Coordinating the development and provision of in-service trainings and information sharing about local services for tribal providers. These trainings and in-service educational sessions include, but will not be limited to:
  - Sharing information about services available to American Indian populations in a specific GSA, county or tribe, such as mobile services for dental, physical and behavioral health care; and telemedicine and tele-psychiatry services
  - Arranging for the availability of educational courses for licensed and unlicensed physical and behavioral health personnel who work on tribal lands, on an as-needed or as-requested basis
  - Collaborating with other health plans in the GSA to facilitate and conduct the semi-annual provider forums with tribal providers, and quarterly forums for behavioral health providers
  - Reporting on progress of collaboration with tribal nations and providers via the Tribal Coordinator Report

Tribal Internship Program— Empowering Communities and Improving the Service Infrastructure

We will replicate in Arizona the tribal internship program that has been highly successful in New Mexico. By providing education, job training and employment, we can empower American Indians in their communities. Because interns work in their own communities, they are a natural bridge to increasing awareness of services available on and off tribal lands. In New Mexico, UnitedHealthcare trained 95 American Indian interns and we employ 14 American Indian interns.

Figure 12. American Indian interns serving tribes in New Mexico.

Question 18

Category 1 applies to UnitedHealthcare Community Plan. UnitedHealthcare Community Plan is a current AHCCCS contractor.

Names and Titles of Participating Individuals for Oral Presentations

Below please find a list of names and titles of the individuals who will participate in the Oral Presentations:

- Joseph G. Gaudio, CPA – CEO, UnitedHealthcare Community Plan of Arizona
- Stephen D. Chakmakian, D.O. – Chief Medical Officer, UnitedHealthcare Community Plan of Arizona
- Karen A. Saelens – Chief Operating Officer, UnitedHealthcare Community Plan of Arizona
- Leslie K. Paulus, MD, PhD, FACP – Medical Director, UnitedHealthcare Community Plan of Arizona
- Leslie Schwalbe, MPA, CCHP – Senior Vice President, State and Local Government Programs
- Lilli R. Correll, LPC - VP, Behavioral Health Product Development & Solution Design

JOSEPH G. GAUDIO, CPA – CHIEF EXECUTIVE OFFICER

OVERVIEW

Challenge-oriented finance executive with more than 20 years of broad and diverse experience in senior leadership positions. Expertise in strategic financial management, reporting, budgeting, acquisition due diligence, capital financing, cash management, receivables management and healthcare benefit consulting. Proven track record of delivering results and recognized for leadership ability. Responsible for financial component of state contract bids including capitated rate proposal, financial projections and best and final offer negotiations. Notable accomplishments include:

- Improved market share by more than 200 basis points in the first year as CEO of UnitedHealthcare Community Pan of Arizona through multiple community engagement strategies
- Reduced accounts receivable days sales outstanding for Soporex Inc., from 105 to 45 days, which played a key role in sustaining business operations in the wake of significant reductions in Medicare reimbursement
- Led an airline industry vertical affordability engagement, developing unique care management solutions that played a meaningful role in obtaining the US Airways business, approximately 55,000 members, for UnitedHealth Group
- Key participant of UnitedHealthcare national senior leadership teams that increased its Public Sector membership by 282,000 lives, 42 percent above net growth target, and increased West Region membership by 175,000 lives, 70 percent above net growth target
- Successfully bid and was awarded numerous Arizona Health Care Cost Containment System (AHCCCS) contracts covering both long-term care and acute care services, growing Arizona Physicians IPA into the largest AHCCCS plan in Arizona

Improved AIGB's working capital in excess of $5.5 million over a seven-month period, driven primarily by a reduction in days sales outstanding from 89 to 50 days and reducing payroll and related expenses by approximately $600,000. The excess cash was used to reduce outstanding long-term debt and fund a strategic investment in Arizona. CFO West

PROFESSIONAL EXPERIENCE

UnitedHealthcare Community Plan – Phoenix, AZ

Chief Executive Officer, Arizona/September 2014 – Present

Responsible for financial performance and all aspects of a managed care health plan that serves more than 525,000 Medicaid and Medicare Dual Eligible members in the State of Arizona under multiple contracts with AHCCCS and the Centers for Medicare and Medicaid Services. Other core responsibilities include rate and program advocacy with key State leaders, community engagement and thought leadership.

Chief Financial Officer – Central Region/January 2010 – August 2014

Responsible for strategic financial management, budgeting, and forecasting for the organization's central region covering approximately 1.2 million Medicaid beneficiaries and representing $6.8 billion in total revenue. Key participant on national senior leadership teams, working closely with operations, network and actuarial to meet net growth and profitability targets. During tenure, the central region grew from 685,000 Medicaid beneficiaries and $2.4 billion in total revenue primarily through the successful bidding of Medicaid contracts in Texas, Ohio and Kansas. Supervised five market chief financial officers.

American Institute of Gastric Banding, Inc. – Dallas, Texas

Chief Financial Officer/January 2009 – October 2009

Senior leader of a $50 million ambulatory surgery company with direct responsibility for finance, human resources, information technology, insurance verification, billing and collections. Reported directly to the chief executive officer and actively participated in monthly board of director meetings. Worked with senior lenders to establish revised debt covenants and successfully negotiated the removal of collateral requirements for a short-term, unsecured credit line. Supervised the controller, vice president of information technology, director of business operations and human resources.

Soporex, Inc. – Dallas, Texas

Chief Financial Officer/January 2008 – September 2008

Key senior management team member of a $40 million respiratory management company, assisting with development of strategic direction and company objectives. Reported directly to the company president and was responsible for all financial aspects of the company including financial and tax reporting, treasury, financial control, inventory management, budgeting, forecasting, financial analysis and audit coordination. Directed the strategic negotiation and management of revolving credit facilities and responsible for acquisition analysis. Served as main financial contact for investment bankers and potential investors during the company's recapitalization effort. Supervised the controller and director of compliance, billing and collections.

UnitedHealthcare – Dallas, Texas

Vice President of Affordability – South Region/April 2005 – December 2007

Led the affordability engagement teams for the organization's south region, which consisted of approximately 80 customers. Affordability engagements included direct customer and consultant interaction with detailed analyses covering financial, clinical and network performance and developing solutions that target improving affordability and health outcomes. Customer-specific engagements included Cracker Barrel, Southwest Airlines, US Airways, The Coca-Cola Company and Sabre Holdings.

Chief Financial Officer, West Region – Public Sector/January 2000 – March 2005

Led regional finance team responsible for strategic financial management, budgeting and forecasting for UnitedHealthcare segments that totaled 3.2 million lives and approximately $5.7 billion in revenue. Served on senior leadership teams, working closely with sales, network, and underwriting teams to meet net growth and profitability targets. Assumed additional companywide responsibility in 2004 as capability owner, receivables manager. Directed a team of collection specialists responsible for receivables management with $27 billion in total revenue. Reduced days sales outstanding from 4.5 to 2.5 over one year and consistently met quarterly cash flow and receivables targets. Supervised four market chief financial officers and two financial analysts.

EDUCATION/CREDENTIALS

- B.S, Accounting (Magna Cum Laude), Arizona State University, 1987
- C.P.A., State of Arizona, Certificate No. 6935-E
- UnitedHealthcare President's Leadership Development Program, Wharton School of Business, 2004
- UnitedHealth Group, General Manager Program, 2011

STEPHEN D. CHAKMAKIAN, D.O. – CHIEF MEDICAL OFFICER

OVERVIEW

Accomplished, mature, ethical physician executive with more than 17 years of executive, clinical and diverse professional leadership experience. Excellent communication, interpersonal and problem-solving skills; builds trust, consensus and promotes innovation, change and teamwork. Proven ability to adapt within a competitive health plan environment, refining managed care strategies, assessing requests for proposals and strategic partner selections. Adept at integrating delivery systems, developing structure, process and policy, and creating, implementing and improving innovative quality and utilization management programs.

Excels in oversight and development responsibility for the full scope of health plan medical operations, including but not limited to: accountable care and community-based clinical care models; inpatient concurrent review; integrated medical and behavioral services; pre-certification and post-service review; disease and case management; high-risk/high-needs member care coordination; maternal child health/EPSDT; behavioral health, dental/oral health; quality improvement; performance management; credentialing; pharmacy programs; transplant services; appeals and grievances; contracting and network development (including alternative payment models/payment transformation); and claims analysis (including fraud, waste and abuse assessment).

Proficient in Arizona public sector insurance programs, including regulatory and state and federal customer requirements and expectations. Current responsibilities include oversight of Medicaid and Dual Eligible Special Needs (D-SNP) Medicare programs, including individuals with developmental disabilities, specialized and complex medical conditions, long-term care, and home and community-based services.

PROFESSIONAL EXPERIENCE

UnitedHealthcare Community Plan – Phoenix, Arizona

Chief Medical Officer/January 2011 – Present

Responsible for health plan clinical and quality operations and performance oversight for health plans that serve more than 530,000 Medicaid and Medicare D-SNP members in Arizona under multiple contracts with the Arizona Health Care Cost Containment System (AHCCCS) and the Centers for Medicare and Medicaid Services (CMS), including five distinct State programs (i.e., Acute Medicaid, Children's Rehabilitative Services, Individuals with Developmental Disabilities, Arizona Long-Term Care Services, and D-SNP). Accomplishments include:

- Consistently sustain performance and improvement in compliance with contract requirements and state partner expectations
- Lead significant and sweeping expansion of health plan clinical partnerships and deployment of value-based contracts across the state for all plan types with Accountable Care Communities
- Awarded three UnitedHealth Group Innovation awards, as well as a UnitedHealth Group Leadership Shadow award for increasing employee engagement
- Lead and mentor a core clinical leadership team and extended clinical and quality support teams

Health Choice Arizona/Health Choice Generations – Phoenix, Arizona

Chief Medical Officer/October 2006 – November 2010

Gained nine years of progressive and cumulative medical administrative experience, growth and development at this AHCCCS managed care health plan.

- Successfully supported successive competitive AHCCCS bid awards and led medical services departments through progressive plan membership and geographic expansion from approximately 35,000 covered lives in two metropolitan counties, to more than 200,000 lives across 10 Arizona counties

- Supported the implementation and management of Health Choice Generations, a D-SNP Part D Medicare Advantage health plan serving dual-eligible members
- Collaborated on Request for Proposal (RFP) development, issuance and selection processes for new plan service delivery vendors
- Supported successful post-implementation of selected vendor partners, demonstrated by operational success, improved appropriateness of utilization, reduced cost, improved data collection and quality control

Medical Director/March 2004 – September 2006

- Redeveloped health plan clinical department policies and procedures, including medical and dental clinical coverage criteria, provider pre-certification denial language and regulatory provider and member correspondence materials
- Added and trained two additional medical directors and defined the health plan pharmacy director role as a result of growth and expansion
- Collaborated on RFP issuance, selection and contract negotiations for a Pharmacy Benefit Management (PBM) vendor, including oversight of a two-stage implementation (Medicare Part D and AHCCCS Acute)
- Updated processes and scalability, improved compliance and timeliness, and reduced costs associated with the provider credentialing program

Associate Medical Director and Pharmacy Director/November 2001 – February 2004

- Oversaw medical and dental clinical coverage criteria development and standardization processes
- Managed Pharmacy and Therapeutics, Drug Utilization Review and related programs; expanding and structuring a robust, safe, cost-effective preferred drug list

IASIS Healthcare – Phoenix, Arizona

The Centre Clinics, Family Practice Offices/September 2000 – February 2004

Catholic Healthcare West/St. Joseph's Hospital and Medical Center

Hospital Emergency Department and Intermediate Care Annex/July 1999 – June 2000

- Served as a dedicated, board-certified, Family Practice Physician with seven years of outpatient, inpatient and emergency department/urgent care practice experience within the Phoenix metropolitan tertiary and quaternary health centers
- Served in a successful private group Family Medicine practice environment with more than 5000 inner-city, primary care patients with diverse insurance coverage and fee for service care
- Oversaw ongoing education to students, residents, physician assistants and family nurse practitioners

EDUCATION/CREDENTIALS

- Family Practice Residency, St. Joseph's Hospital and Medical Center Phoenix, Arizona, 1997–2000
- Doctor of Osteopathic Medicine, Midwestern University/Chicago College of Osteopathic Medicine, Downers Grove, Illinois, 1993–1997
- Bachelor of Arts, Biology (minors in Chemistry and Philosophy), University of San Diego, 1989–1993

PROFESSIONAL AND COMMUNITY AFFILIATIONS

- Arizona Board of Osteopathic Medical Examiners (license #3521) 1/31/2000 – 12/31/2016
- American Academy of Family Practice Board Recertification 2007 – 2017
- American Academy of Family Practice Board Certified 2000 – 2007
- Arizona Osteopathic Medical Association

VOLUNTEER BOARDS

- March of Dimes, Greater Arizona Chapter, September 2014 to present

KAREN A. SAELENS – CHIEF OPERATING OFFICER

OVERVIEW

Highly accomplished leader with experience in varying plan operations, business analysis, information technology (IT) and software development. Results-oriented, decisive leader with proven success building organizations, strategic business planning, project implementation and building solutions for complex problems. Recognized track record building strong processes that exceed operational metrics. Thrive in dynamic and fluid environments while remaining focused on primary business goals.

PROFESSIONAL EXPERIENCE

UnitedHealthcare Community Plan – Phoenix, Arizona

Chief Operating Officer/July 2015 – Present

Responsible for operational performance of UnitedHealthcare Community Plan of Arizona, both internally and with state regulator. Responsible for financial, operational and people goals. Responsible for improving operational performance and increasing member and provider satisfaction. Responsible for successful implementation of key business changes whether regulatory or internally driven. Accomplishments include:

- Consistently exceed state performance measures
- Created operational scorecards for at-a-glance view of key metrics
- Consistently exceed company goals, including employee engagement
- Implemented key system updates with minimal operational impact
- Empowered team to focus on operational excellence resulting in exceeding metrics

Executive Director, Long-Term Care and Medicare/August 2012 – July 2015

Led the long-term care (ALTCS) and Medicare Advantage products for UnitedHealthcare Community Plan in Arizona. Responsible for setting and managing financial, operational and people goals, and for improving operational performance. Responsible for increasing member and provider satisfaction. Reported product operational performance to corporate executives and health plan leadership. Accomplishments included:

- Exceeded state performance measures
- Increased staff visibility on broader UnitedHealthcare company goals
- Improved multiple work flow processes to increase employee engagement
- Reduced administrative costs around manual processes
- Aligned Medicaid and Medicare processes for long-term care members
- Empowered team to focus on operational excellence resulting in exceeding metrics
- Oversaw the successful implementation of key business regulatory-/internally-driven changes

West Region Director, Health Plan Operations/March 2009 – August 2012

Provided regional oversight for health plan operations in Arizona, Hawaii, New Mexico and Washington with additional oversight responsibilities for national Long-Term Care and Medicare operations. Responsible for adherence to regulatory requirements for claims, call center, enrollment and network operations. Responsible for improving operational performance and increasing member and provider satisfaction. Reported operational status and performance outcomes to corporate executives and health plan leaders. Responsible for driving implementation of key business changes both regulatory and corporate driven. Accomplishments included:

- Implemented RFP awards for multiple products with minimal operational impact

- Created performance metric scorecards to monitor performance of operations, which led to improved operations affecting call center, claims and network operations
- Built a strong operations team that focused on operational excellence and exceeded metrics expectations
- Implemented multiple communications channels for changes affecting call center teams, resulting in improved performance

Vice President, Operations/March 2008 – March 2009

Led the claims, member and provider operations teams of our AHCCCS Acute managed care health plan (APIPA) to achieve operational excellence. Implemented operational processes that adherence to AHCCCS regulatory requirements and for claim payment accuracy per contractual agreements among physicians, hospitals and governing agencies. Reported operational status and performance outcomes to corporate executives and the board of directors. Managed key vendor relationships, with a focus on improving performance and achieving and exceeding metrics. Accomplishments included:

- Retained key provider relationships within health plan, enabling strong membership growth for the health plan
- Built strong operations teams that focused on operational excellence and exceeded metrics
- Implemented Children's Rehabilitative Services (CRS) program for AHCCCS
- Exceeded the regulator's performance bonus expectations

Vice President, Claims Cost Management/January 2006 – March 2008

Managed a team of more than 55 professionals while implementing new cost-containment tools and processes for improving claims adjudication accuracy. Led configuration of claims payment system operations to achieve accurate and timely entry of business rules that affect benefit packages, authorizations, provider enrollment rules, membership rules and security rules. Coordinated claims payment quality testing of physician and hospital contracts. Accomplishments included:

- Directly responsible for cost-containment dollars exceeding 2007 goals by 150 percent
- Exceeded cash recovery targets in 2007 by 30 percent
- Created metrics and control processes surrounding configuration of key data in claims payment system, leading to improved process and quality
- Created processes to monitor system fixes, achieving accurate payment first time; process included control chart reporting for ongoing monitoring of fixes
- Built intake and tracking systems for all requests for work from the research/audit team

Senior Director, System Configuration/March 2004 – January 2006

Directed business rules-based system setup to verify physician and hospital contracts, enrollment, and provider rules were loaded into the system for optimal handling of expected rules and claims payment. Accomplishments included:

- Restructured organization to gain efficiencies via automation, mentoring and cross-training
- Reduced turnaround time for configuration work within service levels for 75 percent of customers
- Developed executive training program that addresses claims payment complexities; trained majority of corporate executives on the basics of our claims payment system
- Oversaw end-to-end quality of system configuration, from business rules to testing, improving quality metrics
- 50 percent in the first year
- Built intake and tracking systems for all requests for work from the configuration team
- Created metrics and a monitoring system for service level agreements among departments

- Created and maintained budgets within corporate expectations
- Developed resource planning tools against expected volume of work
- Built relationships with key individuals in other departments resulting in a successful enhancement of the overall configuration process

Project Director/February 2003 – March 2004

Led teams during migration of health plans from mainframe system to client-server based claims payment system. Reported migration status to executive management and escalated issues. Accomplishments included:

- Led the timely migration of two health plans from mainframe system to new claims payment system, involving IT, call centers, health plans, claims processing teams and pertinent business processes
- Created resource plan and budget for migrations – exceeded budget goals

Director, Application Services/April 1999 – February 2003

Translated client business requirements into technical requirements. Scheduled staff to perform necessary technical changes and directed the projects to completion. Accomplishments included:

- Reviewed and contributed to decision of claims payment vendors to replace mainframe system, with focus on systems capabilities and processes
- Led the three IT implementations from mainframe system to new claims payment system within eight months
- Implemented reusable application development and project management templates, which increased efficiencies in subsequent implementations of the new claims payment system
- Led HIPAA implementation for required federal changes in EDI transaction sets
- Designed creative solutions for IT systems

EDUCATION/CREDENTIALS

- B.S., Computer Science, Winona State University, 1983
- B.S., Secondary Mathematics Education, Winona State University, 1983

PROFESSIONAL AND COMMUNITY AFFILIATIONS

- Toastmasters Competent Communicator
- Toastmasters Advanced Communicator
- UnitedHealth Group, General Manager Program, 2017

LESLIE K. PAULUS MD, PHD, FACP – MEDICAL DIRECTOR

OVERVIEW

Dr. Paulus joined UnitedHealthcare in January 2006 and is based in Phoenix, AZ. UnitedHealthcare Community Plan Arizona is United's Government Programs Plan. Dr. Paulus has been the lead Medical Director for the health plan's Children's Rehabilitative Services (CRS) program since October 1, 2008. She helped implement the integrated CRS program in 2013. Prior to being a medical director she was practicing as both a pediatrician and an internal medicine specialist, having completed a combined residency at St. Joseph's Medical Center. She has extensive experience in behavioral health as she was Director of the Department of Medicine at Arizona State Hospital for 4 years, participated as board member for Mental Health Advocates, and was Chair for the Human Rights committee for the Arizona State Hospital. Dr. Paulus is a second generation native of Phoenix, Arizona and has 2 sons, an adopted daughter (granddaughter), 3 other granddaughters and one grandson.

PROFESSIONAL EXPERIENCE

UnitedHealthcare Community Plan - Phoenix, Arizona

Children's Rehabilitative Services Medical Director– October 2008– Present

- Medical Management and Care Management Supporting Medical Director for Integrated CRS program
- Quality Peer Review Committee Involvement Arizona Plan and Regional UnitedHealthcare
- Participant in Healthcare Quality Utilization Management Committee and Health Plan Quality Committee
- Policy and Procedure Development/Revision
- Appeals Determinations
- Claims Review Determinations/State Fair Hearing Witness
- Prior authorizations and inpatient determinations for all lines of business, Medicaid, Developmental Disability Long Term Care, KidsCare, Children's Rehabilitative Services
- Network Development/Provider issue support
- Lead Medical Director for multiple Joint Operating Committees Affordable Care Organizations and Value Based Contracts
- Enrollment Resource for Children's Rehabilitative Services

UnitedHealthcare Evercare Clinical Care Center - Phoenix, Arizona

National Medical Director–/ January 2006 to October 2008

- Medical Director Prior authorization, Inpatient Utilization, Post Hospital Determinations split 26 local markets, 60,000 member and cross coverage for other two national medical directors dual Special Needs(DSNP) Medicare program
- Coordination DSNP with Medicaid management multiple states
- Integrated program management inclusive of medical and behavioral health
- Participated in development of operational processes for utilization
- Mentor and educated level I and II case managers regarding chronic illness and prevention related to unique illness
- Participation in development of Special Needs Plans Quality Indicators around post hospital transitions
- Collaborative interaction with local markets around strategic planning for reduction of bed days and readmissions

- Data analysis of exported reports to evaluate utilization data and local market needs

Chief Medical Officer Banner Mesa Medical Center– Mesa, Arizona/ May 2005-November 2005

- Promote concepts and practice of quality improvement activities
- Analyze, review and present clinical, financial and patient satisfaction outcome data to medical staff.
- Oversee Care Management operations which include utilization and case management.
- Participation in strategy planning for Banner Mesa Medical Center and Banner Health system wide.
- Medical Staff leadership development
- Development of Continuing Medical Education
- Peer Review and Credentialing
- Involvement in Banner Health system wide initiatives
- JCAHO, Arizona State Licensure, CMS certification

Internist/Pediatrician Internal Medicine Specialists, P.C.– Phoenix, Arizona/ November 1998-May 2005

- Private Practice, primary care, integrative treatment of complex patients with multispecialty needs.

Internist/Pediatrician Scottsdale Healthcare – Scottsdale, Arizona/ May 1997 – October 1998

- Private Practice, primary care, integrative treatment of complex patients with multispecialty needs, participant in development for pilot for electronic medical record.

Director of Department of Medicine, Arizona State Hospital– Phoenix, Arizona / July 1993 – April 1997

- Supervisor of 5 Physicians Department of Medicine
- Provided inpatient acute, chronic and preventative care in coordination with the psychiatric attending for adolescent and adult seriously mentally ill and forensic patients
- Director of Laboratory, CLIA certified 1994-1997
- Co chair Pharmacy and Therapeutics Committee, 1993-1995
- Chairperson Emergency Services, 1993-1997
- Chairperson of Medical Utilization Management, 1994-1997
- Supervision of the medical staff employees and dental staff contracted employees
- Provided consultative interface with the Departments of Pharmacy, Nursing, Specialty Clinic Services, Physical Therapy, Radiology, Podiatry, Neurology, Obstetric/Gynaecology, Optician, Audiology, EKG, EEG, Employee Health, Infection Control

Pediatrician Children's Rehabilitative Services– Phoenix, Arizona/ June1989– June 1993

- Pediatric clinic screening evaluations including triage, developmental assessments, case management, interface with community agencies supporting intervention for the patient.
- Moderator function for multidisciplinary clinics including: Myelomeningocele Children and Adults,
- Rhizotomy Screening, Neurofibromatosis, Cranial Remodelling, Surgical Epilepsy
- Supervisory function of the clinic nurse practitioner

EDUCATION / CREDENTIALS

1985, Medical Doctorate, University of North Carolina, School of Medicine, Chapel Hill, NC

1983, PhD, Microbiology & Immunology, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, NC

1972-1978, BS, Microbiology, Arizona State University, Tempe, Arizona

1987-current, Medical License in Arizona

1987-current, DEA

1989-current, American Board of Internal Medicine, Certified,

1990-2004, American Board of Pediatrics Certified

1997-1998, Completed Program in Management I, II, III, American College of Physician Executives, Phoenix, AZ

PROFESSIONAL AND COMMUNITY AFFILIATIONS

- 2015-current, Arizona State Autism Task Force Member: Recommendations made to State of Arizona for best practices and integrated services; Vitalyst Adult with Autism Work Group Member 2017-current
- 2015-current, Prenatal Substance Abuse Task Force member State of Arizona: development of recommendations to State of Arizona for best practices, prevention, evaluation and treatment.
- 2017, Advisory Council Member UnitedHealthcare National Special Needs Initiative
- 2009-current, Newborn Screening Partners Committee member
- 2013-current, Arizona Institute for Public Life Advisory Board Member
- 1993-current, American College of Physicians, fellow since 2005
- 1997-current, American Association of Physician Leadership (previously American College of Physician Executives), member
- 1995-current, Maricopa Medical Society, member
- 1989-current, Arizona American Academy of Pediatrics, member
- 1992-current, Valley Interfaith Project Leader
- 2011-current, Our Lady of Angels , Franciscan Renewal Center parishioner; 1990-2011, St. Francis Xavier, parishioner.
- 1995-2009, Advisory Board for Arizona Social Change , Arizona Community Foundation
- 1998, Advisory Board for Scottsdale. Initiative for Girls and Young Women
- 1998 –2009, Human Rights Committee, Arizona State Hospital, member, chaired 2001 -2008
- 2000-2006, Advisory Board Mental Health Advocates

LESLIE SCHWALBE, MPA, CCHP

SENIOR VICE PRESIDENT, STATE AND LOCAL GOVERNMENT PROGRAMS

OVERVIEW

Knowledgeable and thoughtful healthcare administrator with more than 25 years of experience working in and with state governments, national associations, health plans and community providers.

PROFESSIONAL EXPERIENCE

Optum – Eden Prairie, Minnesota

Senior Vice President, State and Local Government Programs – Tempe, Arizona / March 2015 – Present

- Collaborates with client states and communities to develop solutions to difficult healthcare problems
- Manages corporate relationships with government behavioral health departments, national advocacy organizations and behavioral health trade associations
- Hosts difficult conversations such as the Optum SPARK Initiative on Criminal Justice; solving for important public health problems
- Provide subject matter expertise to existing and new business opportunities
- Present behavioral health and technology trends and innovation at numerous national and local behavioral health conferences

Medicaid Behavioral Health Consultant (self-employed) – Tempe, Arizona / June 2005 - March 2015

Consultant to government and private organization spanning the country including:

- Substance Abuse and Mental Health Services Administration/Center for Mental Health Services
- US Department of Health and Human Services/Assistant Secretary for Planning and Evaluation
- 25+ state health mental health and Medicaid agencies
- National Association for State Mental Health Directors
- Behavioral health providers, behavioral health trade organizations, and managed care/behavioral health care organizations
- Provided training and technical assistance to non-profit groups and provider organizations through numerous presentations on Medicaid and behavioral health

State of Arizona, Phoenix, Arizona

Deputy Director, Division of Behavioral Health Services, Arizona Department of Health Services / December 1999 – June 2005

- Directed the operation of the community behavioral health system by providing inpatient, outpatient, and pharmacy services to more than 140,000 consumers and families, managing more than $800 million annually. Developed and financed new, state of the art covered services for all enrolled Medicaid and non-Medicaid members, including members of two class action lawsuits. Directed the development, negotiation and implementation of behavioral health managed care contracts throughout Arizona.
- Under a contract with the State's Medicaid Agency (AHCCCS), directed the behavioral health carve-out program operating under an 1115 managed care demonstration waiver.

- Directed the implementation of the Arizona Health Insurance Flexibility and Accountability (HIFA) waiver program for newly-enrolled behavioral health members.
- Directed the implementation of an 1115 expansion program for persons receiving behavioral health services up to 100% of the Federal Poverty Level. Included the transition of persons from state-only programs to the new Medicaid expansion group.
- Responsible for the Arizona State Hospital and the Arizona Community Protection and Treatment Center and the care of more than 450 persons committed by the Courts. Responsible for continual JCAHO and CMS accreditation to ensure federal financial participation under Medicare and a CMS approved Medicaid IMD waiver.

Assistant Director, Arizona State Parks / June 1995 - December 1999

- Finance, human resources and procurement director
- Developed and led the financial, human capital and procurement strategies for the development and opening of Kartchner Caverns State Park
- Collaborated with Governor's Office and Joint Legislative Budget Committee to develop ongoing resource commitments for State Parks

Senior Budget Analyst, Governor's Office of Strategic Planning and Budgeting / September 1990 – June 1995

- Analyzed state agency budget requests and prepared Governor's budget recommendations for several large agencies including the Department of Health Services and the Department of Corrections

Education / Credentials

- National Commission on Correctional Health Care – Certified Correctional Health Professional / September 2017
- Harvard School of Public Programs Certification / July 2002
- Master of Public Administration, concentration in Government Finance, Arizona State University School of Public Affairs / December 1991
- Bachelor of Arts, Political Science, Montclair State University / June 1987

Selected Professional and Community Affiliations

- National Alliance on Mental Illness (NAMI) Arizona Board Member /member since 2016
- Arizona State Parks, Public Safety Retirement System Local Board Member / member since 2003
- Past Secretary and Treasurer, Board of Directors, Recovery Empowerment Network, a non-profit mental health peer-run and operated organization providing advocacy and services to Arizona Medicaid members / member from January 2006 – September 2013

Recognition for Mental Health and Substance Use Service Contributions

- MIKID Outstanding Service for Children with Mental Health Issues – Arizona, October 2005
- Community Partnership of Southern Arizona (CPSA) Community Spirit Award – Arizona, April 2005
- Statewide Celebration of Courage Conference, Leadership in Developing Peer Programs Recognition– Arizona, April 2005
- Arizona Council of Human Service Providers, 1st Annual Advocacy Award – Arizona, July 2003
- Western Governors' Association George S. Mickelson Memorial Fellowship – Western States, 2002
- Arizona Mental Health Association's Leadership Award – 2001

LILLI CORRELL – VP, BEHAVIORAL HEALTH PRODUCT DEVELOPMENT & SOLUTION DESIGN

OVERVIEW

- Keen intuition, high energy, genuine, and straight-forward leadership.
- Consistently produce best practice operational improvements and significant SG&A/ROI savings.
- Proven achievements in Healthcare, stakeholder engagement and process improvement.
- Comprehensive business expertise in Medicaid, Medicare, and commercial markets.

PROFESSIONAL EXPERIENCE

Optum – Eden Prairie, MN

VP, Behavioral Health Product Development & Solution Design (Austin, TX) / March 2016 – Present

- Co-led and delivered integrated medical and behavioral health case management to the Medicaid channel including identification and stratification algorithms that factored in behavioral, medical, pharmacy, and social determinants
- Conducted a cross-channel proposal analysis, developed insights and recommendations and delivered them to key stakeholders
- Oversee public sector solution design approach to Medicaid, Medicare and Federal RFP pipeline
- Obtain, analyze and summarize research related to product development, including: clinical literature, industry trends, competitor activities, and health service delivery systems
- Monitor and modify product offerings to maintain competitiveness

Cenpatico – Austin, TX

VP, Clinical Operations, Behavioral Health & STRS / February 2015 – March 2016

- Provided oversight to the Centene behavioral health utilization, disease and case management organization of 500+ staff
- Assisted in evolution of behavioral health approach to case management to ensure identification and stratification of highest need members
- Coordinated with statisticians to align stratification with meaningful interventions that improved health and well-being of members
- Provided interim leadership to Provider Data Management and removed a credentialing and re-credentialing backlog of 5,000+ provider files in 60 days
- Obtained, analyzed and summarized research related to product development, including: clinical literature, industry trends, competitor activities, and health service delivery systems
- Ensure NCQA accreditation readiness as well as internal contract compliance readiness for all markets. Program scored 100% on corporate NCQA audit for compliance with state regulations.

Sr. Director, Specialty Therapy and Rehab Services (STRS) / January 2011 – February 2015

- Ensure NCQA accreditation readiness as well as internal contract compliance readiness for all markets. Program scored 100% on corporate NCQA audit for compliance with state regulations.
- Provided technical and operational oversight/support for Team(s) of STRS Clinical Leadership, Utilization Managers, Clinical Provider Trainer and Care Coordinators.
- Provided consultation and/or guidance around clinically-related issues relative to operational transactions, utilization management, and evaluation of Members' treatment outcomes.

- Provided detailed reporting, analysis, and interpretation in accordance with the project's scope and regulatory requirements, including: claims cost, trend analysis, and financial performance.
- Assisted in setting and proposing risk rate with health plan partners

Manager, Network Development (Contracting & Provider Relations) / October 2008 – January 2011

- Managed a network of more than 2,000 providers, negotiated contracts and renegotiated existing agreements
- Developed a trauma informed care network, established training requirements for inclusion, and ensured providers were captured in the provider directory with expertise

Westover Hills Counseling Center – Austin, TX

Marriage and Family Counselor/ September 2003 – September 2015

- Counseled individuals, couples and families utilizing an outcomes oriented approach
- Documented all sessions and provided overview/therapy summary as requested
- Coordinated with medical and other behavioral health providers to ensure positive outcomes

EDUCATION / CREDENTIALS

- Master of Art, Hardin Simmons University, Abilene, TX, Major: Family Psychology
- Bachelor of Science, Texas Tech University, Lubbock, TX, Major: Speech and Hearing Science; Minor in Substance Abuse Studies

PROFESSIONAL AND COMMUNITY AFFILIATIONS

- Psi Chi Psychological Honor Society (member since 1997)

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.

UnitedHealthcare Community Plan	
Company Name	Signature of Person Authorized to Sign
1 East Washington, Suite 900	Joseph G. Gaudio
Address	Printed Name
Phoenix AZ 85004	CEO, UnitedHealthcare Community Plan
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: Arizona Physicians IPA, Inc. a/k/a UnitedHealthcare Community Plan

Affiliated Organization Name: N/A

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.

UnitedHealthcare Community Plan Company Name	Signature of Person Authorized to Sign
1 East Washington, Suite 900 Address	Joseph G. Gaudio Printed Name
Phoenix AZ 85004 City State Zip	CEO, UnitedHealthcare Community Plan 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 UnitedHealthcare Community 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.

UnitedHealthcare Community Plan	
Offeror Name	Signature of Person Authorized to Sign
1 East Washington, Suite 900	Joseph G. Gaudio
Address	Printed Name
Phoenix AZ 85004	CEO, UnitedHealthcare Community Plan
City State Zip	Title