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**	**Offeror's Page No.**
Offeror's Bid Choice Form	RFP Exhibit B Refer to Bidders' Library	31
Offeror's Completed and Signed RFP Solicitation Page	RFP Section A	2-3
Offeror's Signed Signature Page(s) for each Solicitation Amendment	Refer to Bidders' Library	4-30
Capitation Bid Submission		
Capitation Bid Template/Tool(s)	Instructions to Offerors	32-44
Capitation Actuarial Certification(s)	Instructions to Offerors	45-46
Executive Summary and Disclosure		
Executive Summary	Instructions to Offerors	47-49
Moral or Religious Objections	Instructions to Offerors	50
Narrative Submission Requirements		
Program #1	Instructions to Offerors	51-55
Program #2	Instructions to Offerors	56-60
Program #3	Instructions to Offerors	61-65
Program #4	Instructions to Offerors	66-70
Program #5	Instructions to Offerors	71-75
Program #6	Instructions to Offerors	76-80
Access to Care/Network #7	Instructions to Offerors	81-85
Access to Care/Network #8	Instructions to Offerors	86-90
Access to Care/Network #9	Instructions to Offerors	91-95
Administrative #10	Instructions to Offerors	96-100
Administrative #11	Instructions to Offerors	101-110
Administrative #12	Instructions to Offerors	111
Oral Presentations		
Names and Titles of Participating Individuals	Instructions to Offerors	112
Resumes of Participating Individuals	Instructions to Offerors	113-131
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Exhibit F Refer to Bidders' Library	132

AHCCCS Arizona Health Care Cost Containment System	Notice of Request for Proposal
	SOLICITATION # YH18-0001
	Arizona Long Term Care System (ALTCS) Elderly & Physical Disability (E/PD) Program Contract for Contractors

SECTION A: SOLICITATION PAGE

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

Telephone: (602) 417-4538
E-Mail: EPDYH18_QuestionstoRFP@azahcccs.gov
Issue Date: November 1, 2016

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

DESCRIPTION: **ARIZONA LONG TERM CARE SYSTEM (ALTCS) ELDERLY & PHYSICAL DISABILITY (E/PD) PROGRAM CONTRACT FOR CONTRACTORS**

PROPOSAL DUE DATE: **January 23, 2017** **AT 3:00 P.M. ARIZONA TIME**

Pre-Proposal Conference: A Pre-Proposal Prospective Offerors' Conference has been scheduled for Tuesday, November 8, 2016 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 YH18-0001 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 at the above specified location, 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 and at the location indicated above.

Late Proposals shall not be considered.

Proposals must be submitted in a sealed envelope or package with the Solicitation Number and the Offeror's name and address clearly indicated on the envelope or package. 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.

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.

	Mary Consie
Arizona Transaction (Sales) Privilege Tax License No.:	Name
46-3766901	Chief Administrative Officer
Federal Employer Identification No.:	Title
Mary.Consie@ BannerHealth.com	623-385-0884
Email Address	Phone
Banner - University Family Care	
Company Name	Signature of Person Authorized to Sign Offer
2701 E. Elvira Rd.	James V. Stover
Address	Printed Name
Tucson AZ 85756	Chief Executive Officer
City State Zip	Title

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. The Offeror certifies that the above referenced organization _____ is / ___X___ is not a small business with less than 100 employees or has gross revenues of $4 million or less.

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. YH18-0001.

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		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

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

This Solicitation is amended as follows:

RFP Section I: Exhibits, Exhibit E: Medicare Requirements:
Participation as a Medicare Advantage Special Needs Plan
All ALTCS E/PD Contractors will be required to provide Medicare benefits to dual eligible members as a D-SNP in all awarded counties. Contractors will be required to implement Medicare business on **January 1, 2018** and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as a D-SNP to CMS no later than ~~**November 10, 2016**~~ November 14, 2016. Additional information and exact submission dates for 2017 can be found here:
https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/.

To comply with the statute A.R.S. §36-2906.01, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll ALTCS E/PD full benefit dual eligible members and must have a D-SNP subset that matches this Contract. All Offerors must also submit D-SNP applications to CMS by ~~**February 2017**~~ February 15, 2017. Additional information on D-SNPs can be found at: http://www.cms.gov/SpecialNeedsPlans.

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:
TYPED NAME: James Stover	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 1/9/17	DATE: 11/7/2016

AHCCCS
Arizona Health Care Cost Containment System

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

SOLICITATION AMENDMENT #2		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@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:
TYPED NAME: James Stover	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 1/9/17	DATE: 11/21/2016

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 2 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
1	11/10/2016	Section H. Instructions to Offerors	15. Contents of Offeror's Proposal	239	The RFP states "Unless otherwise specified, responses to each submission requirement must be limited to five 8 1/2" x 11" one sided, single spaced, type written pages." Please confirm that the 5 page limit applies to each of the individual questions noted within in Exhibit C: Narrative Submission Requirements.	Each individual Narrative Submission Requirement, numbered 1 through 12, is limited to the 5 page requirement. Upon review of the submission requirements, AHCCCS is clarifying the page number limit for narrative submission requirement #11. The RFP is amended as follows: (RFP Page 251) Administrative Submission Requirement #11: 'The five page limit applies only to the narrative response. There is no limit to the number of attachments in response to '... the type and full content of any communications the Offeror will send to the provider.'
2	11/10/2016	Section H. Instructions to Offerors	15. Contents of Offeror's Proposal	239	Is the Offeror required to include the full question narrative as part of our response to the questions within Exhibit C: Narrative Submission Requirements. If yes, please confirm that the question will not be counted towards the 5 page limit.	The Offeror has the discretion to include/exclude the narrative submission requirement text. The 5 page limit applies regardless.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 2 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
3	11/10/2016	Section I: Exhibits Exhibit C: Narrative Submission Requirements	12. IT Systems Demonstration	251	Paragraph 4 states: <Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 24, 2017, constitutes fulfillment of Submission Requirement No. 11. Please confirm this should state fulfillment of Submission Requirement No. **12.**	Yes, this should state No. 12. The RFP is amended as follows: (RFP Page 251) Administrative Submission Requirement #12: 'For this Submission Requirement, the Offeror shall provide written acknowledgement as follows: <Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 24, 2017, constitutes fulfillment of Submission Requirement No. ~~11~~ 12. <Offeror> acknowledges that it will comply with the stated guidelines and calendar for this process. <Offeror> acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.'
4	11/10/2016	Section I: Exhibits Exhibit C: Narrative Submission Requirements	12. IT Systems Demonstration	251	Please confirm that the written acknowledgment represented in paragraph 4 is the only response required for this question.	Yes the written acknowledgement is the only response required for this question. Note, the 10 -day demonstration itself begins on January 24, 2017.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 2 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
5	11/10/2016	Section J. Program Requirements	3. Grievance and Appeal System	280	Per Section J.3, the Contractor is required to implement and administer an SMI Grievance and Appeal system. Are there any restrictions on integrating the SMI Grievance and Appeal process with the Contractor's non-SMI Grievance and Appeal system assuming that all required processes are followed and data is reported separately under contract requirements?	The Offeror has the discretion to design an SMI and non-SMI Grievance and Appeal System as long as it complies with AHCCCS requirements.
6	11/10/2016	Section H. Instructions to Offerors IT Demo Q&A Process Provisions	1. Prospective Offeror's Inquiries	228	This section provides detail on how to submit questions related to the RFP but indicates that questions related to the IT Systems Demonstration will follow different instructions. The RFP supplemental IT Demo Q&A Process Provisions document indicates "Questions received between 8:00 a.m. Arizona Time and 12:00p.m. Arizona Time will be answered, if appropriate, no later than 3:30 p.m. Arizona Time the same day. All questions and responses will be made available to all Offerors by means of posting to the SFTP folder as noted below." What is the deadline for submitting IT Demonstration related questions through this process?	Questions may be submitted at any time of the day during the 10 day IT demonstration. Questions that are received after 12:00 p.m. weekdays will be answered the next business day.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 2 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
7	11/10/2016	D. Program Requirements	25	90	Please clarify the language in the referenced section. Is it AHCCCS' intention that the bidder maintain staff dedicated only to the ALTCS program per the following requirement: Except as otherwise specified below, a staff member is prohibited from occupying more than two positions within one line of business *or from occupying two positions across multiple lines of business (including non-AHCCCS lines of business)* unless prior approval is obtained by AHCCCS, Division of Health Care Management (DHCM). Are there any positions that AHCCCS would not consider approving to be used across multiple AHCCCS lines of business? Is it your intention that one person cannot work on multiple lines of business? Does this apply to every position, such as provider relations reps, prior auth reps, claims examiners, etc? And if so, how does this apply to staff working with the dual eligible population?	A staff member is prohibited from wearing more than 'two hats', regardless of whether the staff member occupies two positions within a single line of business or one position across two lines of business (including non-AHCCCS lines of business). The Contractor has its discretion to consider how it deploys it staff as long as the 'two hats' requirement is met. A position for which it is reasonable that a staff member would assist a provider for example, across all lines of business, or members from all lines of business, would likely be granted an approval by AHCCCS. The Offeror's D-SNP is also considered a line of business. The RFP is amended as follows (RFP Page 90): Except as otherwise specified below, a staff member is prohibited from occupying more than two positions, regardless of whether the staff member occupies two positions within a single line of business or one position across two lines of business (including non-AHCCCS lines of business) ~~within one line of business or from occupying two positions across multiple lines of business (including non-AHCCCS lines of business)~~ unless prior approval is obtained by AHCCCS, Division of Health Care Management (DHCM). AHCCCS will not permit any Contractor staff to hold positions which may present a conflict of interest.

AHCCCS
Arizona Health Care Cost Containment System

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

SOLICITATION AMENDMENT #3		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@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: James Stover	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 1/11/17	DATE: 01/06/2017

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 3 TO RFP YH18-0001

	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	12/02/2016	N/A Located in the Bidders' Library	N/A	N/A	AMPM Policy 1250-D has an effective date of 11-01-2017 is this accurate?	No this is not correct the effective date should be 10-1-17. The draft policy will be corrected to October 1, 2017.
2	12/09/2016	Section D	16	69	This language seems to conflict with the caseload ratio language later in the paragraph. Can you please provide a clarification? 'The Contractor shall submit to AHCCCS for approval, case manager ratio plans based on national standards that will take into account member acuity, legal, and environmental needs.' 'The Contractor shall comply with established caseload ratios for case managers assigned to serve children identified as having high/complex needs.'	The RFP is amended as follows: ~~The Contractor shall submit to AHCCCS for approval, case manager ratio plans based on national standards that will take into account member acuity, legal, and environmental needs.~~ ~~The Contractor shall comply with established caseload ratios for case managers assigned to serve children identified as having high/complex needs.~~ The Contractor shall ensure adequate staffing to meet case management requirements. Each case manager's caseload may not exceed a weighted value of 96. The Contractor may assign a weighted value lower than those outlined below however, the Contractor must obtain authorization from the Division of Health Care Management prior to implementing caseloads whose values exceed these AHCCCS standards.
3	12/7/2016	H. Instructions to Offerors	1	240	Please clarify the requirements for attachments for narrative submission questions. Is it permissible to include as an appendix to our response, for example, a sample of an assessment tool to supplement the reviewers' understanding of our narrative submission?	No, attachments are not allowed for the Narrative Submission Requirements unless specified in the RFP. The only narrative submission requirement which allows attachments is Narrative Submission Requirement #11. As stated in RFP Section H: Instructions to Offerors, AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's Proposal. *At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the Proposal when reviewing a specific response to an individual submission requirement.*
4	12/7/2016	Oral Presentation	1	244	We understand the Oral presentation schedule will take place during the weeks of January 30 and February 6, 2017. One of our key personnel had scheduled to travel out of state from January 21-28, 2017 prior to the bid submission deadline update. Our staff will be out of state to serve as caregiver for their elderly and ailing mother while their sibling is away. We respectfully request our Oral Presentation to be scheduled for the week of February 6, 2017 to allow our staff member to participate in the Oral Presentation.	AHCCCS will not accommodate individual requests for scheduling of Oral Presentations. As stated in RFP Section H: Instructions to Offerors: *All presentations will be scheduled to occur during the weeks of January 30 and February 6, 2017.* However, should an unforeseen circumstance arise the Offeror must contact the AHCCCS Chief Procurement Officer in order to request participation of an alternate representative.
5	12/7/2016	Staff Requiremets	5	90	At what point will AHCCCS review and approve staff positions that support more than two lines of business or who occupy more than two positions within one line of business? Are we permitted to submit for review and approval prior to our proposal sumission on January 23, 2017.	No, AHCCCS will not accept requests prior to an award as it is unknown which Offerors will be awarded a Contract. All requests for prior approval regarding staffing are to be submitted no earlier than March 27th, 2017.
6	12/07/2016	Section G	g	3	We have a variety of "Management Information Systems, software or hardware systems" ranging from claims adjudication systems to desktop MS Office software. Can you clarify what is meant by "Management Information Systems, software or hardware?" What types of vendor applications are you interested in us providing background information on, e.g. claims systems, medical management systems, reporting software, etc.?	42 CFR 438.242 requires that the State must ensure, through its contracts that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 3 TO RFP YH18-0001						
	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
7	12/07/2016	Section G	g	3	We have a number of Management Information Systems in place to support the population within ALTCS. While we will continue to have the needed Management Information Systems in place during the term of the contract, we expect that new or updated contracts may be needed to acquire new or additional technologies such as servers, applications, etc. as well as updates to services and pricing. Additionally, our contracts typically do not extend for seven years. Is the expectation that we can "arrange for" Management Information Systems, software or hardware during the "term of the contract" as necessary by adding, renewing, or replacing vendor contracts?	Yes, the expectation is that Management Information Systems software or hardware can be arranged for (i.e. renewed, replaced, added) during the term of the contract in accordance with the subcontractor Contract provisions and approval requirements.
8	12/07/2016	Section D	27 ND	98	Please validate the correctness of the sentence underlined below: Alternative HCBS Settings: To ensure members are residing in the most appropriate, least- restrictive setting the Contractor shall develop and implement proactive strategies directed at reducing the percentage, not to exceed 20%, of members residing in their own homes and in Alternative HCBS Settings.	The RFP is amended as follows: Alternative HCBS Settings: To ensure members are residing in the most appropriate, least- restrictive non- institutional setting, the Contractor shall, on an ongoing basis, monitor and evaluate member placement data. The Contractor shall develop and implement proactive strategies to increase the percentage ~~directed at reducing the percentage, not to exceed 20%,~~ of members residing in their own homes ~~and in Alternative HCBS Settings~~. The strategies that are developed and/or implemented shall not ~~lead to or incentivize an increase in the percentage of members residing in nursing facilities and shall not~~ infringe upon member's choices and preference. Upon identification that 20% or more of the Contractor's membership are residing in Alternative HCBS Settings, in any GSA, the Contractor will be required to reevaluate and provide evidence of interventions utilized to reduce the percentage. The strategies that are developed and/or implemented shall not lead to or incentivize an increase in the percentage of members residing in nursing facilities and shall not infringe upon member's choices and preference.
9	12/07/2016	Section I / Exhibit C	3	248	Narrative submission 3. For this narrative , it states (excluding CMS mandates and the provision of supplemental benefits). Does this exclusion of CMS mandates include HEDIS, STARS and CAHPS?	HEDIS and STARS are CMS mandates that are excluded. Offerors are allowed to refer to CAHPS.
10	12/07/2016	Section H	15	239-240	Can the offerors logo be positioned on the page outside of the 1/2" margin or must it be included within the 1/2" margin. Is the offeror's logo submit to the same font type and font size restrictions?	Yes, the Offeror's logo can be included outside the margins. The logo is not subject to font type size restrictions.
11	12/07/2016	Section H	15	239-240	Can the page numbering fall outside the 1/2" margin or must it be incuded within the 1/2" margin?	The Offeror's page numbering can be included outside the border but must be legible.
12	12/07/2016	Section H	15	239-240	Is a footnote citation required to be outside of the 1/2" margin or must it be included within the 1/2" margin?	Footnotes must be included within the 1/2" border.
13	12/07/2016	Section H	15	239-240	If tables, charts or other graphics are incorporated into responses, are these graphics subject to the font size limitations (11 point font) or can the font size be smaller?	Tables, charts and graphics are subject to the font type and size limitations specified in the RFP.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 3 TO RFP YH18-0001

	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
14	12/07/2016	Section H	16	244	In the Executive Summary, the offeror must describe how it will meet the requirements specified in RFP section I, Exhibit E, Medicare Requirements, Section 2. Must the offeror describe how it will meet each specific requirement in this Section 2, or can the offeror describe, overall and/or more generally, how it will meet the requirements outlined?	The Offeror shall respond as it deems appropriate. The RFP is amended as follows: **Executive Summary** The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting Contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in RFP Section I, Exhibit E, Medicare Requirements~~, Section 2~~. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following Contract awards. (3 page limit)
15	12/07/2016	Section I / Exhibit C	11		Narrative submission 11. Are the attachments for response 11 subject to the same font type, font size, and margin restrictions?	No, the attachments for response to Narrative Submission Requirements #11 are not subject to the font type, font size, and margin restrictions.
16	12/07/2016	Section H	15	240	Is the offeror able to include logos and/or images and/or mission, vision, value statements on the dividers which separate each section? If yes, is the font on these dividers subject to the same font type, font size and margin restrictions?	No, the dividers must be blank.
17	12/07/2016	IT Demo Calendar	n/a	1	The IT Demo documentation indicates both paper and electronic claims will be provided by AHCCCS. What received date should the Offeror use on the claims?	A single scenario will be provided in the form of either paper claims or electronic claims but not both. Dates of Receipt for all claims will be the date the Offeror receives the claim from AHCCCS.
18	12/07/2016	IT Demo Calendar	n/a	2	If the Offeror has the capability of producing 837 encounter files, would this be allowed?	No, AHCCCS cannot support processing of inbound 837 Encounter files as part of the IT Demo.
19	12/07/2016	IT Demo Calendar	n/a	1	The IT Demo documentation indicates both paper and electronic claims will be provided by AHCCCS. Will the electronic claims be delivered in a HIPAA compliant 837 format?	Yes, it is AHCCCS' intent to provide compliant claims.
20	12/07/2016	IT Demo Calendar	n/a	1	The IT Demo documentation indicates 834 and 820 files will be provided, will they be in a HIPAA compliant format?	Yes, it is AHCCCS' intent to provide 834 and 820 compliant files.
21	12/07/2016	IT Demo Calendar	n/a	1	The IT Demo documentation indicates both paper and electronic claims will be provided by AHCCCS. Will each claim be available in paper or electronic formats? Or will there be some claims in paper and some in electronic format?	A single scenario will be provided in the form of either paper claims or electronic claims but not both. The IT Demo Calendar is amended as follows: Data Provided FROM AHCCCS TO OFFEROR // Data and Reports Available Via SFTP Claims (Professional, Institutional and Dental) (Paper ~~and~~ or 837) and Layout for Expected Summary Response
22	12/07/2016	IT Demo Calendar	n/a	1	Will the 834 files include members with primary insurance? If yes, will all needed primary insurance information be included on the 834 in the appropriate segments?	Specifics as to the mock data will not be provided prior to the IT Demo. As noted above it is AHCCCS intent to provide compliant 834 files.
23	12/07/2016	IT Demo Calendar	n/a	1	If the 834 files include member primary insurance information, should the Offeror expect that the paper and electronic claims will include the primary insurance payment information to coordinate benefits?	Specifics as to the mock data will not be provided prior to the IT Demo. It is AHCCCS intent to provide all data necessary to complete mock scenarios.
24	12/07/2016	IT Demo Calendar	n/a	1	Will copay levels be included in the 834 files? If yes, will the expectation be that the Offeror will apply the appropriate copay to a claim?	Specifics as to the mock data will not be provided prior to the IT Demo. It is AHCCCS intent to require all data necessary to respond to mock scenarios.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 3 TO RFP YH18-0001

	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
25	12/07/2016	Section D	10	58	The ALTCS RFP indicates the following: Case Management: All case management services are provided by the Contractor. See Section D, Paragraph 16, Case Management." The RFP does not indicate that Case Management for Behavioral Health services (T1016 -HO/T1016-HN) is a billable and allowable service/code. In the Arizona Administrative Code Title 9, Chapter 21,which addresses the rights of individuals with Serious Mental Illness (SMI), specifically R9-21-101 indicates the individual service planning requirements for persons with Serious Mental Illness, including the reference to case management services and a case manager. Please confirm that ALTCS members with an SMI designation receiving behavioral health services may/ may not receive case management services which are billable to the health plan.	Case management services provided for ALTCS E/PD members, including members with an SMI designation, are administrative services and not services which are billable to the health plan.
26	12/07/2016	Solicitation Amendment # 2	Question and Responss # 7	5	AHCCCS has clarified the language in the RFP to state: "...a staff member is prohibited from occupying more than two positions, regardless of whether the staff member occupies...one position across two lines of business unless prior approval is obtained by AHCCCS, DHCM." Given that AHCCCS Acute Care and Medicare Advantage D-SNP are considered as two separate lines of business, would AHCCCS ALTCS E/PD be a third (or greater) line of business and result in the need to obtain prior approval from AHCCCS for all Prior Authorization Reps, Provider Relations Reps, Member Service Reps, Claims Examiners, etc. if the intention is that these staff members will work across all lines of business?	Yes, AHCCCS approval is required. A position for which it is reasonable that a staff member would assist a provider for example, across all lines of business, or members from all lines of business, would likely be granted an approval by AHCCCS. The Offeror's D-SNP is also considered a line of business.
27	Dec. 7, 2016	Section G, Representations and Certifications of Offeror and Section G, Disclosure Information	5 a., b., c., and f.	4	In Section G, Representations and Certifications of Offeror, there is a requirement for Social Security numbers and dates of birth. The RFP states, "Information regarding Social Security Numbers and Dates of Birth will be maintained in a secure location and will only be used for the purposes as required by 42 CFR Part 455." Given the rise of identity theft, we are concerned about disclosing sensitive information. Will providing the last four digits of the Social Security numbers suffice for this requirement?	Submission of the last four digits of the Social Security numbers will not suffice. Submission of the entire Social Security is required.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 3 TO RFP YH18-0001

	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
28	12/07/2016	Section D	6	38	The RFP states "Member may submit Contractor change requests to the Contractor or AHCCCS." Please confirm that the member must submit a request for a contract change (disenrollment for cause) first to the Contractor through the grievance process prior to submitting a request to AHCCCS, as documented on p. 35, Section 3, Enrollment and Disenrollment (4th paragraph).	Yes, disenrollment requests for cause as described in 42 CFR 438.56 must be submitted first to the Contractor through its grievance process which must comply with the provisions in this regulation. The RFP is amended as follows: In Geographic Service Areas where the member has a choice of Contractors, the member may submit a request to change Contractor, when outside of a member's Annual Enrollment Choice, ~~change Contractors~~ in accordance with ACOM Policy 403 for the following reasons: 1. Medical Continuity of Care Requests 2. Erroneous network information or agency error 3. Lack of initial enrollment choice 4. Lack of annual enrollment choice 5. Family continuity of care 6. Continuity of institutional or residential setting 7. Failure to correctly apply the 90-day reenrollment policy ~~Members may submit Contractor change requests to the Contractor or AHCCCS.~~ A denial of any Contractor change request shall include the Contractor's reason for not approving the change and options for resolution. The notice shall advise the member of the ~~AHCCCS and Contractor's~~ grievance policies and timeframes for filing a grievance. The notice shall also advise the member of his/her right to request a hearing, including how to request a hearing and the timeframe for making the request.
29	12/07/2016	Section H	7	230	The RFP states that four components will be evaluated and weighted in the order listed: Program, Capitation, Access to Care/Network, Administrative. Will each of the components be weighted evenly at 25% each? If not, please provide the weighting for each component.	AHCCCS is not providing the actual weighting of the four components.
30	12/07/2016	Section H	16	243	The RFP states "The lowest dollar bid within each GSA for dual and non-dual risk groups will receive the maximum allowable points." Please confirm that the lowest dollar bid is calculated based on the sum of the medical + case management + administrative components.	AHCCCS will not disclose any additional information related to scoring.
31	12/07/2016	Section H	16	243	Will the total bids (i.e., the sum of medical, case management, and administrative components) for duals and non-duals within a GSA be weighted prior to determining the lowest dollar bid? If yes, please provide further information on the weights.	AHCCCS will not disclose any additional information related to scoring.
32	12/07/2016	Section H	16	243	It is stated that the Pima County-only Contractor's capitation rates will be determined factoring in the medical and the case management components of the Contractor's South GSA bid adjusted by RFP "Section D, Paragraph 54, Capitation Adjustments specific to Pima Count-only." Please explain in greater detail how the Contractor's South GSA bid components will be adjusted to ensure that the rates for that Contractor are actuarially sound.	Adjustments will be driven by the differences in medical costs and HCBS mix between Pima County and the whole South GSA.
33	12/07/2016	Section H	16	243	It is stated that "after award, AHCCCS will adjust the medical and case management components of the Awarded capitation rates for Contractor-specific capitation factors and reserves the right to adjust awarded capitation rates for reasons including, but not limited to, the following:" changes in trend, population risk, updated encounter experience, and other actuarial assumptions. Please explain this process in greater detail. In particular, what process will AHCCCS use to ensure that these changes were not already reflected in a Contractor's bid?	The Offeror should not consider their specific population risk, acuity, or Contractor specific factors and trends outside the data provided by AHCCCS as the Offeror should bid capitation rates based on the data provided by AHCCCS. In the Instructions to Offerors it states that it is recommended that the Offerors bid rates utilizing the average pmpm costs provided in the Databook.
34	12/07/2016	Section H	16	244	Will AHCCCS provide membership projections by county, rate cell, and HCBS/institutional status for contract year 2018?	AHCCCS will not provide projections for CYE18.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO. 3 TO RFP YH18-0001						
	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
35	12/07/2016	Section H	16	243 - 244	How does AHCCCS intend to incorporate non-system claims expenses (e.g. claims settlements, manual payments, etc.) and other differences between MCO financial statements and encounter data into the development of the rate ranges for procurement and subsequent rate development?	Encounters are compared to financial statements for validation. Non-Encountered costs are not considered in the capitation rate development.
36	12/07/2016	Section H	16	245	The RFP limits the number of individuals in the Oral Presentation to 6 participants. The RFP states that "The Offeror shall submit with its Proposal a list of names and titles along with resumes of the participating individuals" for the Oral Presentation. Is the Offeror permitted to submit 1-2 alternate representatives and accompanying resumes in the event of unforeseen circumstances preventing any identified individual from participating?	AHCCCS is not accepting submittal of alternate representatives at the time of the Proposal Submission. Should an unforeseen circumstance arise the Offeror must contact the AHCCCS Chief Procurement Officer in order to request participation of an alternate representative.
37	12/07/2016	Data Book, Sect C	1	1	How are Acute Care Only members and their costs identified in the data book?	Acute Care Only members cannot be uniquely identified in the databook. They are considered part of the "Other" placement category, which also includes members who are not placed. The Capitation Rate Range and Rate Setting Information document which was released 12-19-16 explains this and also provides Acute Care Only member months.
38	12/07/2016	Data Book, Sect C	1	1	Please confirm that Prior Period Coverage (PPC) members are not reflected in the membership files. Please explain if/how costs attributable to PPC members is reflected.	Confirmed. The PPC members are not reflected in the membership files. The PPC cost and utilization are not reflected in the utilization and cost text files.
39	12/07/2016	Data Book, Sect C	2	4	Please explain what would be represented by the Placement type "Other."	"Other" includes both acute care only members and members who are not placed.
40	12/07/2016	Data Book, Sect G	Exhibits	2012 - 2015	The ALTCS Enrollment reports for 2012 - 2015 provide enrollment information for Native Americans who are not enrolled in managed care. Can you please provide the number of Native American enrollees by county for each year?	The ALTCS Enrollment reports for 2012-2015 included in section G of the Data Supplement exclude American Indians who are not enrolled in managed care from the ALTCS E/PD contractor totals. Information regarding American Indians enrolled in ALTCS FFS are included in the bottom of the report for information purposes only. The Offeror does not need the number of American Indian enrollees by county by each year thus data will not be provided.

AHCCCS
Arizona Health Care Cost Containment System

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

SOLICITATION AMENDMENT #4		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@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: James Stover	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 1/11/17	DATE: 01/06/2017

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
1	12/27/2016	Data Supplement - Section F - Capitation Rate Ranges and Rate Setting Information	N/A	Page 1	In the "Capitation Rate Ranges and Rate Setting Information" memo, AHCCCS indicates that the NF and HCBS components of the capitation rates are grouped by service category in accordance with Appendix 1, and are not grouped by member placement. Is the HCBS/NF Mix percentage applied to the capitation rates also based on service category and not member placement? If not, how has AHCCCS accounted for the underlying member placement mix included in the gross Nursing Facility and HCBS costs? Differences in placement mix can have a significant impact on the underlying "gross" Nursing Facility and HCBS costs.	The HCBS mix percentage is based on member placement. The encounters are grouped by service category.
2	12/27/2016	Data Supplement - Section F - Capitation Rate Ranges and Rate Setting Information	N/A	Page 3	Can AHCCCS provide the trends used in the rate development by service category and rate cell?	No, AHCCCS will not provide the trends used in rate development. The Offerors are free to develop trends from the three years of experience in the Data Book at any level of detail and using any reasonable method of calculation.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
3	12/27/2016	Data Supplement - Section F - Capitation Rate Ranges and Rate Setting Information	N/A	Page 2	In the "Capitation Rate Ranges and Rate Setting Information" memo, AHCCCS indicates that all three years of experience included in the data book were used to develop the trend assumptions. Were historical changes in member placement (HCBS/NF Mix) accounted for in the trend calculation? If so, how was it applied?	Yes, historical changes in member placement (HCBS/NF mix) were accounted for in the trend calculation; they are necessary to determine the proper denominator for the PMPM expense amounts by category of service. AHCCCS has added a table to Section F - Bid Submission Information to provide offerors with the historical mix percentages that were used in the trend development (as well as the capitation rate range development). See *HCBS Historical Mix Percentages.*
4	12/27/2016	Data Supplement - Section F - Capitation Rate Ranges and Rate Setting Information	N/A	Page 2	Were any adjustments applied to account for changes in the HCBS/NF placement mix between the base data period and the contract period? If so, can AHCCCS provide those adjustments and describe how they were applied?	Please refer to #3. Please note the HCBS mix percentage data already provided in Section F - Bid Submission Information is the combined July, August, September 2016 mix percentage to be used in the CYE 18 rate submission.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
5	12/27/2016	Data Supplement - Section F - Capitation Rate Ranges and Rate Setting Information	N/A	Page 2	In addition to the information provided in Section B of the Data Supplement, can AHCCCS provide the program and fee schedule changes by the Service Matrix categories listed in Appendix 1? Some changes do not correspond to Service Matrix categories. For example, there is a change listed that applies to "Drugs and Injectables," but no corresponding category split provided in the Service Matrix.	No, AHCCCS will not provide this information. The drugs/injectables subject to the Physician Fee Schedule account for 1.57% for CYE13, 1.45% for CYE14, and 1.46% for CYE15 of the total Acute Care expenses for ALTCS EPD.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
6	12/27/2016	H	16	243	How will the case management component of the rate be adjusted based the Contractor's actual mix of HCBS and nursing facility members as of 10/1/2017?	Case weights (the maximum allowable ratio of members to case managers) vary by placement. As such, whenever the mix percentage projections are revised or updated, the case management expense PMPM assumptions will be modified to reflect the change in demand for case management services. Capitation rates will be adjusted prior to 10/1/17 based on the anticipated member mix of awarded contractors. If mix percentages are not known at the time CYE 18 rates are due to CMS, AHCCCS will amend the CYE 18 capitation rates retroactive to 10/1/17, if updated placement forecasts are materially different than those submitted to CMS.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
7	12/27/2016	H	16	243	How will the administration component of the rate be adjusted based the Contractor's actual mix of HCBS and nursing facility members as of 10/1/2017?	AHCCCS does not adjust the administrative bid based on mix percentage.
8	12/27/2016	H	16	244	For which contract year will AHCCCS actuaries use each Contractor's actual experience (rather than their bids) to develop their renewal capitation rates?	The renewal capitation rates developed by AHCCCS will incorporate elements of bids and subsequent experience, all within the context of the requirements for actuarial soundness.
9	12/27/2016	H	16	244	Will the administrative component of the capitation rate be increased with revenue (i.e., as a percentage of premium) for each year of the contract?	No, the administrative component is not tied to the medical expense, therefore as revenue fluctuates the administrative PMPM will not fluctuate. That said, on occasion, AHCCCS will consider adjustments to the administrative component as appropriate.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
10	12/27/2016	Solicitation Amendment #3	Question 33		Per the response to Question 33, "The Offeror should not consider their specific population risk, acuity, or Contractor specific factors…", Please explain how a Contractor's bid will be adjusted based on their actual mix of members by county within a region?	As noted in #6 whenever the mix percentage projections are revised or updated, the capitation rates are updated to reflect those changes to both the medical and case management components. Capitation rates will be adjusted prior to 10/1/17 based on the anticipated member mix of awarded contractors. If mix percentages are not known at the time CYE 18 rates are due to CMS, AHCCCS will amend the CYE 18 capitation rates retroactive to 10/1/17, if updated placement forecasts are materially different than those submitted to CMS. AHCCCS anticipates reviewing member acuity by awarded Contractor to determine if rates remain actuarially sound. The same timing will apply as noted above.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
11	12/27/2016	Solicitation Amendment #3	Question 35		Per the response to Question 35, "Non-encountered costs are not considered in the capitation rate development", are costs that are not typically tied to specific encounters, such as provider incentive payments, reflected in the base data?	No. Only costs as reflected on adjudicated and approved encounters are included in the base data.
12	12/27/2016	Section F - Capitation Rate ranges and Rate Setting Information	Last paragraph	Page 1	Should the denominators described in this paragraph use *historical* HCBS mix percentages rather than the HCBS mix percentages provided in Section F (based on CYE 2016 actual mix for July, August, and September)?	Yes, see #3.
13	12/27/2016	Section F - Medical Component Ranges			Please list the factors that varied in development of the medical cost ranges (e.g., trend, base data)?	Development of the ranges considered variations including, but not limited to, trends, adjustments for program changes, weighting of each year of base data, and assumptions regarding provider reimbursement rates for NF, HCBS, and ALF services.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
14	12/27/2016	Capitation Rate Ranges	-	-	Please provide the trend assumptions that were used to trend forward the expenses from the base data period (CYE15) to the projection period (CYE18)? Please provide at the same level of detail that was incorporated into the capitation rate development and for the development of the rate ranges.	No, AHCCCS will not provide the trends used in rate development. The Offerors are free to develop trends from the three years of experience in the Data Book at any level of detail and using any reasonable method of calculation.
15	12/27/2016	Capitation Rate Ranges	-	-	No description for how the reinsurance offsets were developed was included in the rate development documentation. Please provide a detailed description of how the reinsurance offsets were developed for CYE18.	AHCCCS develops reinsurance offsets in capitation rate setting using historical reinsurance payments as a base, applying relevant trends and adjusting for items expected to have a material impact on the encounters subject to reinsurance (e.g. the move to DRG reimbursement). However, please note that the Acute Care component of the Offeror's bid should be the gross PMPM prior to any reinsurance consideration. It is therefore not necessary for an Offeror to develop a reinsurance projection for CYE 18 in order to develop a bid.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	RFP SECTION	PARAGRAPH No.	PAGE No.	OFFEROR'S QUESTION	AHCCCS RESPONSE
16	12/27/2016	Capitation Rate Ranges	-	-	In our review of the changes to the ALTCS program with this RFP, most inpatient hospital expenses previously covered under the ALTCS PPC program will be moving to the ALTCS EPD prospective program. However, we did not see this listed as one of the program changes that was accounted for in the development of the Acute Medical expenses for the ALTCS EPD prospective program. Please explain why it was not included or if it will be included at a later date. Please also explain and quantify how this change was incorporated into the projection of reinsurance offsets.	It is unclear from your question whether you are referring to the upcoming eligibility change effective 10/1/17 relative to enrollment activity during a member's inpatient hospitalization, or the historical change related to DRG (referenced on page 3 of the Program Changes and Fee Schedule Changes document in the Bidder's Library), or some other issue. With regards to future program changes such as the eligibility and enrollment process during a hospitalization, AHCCCS may adjust successful bid amounts to incorporate the program changes that will take effect at the beginning of the RFP contract period if material. Offerors do not need to account for future programmatic changes in their bids. AHCCCS did not provide projected reinsurance offsets, only historical.

ALTCS E/PD RFP YH18-0001 QUESTIONS AND RESPONSES AMENDMENT NO.4 TO RFP YH18-0001						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
17	12/27/2016	Capitation Rate Ranges	-	-	In our review of the changes to the ALTCS program with this RFP, the skilled nursing facility expenses will no longer be an included expense for reinsurance coverage. Please explain and quantify how this change was incorporated into the projection of reinsurance offsets.	AHCCCS did not provide projected reinsurance offsets, only historical. Additionally, SNF expenses were not previously included for reinsurance coverage, this is not a change.
18	12/27/2016	Capitation Rate Ranges	-	-	What increase in Hepatitis C virus drug utilization was assumed to account for the increase in coverage to stage F2 individuals in addition to covering stage F3 and F4 individuals?	AHCCCS assumed a 50% increase in Hep C Rx utilization associated with coverage for F2. AHCCCS will continually monitor utilization of Hep C Rx and adjust rates as appropriate and feasible.

SOLICITATION AMENDMENT #5		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

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

This Solicitation is amended as follows:

1. The attached IT Demo Calendar revisions 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:
TYPED NAME: James Stover	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 1/11/17	DATE: 01-11-2017

	Tuesday January 24th	Wednesday January 25th	Thursday January 26th	Friday January 27th	Monday January 30th	Tuesday January 31st	Wednesday February 1st	Thursday February 2nd	Friday February 3rd	Monday February 6th
Data Provided:* FROM AHCCCS TO OFFEROR: Available to Offerors *no later than 7:00 a.m. Arizona Time on day noted.										
Data and Reports Available Via SFTP										
834 - Enrollment File and Layout for Expected Summary Response	Initial Daily (Adds Only)		Second Daily (Adds, Changes and Terminations)		Third Daily (Adds, Changes and Terminations)		Last Daily (Adds, Changes and Terminations)	Monthly		
820 - Capitation File and Layout for Expected Summary Response		Initial							Monthly	
Eligibility Status Inquiry					Inquiry - 1				Inquiry - 2	
Claims (Professional, Institutional and Dental) (Paper and 837) and Layout for Expected Summary Response	Claims Scenarios - Group 1			Claims Scenarios - Group 2			Claims Scenarios - Group 3			
Encounters 837 ~~Template~~ (Professional, Insitutional and Dental) and Layout for Expected Summary Response			Encounters Submission 1				Encounters Submission 2			
Claims Status Inquiry						Status Inquiry -1			Status Inquiry -2	
Reference Data Extract	Initial Extract					Second Extract				
Provider Data Extract	Initial Extract					Second Extract				
Data Exchange/Blind Spots							Extract			
Encounter "Magic" File Extract							Extract			
Expected Data:* FROM OFFEROR TO AHCCCS: Must be Submitted to AHCCCS *no later than 5:30 p.m. Arizona Time on day noted.										
Data and Reports Submitted Via SFTP										
Summary of 834 - Enrollment File Processing		Summary of Initial Daily		Summary of Second Daily		Summary of Third Daily			Summary of Last Daily	Summary of Monthly Reconciliation
Summary of 820 - Capitation File Processing			Summary of Initial							Summary of Monthly
Eligibility Status Response						Response - 1				Response - 2
Summary of Claims Processing			Summary for Claims Scenarios Group 1			Summary for Claims Scenarios Group 2		Summary for Claims Scenarios Group 3		
~~837 Encounters - Completed Template~~					~~Initial 837 Encounter Submission~~				~~Second 837 Encounter Submission~~	
Summary of Encounter Processing					Initial 837 Encounter Submission				Second 837 Encounter Submission	
Claims Status Inquiry Response							Status Responses - 1			Status Response - 2
Summary of Reference Data Extract		Summary of Initial Extract						Summary of Second Extract		
Summary of Provider Data Extract		Summary of Initial Extract						Summary of Second Extract		
Summary of Data Exchange/Blind Spots								Summary of Extract		
Summary of "Magic" File Extract								Summary of Extract		

SOLICITATION AMENDMENT #6		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

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

This Solicitation is amended as follows:

Section D: Program Requirements, Paragraph 80 – Value- Based Purchasing

Value-Based Purchasing Initiative: The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 318 CYE 16 and CYE 17 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will be funded by assessing 1 percent of Prospective Gross Capitation (Quality Contribution) exclusive of Acute Care Only payments. One hundred percent (100%) of the Quality Contribution will be distributed to one or more Contractors according to the Contractors' performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors' ranking on QMPMs. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a Contract Year basis. It is the intent of AHCCCS to require that the Contractor move to the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 effective October 1, 2017. Additionally, AHCCCS intends to update ACOM Policy 318 CYE 16 and CYE 17 requirements regarding the percentage of payments that must be governed by VBP strategies. That language shall require that both the ALTCS E/PD Contract, and the MA-DSNP Contract for ALTCS E/PD Duals, each reach 35% and 50% of total payments governed by VBP strategies for CYE 18 and CYE 19 respectively. Inclusion of payments for Room and Board for members residing in Nursing Facilities (which are included in per diem payments and not separately identifiable) are permissible when computing the percentage of total payments that are governed by VBP strategies.

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: James Stover	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 1/17/17	DATE: 01-17-2017

EXHIBIT B: OFFEROR'S BID CHOICE FORM

ALTCS E/PD YH18-0001 BID CHOICE

Banner – University Family Care
_____ **is bidding on the ALTCS E/PD Program**
Offeror's Name **in the GSA(s) checked below:**

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

PERMISSABLE BIDS BY GSA		
N/A	Central Only	No
N/A	Central and South Only	No
☒	North Only	Yes
☒	South Only	Yes
☒	North and South Only	Yes
☒	Central and North Only[1]	Yes
☒	Central and North and South[2]	Yes

[1]In order to be considered for award in the Central GSA, the Offeror must submit a competitive bid in the North GSA as well. A submission for the Central GSA that does not include a proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a contract for both GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.

[2]AHCCCS does not intend to award contracts for all GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.

1/17/17

Authorized Signature — Date

James Stover — Chief Executive Officer

Print Name — Title

ALTCS/EPD RFP Bid Template

Enter Offeror's Name

Banner – University Family Care

Select GSA and Risk Group to Bid

North | Dual | Bid

ALTCS/EPD RFP Bid Template -

Enter rate component amounts determined by Offeror in yellow cells, other cells auto-populate.

Selected Risk Group: **Dual** Selected GSA: **North**

Service Categories:	**Gross**	**Mix**		**Net**
Nursing Facility	$5,274.30	31.00%	$	1,635.22
HCBS Home and Community	$1,171.10	69.00%	$	808.02
Acute Care Prior to Reinsurance				$131.13
Medical Component			$	2,574.37
Case Management				$129.67
Administration		6.50%		$175.76
Sub-Total of Scored Components			**$**	**2,879.80**

Key

user input
number provided by AHCCCS
formula

ALTCS/EPD RFP Bid Template

Enter Offeror's Name

Banner – University Family Care

Select GSA and Risk Group to Bid

North | Non-Dual | Bid

ALTCS/EPD RFP Bid Template -

Enter rate component amounts determined by Offeror in yellow cells, other cells auto-populate.

Selected Risk Group: **Non-Dual** Selected GSA: **North**

Service Categories:	**Gross**	**Mix**	**Net**
Nursing Facility	$5,836.43	24.39%	$ 1,423.68
HCBS Home and Community	$1,482.23	75.61%	$ 1,120.67
Acute Care Prior to Reinsurance			$2,619.53
Medical Component			$ 5,163.88
Case Management			$126.95
Administration		6.50%	$343.90
Sub-Total of Scored Components			**$ 5,634.73**

Key

user input
number provided by AHCCCS
formula

ALTCS/EPD RFP Bid Template

Enter Offeror's Name

Banner – University Family Care

Select GSA and Risk Group to Bid

South | Dual | Bid

ALTCS/EPD RFP Bid Template -

Enter rate component amounts determined by Offeror in yellow cells, other cells auto-populate.

Selected Risk Group: **Dual** Selected GSA: **South**

Service Categories:	Gross	Mix	Net
Nursing Facility	$5,549.61	28.00%	$ 1,553.68
HCBS Home and Community	$1,464.34	72.00%	$ 1,054.38
Acute Care Prior to Reinsurance			$174.03
Medical Component			$ 2,782.09
Case Management			$128.15
Administration		4.75%	$138.24
Sub-Total of Scored Components			**$ 3,048.48**

Key

user input

number provided by AHCCCS

formula

ALTCS/EPD RFP Bid Template

Enter Offeror's Name

Banner – University Family Care

Select GSA and Risk Group to Bid

South | Non-Dual | Bid

ALTCS/EPD RFP Bid Template -

Enter rate component amounts determined by Offeror in yellow cells, other cells auto-populate.

Selected Risk Group: **Non-Dual** Selected GSA: **South**

Service Categories:	Gross	Mix	Net
Nursing Facility	$7,100.45	25.50%	$ 1,810.29
HCBS Home and Community	$1,748.56	74.50%	$ 1,302.76
Acute Care Prior to Reinsurance			$2,515.25
Medical Component			$ 5,628.30
Case Management			$127.10
Administration		4.75%	$273.38
Sub-Total of Scored Components			**$ 6,028.78**

Key

user input
number provided by AHCCCS
formula

ALTCS/EPD RFP Bid Template

Enter Offeror's Name

Banner – University Family Care

Select GSA and Risk Group to Bid

Central | Dual | Bid

ALTCS/EPD RFP Bid Template -

Enter rate component amounts determined by Offeror in yellow cells, other cells auto-populate.

Selected Risk Group: **Dual** Selected GSA: **Central**

Service Categories:	Gross	Mix	Net
Nursing Facility	$5,910.20	23.75%	$ 1,403.61
HCBS Home and Community	$1,585.73	76.25%	$ 1,209.14
Acute Care Prior to Reinsurance			$234.71
Medical Component			$ 2,847.45
Case Management			$124.14
Administration		5.00%	$148.58
Sub-Total of Scored Components			**$ 3,120.17**

Key

user input

number provided by AHCCCS

formula

ALTCS/EPD RFP Bid Template

Enter Offeror's Name

Banner – University Family Care

Select GSA and Risk Group to Bid

Central	Non-Dual	Bid

ALTCS/EPD RFP Bid Template -

Enter rate component amounts determined by Offeror in yellow cells, other cells auto-populate.

Selected Risk Group: **Non-Dual** Selected GSA: **Central**

Service Categories:	**Gross**	**Mix**	**Net**
Nursing Facility	$7,698.01	24.14%	$ 1,858.17
HCBS Home and Community	$2,038.63	75.86%	$ 1,546.54
Acute Care Prior to Reinsurance			$2,823.16
Medical Component			$ 6,227.87
Case Management			$128.12
Administration		5.00%	$317.80
Sub-Total of Scored Components			**$ 6,673.79**

Key

user input
number provided by AHCCCS
formula

ALTCS/EPD RFP Bid Template -

Scored Rate Components by Risk Group and GSA

Dual	North	South	Central
Medical Component	$2,574.37	$2,782.09	$2,847.45
Case Management Component	$129.67	$128.15	$124.14
Administrative Component	$175.76	$138.24	$148.58
Sub-Total of Scored Components	$2,879.80	$3,048.48	$3,120.17

Non-Dual	North	South	Central
Medical Component	$5,163.88	$5,628.30	$6,227.87
Case Management Component	$126.95	$127.10	$128.12
Administrative Component	$343.90	$273.38	$317.80
Sub-Total of Scored Components	$5,634.73	$6,028.78	$6,673.79

1/16/17 16:51

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January 18, 2017

Actuarial Certification
The University of Arizona Health Plans
ALTCS Elderly & Physically Disabled Capitation Bids
October 1, 2017 – September 30, 2018

I, Thomas D. Snook, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by The University of Arizona Health Plans (UAHP) to provide a certification of the actuarial soundness, as defined below, of its proposed capitation rates for Elderly & Physically Disabled Services under the Arizona Long Term Care System (ALTCS).

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

The capitation rates to which this certification apply are shown in the table below. The rates apply to the period October 1, 2017 through September 30, 2018. These rates are inclusive of Case Management and Administration, are not inclusive of Risk/Contingency and Premium Tax, and are gross of Reinsurance and Share of Cost. The bids reflect the Home and Community Based Services (HCBS) mix values provided by AHCCCS.

The University of Arizona Health Plans
Proposed Capitation Rates

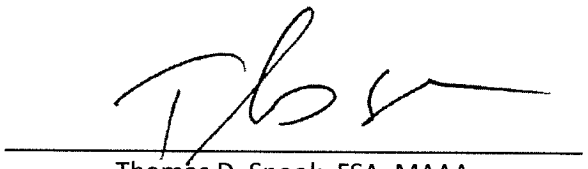
Region	Dual	Non-Dual
GSA South	$3,048.48	$6,028.78
GSA Central	$3,120.17	$6,673.79
GSA North	$2,879.80	$5,634.73

It is my opinion that the above rates are adequate to fund claims and administrative expenses for an average elderly & physically disabled population for the bid GSAs during the time period for which they are intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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



Thomas D. Snook, FSA, MAAA
Milliman, Inc.
5415 E. High Street, Suite 275
Phoenix, AZ 85054

January 18, 2017

OVERVIEW OF THE ORGANIZATION AND RELEVANT EXPERIENCE

As the only locally-owned health plan focused exclusively on Arizona, The University of Arizona Health Plans (UAHP) is a recognized Medicaid managed care leader. For more than 30 years, we have pursued system transformation through reinvention and rethinking. We share a passion with the Arizona Health Care Cost Containment System (AHCCCS) – to serve Arizona's most vulnerable citizens – in a manner that honors their unique needs and goals. As our current member satisfaction score of 95.7% attests, we help our members navigate the often impersonal and complicated world of health care with culturally competent approaches and a focus on providing VIP access to the highest quality health care solutions. UAHP's person-centered approach aligns to the Arizona Long Term Care Services (ALTCS) program and its values and guiding principles. Our long-term care plan, Banner –University Family Care (B-UFC) will benefit from our experience, creativity, adaptability and agility needed to exceed member, provider and regulator expectations.

UAHP began as a Medicaid Acute Care Contractor in 1985 and built successful operations in the Medicare, commercial, and integrated behavioral health arenas. Our membership has grown an average of 15% on a yearly basis and, today we serve members in rural and urban settings in Southern, Central and Northern Arizona. UAHP owns and operates University Family Care (UFC), our Acute Care Plan serving more than 138,000 members. In 2008, UAHP integrated all required processes from the Centers for Medicare and Medicaid Services (CMS) into our acute care operations and launched University Care Advantage (UCA), our Dual Eligible Special Needs Plan (D-SNP) serving more than 6,000 dual eligible members. In 2014, UAHP entered into an innovative partnership with Cenpatico of Arizona to form Cenpatico Integrated Care (CI), serving more than 13,000 members with serious mentally illness (SMI). UAHP operated Maricopa Health Plan (MHP) for almost 11 years, serving more than 85,000 MHP and 1,900 Maricopa Care Advantage (MCA) members. UAHP is a subsidiary of Arizona-based Banner Health (Banner), one of the largest non-profit health systems in the country, giving us access to a robust integrated network, institutional knowledge, hiring power and expertise to rapidly implement new programs.

HIGH-LEVEL DESCRIPTION OF PROPOSED APPROACH TO MEETING CONTRACT REQUIREMENTS

UAHP will leverage our experience as both a Medicaid and Medicare managed care plan with AHCCCS to meet ALTCS E/PD contract requirements. During pre-procurement preparation, UAHP developed many processes and policies to meet operational requirements, just as we have done for the General Mental Health/Substance Abuse (GMH/SA) dual integration, Value-Based Purchasing (VBP), the Veteran's System, and Justice System programs. UAHP contracted with an array of ALTCS experts and tapped into community experts to conduct a full evaluation of current systems and processes. As a result, we understand the ALTCS requirements, such as the need to employ a seasoned ALTCS Program Administrator and a comprehensive Case Management Team. UAHP anticipates adding up to 310 ALTCS-unique employees, including up to 230 new case managers (CMs). To nimbly scale up, UAHP developed a detailed implementation plan and is actively implementing all required elements. This includes proactive development of an ALTCS Case Management model that meets all requirements in the AHCCCS Medical Policy Manual (AMPM) including a program evaluation process to continue to meet requirements after implementation. Our case management plan follows all ALTCS E/PD caseload standards. In geographic locations that can support a specialized caseload model, UAHP will employ expert CMs to manage areas such as pediatric, Assisted Living Facility (ALF), Skilled Nursing Facility (SNF) or Home and Community-Based Services (HCBS). CMs live in the communities where they serve members and are supported by licensed experts on their Case Management Teams.

UAHP's current bundle of IT applications and robust infrastructure will successfully support ALTCS members' care. Our applications are agile, and we can apply changes quickly, offering minimal downtime to end-users. UAHP's clinical platform is integrated and supports all case, disease, utilization, quality of care and referral management processes. CMs can directly enter care plans into our systems via a laptop or tablet in the field, allowing them more time to spend directly serving members. Our highly integrated applications allow data to interface between applications and with our Enterprise Data Warehouse. For VBP, UAHP will utilize our population health platform to create clinically actionable disease registries and provider scorecards. These allow users to identify care opportunities, gaps in care, and to view key quality metrics at the population, practice, provider and member level. UAHP will also use member engagement/telehealth solutions to provide high-touch, high-tech in-home virtual care delivery via a tablet. Members will be able to interact directly with their health team to address concerns while improving quality of life and reducing

cost of care. Additionally, UAHP has been an active participant of the Arizona Health Information Exchange (HIE) since its inception. UAHP utilizes this information to support care coordination by accessing patient summaries and being notified when high-risk members are admitted to an emergency department or inpatient facility.

UAHP collaborates with all AHCCCS RBHAs to provide a seamless transition for ALTCS-eligible members moving from a RBHA to B-UFC. As a result of our UAHP/CI relationship, we have the expertise to address added care and support services that persons with SMI require, including access to Permanent Supportive Housing and Supported Employment. To support those efforts, UAHP CMs have cross-specialty training and access to expert behavioral health/substance abuse consultation, including guidance on State-only and Medicaid reimbursable services.

UAHP has a robust provider network throughout Arizona, with more than 90% of our 13,167 providers contracted for UFC, B-UFC and UCA. Our current network will serve B-UFC ALTCS members as we aggressively expand our network to include ALTCS-unique providers. With more than 450 additional formal Letters of Interest from ALTCS-unique providers already in place, we have reached and/or exceeded network expansion goals for most mandated ALTCS categories. We will conduct more than the minimum required provider education forums to build face-to-face relationships and thoroughly orient new ALTCS providers to UAHP policies and processes. Once oriented, we will continue to employ our high-touch provider relations approach and address any questions or concerns in a timely manner.

HOW UAHP WILL BRING ADDED VALUE TO THE ALTCS PROGRAM

UAHP will incorporate innovative long-term care initiatives along with demonstrated successes from our acute care and D-SNP plans. These efforts will reduce fragmentation, integrate delivery systems and promote future sustainability. We will deploy Banner programs – such as the Banner Alzheimer's Institute, Banner Health Network's Accountable Care Organization (ACO), Telehealth and Telepsychiatry services, and the Banner home-based palliative care program – to support our ALTCS members.

UAHP's ALTCS case management model has several value-adds including our CM staffing model that assigns one Qualified Behavioral Health Professional (QBHP) to every two case management teams. The QBHP will provide the CMs with ongoing training, consults and support while carrying out their required duties. The use of licensed staff with behavioral and physical health expertise on these Teams to support all CMs combined with our Telehealth solutions are critical value-adds for unlicensed CMs in rural Arizona to address disparities by providing their members with the best care. We are adding Training Manager and Trainer positions that exceed ALTCS requirements to orient and train all employees on any ALTCS program changes. As described in our responses, UAHP's CM model exceeds AHCCCS standards by using a unique Priority System to determine when the timing of the initial visit should be less than the AHCCCS standard of 12 business days, delivering each member the right care at the right time.

Our long-standing affiliation with the University of Arizona (UA) will also result in multiple value-adds. UAHP will partner with the UA Center of Aging to establish a Dementia Care Program focused on training CMs and provider's staff statewide on detecting early signs of dementia to provide support and education to families. UAHP will mandate that all CMs become dementia-capable. We will continue to partner with the UA Center for Population Science and Discovery and expand our population health focus to include ALTCS. This includes our co-developed analytic tools to optimize care delivery, utilizing the newest machine learning techniques for improved targeting of interventions and accurate measurements of program impact. In addition, we will partner with providers throughout Arizona to replicate key components of our Healthy Together Care Partnership (HTCP) model, which we developed in concert with the UA Geriatrics Program to serve high-risk members with complex needs in their homes.

UAHP has developed strong relationships with numerous community organizations and agencies throughout the state that support the ALTCS population with advocacy and non-medically necessary services. These include but are not limited to the eight Arizona Area Agencies on Aging, Arizona Center for Disability Law, Arizona Health Care Association, Arizona Alzheimer's Association-Desert Southwest Chapter, five Arizona Centers for Independent Living (CIL), Arizona Brain Injury Alliance and the Foundation for Senior Living. We understand the importance of forging community partnerships to facilitate and provide an array of resources and services for our members that will support AHCCCS'

implementation of *Arizona's Systemic Assessment and Transition Plan*, critical to members having full access to the benefits of community living. These connections allow us to care for the whole person, improve quality of life, provide sustainable health outcomes and reduce health care costs.

As a value-add, we will provide focused support, education and technological tools to formal and informal caregivers due to their critical role. Our ALTCS CMs will be trained to notice signs of stress and burn-out, encourage use of respite and attend caregiver support groups. UAHP will develop programs to support Attendant Care and in-home HCBS providers, as these are critical team members who provide our members hands-on care. These programs will support agencies in training paraprofessionals, supplementing required training Direct Care Workers have completed. This helps UAHP to better serve members in their homes. UAHP will collaborate with Arizona coalitions dedicated to helping caregivers dealing with issues of declining health and emotional decisions at the end of life. Where not available, UAHP will develop End of Life (EOL) care programs to educate families and providers on how to receive, direct and provide EOL care that helps family members understand planning and decisions while educating them about needed documents. An additional value-add focuses on integrating Medicare and Medicaid benefits. In anticipation of serving ALTCS members, we added supplemental benefits in our 2017 D-SNP benefit package, including meals after hospitalization that are more specific to the post-hospital nutritional needs as an interim to the ALTCS covered meal program.

HOW UAHP WILL MEET MEDICARE REQUIREMENTS SPECIFIED IN RFP SECTION I., EXHIBIT E

UAHP has an integrated Medicaid/Medicare infrastructure and the expertise to meet all requirements. UCA contracts with CMS to operate a Medicare Advantage Part D Plan (MAPD), D-SNP. As required by A.R.S. §36-2906.01, B-UFC is established as a separate corporation, and the only authorized business of UFC is to provide services under this contract to AHCCCS-eligible persons enrolled to B-UFC. UCA is dedicated to serving D-SNP members, has timely submitted its notice of intent to apply for a service area expansion for contract year 2018 and is AHCCCS-certified as a risk-bearing entity. UCA's application will be submitted to CMS by February 15, 2017 to include a D-SNP subset matching any ALTCS contract award. UCA will provide D-SNP benefits in all awarded counties, including those UAHP has the legal and actual authority to direct, manage and control both B-UFC and UCA, and we will provide integrated Medicaid/Medicare services to our members. UCA branding strategies promote the UCA and B-UFC relationship, targeting B-UFC dual eligible members to educate them on aligned care coordination benefits. B-UFC will employ these strategies for ALTCS members. UCA is committed to comply with these AHCCCS and CMS requirements outlined in this exhibit:

- ACOM policy 318 – UCA has VBP arrangements in place and will continue to implement VBP contracts.
- UCA's policies align with AHCCCS policies designed to improve dual eligible care coordination and timely information sharing, including a D-SNP care coordinator, and UCA will establish a contact at each ALTCS E/PD Health Plan.
- Maintain in-depth Medicaid knowledge through ongoing review of laws, rules, policies, contracts and guidance.
- UCA and B-UFC provider contracts contain provisions that prohibit Medicare cost-sharing on UCA members for services covered by both programs. Our contracts ensure providers comply with AHCCCS requirements, including not balance billing QMB members and accepting Contractor payment as payment in full, or to bill the appropriate Contractor for payment. More than 90% of B-UFC providers are contracted with B-UCA, and we intend to maintain this as we continue to recruit ALTCS-unique providers.
- To accurately verify Medicare and Medicaid eligibility of potential and enrolled members via access to AHCCCS and Medicare systems and portals as well as from data transmitted through AHCCCS daily files. B-UHP will submit Medicare encounter data as AHCCCS requests and has processes in place to support this.
- To actively participate in all meetings and other activities, which pertain to member transitions due to D-SNP contract terminations. B-UHP will notify AHCCCS in case of significant changes to the contract with CMS for non-renewals, service area changes, terminations, deficiencies, notices of intent to deny and novation agreements. B-UHP will submit CMS warning letters or corrective action plans within 10 business days of receipt. B-UHP will actively participate in new AHCCCS requirements that improve dual eligible alignment.

B-UHP has the requisite infrastructure and in-depth local expertise to serve ALTCS members. Together with UA and Banner, we are redefining the health care model in order to drive revolutionary solutions. Through the consistent application of our member and provider-centric philosophy, we will enhance our members' health care experience, resulting in improved member engagement and sustained health outcomes.

Moral or Religious Objections

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

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

1. AN 85-YEAR-OLD AMERICAN INDIAN MEMBER CURRENTLY ENROLLED WITH THE OFFEROR, WITH MEDICARE…

University of Arizona Health Plans (UAHP), which owns our acute care plan University Family Care (UFC), our long-term care plan Banner – University Family Care (B-UFC) and our Dual Eligible Special Needs Plan (D-SNP) University Care Advantage (UCA), has continually demonstrated its ability to minimize fragmentation of care for Arizona's diverse populations through culturally appropriate delivery of care coordination. Our member-centric and culturally sensitive approach has resulted in UFC being one of the two highest rated health plans on AHCCCS' CAHPS® survey. We received a 5-Star rating for customer service on the same survey, and more than 97% of members reported their doctor respected their beliefs, culture and customs when discussing their health care. Our multicultural workforce reflects Arizona's population and our American Indian employees led the development of our Cultural Competency plan, which includes recurring training on I.H.S., Tribal Health and Urban Indian Health Program (I/T/U) coordination of care. Ms. Silvia Parra, our Chief Operations Officer, is a member of the Tohono O'Odham Tribe and an expert on tribal health care, teaching a course on American Indian Health Policy at the University of Arizona (UA) College of Public Health.

All UAHP Case Managers (CMs) and member-facing staff receive training in cultural competency, American Indian health care, Medicare and Medicaid alignment, general mental health, serious mental illness (SMI) and dementia. Trainings include coordination of benefits and how to eliminate barriers to care for these vulnerable populations.

PROACTIVE CARE COORDINATION PRIOR TO ENROLLMENT WITH UAHP

As we manage Frances' care, this recently re-enrolled B-UFC member, we will build on our extensive experience, efficient operations and long-standing community partnerships, while leveraging our local orientation to respond to Frances' strengths and needs. We embrace the ALTCS program values and give Frances choice, dignity, independence, individuality, privacy and self-determination with respect to her traditional way of life. This approach decreases the care fragmentation Frances has experienced and helps her achieve the best health outcome. Prior to the Parker relocation, Frances notified her Tribal ALTCS CM of her move and, in turn, the Tribal ALTCS Contractor on the Hopi Reservation sent a Program Contractor Change Form (PCCR 1620-8) to B-UFC in order to agree upon an effective transfer date. B-UFC's Transition Coordinator received the PCCR and an effective transfer date was agreed upon, offering a seamless continuation of services for Frances (ACOM policy 402; AMPM 1620-M). The Tribal ALTCS Contractor is required to send other documentation, including the ALTCS Enrollment Transition Information (ETI Form 1620-9). Upon receipt of provided documentation, the CM Supervisor reviewed the information, assigned the case to Ana due to her extensive experience as a CM working with American Indians and determined Frances to be a Priority 2, which requires an initial home visit within seven rather than 12 days.

Along with clinical judgment, each CM Supervisor uses B-UFC's CM Priority System to determine the CMs initial visit timing and whether it should exceed the AHCCCS 12 business day standard. Priority 1 is for immediate or urgent need for services and CM must make an appointment immediately or within one business day. Priority 2 is for routine Home and Community-Based Service (HCBS) members living in their own/family home and an assessment visit must occur within seven business days of enrollment. Priority 3 is for members currently residing in Assisted Living Facility (ALF) or Skilled Nursing Facility (SNF) and CMs follow the AHCCCS 12 business day standard.

Ana reviewed the ETI information and other supplied documents that included last CM assessment, list of medications, contingency plan for critical services, inpatient days utilized, CM summary, respite hours utilized and outpatient adult physical therapy visits during the current contract year. Ana followed up with the Tribal ALTCS CM after realizing expected documentation regarding Advance Directives (AD), Power of Attorney (POA) and the use of Community Transition Service were not received. The Tribal CM reported Frances last used Community Transition Service funds more than five years ago when being institutionalized following her stroke (AMPM policy 1240-C). The tribal CM agreed to send specific information with dates when records arrive from their storage facility. Ana learned Frances had not designated a POA nor returned the AD forms given to her on two occasions; she will address this during the initial visit.

In addition to the information from Tribal ALTCS CM, Ana accessed Frances' prior information retained from her past enrollment with B-UFC. Ana generated a customized Member-at-a-Glance (MAAG) report with claims, utilization, pharmacy data and previously supplied AHCCCS Blind Spot data. Once Frances became a B-UFC member, Ana also accessed Frances' patient summary in Arizona Health-e Connection-Health Information Exchange (HIE) web portal to obtain a more comprehensive history of Frances' fragmented care. The HIE offers recent health care utilization history,

including medical conditions, labs, procedures, encounters and medications. During this review of Frances' information, Ana identified the need to alleviate Frances' fragmentation of care and provide her with services reflecting her cultural viewpoint. Due to Frances' Priority 2 status, within two business days of the effective enrollment date, a Case Aide made an initial outreach call to Frances. The Case Aide welcomed Frances to B-UFC and provided the name of her CM, Ana. The Case Aide also identified any immediate needs, clarified Frances' preferred language and scheduled an initial home visit within seven days of enrollment. Frances returned to Parker to be closer to her son and his family. She requested he be invited to the visit and gave B-UFC permission to contact him. At Ana's recommendation, Frances also agreed to invite the Community Health Representative (CHR) from the Community Health Services of the Colorado River Service Unit of the I.H.S in Parker. The CHR is a well-trained, medically guided tribal or native community-based health care provider offering health services to American Indian communities. The worker assigned to Frances knows her from her prior stays in Parker.

B-UFC will exceed AHCCCS' requirements by employing a Tribal Liaison. The liaison will provide internal expertise regarding tribal health, training on Cultural Competency and I/T/U coordination of benefits along with being the primary contact with all I/T/U agencies, AHCCCS and other community stakeholders.

INITIAL VISIT AND INITIAL ASSESSMENT

The goal of Ana's initial home visit is to identify Frances' strengths, needs and outstanding problems while implementing solutions, such as the development of a care plan and member goals. With a person-centered approach, Ana utilizes her training, experience, cultural competence and knowledge to recognize and respond to Frances and her son's preferences, interests, needs, language, culture and belief system. This person-centered approach places Frances at the center of all support and service planning decisions. Ana and Jasper identify other natural supports able to assist Frances with life domain activities, such as community events, social activities and activities of daily living. In addition, each B-UFC CM has access to licensed behavioral and physical health professionals on their Case Management Team to support the receipt of evidence-based care and best practices. Ana meets with Frances, her son Jasper and the CHR at Frances' home, bringing along a full-page magnifier for Frances' use. They discuss Frances' experience leaving the Hopi Reservation and the likely difficulty of such a big change. Ana explains her role as the ALTCS CM, which includes conducting a needs assessment, service planning and coordination; brokering services to maximize the effectiveness of the service plan; facilitating and advocating on Frances' behalf for covered and non-covered community-based services; conducting ongoing monitoring and reassessment of Frances' needs; revising the service plan as needed; determining the cost effectiveness of ALTCS services to meet Frances' needs; and identifying and coordinating benefits, such as Medicare, I.H.S. direct services, Purchased Referred Care and Tribal 638 services. Ana explains enrollment in B-UFC does not preclude Frances from receiving services at I/T/U facilities. Ana will be Frances' primary point of contact and will coordinate all aspects of her care, along with her PCP, specialists, ALTCS providers, family members and tribal/community organizations. This centralized approach makes it easier for Frances to navigate the system and build trust. Ana mentions how to contact her, leaving a refrigerator magnet with her name and phone number as well as her business card. Although both Frances and Jasper demonstrate fluency in English, Ana explains she can arrange for an interpreter if Frances prefers to express herself in her native tongue.

Ana confirms Frances' receipt of her member I.D. card (which will arrive within 12 days of enrollment) and reviews the new Member Kit. The kit includes a Member Handbook, provider directory including zip code specific urgent care listing, information on HIPAA, Member Rights and Responsibilities Acknowledgement, Critical Service Gap Report Form, self-directed Attendant Care (AC) pamphlet and an AD form along with a 5 Wishes pamphlet. Ana also reviews specific sections from the Member Handbook, such as the entire spectrum of Long-Term Care (LTC) services, Behavioral Health (BH) crisis line, non-cost translation and transportation services and instructions on how to file a grievance or appeal along with confirming that Frances does not require special assistance. In addition, Ana provides Frances with an informational brochure developed for B-UFC American Indian members describing coordination of benefits and care among the multiple systems available to American Indians. Frances is asked to sign an acknowledgement form indicating she received, reviewed and understands all the member packet information described above. Ana points out the brochure for our D-SNP, UCA, in the Member Kit that describes receiving integrated Medicaid and Medicare services and how to obtain more information. Ana confirms Frances' previous PCP (as identified on the MAAG Report) is still practicing in Parker and available in the B-UFC network, which pleases Frances. Ana also explains how to change PCPs,

should Frances so choose, mentioning B-UFC has more than 40 contracted PCPs in the area. Frances and Jasper are also informed of Frances' access to selected B-UFC innovative programs as appropriate, such as home-based primary care and home-based telemedicine visits due to her agoraphobia; and Short Term Assistance Team (STAT) for extra support during times of acute intense need as occurs during care transitions, which might occur if she has cataract surgery.

UAHP has used the *9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems* to evolve our whole-person approach to care. The principles are foundational to our success with not only Behavioral Health care, but also for addressing health-related behaviors associated with chronic conditions along with debilitating physical health conditions.

Ana conducts a detailed Strengths and Needs Assessment (SANA) of Frances' current medical conditions, Activities of Daily Living (ADLs) functional levels and psychosocial needs. She assesses her home availability of water, electricity, heat, cooling and functioning essential appliances along with Frances' safety and need for any Durable Medical Equipment (DME) to prevent falls and promote the highest level of independence possible. Ana's approach, guided by the *Arizona Adult Service Delivery System's 9 Guiding Principles*, helps her to patiently and actively listen while making sure all parties present are playing a meaningful role in planning and directing Frances' care plan and service needs. In addition to talking with Frances and Jasper and observing Frances' movements and behaviors, Ana uses additional targeted assessment tools and completes the Uniform Assessment Tool (UAT). Ana asks Frances and Jasper about their main concerns. Frances is clear about wanting to receive services in her own home in Parker. She and Jasper state their main concerns are making sure Frances is eating well and being supported with light housekeeping and personal care tasks in her home. It appears Frances will need AC so the CM completes the HCBS Needs Tool (HNT Exhibit 1620-17) to determine the number of hours to authorize so Frances can remain safe and independent at home. Ana also assesses Frances' current comfort with leaving her home due to her history of panic attacks associated with agoraphobia. When her son accompanies her, Frances notes she is willing to seek care outside of her house, if necessary, but prefers the delivery of care within her home when possible. Ana reassures Frances she will not experience interruptions in her BH care. Ana also addresses other health information she reviewed in the documents sent by the Tribal CM, including the most recent assessment and services Frances received on the Hopi Reservation. These include the vision problems caused by cataracts, her medications, her memory problems and the BH diagnoses of depression and panic disorder with agoraphobia. Due to Frances' confusion and her son's lack of knowledge regarding her medications, Ana reviews all medications with them. The prescription bottles are examined for expiration dates and prescriber information, and all are compared with Frances' ETI form and Tribal Service Plan to clarify immediate questions for the family. Frances is becoming tired, so Ana ends the visit by informing them about the options of member-directed care, including Agency with Choice and her availability to discuss at a later date should they have interest in exploring those options further.

The Banner Alzheimer's Institute or the UA Center on Aging, dependent on the CM's physical location, trains all B-UFC CMs as dementia-capable. This training leads to early detection, understanding of behavioral and psychiatric symptoms, communication tips, use of non-pharmacologic interventions, adaption of the physical environment and End of Life (EOL) planning along with timely referrals to optimize short- and long-term outcomes.

PROPOSED CARE PLAN AND DESIRED OUTCOMES

Once all pertinent information is gathered, Ana initiates care planning using a person-centered approach to focus on Frances' strengths, needs, preferences, cultural beliefs and the goals defined by Frances and Jasper. Keeping in mind Frances' existing formal and informal support system of both natural and community supports, Ana develops a service plan to address each of her conditions along with her behavioral health, social and environmental needs. The Service Plan will incorporate not only ALTCS-provided services, but also community and tribal programs available in Parker. Ana helps Frances identify meaningful and measureable goals for herself. Goals are built on her strengths and include steps she will take to achieve them. Ana and Frances clearly outline meaningful and measurable goals along with expectations about what will be achieved through the service delivery and care coordination processes.

Issue 1: History of CVA, TIAs, memory concerns and preventive health needs. **Plan**: Jasper will make a PCP appointment for Frances as soon as possible, understanding many of Frances' services will require the PCP's order to initiate. In addition to addressing her medical problems and preventive care, the PCP will perform an assessment of her nutritional

status and dentition. Ana will use her dementia-capable training to educate the family. Ana will make sure Jasper is available for the appointment to accompany Frances out of the house, as she has requested. **Goal**: Maximize Frances' health and memory by re-engaging with her health care team in Parker to receive coordinated care so she will continue to live independently in her own home, her least restrictive environment.

Issue 2: Limited vision due to cataracts. **Plan:** The CM coordinates with Frances' PCP to have Frances seen by an ophthalmologist within 30 days. The CM coordinates all follow-up treatment, including arranging for cataract surgery if necessary. Ana will arrange appointments so Jasper can accompany Frances out of the house, as she has requested. If surgery occurs, Ana will arrange for a STAT team to provide additional support during the transition. **Goal:** Frances' vision will be at its maximum level and she will be able to read normal or large size text in books and on pill bottles.

Issue 3: Inability to prepare meals independently, difficulty standing for long periods and at risk for inadequate nutrition. **Plan:** Frances chooses to receive AC to prepare meals for her from *Home Instead* in Yuma as they hire American Indians from the Lake Havasu area who are familiar with traditional food preparation. Ana works with the provider to begin services within 14 days. Frances plans to eat with her son and family on most weekends. The CHR and Ana review social services available through the Bureau of Indian Affairs in Parker to address Frances' interim needs until ALTCS services are initiated, such as State Title VI Elderly Programs that include home delivered meals, socialization programs via the Senior Services Programs and congregate meal programs at the Elderly Center. **Goal:** Frances will maintain adequate nutrition as evidenced by maintaining a stable weight.

Issue 4: Unable to perform some tasks of daily living, such as housecleaning, laundry, shopping and bathing. **Plan:** ALTCS or the local Tribal Family Assistance and Senior Services Program offer a choice of services. Frances prefers one person in her home; therefore, additional AC hours from *Home Instead* are authorized to provide the needed personal care and Instrumental ADL (IADL) assistance. Future consideration for services from the General Assistance programs for the elderly will be given as the CHR introduces her to individuals involved in these programs. **Goal:** Maintain her personal hygiene and maintain a sanitary home as evidenced by clean living quarters, clean clothes and reports that Frances is regularly bathing with the help of her Attendant Care Worker (ACW).

Issue 5: Frances is at risk of falling due to unsteady gait and occasional loss of balance. She has a walker but has no assistive equipment in her bathroom. **Plan**: A comprehensive fall risk assessment by the local contracted home health agency is completed in conjunction with arranging for a raised toilet seat, shower chair, grab bars for the bathroom and provision of an Emergency Alert System. The option of receiving a cell phone from the Lifeline Assistance program is discussed, but Frances prefers having a landline that her son will provide. **Goal:** Frances will be able to remain safely in her own home, with no falls occurring in the next 90 days.

> Banner Health (Banner) and UA are leaders in the use of telehealth and telemedicine to improve monitoring and access to care for susceptible members. UAHP, in conjunction with its organizational partners – Banner and UA – will offer telemedicine, including telepsychiatry, visits when appropriate via tablets provided to care attendants from the CM in order to improve access to care for homebound and rural members.

Issue 6: Frances is experiencing symptoms of depression and gets extremely anxious when she leaves her house, resulting in social isolation. Her son reports she is sometimes confused and forgetful. **Plan:** Ana confirms with Frances and Jasper the names and types of BH and traditional healing providers she saw in the past along with her response to treatment. Transfer of services to Parker providers is expedited to provide Frances with uninterrupted BH care in order to maintain relief from her symptoms. Ana and B-UFC's Qualified BH Professional (QBHP), who is on Ana's Case Management Team, hold an initial consult and ongoing quarterly consults are scheduled. The consult confirms BH services are medically necessary and a BH professional will evaluate Frances within 30 days to make sure she is responding to the current BH and healing services. Pending outcome of the psychiatric assessment, referrals will be made for an additional assessment of her cognition by a neuropsychologist and counseling for ongoing therapy to include arranging for SMI Eligibility Determination, if appropriate. Through the use of the BH Coordination Form, Ana communicates with the PCP and BH providers involved in Frances' care making sure all care is integrated with other agencies and involved parties. Due to Frances' agoraphobia, Ana offers the option of having some specialty visits done in her home through telemedicine. The medication regimen for her mental health problems is reviewed, and Ana will document any psychotropic medication being taken in accordance with BH Standard AMPM 1620-G, noting any specific medication side effects. Ana informs Frances of ALTCS covered traditional healing services available in Parker or nearby communities. If Frances is amenable, the CM will facilitate a Peer Support Specialist to visit Frances at home in order to build trust and understanding with someone who has "lived experience." **Goal:** Frances will report decreased symptoms

of depression and anxiety about leaving her home. She will attend at least one tribal social event within the next 90 days.

Issue 7: Frances is not taking her medications as prescribed, which could be a factor in her confusion. **Plan**: Ana lists all medications Frances has shown to her. She compares this list with the list of current medications recorded in the ETI and other information received from the Tribal CM, while confirming all outdated medications are properly disposed. Ana then reviews the medications with the B-UFC pharmacist and follows up as indicated with health care providers who prescribed medications along with establishing a monitoring system to gauge how Frances is doing with her medications. This includes arranging for a CHR to set up her medications and monitor her weekly; informing Jasper about appropriate medications; giving him a list of medications with dosage regimen, indications and side effects; and setting up a monitoring system. Ana offers Frances the option of receiving a 90-day supply of her medications through mail order so she will not need to leave the house to obtain her medications. Ana will explain Frances' pharmacy drug benefits through Medicare, ALTCS and I/T/U. **Goal**: Frances will adhere to the most effective and simplest medication regimen.

After Frances, Jasper and Ana discuss all of her needs, the goals and the plan to address these needs, a formal service plan (using ALTCS Exhibit 1620-13) is created, which reflects all services to be authorized, the providers, the number of hours or units for each service and an indication of Frances' and her son's agreement or disagreement with the service. All non-ALTCS covered services and their funding sources are listed. The service plan developed for Frances indicates she needs 15 hours of AC assistance per week. Since this is Critical Service, Ana explains the need for a Contingency Plan (Exhibit 1620-14) outlining what Frances wants to do if the ACW does not arrive or is late. She helps Frances complete a Contingency Plan, which includes the Member Service Preference Level for addressing gaps in service as well as the back-up plan and service provision timeline. Ana reminds Frances and Jasper that informal support is not considered the primary source of assistance when a gap occurs, unless it is Frances' choice. Ana gives Frances the Critical Service Gap Report Form in case she wants to notify AHCCCS by mail and Important Member Rights Notice. Ana will notify the provider of the Contingency Plan and Preference Level once the provider has been identified and authorized. After answering all questions, obtaining needed signatures and providing copies to Frances, Ana completes the visit and mentions she will call after services have started to gauge Frances' satisfaction. B-UFC honors choice and self-direction. If Frances is dissatisfied with Ana and we are unable to correct her concerns, Frances can choose a different CM.

CASE MANAGEMENT FOLLOW-UP AND ADMINISTRATIVE TASKS

After the visit, Ana enters all the required information into the B-UFC Acuity Care Management System and updates it in the CATS system within 10 business days of the date of action. The CA161 (placement screen) and Service Plan are updated to reflect changes in placement, services and contractor enrollment dates. Ana initiates all required and agreed upon referrals for services, making sure all new services are started. Before services begin, Ana completes a CES, calculates the cost of the services authorized and determines what this would cost if Frances were in a SNF. She reviews the need for adaptive bathroom equipment with her supervisor and Medical Director, receiving a decision within 14 days. Once approved, she contacts Frances' PCP for an order to initiate the services. The CM continues to monitor Frances' condition along with the results of her initial PCP visit, BH provider visits and vision evaluation. Within 30 days, Ana contacts Frances and Jasper in order to: confirm all services have been initiated to Frances' satisfaction; review the process to become a POA for his mother; check on completion of the AD form; and at Jasper's request, provide a referral to the UCA sales staff to discuss the benefits of aligning her care with our D-SNP. Ana also explains more about Agency with Choice or co-employer models available as well as the fiscal management model to Jasper because Frances would like her granddaughter to be her attendant. Ana coordinates and authorizes any follow-ups as needed. Frances is formally re-assessed on her progress toward her goals in 90 days or upon notification of any changes in her condition or service needs from her family or providers. Over the next months, Frances settles into her new life in Parker, enrolls in UCA and has a more coordinated care experience with advantageous supplemental benefits, such as dental, vision, and meal provision at times of care transitions. Following Frances' provider visits, Ana incorporates the new information and treatment goals into her service plan and coordinates the provision of service needs with the CHR, who has been checking on Frances and assisting with her socialization efforts. After removal of her cataracts and successful management of her agoraphobia, Frances is more mobile and independent, resulting in a modified Service Plan consistent with her increased independence.

2. A 71-YEAR-OLD HISPANIC MEMBER, RESIDING IN KINGMAN, DIAGNOSED WITH SCHIZOPHRENIA…

The University of Arizona Health Plans' (UAHP) long-term care plan, Banner-University Family Care (B-UFC) is uniquely qualified to meet the needs of this member, Raul, while improving his physical and behavioral health (BH), supporting him to live in the least restrictive setting and enabling his family to build closer connections with him as active members of his care team. We will utilize our extensive experience, efficient operations and long-standing community partnerships, while leveraging our local orientation to offer an integrated care model that successfully responds to Raul's complex needs. Our integrated approach to case management will honor the ALTCS values of choice, dignity, independence, individuality, privacy and self-determination while Raul engages in effective and evidence-based services designed to treat the whole person. We have a long history of providing holistic case management along with care coordination to high-cost/high-needs AHCCCS members and Dual Eligible Special Needs Plan (D-SNP) enrollees, many of whom become ALTCS-eligible and successfully transition to the ALTCS program. UAHP has operated an acute integrated physical and BH Case Management program since 2015, and we have successfully delivered integrated case management to our D-SNP members, of which 34% have a psychotic disorder. Our current BH Department has a combined experience of 128 years working in integrated settings and has held 88 integrated staffings over the past year. As part-owner of the RBHA, Cenpatico Integrated Care (CI), we have designed effective integrated case staffing procedures, uphold *AZ's 9 Guiding Principles for Adult BH Services & Systems* and are familiar with the community of BH providers across AZ. We will build upon this experience to meet Raul's whole-person needs while supporting his family. Furthermore, all B-UFC Case Managers (CMs) will be trained in a person-centered approach, the self-directed philosophy and application of the principles of self-direction – giving members more control over the services they want and by whom they are provided.

ENROLLMENT TRANSITION AND INTEGRATED CASE STAFFING

Upon notification of Raul's enrollment into B-UFC, we will immediately (within the same business day) coordinate with the RBHA to gather information about Raul's psychosocial-medical history and past treatment. Our ALTCS Transition Coordinator (per ACOM policy 402) will be responsible for developing, implementing and monitoring adherence to our internal Transition Policy and Procedure, complying with all AHCCCS policies for ALTCS member transitions. Our Transition Coordinator will oversee Raul's smooth transition from the RBHA to B-UFC. The Transition Coordinator will receive the Enrollment Transition Information (ETI) Form from the assigned RBHA and share it with the CM Supervisor. The CM Supervisor will review the ETI Form in consultation with the Qualified BH Professional (QBHP) assigned to the ALTCS Case Management Team, gleaning information about current Prior Authorizations to continue his current services without interruption, initially with the same providers, even if under a single case agreement. The CM Supervisor, in consultation with the QBHP on the team, will determine priority level and assign a CM to become Raul's single point of contact. Given Raul's complex BH needs, he is assigned Jen, a BH CM. The CM Supervisor, QBHP and Jen will participate in an integrated staffing in collaboration with the referring RBHA. Jen will live and work in Raul's community – meeting Raul where he is and working to build a relationship of trust while fostering hope. As a BH CM, Jen has expertise in BH needs and resources, including application of the *9 Guiding Principles for Recovery-Oriented Adult BH Services & Systems*. Jen is part of a regional Case Management Team and has support from other specialized CMs, such as Community Specialists with in-depth knowledge of local housing, education and retraining, vocational and local community resources, as well as RN CMs who can provide advice when complex medical issues arise. Every team has a QBHP responsible for required quarterly BH consultations, identifying individuals appropriate for BH reinsurance, monitoring BH tracking requirements, and offering BH related consultation and training for all CMs and providers. Jen has received training in suicide prevention in alignment with An End to Suicide in Arizona 2016 State Plan.

During the integrated staffing, we will request the RBHA to supply pertinent clinical information and establish background related to but not limited to:

- Completed transfer packet and letter of transition with clinical information regarding on-going needs, cultural and language preferences, attitudes and beliefs, discharge and transition plans
- Confirmation of status and date of Court Ordered Treatment (COT), original reason for COT, history of suspensions, judicial reviews, and consult with the Supervising Agency to transfer COT to the new county and providers
- Verification of history and current need for Special Assistance due to his serious mental illness (SMI) status – including name and contact information of assigned advocate, if applicable; and verification Raul or his Member Representative (Representative) understands his rights to Grievances and Appeals

- All unexpired releases of information, number of respite hours used for the calendar year, summaries of Adult Recovery Team meetings and Level 1 medical record
- Current information regarding Raul's physical health providers, status of his diabetes and ability to self-manage his medications, diet and overall lifestyle as it relates to his diabetes and dementia
- Copy of the Out-of-Home Packet provided by his BH provider for approval to a BHRF and all concurrent review documents, indicating his service planning goals, progress and discharge summary
- Summary of substance use history, past and current Individual Service Plans, response to treatment, Crisis Plan, support system and attempts to offer healing services or other cultural treatment approaches

Per AMPM 320-R, if it is determined that Raul was not correctly identified as needing Special Assistance, Part A of AMPM Exhibit 320-6 will be completed and submitted to the Office of Human Rights within five working days. Raul and his Representative will be informed of the notification and the benefits of having another person involved who can provide Special Assistance. Jen will verify if UAHP has a contract with the current inpatient facility and establish a Single Case Agreement if needed. If the Pre-Admission Screening (PAS) Assessment indicates a guardian, conservator, Power of Attorney (POA) or indicated support network, Jen will contact them. Jen coordinates with the BHRF where Raul previously resided to gather information not collected during the RBHA Integrated Staffing. Jen acknowledges the complexities of Raul's situation, given his dementia, and understands the importance of working with a Representative and family/caregiver, including such representatives in the explanation of benefits and all care decisions. When Raul is referenced in this response, Jen will consistently include his Representative and family/caregiver.

UAHP'S DEMENTIA-CARE PROGRAM will give Raul, his family and his providers the necessary support to address Raul's dementia-related needs. Leveraging the depth of knowledge within both the UA Center on Aging and the Banner Alzheimer's Institute, we will offer workforce development and capacity building related to early detection and ongoing quality care. All UAHP ALTCS CMs will be dementia-capable by receiving specialized training, ongoing staff development and availability of expert resources – allowing CMs to detect signs of dementia sooner and connect members with proactive care. The program is available to support Raul's family to further their understanding of his condition and how to best support him. The program also offers expert consultation to Raul's providers – including clinical guidance and out-of-the-box solutions to maximize Raul's independence.

INITIAL ASSESSMENT AND PERSON-CENTERED PLANNING

Each CM Supervisor uses the following CM Priority System coupled with his/her clinical judgment to determine when the timing of the initial visit should be less than the AHCCCS standard of 12 business days: *Priority 1-Urgent need for services and CM makes appointment within one business day; Priority 2-Routine Home and Community Based Services (HCBS) member living in their own/family home and CM makes appointment within seven business days; Priority 3-Member residing in an Assisted Living Facility (ALF) or Skilled Nursing Facility (SNF) and the AHCCCS 12 business day standard from date of enrollment is followed*. Because Raul is enrolled in ALTCS during a hospital stay, he is assigned a Priority 1; Jen conducts initial outreach within one business day via a face-to-face visit at the hospital. While at the hospital, Jen will conduct a medical record review, including current psychosocial assessments, mental status exams and information related to history of suicidal ideation and crisis plans. Through spending time with Raul and his Representative, Jen will employ a systematic approach to assess Raul's strengths and needs as they relate to functional abilities, medical conditions, behavioral health, need for Special Assistance; social, environmental and cultural factors; existing support system, language and health/safety risks. Jen will utilize UAHP's proprietary Strengths and Needs Assessment (SANA) to gather in-depth bio-psycho-social-spiritual information about Raul in a strengths-based, member-centered manner. The SANA also includes a health risk and BH risk assessment with corresponding risk scores. Per AMPM Chapter 1600, the SANA gathers all necessary information to populate the required Uniform Assessment Tool. All assessment tools are uploaded to Jen's hand-held tablet, with a section for Raul's signature. Due to Raul's SMI diagnosis, Jen must identify service providers within five days of the initial assessment, per AHCCCS requirement. Jen provides Raul and his Representative with the Member Handbook and highlights the local crisis provider contact information. He is given a specialized ALTCS Member Kit, making the Member Handbook and Member Rights easier to review and digest. The ALTCS Member Kit also includes Jen's magnetic business card, the Advance Directives (AD) booklet, 5 Wishes, and a quick guide to resources and advocacy strategies. Jen lets Raul and his Representative know that UFC has a sister D-SNP plan and points out the UCA brochure in the Member Kit, which describes receiving integrated Medicaid and Medicare services and how to obtain more information if he wishes. After reviewing the kit with Raul and his family – including his

Member Rights, ALTCS program components and covered services, placement and service delivery options, as well as Grievance and Appeals procedures – Jen obtains the necessary signatures. With Raul's permission or through the permission of guardian or health care POA if applicable, Jen involves his family and support network in the person-centered planning process. With agreement from Raul and/or his Representative, Jen also invites a NAZCARE Peer Support Specialist to be a part of the discharge and person-centered planning. Through the person-centered planning process, Raul, his Representative, his family, Jen and other supports work together to develop a mutually agreed upon, appropriate and cost-effective service plan that meets Raul's medical, functional, social and BH needs in the most integrated and least restrictive setting. Jen works with Raul and his family to develop meaningful and measurable long-term and short-term goals based on his strengths, including steps he will take to achieve his goals. A focus of his goals is to confirm alignment with the COT plan in collaboration with the Adult Recovery Team. A Goal Sheet and Individual Service Plan are developed as a result of this face-to-face process and include Raul's wishes and desires. Raul signs and receives a copy of both forms and they are updated with each re-assessment. Jen updates entries in B-UFC Acuity Care Management and CATS within 10 business days.

MEETING RAUL'S NEEDS AND ASSISTING HIM TO ACHIEVE HIS GOALS

Independent Living. Issue 1: Identify placement and discharge from Level 1 Psychiatric Inpatient Facility. **Plan:** Raul's team initiates discharge from the Level 1psychiatric inpatient facility. Jen reviews discharge planning information, such as psychiatric medications, dosage, frequency and response to medications, crisis plan to address suicidal ideations and immediate interventions to deploy support system and coping strategies. Jen works with Raul, his family and his NAZCARE Peer Support Specialist to outline the options related to Raul's discharge and potential living arrangement. His options include a BHRF in Flagstaff, HCBS with family in their home or an Assisted Living Home (ALH) in Flagstaff with community-based mental health, rehabilitation, primary care and dementia services. (Once a placement decision is made and placement is secured, the UAHP BH Department will work with Jen and Supervising Agency to complete a revised COT plan and submit to the court for approval. Approval by the court is required before discharge from a Level 1 setting. The county requires that any changes to a COT plan, clinical or residential, must be submitted for approval. If Raul moves to a different county, a Change in Venue form will be filed and transfer of jurisdiction of the COT will be coordinated.) Jen pre-screens available BHRFs and ALHs in the Flagstaff area and creates a list of those equipped to meet Raul's needs and preferences. Jen invites BHRFs and ALHs to come to the hospital to present to Raul and his family. Jen also sets up transport for Raul and/or his family to visit the pre-screened sites.

Through person-centered planning, Raul and his family developed a long-term goal of living at home with his family. However, his behaviors need to stabilize and he needs time to adapt to his new outpatient service plan in a safe and supportive living environment before achieving this goal. Raul and his family decide to move to an ALH (as it gives him time to adjust before moving home with family and offers a more home-like environment than a BHRF). They select Elder Springs, an ALH with memory care managed by Flagstaff Care Homes. Raul has been through a lot and is currently in the most restrictive setting. The team does not want to step him down too quickly without the right supports in place. Furthermore, the family has not been heavily involved in his treatment until now. A short period in an ALH will allow the family to explore their role and how their lives will change with Raul's move home. Finally, it is challenging to fully assess ADLs and IADLs while in the hospital. Moving to an ALH will give Jen more time to assess ADLs and IADLs in a natural living environment while putting the appropriate supports in place to promote Raul's future independence. The Cost-Effectiveness Study conducted by Jen supports the placement. Jen authorizes a 90-day stay, with plans to rapidly reassess and determine viability of moving home with the family. Raul makes an overnight visit to the family so Jen and family can evaluate how he and the family adjust while creating a gradual transition. Jen assesses his independent living skills, confirms problem behaviors are stabilized and begins working with Raul, his family and his community-based providers to address the plan for moving to a less restrictive environment, his family's home. Given his advancing dementia and associated shuffling/imbalance, Raul's fall risk is increased and Jen arranges for the necessary home safety assessments. Jen helps the family identify resources to assist in moving Raul's belongings to his new home in Flagstaff. The NAZCARE Peer Support Specialist, based in Flagstaff, provides Raul with support and encouragement during the move. Jen utilizes our internal transfer policy to make certain that there is continuity of care and ease of transition for members moving across county lines**.** At this time, a Flagstaff-based BH CM is identified, allowing for Raul to continue receiving case management services from someone who lives and works in his community. A *Member Change Report* is submitted to AHCCCS electronically to document change of address and newly assigned CM, Sue. Sue reviews Raul's responsibility to pay room and board and any other member assigned financial responsibility, based on the PAS outline.

The Residency Agreement is completed in adherence with AMPM Chapter 1600, Exhibit 1620-15. Sue conducts an on-site review within 10 days or less of his change of placement. If applicable, Sue will confirm all COT requirements as outlined in ARS, Title 36, Sections 504-544 are adhered to and required legal documents are submitted to the court, including but not limited to: change of residence, change of treatment, change of venue, number of inpatient days utilized, any status reports ordered by the court and annual evaluations with BH Medical Practitioner (BHMP).

Acknowledging this is a dramatic transition from inpatient to outpatient, from Kingman to Flagstaff, with exacerbating factors related to increased dementia, Sue coordinates a provider-based Short-Term Assistance Team (STAT) to overlay additional expert supports during this intense period of transition. The innovative, provider-based STAT model will be developed specifically for the ALTCS population and built from our success in implementation of the Healthy Together Care Partnership (HTCP). The STAT offers boots-on-the-ground and virtual support to Raul, his family and various provider staff supporting him in his new setting. The team consists of: clinical nurse CM, social worker/BH partner, community health partner, peer support specialist and family support specialist. The team also consults with a B-UFC nurse practitioner and clinical pharmacist as needed. In conjunction with our Dementia Care Program, the team provides expert guidance related to the treatment of Raul's dementia, strategies for self-management and ways to increase his independence despite his worsening dementia. Through a unique approach to Value-Based Purchasing, this provider-based team offers flexibility and expertise to provide support not only to members during times of transition, but also to the providers working with those members. The STAT team will be especially helpful in offering additional expertise and guidance to the NAZCARE and Elder Springs staff as it relates to dementia care – building network and individual provider capacity while reducing burn-out of paraprofessional staff. STAT works in conjunction with Sue, Raul, his family, and all other relevant physical and BH providers. STAT is not designed to take over care or become the primary point person of care, but rather to add an extra layer of support for Raul and the providers during a time of transition. UAHP has a proven track record of success employing similar models with our acute population through our already existing HTCP program. Formal program evaluation of HTCP demonstrated that as of August 2015, the HTCP program served more than 800 members (both acute and D-SNP) with a reduction of 24% in hospital admissions and 16% in Emergency Department (ED) utilization over the baseline year. Program participants reported a 97% satisfaction rate, with 92% reporting increased ability to manage health conditions and 87% reporting improved health. **Goals:** Short term – discharge from hospital to ALH in Flagstaff; long term – live at home with family in Flagstaff.

Improved BH and Physical Health Outcomes **Issue 1:** History of suicidal ideation, poor engagement in treatment and unstable behaviors related to both schizophrenia and dementia. **Plan:** Sue makes arrangements for Raul and his family to tour the A.Z.P.I.R.E. Wellness Center in Flagstaff, run by NAZCARE – a local peer-run organization offering peer support services, social and recreational opportunities, vocational services and additional strategies to promote member health in small, realistic achievements. NAZCARE also offers support to Raul's family to help them improve their ability to support Raul, understand his illnesses, embrace strengths-based communication strategies, and learn how to navigate the system and become advocates for Raul. Sue connects NAZCARE with the Dementia Care Program for provider consultation related to Raul's dementia if needed. Sue connects Raul's family with the local National Alliance on Mental Illness (NAMI) affiliate; they sign up for NAMI Family-to-Family Classes in addition to participating in the NAMI Family Support Group held at the A.Z.P.I.R.E. Wellness Center. This helps establish a network of support for the family. Through NAMI, the family learns more about Raul's schizophrenia and warning signs if he stops taking medication. Raul participates in psychiatry, evidence-based co-occurring substance abuse counseling (both group and one-on-one), and other support and rehabilitation services to promote his recovery through The Guidance Center, a community-based Patient Centered Health Home (PCHH) in Flagstaff. The Guidance Center offers integrated care to meet Raul's whole-health needs, deploying staff to provide services in the home and community. This is especially critical as it teaches Raul the necessary independent living skills to move out of the ALH and into his family's home. Teaching strategies used consider Raul's advancing dementia and offer prompts and tools for task completion. Teaching also incorporates the family, equipping them with the tools to make certain Raul receives all the necessary prompts and reminders throughout his day, while maximizing his independence. The Guidance Center is a long-standing RBHA provider, familiar with the various providers and programs Raul utilized while in Kingman, and offers continuity of care. **Goals:** Be able to ask for help and know at least three different coping skills to utilize in the instance of suicidal ideation. Identify a minimum of two new social outlets.

Issue 2: Physical health, including diabetes, progressing dementia and poor self-management skills. **Plan:** As an integrated PCHH, the Guidance Center enables Raul to get comprehensive physical and BH care at one location. This limits the number of new providers Raul interfaces with, streamlines services, eliminates redundant paperwork and improves his ability to build a relationship of trust and rapport with his team of providers. The Guidance Center helps address Raul's general health care and preventative services, providing a special focus on his dementia and diabetes related needs. Nursing staff and community health workers at the Guidance Center keep Raul on-track to manage his diabetes, offering disease and medication education and health promotion. In partnership with A.Z.P.I.R.E. Wellness Center, the team is able to improve Raul's diabetes self-management skills. Sue arranges for his diabetic testing supplies to be approved even if off-formulary. Raul works with a nutritionist to create an easy to follow diet plan. The nutritionist communicates the diet plan to the ALH so he has the necessary assistance and encouragement to follow his plan. The NAZCARE Peer Support Specialist helps Raul engage in daily physical exercise. They work together to find a yoga class at a local senior center, which Raul attends twice a week. His Peer Support Specialist and brother rotate attending the class with him to encourage and motivate him. The ALH staff will provide him with the ADL assistance needed as it relates to his dementia. **Goals:** Identify and regularly engage in a minimum of one physical activity. Maintain healthy diet and blood glucose levels within normal range. Identify and regularly utilize a minimum of two self-management strategies.

Issue 3: Opiate use disorder. **Plan:** Raul will have access to co-occurring integrated treatment and support groups that follow SAMHSA's evidence-based practice – including clinicians trained to treat both substance use disorders and mental illness; treatment in stages; counseling that utilizes a cognitive-behavioral approach to treat Raul when in the active treatment and relapse prevention stages in a variety of formats (individual, group, self-help and family); and an integration of medication and psychosocial services. Such evidence-based programming will be made available to Raul through both The Guidance Center and NAZCARE. If appropriate, Raul will receive Medication Assisted Treatment (MAT) for his opioid use disorder. UAHP contracts with several MAT providers offering this specialized substance abuse treatment. If Sue learns Raul meets the criteria for pharmacy or sole provider restriction, he will be entered into UAHP's Opioid Use Program. Through this program, a report of all members with claims for opioids is generated quarterly. Members who are in the top 10% of utilizers receive case management intervention. The prescriber is contacted and the need for a decreased dose of opioids is discussed. The member is contacted to discuss the risks of high dose opioids and encouraged to work with their provider. **Goals:** Short term – reduce opiate use; long term – abstinence from opiates.

RESOLUTION AND FUTURE MOVE TO LIVE WITH FAMILY

Raul is safely discharged from the hospital, residing in a less restrictive setting closer to his family. He and his family receive ongoing support and are included in all decisions made about his care. They are assigned tasks to help him progress towards discharge and are identified as informal supports. Sue reassesses the placement with a visit in 10 days or less to confirm Raul's needs are being met. Sue will continue to keep track of Raul's progress in his current placement to assess the viability of having Raul move in with his family after his initial 90-day stay at the ALH. Sue continues discussions with the family about becoming Direct Care Workers, in accordance with the AMPM policy 1240-A Direct Care Services, as Raul and his family explore options for Self-Directed Care and Agency with Choice. Sue and the family work together to identify their future role in providing ADL and IADL assistance, medication management, safety planning, need for respite, meal service and other potential needed supports. They discuss dementia related needs as they pertain to meals – choking hazards and need for softer foods and inability to detect hot/cold. Sue helps the family connect to a B-UFC contracted family-run organization for support, education, and advocacy – helping the family best support Raul, advocate on his behalf, and reduce their risk of compassion fatigue. The family continues to work with UAHP's Dementia Care Program for coaching and prompting related to Raul's dementia. Sue informs the family about technology options available through UAHP to maximize Raul's independence while living in the family's home such as:

- Apps that can be built into the home to assist with ADLs, including video modeling and prompting, scannable QR codes throughout the home, auto shut-off for appliances, stabilized temperature for faucets, etc.
- Home body sensors for vital signs monitoring and measuring of blood-glucose levels.
- Pill box sensors to assist with medication self-monitoring – empowering Raul to self-manage while allowing coaching as needed and preventing major losses if medication adherence decreases by providing direct alert to the CM.
- HIPAA-compliant apps to allow ease of data entry and monitoring by non-skilled care takers and paraprofessionals.

Raul and his family receive a highly coordinated, individualized experience with a member-centric approach to care. They are fully involved in decisions about services and invested in outcomes.

3. PROVIDE A DESCRIPTION OF THE OFFEROR'S PAST EXPERIENCE AS A MEDICARE D-SNP PLAN. THE OFFEROR MUST…

The University of Arizona Health Plan (UAHP) is made up of University Care Advantage (UCA), our Dual Eligible Special Needs Plan (D-SNP), University Family Care (UFC), our acute care plan, and Banner – University Family Care (B-UFC), our ALTCS E/PD plan. UCA has been dedicated to caring for dual eligible members in urban and rural Arizona since 2008. To promote alignment and provide integrated Medicaid/Medicare services, our D-SNP sales strategy is simple: we market exclusively to UFC and B-UFC members. We expanded from two to three counties in 2011, with further expansion in 2015 to include 10 counties across Arizona. Today, UCA serves D-SNP members in Cochise, Gila, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, Yavapai and Yuma counties. UCA has 6,659 members currently enrolled and nearly 41% reside in rural counties. UCA has continually improved our members' experience as evidenced by a decreased disenrollment rates, from 3.5% to 1.5% in 2016. We also successfully managed Maricopa Care Advantage (MCA) on behalf of Maricopa Integrated Health System (MIHS) since 2008. Over the past eight years, we have employed the necessary resources and strategies to successfully operate both UCA and MCA. Strategies vary depending on the health and cultural needs of the members but always remain focused on the four dimensions of the Quadruple Aim: reducing the per capita cost of health care; improving health outcomes; improving the member experience; and positively impacting the work life of health care providers, including clinicians and support staff.

Managing and Coordinating Member Care

All aspects of UCA members' care are overseen by our Model of Care (MOC) Committee. UCA's MOC has always received the maximum three-year approval and most recently received 100% on its MOC plan. Our MOC specifically identifies frail, elderly members and those with serious mental illness (SMI) as vulnerable populations, with programs to meet their needs. Other vulnerable populations include those prevalent among the ALTCS population, such as members with chronic renal disease, chronic cardiovascular disease, chronic pulmonary disease, depression and multiple co-morbid chronic conditions. Because of the D-SNP success, UCA is able offer increasing levels of supplemental benefits each year. These benefits are designed to be the most beneficial for our members, including eye care, dental, over-the-counter medication, a personal emergency response system and home-delivered meals following hospital discharge to assist members during this vulnerable moment in their care transition and decrease the risk of readmission.

Delivering Integrated Behavioral and Physical Health Care

UCA's recent experience of successfully managing the Medicare benefits for aligned beneficiaries with Cenpatico Integrated Care (CI) – the RBHA serving AHCCCS members with Behavioral Health (BH) needs in Southern Arizona – demonstrates our ability to care for the most vulnerable D-SNP members who require integrated care. As joint owner, we work collaboratively to help members with SMI, enrolled in both UCA and CI, to experience seamless care transitions and coordination of benefits. Employees in Case Management, Utilization Management, BH, Prior Authorization and Member Services received collaborative cross-entity training to respond to member and provider inquiries as if they were contacting one seamless entity. Pre-implementation planning designed to overcome technological and confidentiality challenges between organizations resulted in systems and processes to help staff exchange real-time health care information on their respective proprietary medical management software systems. Additionally, designated clinical employees at both organizations communicate daily on hospitalized members to discuss the member's discharge plans, including the need for medication review and reconciliation, Durable Medical Equipment (DME), Skilled Nursing Facility (SNF) placement and BH services, such as housing and supported employment. Furthermore, UFC successfully incorporated the Medicaid BH covered benefits for eligible GMH/SA dual members on October 1, 2015. Contributing factors to our success included a comprehensive implementation plan focused on offering an accessible and robust network, integrating benefits, regulations, oversight processes and the well-established state BH delivery system protocols. We conducted extensive employee and provider education, including process changes, payment codes and billing, provider credentialing processes, case management, claims, and encounter and quality management requirements. Because of these efforts, 739 GMH/SA dual members receiving BH services through their RBHA were seamlessly transitioned to UCA to cover their BH services without disruption.

Strategies to Align Members

To decrease fragmented care, we have successfully increased the rate of alignment by analyzing our AHCCCS membership to identify dual eligible members not enrolled in UCA and other eligible members appropriate for outreach. We prioritize member outreach by the frequency and chronology of previous contacts. Employed sales staff and contracted broker-agents receive eligible member lists and outreach to let them know we have both an AHCCCS and D-

SNP plan they may want to join. When reached by phone, we offer eligible members various ways to learn more about UCA at their discretion, all at no cost, in multiple languages and the communication method of their choosing: by mail, in-person or on the phone. This approach has resulted in a 51% alignment of our duel eligible members.

Advancing Alternate Payment Models (APM) in Medicare

UCA currently has seven active Value-Based Purchasing (VBP) contracts for our Medicare line of business, serving 35% of our D-SNP members. They include Marana Healthcare, Chiricahua, El Rio, Sun Life, Sunset, Mariposa and Yavapai Community Health Centers. To improve care coordination and decrease fragmented care, UCA incents Medicare providers to complete an annual wellness visit (AWV) and offers shared savings in association with a decrease in medical costs. In place for two years, these incentives have resulted in a 131.34% increase in AWVs conducted (P<.001). The nature of these arrangements is driven by the volume of UCA members a group serves. For lower volume providers that we anticipate will grow their UCA patient base, UCA provides a separate payment for each AWV the provider performs for its UCA members. This promotes delivery of the service and provides funding for practice transformation. For larger volume providers, the VBP arrangement involves a shared-savings component based on meeting certain quality metrics, which includes AWV completion. UCA anticipates renewing these arrangements for 2017 and moving provider groups to shared savings as their UCA patient base materially increases.

SUCCESSFUL INITIATIVES AND INNOVATIONS IN POPULATION HEALTH MANAGEMENT

Since inception, UCA has successfully implemented population health management processes to improve the Triple Aim outcomes of our covered D-SNP members. Since the D-SNP population is by definition a high-need, high-cost population, we incorporated **six primary approaches**[1] to improve the health and experience of our members: (1) timely assessment of member risk in order to target specific vulnerable sub-populations, (2) develop person-centered care plans, (3) engage members and their natural supports, (4) connect members with other community services, (5) coordinate care and improve communication, and (6) monitor their progress across the care continuum. These approaches have resulted in the implementation of multiple cross-departmental initiatives which continue to be monitored and improved throughout our organization. Specific to this response, we identified **three key strategies** that have improved Triple Aim outcomes for our covered D-SNP members that we believe are pertinent to the ALTCS D-SNP population. The specific tactical initiatives aligned with each of these strategies discussed below include: (1) **D-SNP On-boarding Improvement** in order to welcome and expeditiously assess each member's risk level and engage members in Case Management within the first month of UCA enrollment; (2) **In-Home Comprehensive Health Assessments** completed by Nurse Practitioners (NPs) when members need support during a vulnerable time or transition; and (3) **Healthy Together Care Partnership (HTCP)** for our most vulnerable members with on-going support needs due to the complexity of their situation. Two of the initiatives below have more than one improvement cycle reported since we use the Plan-Do-Study-Act (PDSA) process to continually improve initiatives for all of its lines of business.

D-SNP On-boarding Improvement

In 2013, we identified that our D-SNP populations had higher than expected disenrollment and admission rates, which were negatively impacting our medical costs and appeared to reflect member dissatisfaction. Further analysis identified a disenrollment spike and admissions within the first three months of enrollment and BH conditions were a significant driver of admissions. Planning occurred in the latter half of 2013, with the initial launch of our D-SNP On-boarding Improvement Initiative in January 2014. Planned interventions were three-fold: (1) contract with The University of Arizona (UA) Department of Systems and Industrial Engineering to re-engineer our onboarding process for D-SNP members during their first three months of enrollment; (2) improve the predictive accuracy of our Health Risk Assessment (HRA) tool to identify members at high risk for admission within subsequent three months; and (3) improve BH and adult case management collaboration within the Interdisciplinary Care Team (ICT) and have Case Managers (CMs) complete all outreach, including HRA completion, to new beneficiaries within the **first month** of enrollment (Medicare requires HRA outreach within first 90 days of enrollment). Using the PDSA model and our partnership with the UA Systems and Engineering Department, we developed a process to improve communication between sales, enrollment and clinical teams during the critical first month of enrollment. The new on-boarding timeline emphasized **rapid risk assessment** and **triage to appropriate care models designed for distinct segments of the population**. Both

[1] McCarthy, D., Ryan, J. & Klein, S. (2015). Models of care for high-need, high-cost Patients: An evidence synthesis

computerized machine learning techniques and standard statistical regression models were completed on D-SNP populations from past years to identify which HRA questions were most predictive of subsequent admission within the first three months of enrollment and answers were re-weighted accordingly to improve tool accuracy. From January 1, 2015 to present, 9,192 newly-enrolled UCA members completed the onboarding process. The table below highlights improvements associated with this initative, including improved completion rate and predictive performance of our HRA, decreased admissions during the first three months following enrollment and overall decreased admission rate. Improvement in member experience was demonstrated through an improved disenrollment rate, from a 3-Star to a 4-Star level during the same time frame.

Initiative	**D-SNP On-boarding Improvement**			
Implementation Dates	May 2013 through May 2015 (and new process on-going)			
Average Membership	UCA membership: 2013 – 2,783, 2015 – 6,659			
Participating Members	A total of 9,192 new members were on-boarded			
Outcome and Process Metrics Used to Evaluate Initiative				
	2013 Baseline	***2015 Implementation***	***% Improved***	***P-Value***
Admits/K (UCA)	354.27	252.80	29%	<.01
% admitted within 3 months of completing HRA	9.5%	3.0%	68%	<.001
% of new members completing HRAs in 1st month	12%	45%	275%	<.001
Disenrollment Star Rating	3 Star	4 Star	1 Star	N/A
Predictive accuracy of HRA [>.75 is effective tool]	.560	.801	39%	<.01

Replication for D-SNP ALTCS Members in Awarded Geographic Service Areas (GSAs)

We will replicate this process for our members using process improvement, analytics and care innovations. ***Process Improvement***: In addition to completing thorough assessments during ALTCS enrollment and ongoing care, CMS requires D-SNP programs to have enrollees complete the HRA approved with their Model of Care. This can lead to "assessment fatigue" and low completion rates, especially among the elderly and disabled. We will adjust our Strengths and Needs Assessment (SANA) and HRA to maximize overlap without sacrificing the integrity of either tool. We will also create a technology solution to auto populate all fields in common among the required assessment forms when the response is entered once into the software solution. ***Analytics:*** Undoubtedly unique risk factors will be present within the ALTCS D-SNP population, and outcomes other than hospital admissions are of interest. Therefore, UA Center for Population Science and Discovery will develop a "Life Transitions Predictor" to identify members at risk for each of three outcomes: (1) admission to an acute facility, (2) transition to a SNF from a HCBS setting or (3) being within six months of the end of their life. ***Care Innovations***: Integrated, whole-person case management will be adapted for the ALTCS D-SNP population with the support of the Comprehensive Health Assessment (CHA) and HTCP initiatives discussed below in addition to telehealth/medicine, palliative care, hospice and other specialty services presented in this RFP response.

In-Home Comprehensive Health Assessments

Beginning in 2012, UCA introduced the use of in-home assessments completed by NPs to improve the plan's ability to assess and identify a member's risk for hospitalization, declining health and need for care coordination. These assessments also include a "one-touch" clinical intervention consisting of delivery of clinical care, health education, help with medications, a home safety evaluation and other clinical interventions deemed appropriate by the NP. UCA contracts with UA College of Nursing (CON) to conduct in-home CHAs for select UCA D-SNP members living in Pima, Cochise, Santa Cruz and Pinal counties. The CHA is used to collect important health measures; address immediate care needs and more accurately triage members to ongoing case management or referral for intensive home-based care (see HTCP below). Through our experience, we found the most effective use of these CHA assessments and "one-touch" clinical interventions are for members struggling with a challenging time or transition impacting their health care.

Therefore, we have focused on improving the real-time identification of members at such vulnerable moments through expanded referral sources. Currently, referral sources include CMs, concurrent review RNs, prior authorization RNs, providers, customer care staff, Interactive Voice Recognition (IVR) alerts generated by our Altegra Condition Management programs and the Arizona Health-e Connection-Health Information Exchange (HIE). The CHA provides reliable and accurate information back to us and complements the HRA by including a history and physical, medication reconciliation, a review of medical and social background, family situation and how the member functions in their own environment. The NP develops a Care Plan that identifies the member's health management goals and includes counsel to follow-up with their Primary Care Provider (PCP) and/or other specialists as needed. The completed CHA is faxed to the member's PCP. Members are referred to case management as appropriate. Completed CHAs are reviewed and uploaded to Acuity, our comprehensive health care management system, where they are accessible to our Case Management, Medical Management and Quality Management Departments. The table below highlights the successful outcomes associated with the CHA initiative. Key performance measures included utilization, cost and quality metrics. Selected measures are based on the utilization patterns, PMPM medical cost and low-performing quality measures.

Initiative	**In-Home Comprehensive Health Assessments (CHAs)**			
Implementation Dates	PDSA Cycle 1: 1/1-12/31/2013; PDSA Cycle 2: 1/1-12/31/2015			
Average Membership	UCA membership: 2013 – 2,783, 2015 – 6,659			
Participating Members	82 members received a CHA in 2013 & 146 members received a CHA in 2015			
Outcome and Process Metrics Used to Evaluate Initiative				
PDSA Cycle 1	***Non-CHA Comparison Group 2012***	***CHA Intervention Group 2013***	***% Improved***	***P-Value***
Admissions/K	798	660	17%	<.001
ED Visits/K	1,586	1,823	-15%	<.01
PDSA Cycle 2	***Non-CHA Comparison Group 2015***	***CHA Intervention Group 2015***	***% Improved***	***P-Value***
Admissions/K	260.12	164.38	37%	<.001
Days/K	1217.52	787.67	35%	<.001
Readmission Rate	13.8%	8.3%	39%	<.001
ED Visits/K	661.84	452.05	32%	<.001
Total Cost of Care/PMPM	955.28	732.40	23%	>.10

Replication for D-SNP ALTCS Members in Awarded GSAs

A key difference with the ALTCS D-SNP is each ALTCS D-SNP member will have an assigned CM as a primary point of contact who conducts face-to-face assessments regularly. This provides a highly skilled and attentive referral source to identify members experiencing a vulnerable time or care transition. Our experience through two improvement cycles has demonstrated that success of this intervention is directly proportional to the timeliness of referrals **prior** to members experiencing an adverse impact on their health. Therefore, timely referrals by the assigned CM during moments of intense member needs make this initiative ideal for replicating among ALTCS D-SNP members. Because geographic limitations exist for the UA CON team, we will contract with additional partners to expand this program throughout all awarded GSAs. This includes contracting with providers such as Geriatric Solutions and Matrix, as well as potential collaboration with the Arizona State University (ASU) CON to support CMs for our entire membership. Depending upon GSAs awarded, full expansion of this program is expected within two years of contract initiation.

Healthy Together Care Partnership (HTCP)

Because a small percent of patients account for most health care expenditures, successful population health management strategies include the use of multidisciplinary, home and community-based, mobile care teams to address the biopsychosocial needs of these high utilizing individuals. HTCP, our home-based primary/collaborative program, offers an evidence-based, high-touch approach to coordinating care for members with the greatest need and highest costs. The HTCP model has employed two approaches with our D-SNP members. The first model, an interdisciplinary team providing Primary Care at Home (PCAH), was used in 2013. This program is for members with advancing chronic

conditions and near homebound status and it incorporates elements from the Veteran's Administration Home-Based Primary Care and the CMS Independence at Home programs. The second model, implemented in 2015, is a collaborative care, co-management, integrated framework for members who can still access primary care in the clinic but whose complex needs are not being addressed within the clinic setting alone. In partnership with the patient, family, PCP, specialists and local community-based providers, HTCP provides at-home supports to align care services and increase self-efficacy and independence. The HTCP team consists of a NP, nurse care manager, BH consultant, clinical pharmacist and community health worker. The team assists members and providers by helping them with care transitions, medication adherence and optimization, palliative and End of Life (EOL) care, chronic condition management, BH interventions and care coordination. Our data analytics and care teams work together to identify the highest risk members for outreach. In addition, alerts are generated from the Banner Electronic Health Record (EHR), with its decision support tools, and the HIE to trigger timely outreach by the care team. Due to the complexity of analyzing such population health based interventions, we utilized outside experts to evaluate the HTCP's impact on utilization and cost of care. Jonathan M. Hendrickson FSA, MAAA, a Principal and Consulting Actuary with Milliman, Inc., conducted the analysis of HTCP in 2015. His analysis found that HTCP realized a $61 PMPM savings in medical expense. In addition, health economists with the UA Center for Population Science and Discovery evaluated HTCP's (using a Collaborative Care model) performance in 2015 by applying a propensity-score matching approach. They found HTCP engagement for participating UCA members led to a statistically significant 10% decline in total expenditures (per member month) and a 16% decrease in the number of ED visits. Additionally, a member survey demonstrated 97% satisfaction rate, with 92% reporting better ability to manage their health conditions and 87% reporting improved health status. A provider survey found 85% satisfaction with the support they and their patients received from HTCP.

Initiative	**Healthy Together Care Partnership**			
Implementation Dates	PDSA Cycle 1: 1/1-12/31/2013; PDSA Cycle 2: 1/1-12/31/2015			
Average Membership	UCA membership: 2013 – 2,783, 2015 – 6,659			
Participating Members	29 Members in HTCP in 2013 & 34 Members in HTCP in 2015			
Outcome Metrics used to Evaluate Initiative				
PDSA Cycle 1 [PCAH]	***HTCP Population Pre-Intervention 2012***	***HTCP Population Post-Intervention 2013***	***% Improved***	***P-Value***
Admissions/K	1,668	1,076	35%	<.05
ED Visits/K	4,813	2,637	45%	<.05
Total Cost of Care/PMPM	$2,074.13	$1,613.67	22%	>.10
PDSA Cycle 2 [Collaborative Care]	***HTCP Comparison Population 2015***	***HTCP Intervention Population 2015***	***% Improved***	***P-Value***
ED Visits/K	1,378	2,441	42%	<.01
Total Cost of Care/PMPM	$2,826	$6,811	59%	>.10

Replication for D-SNP ALTCS Members in Awarded GSAs

We envision the next major improvement opportunity for the care of ALTCS members to be in the delivery of care within their home or other HCBS setting. We believe the combination of our expertise in delivering personalized team-based care within the home with the telehealth/medicine expertise of our organizational partners, UA and Banner Health, offers a unique opportunity to blend high-touch with hi-tech to optimize the delivery of care and services in HCBS settings. There are two challenges to the financial sustainability and geographic expansion of such a program. First, to support financial sustainability, the care model must be targeted appropriately. Via our experience with using HTCP as both a PCAH model and a Collaborative Care model and our partnership with the UA Center for Population Science and Discovery, we have the necessary analytic tools to target members and population segments optimally. Second, the geographic expansion of this program will be done through a phased approach and need to incorporate telehealth technologies. Phase 1 will focus on urban areas, Phase 2 those lower density regions surrounding urban areas and Phase 3 will focus on the most rural areas. Depending upon the GSAs awarded, we anticipate coverage in all regions within two to three years of contract implementation.

4. APPROXIMATELY 20% OF THE ALTCS E/PD POPULATION DIES ANNUALLY REPRESENTING A SIGNIFICANT…

Our parent company, Banner Health (Banner) recognized by Truven Health Analytics as one of the top five health systems in the country, is committed to improving End of Life (EOL) care for every patient served through cost-effective, evidence-based medicine and care that meets the specific desires of each patient. To that end, Banner's initiative of encouraging all employees to complete an Advance Directive (AD) is an effective and innovative tactic to prepare employees for EOL decisions and help clinicians overcome uncomfortable barriers related to EOL communication with patients and their family. In addition, Banner has devoted many resources toward developing programs and service lines that provide EOL care and services to patients and families.

ALTCS members experience some very challenging life transitions, such as leaving a home they have lived in for years or having to give up a beloved pet due to placement restrictions. The struggles that come with declining health and increased dependency on others cannot be minimized. Frequently, the anxiety and depression experienced by ALTCS members are the result of coping with multiple life transitions in very short time periods. Our ALTCS CMs, providers and caregivers will provide the needed supports and services to our members through these difficult transitions often exacerbated by illness or aging as well as social determinants of health and family dynamics. In accordance with AMPM policy 310, Banner – University Family Care (B-UFC) will ensure members with chronic, complex or terminal illnesses receive medically necessary EOL care that includes: Advanced Care Planning (ACP), palliative care, supportive care and hospice services. Our ALTCS CMs will be highly trained in helping members and their families through these life transitions and will receive regular and on-going training in EOL care per AMPM 1630. We understand and support the use of both curative and palliative care to improve the member's quality of life and member/family satisfaction. Members who receive EOL care can also opt to receive curative care until they choose to transition to hospice services.

EXPERIENCE

An Experienced Case Management Program Providing a Full Continuum of Services to Meet Member Needs

We will offer ALTCS members a broad complement of highly effective case management services that have been built upon over 30 plus years of delivering care to AHCCCS and Medicare populations. We currently provide integrated care across the continuum, from prevention to EOL, centered on the member and their Case Manager (CM) supported by an array of care coordination programs to reduce the fragmentation of care. Each CM is supported by licensed physical and Behavioral Health (BH) professionals consisting of nurses, social workers, physical health medical directors and a psychiatric medical director. Our Case Management Teams have access to innovative home-based care programs such as Healthy Together Care Partnership (HTCP) and Nurse Practitioners (NPs) providing Comprehensive Health Assessments (CHAs) for members with complex needs, and those experiencing care transitions, declining health and terminal illness. Furthermore, these services are enhanced by our Value-Based Purchasing (VBP) contracts with Patient-Centered Medical Homes (PCMHs), palliative care and hospice programs that are all incentivized to support members and families managing EOL transitions and decisions.

The primary point of contact for each member is their CM who is trained to assist even the most complex and high-risk member during both normative (aging, declining health) and non-normative (terminal illness, catastrophic trauma) life transitions. Our CMs are experts in widely diverse fields such as intensive care, emergency medicine, trauma, psychiatric nursing, skilled nursing, home health, BH, oncology and hospice nursing. We have built upon this foundation to evolve into a fully integrated case management program with a multidisciplinary team including CM Assistants, BH CMs, Maternal Child CMs, Care Transition RNs, Transplant CMs and robust condition-specific programs to address to needs of our covered populations. Our CMs follow the members through all settings, inpatient, home or Skilled Nursing Facilities (SNF). The CMs receive referrals from many sources, both internal and external per criteria established by the health plan. We utilize our Predictive Modeling Platform to merge claims and utilization data with physician documentation, member self-reported information including the Health Risk Assessments (HRA), internal Prior Authorization (PA) referrals (pre-procedure), along with the Arizona Health-e Connection portal and outside referrals from providers and specialists to assist us in identifying high-risk, high-cost members. Thus, CMs are often serving members with declining health, chronic or terminal illnesses and can provide education and support to members as they need to make critical decisions about their course of treatment, care planning and EOL decisions. The CMs are skilled in recognizing changes in status or current functional capacity that may qualify them for ALTCS or EOL services; including hospice and palliative care, and assist with enrollment in these programs as appropriate.

Approximately 50% of our Dual Eligible Special Needs Plan (D-SNP) members enter hospice before death. The role of the CM during this time of transition varies in response to the member's health care status. In addition, they work with members and/or their families to avoid gaps in care and to make certain the safety and needs of the member are met, including emotional support, navigation of health care benefits, education and advocacy. The CM also assesses the member's knowledge of their disease process and understanding of their health care benefits and provides coordination of care with the member's family and treatment team, including Primary Care Providers (PCPs), specialists, hospice providers, outpatient specialty clinics and community support services. Our primary focus is to help members successfully transition throughout the continuum of care, eliminating their experience of fragmentation. The CMs work to make certain there is active care coordination among entities through collaborative efforts with the Interdisciplinary Care Teams (ICT) made up of our Utilization Management (UM) Manager, BH CMs, CMs, and Medical Director and Pharmacist. This is especially important during changes of placement, transitions necessitating referrals to new programs, such as hospice. When the needs of the member can be better met with alternative options such as ALTCS, the CM assists the member with the application process. In the event the member has transitioned to ALTCS while receiving hospice services, along with our Transition Coordinator following required processes our CM will reach out to the receiving hospice CM to provide meaningful information and help create a seamless transition for the member with no interruption of services.

Banner Home-Based Palliative Care

One approach to treatment that optimizes member quality of life by anticipating, preventing and treating suffering is palliative care. This patient and family-centered approach addresses physical, intellectual, emotional, social and spiritual needs while facilitating patient autonomy, access to information and choice. It allows for the provision of curative treatment regimens, but with an emphasis on symptom-relieving care, especially controlling pain. Through our Banner Home-Based Palliative Care (HBPC) program and our partnership with the University of Arizona (UA) Center on Aging, we participated in the development of effective care models to identify patients who will benefit from palliative care and hospice in a patient-centered, culturally appropriate manner consistent with their ADs. Our program is available for members at of any age or any stage in the illness and can be provided in conjunction with curative treatment outside of hospice. Palliative care is a collaborative approach, which includes physicians, NPs, RNs, social workers, patient care coordinators and chaplains, when requested. This team works alongside a patient's provider delivering treatment concurrently with disease-directed therapies. The HBPC services are triggered by a decision-support algorithm within the Electronic Health Record (EHR) which generates clinical referrals for patients who would benefit from palliative care. These criteria depend on symptom burden, functional dependencies, family and social support needs, and requirements for clear information about options and what to expect. The HBPC program provides consultative services throughout many parts of Arizona, including many rural and culturally diverse areas. Through a collaborative agreement, B-UFC will provide members of any age with serious chronic or complex illnesses the needed medical care for their condition and member-centered palliative care as required in AMPM policy 310. The key elements of the program include coordination of care with PCPs, patient and family education, as well as support and assistance with AD execution. The program also focuses on improved communication throughout the continuum of care so that all are aware of the member's treatment choices and EOL preferences. In addition, patients are seen within 72 hours of referral to conduct a psychosocial assessment, discuss symptom management and complete a reconciliation of all medications. Banner conducted an evaluation in 2014 and 2015 to evaluate the impact of their program by reviewing the costs of care prior to death among patients cared for within their palliative care program compared to those who received routine care as described in the table below. The palliative care group had statistically significant lower readmissions and costs in the last three months of life.

Performance Indicators	Routine Care Measurement Period 2014 - 2015	Palliative Care Measurement Period 2014 - 2015	p-Value
Readmission Rate	22.6%	7.7%	<.0001
Per member inpatient medical costs in last 3 months of life	$5,946	$1,137	<.0001
Per member total medical costs in the last 3 months of life	$27,530	$9,834	.002
Per member total medical costs in the	$26,676	$10,650	.015

last 3 months of life with cancer			
PMPM total medical costs in the last 3 months of life with at least one chronic condition	$2,461	$1,313	0.049

INNOVATIONS

B-UFC stands committed to the development and expansion of innovative programs and delivery options for members experiencing major transitions in their lives. As an ALTCS Contractor, B-UFC will accomplish this through continued collaborations with key partners and the formation of new partnerships to address the critical life transition issues caregivers, families and members face daily.

Palliative Care Telemedicine Program

Beginning in 2018, B-UFC will expand our HBPC program by financially and operationally supporting the development of a Palliative Care Telemedicine Program (PCTP). The PCTP team will include physicians, psychologists, nurses, social workers and chaplains who can assimilate and negotiate the interpersonal relationship skills and the intimacy required to enhance the patient's peace and psycho-social-spiritual comfort. Compassionate palliative care requires a professional readiness of those specialized in this field to explore the integrity-preserving issues that will foster growth in dignity and transcendence. As with the current HBPC, the PCTP program will focus on co-management with PCPs, goal setting and ACP, symptom management, disease-specific prognostication, psychosocial assessment, patient and family education, practical and social supports, continuity improvement across the continuum of care, and pharmacy medication reconciliation. Once the physically adverse symptoms and distress are addressed, the PCTP team will broaden its integrated response to address the psychosocial and spiritual issues that are an inherent part of the aging process. Though not all support care services are Medicaid covered benefits, our CMs and the PCTP team will coordinate many of these services through natural supports or community resources. This serves members greatly, helping them to find meaning in the dying process and achieve a sense of control while confronting serious declines in health, the inability to remain in one's home as well as preparing for death.

The PCTP will employ available technologies, including a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology. Through this technology, the program will include the monitoring of symptoms by conducting video consults and visits as appropriate and conducting family meetings. A comprehensive psychosocial and spiritual assessment allows the team to lay a foundation for healthy patient and family adjustment, coping and support. The team will use skilled therapeutic communication tactics to facilitate discussions on treatment options and choices, and decisions about members' wishes as they approach the end of life.

Palliative Care for Dementia

Dementia care requires a distinct approach to delivering care and service to members with dementia: in part because of the long, unpredictable course of the disease, the complicated issues around capacity for decision-making, difficulties in communication and lack of community understanding. Dementia, prevalent among elderly ALTCS members, will be an important focus of our innovative training strategies. Drawing from current successful models such as the Banner HBPC program, Hospice of the Valley's (HOV) Palliative Care for Dementia Program (PCDP) and Comfort Matters at Beatitudes Campus, B-UFC will develop a person-centered and palliative approach to dementia care in our contracted SNFs and Assisted Living Facilities (ALFs). During the first year of the contract, UAHP will identify SNFs and ALFs that are interested in implementing the PCDP and assess their level of readiness. During the readiness process, B-UFC will meet and discuss the specific requirements of the program and the infrastructure needed to achieve implementation. As appropriate, B-UFC will offer support services to assist willing providers in moving toward a state of readiness to implement the program. By the end of contract year one, B-UFC expects to have identified two to three facilities that are prepared to offer this innovative program. During year two of the contract, UAHP will pilot the program with two to three select providers. UAHP will incentivize providers who offer the PCDP through a two-tier reimbursement arrangement. Tier one includes additional reimbursement for implementing the program; tier two offers additional reimbursement based on select performance measures, such as the completion of ADs, timely referrals to hospice, a decrease in the utilization of anti-psychotic medications and a decrease in inappropriate utilization associated with dementia. B-UFC will continually

monitor the success of the program and implement modifications as needed. Additional providers will be offered participation in the PCDP as appropriate.

Expanding Education Opportunities

Beginning in year one of the contract, B-UFC will comply with AMPM policy 310 by offering providers, members and employee's on-going EOL care education and training. Working with our established partners and developing collaborations with other agencies and organizations, B-UFC will offer innovative and customized training not only for CMs but also for other health care professionals, members and their families. In both urban and rural areas, we will offer training programs to educate people and professionals about EOL choices, ACP discussions, hospice and palliative care. We will seek to collaborate with internal and external organizations and agencies that are focused on palliative and EOL care for members of all ages.

Currently, we have affiliations with organizations that have expertise in providing care and service to the frail and elderly. These include partnerships with the UA Center on Aging, the Banner Alzheimer's Institute, the Banner HBPC program and the Arizona Geriatrics Workforce Enhancement Program (AzGWEP). Through our affiliation with the UA Center on Aging, the Banner Learning Center and the Banner Alzheimer's Institute, all our ALTCS CMs will have access to additional training on topics such as dementia, Alzheimer's, depression in the elderly, hospice and sensory/mobility deficits which are prevalent among ALTCS members. In addition, all our CMs will receive training in managing life transitions for members with dementia and be classified as dementia-capable. A core set of training will be required for all LTC CMs during their first year of employment. The AzGWEP provides critically important interprofessional education and training throughout Arizona. B-UFC will continue to work with them to improve the interdisciplinary geriatric training for health care professionals throughout Arizona. The goals of the AzGWEP program include: (1) develop and disseminate curricula throughout Arizona related to the treatment of the health problems in the elderly, (2) improve access to geriatric services for those seeking quality care in a culturally sensitive manner and (3) improve the training of health professionals caring for vulnerable and culturally diverse populations in Arizona, especially in rural areas. In addition, Banner's Cardon Children's Medical Center is developing a Pediatric Palliative Care program. B-UFC will call upon experts from this program to augment our training program to address EOL issues for pediatric members and their families. Via our partnerships and collaborations, we will offer these trainings through a variety of formats, such as provider forums, live streaming, on-demand webinars and in-person training. We will offer CMEs to physicians who participate in the training and CEUs for other clinicians as appropriate.

Legal Services Education Model

Through the RFP process, B-UFC will identify and partner with a legal/family advocacy agency with expertise in supporting and educating those who are experiencing significant decision making challenges associated with ACP and other EOL decisions. Through this partnership, we will develop a legal services education model that will offer CMs, Direct Care Workers (DCWs), Community Health Workers (CHWs), members and their families with education and resources focused on significant life transitions. The content will include culturally competent ACP, ADs, Power of Attorney (POA), medical POA, mental health POA and other topics relevant to those facing EOL decisions. The RFP will be released in Q2 of year one of the contract, a partner will be selected in Q3 of the first year of the contract and the education model will be implemented in Q1 of year two of the contract.

In addition, UAHP will award Capacity Building Grants to community-based organizations throughout our covered GSAs. Through a Request for Grant Application (RFGA) process, UAHP will award grants in the amount $10,000 to up to six entities throughout all awarded GSAs to become Master Trainers in EOL decision-making and the associated legal considerations. Grantees will receive the following:

- Travel and administrative expenses to send two representatives to Tucson for a five-day Train-the-Trainer Series delivered by our partner advocacy agency.
- Monthly technical assistance sessions offered in a group format to all new trainers to confirm understanding of the material, answer questions and provide support as trainers begin facilitating their regional workshops.
- The Trainers will co-facilitate or observe a minimum of one workshop offered by each new trainer and provides coaching/feedback for continued enhancement.

After the initial training series, participants will be considered B-UFC Certified Trainers. After the first year and through participation in the monthly technical assistance sessions and B-UFC Trainer co-facilitation or observation of at least one

workshop, participants will be considered Certified Master Trainers. Each grantee will be required to provide a specified number of trainings/workshops annually to CMs, DCWs, CHWs, members and their families based on regional need. Target audiences may vary per workshop. For example, a grantee may choose to provide one workshop exclusively for members and their families and a separate workshop exclusively for DCWs. Grantees will also be required to provide individual support services to caregivers, CMs, members and families as needed and within their geographical area. A Master Trainer Team will be assigned to one of six regions depending on the GSAs awarded.

- Pima County
- Southwest Arizona
- Southeast Arizona
- Maricopa County
- Northwest Arizona
- Northeast Arizona

Community Health Worker Webinar Series

In addition, through our advocacy agency partnership described above, we will develop a webinar series consisting of five, 45-minute webinars providing educational information on culturally competent ACP, ADs and other EOL care planning matters facing ALTCS members and their families. Each of the five webinars in the series will include a required competency test to progress to the next webinar within the series. Participants will also be required to pass a longer competency test with a culmination of information after completing all five sessions. UAHP will host the webinar series on our web-based learning management system platform, will advertise the availability of the series and will manage participant tracking. Target audience is CHWs. All CHWs who complete the series and pass the required competency tests will be given a B-UFC Certification as having advanced knowledge in EOL care planning. This program will be implemented on or before September 30, 2019.

Cultural Awareness during Life Transitions

Enrollees of non-Anglo ethnicity make up almost half of our D-SNP, University Care Advantage (UCA) membership and are half as likely to complete ADs. Twenty-three percent of Anglo enrollees completed ADs, while only 10% of Hispanic enrollees did so, and 13% of other non-Anglo non-Hispanic enrollees did so. To address this disparity of our ALTCS members who have specific cultural needs, B-UFC will promote the following tactics to help foster a culturally sensitive approach to EOL transitions. B-UFC will partner with community agencies in all GSAs awarded to develop culturally competent community health Promotora models for EOL transitions. The goal of the models will be to help bridge communication gaps between the plan, providers and the member/family. Most importantly, they can serve as the family's advocate and a "sounding board" for questions along an unfamiliar journey. The cultural sensitivity and skills required for these tasks suggest the need for a trained bi-lingual, bi-cultural community member who is aware of the values of secrecy and denial, as well as the important role of the family in these decisions. B-UFC will employ a regional case management program where our CMs will likely live in or near the communities they serve and will be familiar with cultural customs and norms. Also, in partnership with Martha Monroy, Rural Programs Manager at the UA College of Public Health and Promotora trainer, B-UFC will develop curricula to train the Promotoras to engage ethnic minority members and their families in Pima and Yuma counties in dialogue regarding their EOL wishes within the first contract year of this award, with geographic expansion to follow later to all awarded GSAs.

Supporting Provider/Member ACP Discussion through Reimbursement and Incentives

CMS ACP codes were effective January 1, 2016. CPT Code 99497 ACP includes the explanation and discussion of ADs such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or representative. CPT Code 99498 is used for each additional 30-minute discussion. ACP services can be appropriately rendered in both facility and non-facility settings, and are not limited to particular physician specialties. B-UFC will reimburse providers for the approved CMS codes for our dually enrolled members in UCA. In addition, per AMPM policy 310, beginning October 1, 2017, B-UFC will reimburse providers who conduct face-to-face ACP discussions with the member or designee during a well or sick visit per AMPM policy 310. Further, we will augment provider revenue though our VBP agreements, intended to incentivize ACP and share savings with providers who can meet EOL and other relevant quality of life metrics, while reducing avoidable high-cost medical expenses.

5. THE OFFEROR HAS A NEWLY ENROLLED 32-YEAR-OLD MALE WITH A TRAUMATIC BRAIN INJURY WHO…

The University of Arizona Health Plans (UAHP) works with the member, Simon, to help him achieve overall health and wellness while placing him at the center of all service planning decisions. We will build upon our extensive experience, efficient operations and long-standing community partnerships, while leveraging our local orientation to respond to Simon's strengths and needs. We embrace the ALTCS program values and will make certain Simon is given choice, dignity, independence, individuality, privacy and self-determination. We are best equipped to meet Simon's needs and maximize his health outcomes through our member-centered, community-based approach to case management that integrates self-directed philosophy; our expertise in bariatric and healthy lifestyle programming; our Traumatic Brain Injury (TBI) training and consultation program; and our flexible approach to the delivery of primary care services.

INITIAL VISIT AND ASSESSMENT

Within two days of Simon's enrollment in Banner – University Family Care (B-UFC), the designated Case Aide (CA) contacts Simon by phone to welcome him and conduct a brief assessment of his situation and immediate needs. After the phone call, the CA creates a member electronic record in B-UFC Acuity, our comprehensive case management system, and sends it to a Case Manager (CM) Supervisor for review and assignment. The CM Supervisor uses the following Priority System coupled with his/her clinical judgment to determine if the timing of the initial visit should be less than the AHCCCS standard of 12 business days: *Priority 1-urgent need for services and CM makes appointment within one business day; Priority 2-routine Home and Community Based Services (HCBS) member living in their own/family home and CM makes appointment within seven business days; Priority 3-member residing in an Assisted Living Facility (ALF) or Skilled Nursing Facility (SNF) and the AHCCCS standard of 12 business days is followed*. Although Simon is in a SNF, the CM Supervisor categorizes him as Priority 1, given the pressure ulcer. The CM Supervisor assigns a CM based on his Pre-Admission Screening (PAS), priority level, geographic location, placement and demographic needs, such as language and cultural preferences. Due to his weight loss needs, open wound and potential risk for comorbidities, Simon is assigned an RN CM. We honor choice in the assigning of CMs consistent with self-directed philosophy.

TBI EXPERTISE

B-UFC will partner with the University of Arizona's (UA's) Arizona Leadership Education in Neurodevelopmental and Related Disabilities (ArizonaLEND) to offer training and expert consultation services to CMs. ArizonaLEND offers leadership training to prepare the next generation of policy makers, faculty, clinicians and researchers – positively impacting the workforce as it relates to providing quality care to members with TBI. We will also collaborate with the Brain Injury Alliance of Arizona (BIAA) to offer provider education related to TBI. Our parent company, Banner Health (Banner), has a long-standing relationship with BIAA, as a corporate sponsor, community partner and active volunteer for the non-profit organization. Collaboration with this nationally recognized leadership institute and statewide community partner prepares our CMs to respond to the unique strengths and needs of members with TBI.

Simon's CM, Lee, becomes his primary point of contact. Lee is trained in person-centered planning, self-directed philosophy and the recovery model. Lee lives and works in Simon's community, with awareness of all community, provider and social supports in Simon's region. Looking ahead to Simon's discharge, Lee is focused on caregiver support, as the additional mood disorders coupled with motor and cognitive issues associated with TBI can add additional stress and be exhausting to caregivers. This includes coordinating the most helpful services for Simon's caregivers, family and friends – such as home health aides or personal care assistants, respite care to provide breaks from caregiving, brain injury support groups, family psychoeducation, and ongoing or short-term counseling for caregivers and natural supports to adjust to the changes that have come as a result of the injury. Lee is part of a regional interdisciplinary Case Management Team and has access to and support from other specialized CMs, such as Community Specialists with in-depth knowledge of local housing, education and retraining, vocational and local community resources, as well as Behavioral Health (BH) CMs. Every team has access to a Qualified BH Professional (QBHP) responsible for required quarterly BH consultations, identifying individuals appropriate for BH reinsurance, monitoring BH tracking requirements, and offering BH-related consultation and training for all CMs and providers. The QBHP will review Simon's case a minimum of quarterly and will utilize evidence-based Milliman Care Guidelines for TBI, including access to educational resources for families experiencing challenges.

Lee conducts an initial face-to-face visit at the SNF within one business day, exceeding AHCCCS standards. While on-site, Lee reviews Simon's chart in detail with close attention to the pressure ulcer. He also reviews the PAS, Resident Review

and Minimum Data Set. During the initial visit, Lee orients Simon to B-UFC program components, including the benefits, covered services, placement and service delivery options, and grievance and appeals process. Lee provides Simon with a specialized ALTCS Member Kit, making the Member Handbook and Member Rights easier to review and digest. The ALTCS Member Kit also includes the Advance Directive (AD) booklet, 5 Wishes, a magnetic business card with Lee's contact information, and a quick guide to resources and advocacy strategies. A cover sheet is also provided to the SNF. After reviewing the kit with Simon (and if applicable, his family of choice), Lee obtains the necessary signatures – acknowledging Simon has received a clear explanation of the program and written copy of the Member Rights. Due to the record review, Lee believes Simon is receiving substandard care for the pressure ulcer and files a report with our Quality Management (QM) Department the same day.

Lee works with Simon to complete all necessary assessments, employing a systematic approach to assess Simon's strengths, needs, goals, hopes and dreams as they relate to: functional abilities; medical conditions; behavioral health; social, environmental and cultural factors; existing support system; and health/safety risks. Lee will utilize B-UFC's proprietary Strengths and Needs Assessment (SANA) to gather in-depth bio-psycho-social-spiritual information about Simon in a strengths-based, member-centered manner. Exceeding AHCCCS requirements, the SANA also includes a health risk and BH risk assessment with corresponding risk scores. These assessments are modeled after our success in implementation of the Health Risk Assessment (HRA) with our D-SNP population. Per AMPM Chapter 1600, the SANA gathers all necessary information to populate the required Uniform Assessment Tool (UAT). All required and additional assessment tools are uploaded to Lee's portable electronic device, with a section for Simon's signature.

Lee meets with Simon, along with anyone else Simon identifies for his care team, to initiate the person-centered planning process. Lee helps Simon develop reasonable, measurable and clearly defined short- and long-term whole-person goals related to his health, wellness and independence. Lee works with Simon, his identified natural supports and care team as part of the person-centered planning process and empowers Simon to manage his own health, create opportunities for positive change and select the appropriate care model and setting while upholding AZ's *9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services & Systems*. Person-centered planning is used to uncover Simon's strengths, goals and resources. Once established, the service plan is updated in the Client Assessment Tracking System. Lee also explains ALTCS self-directed care options and encourages him to think about whether the options meet his care needs in the future. Simon is told that with self-direction he can select or hire his own caregivers, set wages and give input to scheduling through the co-employer or fiscal management model.

Since Simon was living in a SNF at the time of enrollment, the Prior Period Coverage (PPC) Policy will likely apply. Lee will look at the services provided by the SNF before Simon was officially enrolled with B-UFC to make sure they were medically necessary and provided by an AHCCCS-registered SNF. If so, B-UFC is retroactively responsible for payment to the SNF at the agreed AHCCCS rate, less Simon's Share of Cost during the PPC. In turn, B-UFC will receive a PPC capitation from AHCCCS for the cost of PPC. In case Simon paid privately for some of his care during this PPC, Lee will confirm that the SNF refunds his money and agrees to accept the capitation amount.

QUALITY OF CARE (QOC) CONCERN

Upon receiving information from Lee, the QOC Team processes the QOC concern regarding Simon's Stage 3 pressure ulcer. The case is immediately assigned to a QOC nurse. The nurse and Lee make an on-site visit to the SNF within 24 hours. The investigation includes a tour of the facility, an interview with Simon, review of Simon's medical record, interviews with facility leadership and review of the facility's relevant policies and procedures. The nurse and Lee review the information with the Medical Director and determine the SNF's substandard care led to the development and progression of the ulcer. Upon this determination, Lee immediately starts coordinating with Simon, his family and other members of the care team to find an alternative placement. During placement coordination, the QM Department determines no other B-UFC members are currently residing at the facility. The QOC nurse calls AHCCCS to tell them B-UFC will be moving a member from the facility due to substandard care and will be placing a hold on any new admits. Lee finds an alternative SNF placement for Simon as soon as possible, confirming it has been verified to have bariatric care capabilities, decubitus specialization and the appropriate training and equipment to help Simon's wound heal and prevent future sores. Upon finding an alternative placement, Lee notifies and confirms agreement from Simon and his family, and the transfer is coordinated. The QM Team issues a findings letter to the facility within three business days of

the above decision and requests a Corrective Action Plan (CAP) related to the noted deficiencies. The CAP is due to B-UFC within seven business days of receipt of our deficiency letter. The facility provides B-UFC with a comprehensive CAP, including copies of their revised policies and procedures for pressure ulcer prevention and care along with documentation of training for all clinical staff. The CAP also speaks to how the prevention and care activities will be documented within the medical record and how pressure ulcers will be tracked and trended by the SNF's Quality Committee. B-UFC accepts the CAP and agrees to resume placement of members to this facility with close monitoring of any new admits.

MEETING SIMON'S NEEDS AND ASSISTING HIM TO ACHIEVE HIS GOALS

Living Arrangement. Issue 1: Stage 3 Pressure Ulcer **Plan:** Since the pressure ulcer was SNF driven, Simon must be immediately relocated. Simon's ulcer must be treated immediately to prevent escalation to a Stage 4. A wound specialist visits him and determines a shallow Stage 3 with necrotic tissue. The wound specialist debrides the wound at bedside to remove accumulated debris and handle the undermined wound edges. The wound specialist starts Simon on antibiotics and recommends negative pressure wound therapy along with low-air loss bed for optimal recovery. **Goals:** Stage 3 pressure ulcer is stabilized and begins to heal.

Issue 2: Need Alternative, Less Restrictive Placement **Plan:** Simon and his team all agree a SNF is not the best living arrangement for him, and he is no longer in need of institutional care. Lee helps him explore various living arrangements, such as moving to an Assisted Living Home (ALH) with TBI and bariatric specialization or to live with his family in a HCBS setting. The HCBS setting would include additional services – Attendant Care: for cleaning, laundry, etc.; Home Health Aide: for personal care related to bariatric needs; Home Health Intermittent Skilled Nursing Services: for wound care due to his pre-existing pressure ulcer, promoting proper care of his skin and avoiding further skin breakdown. Lee pre-screens a variety of placements, creates a list of ALHs that meet Simon's needs and arranges for visits. After exploring a few different ALHs, Simon chooses *Arnold's House*, an ALH with specialization in both bariatric and TBI related needs. Lee completes a Cost-Effectiveness Study prior to placement and sets up Home Health Intermittent Skilled Nursing Services to make sure Simon's wound is cared for safely and appropriately. Simon will receive assistance with his ADLs and IADLs from the ALH staff and will participate in his own care at his placement. Once Simon has decreased his weight and improved his mobility, he would like to explore opportunities to live in his own home or apartment. Lee supports Simon's goal to move into his own home and will reassess his living arrangement at a minimum of every 90 days. When Simon is ready to move, Lee will work closely with the B-UFC Supportive Housing Liaison to identify affordable integrated housing options for Simon. Lee works with our Durable Medical Equipment (DME) Specialist to identify all DME options that will maximize Simon's independence and safety. Considerations will be made to repair existing DME if viable, before purchasing new equipment (as outlined in AMPM policy 1250-F Customized DME and AMPM policy 310-P Covered Services). B-UFC contracts with *Sizewise* and other vendors that provide state-of-the-art DME. The table below outlines potential DME to assist individuals like Simon. While some of these options will be explored for Simon, only options determined to be reasonable, medically necessary and prescribed by his Primary Care Provider (PCP) will be ordered. Final decisions regarding the purchase of new DME will be made through consultation with B-UFC's DME Specialist. All purchases over $5,000 will be sent to our DME Review Committee to confirm medical necessity, explore alternatives and approve/deny as appropriate. Lee will coordinate benefits with Medicare, if applicable, and will work closely with the PCP. **Goals:** Short term – move from SNF to ALH; long term – live in own home.

Specialized bariatric bedframes that offer the following: • Prevent, assess and treat pressure injuries by managing moisture • Hold up to 1,000 lbs. • Offer easy entrance and exist with varying heights and lifts
Therapeutic support surfaces with solutions to help bariatric patients heal faster, including but not limited to: • Assistance repositioning while supporting pressure injury prevention protocols • Combination of alternation and static low air loss therapy to prevent and treat pressure injuries • Cooling technologies • Multi-zone technology to redistribute pressure • Perimeter foam for extra support

• Air chamber and pulsation technologies for pressure redistribution
Mobility items to support independence while preventing falls, including but not limited to: • Wheelchairs designed to support higher than average weights • Air transfer devices to make lateral transfers easier • Bedside lift and transfer devices • Bedside, shower and other specialized commodes • Devices promoting safe transfer to tubs • Specialized walkers, canes and crutches

Physical and Mental Wellness. **Issue 1:** Depression and Isolation. **Plan:** As individuals with TBI begin to recover from their brain injury and progress on the *Rancho Los Amigos Scale of Cognitive Functioning*, it is not uncommon for them to begin to feel levels of depression. This widely accepted scale to assess recovery from TBI includes 10 levels of cognitive functioning, beginning with Level 1 – no response/total assistance, and progressing to Level 10 – purposeful, appropriate/modified independent. Typically, when an individual reaches a Level 8, they begin to realize the losses in their life since their injury. This is likely the case for Simon as he grieves his divorce and loss of job, while realizing his morbid obesity and the barriers it poses for leading a healthy and independent life. Lee will coordinate his participation in a cognitive rehabilitation therapy program specialized in treating TBI, such as Arizona Institute for Communication and Cognitive Disorders, Banner Desert Neurological Rehabilitation, Banner University Rehabilitation and HealthSouth Rehabilitation (all with which we have contracts/Letters of Interest in place). The cognitive rehabilitation therapy will help Simon work through his feelings of grief, depression and isolation while teaching him new ways to manage his life and increase his independence. Simon will also learn how to utilize assistive technology and other strategies to improve his self-management and provide necessary prompting for independence. Through the cognitive rehabilitation program, Simon connects with a TBI support group, helping him identify and accept his limitations. The QBHP will determine if Simon's depression requires a referral to a BH prescriber for further evaluation and care coordination if medication is prescribed for his depressive symptoms. Lee will confirm medication reconciliation and review of all medications by the pharmacist, medical director and his providers to track any contraindications and his response to medications. Recognizing the mind-body connection, decreased depression and isolation is also likely to aid in progress towards Simon's weight loss goals. **Goals:** Decrease depression based on valid depression screening scores (such as the PHQ-9). Develop and utilize a minimum of three new life skills. Identify and utilize a minimum of two assistive technology solutions to improve independent living. Engage in a minimum of one social activity per month.

Issue 2: Morbid Obesity. **Plan:** With guidance from Lee, Simon decides to work with Banner Gateway Weight Loss Center, a Bariatric Surgery Center of Excellence accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, to address his weight loss goals. Banner Gateway Weight Loss Center offers several programs to meet Simon's medical, behavioral and nutritional needs, including non-surgical weight loss, minimally invasive bariatric surgery and a unique Back on Track program for those who have had bariatric surgery and may be gaining weight back. Simon is assigned a team of bariatric specialists, including a doctor, nurse practitioner, dietitian, exercise physiologist and psychologist. His team begins the necessary assessment for appropriateness of minimally invasive bariatric surgery while also focusing on lifestyle changes for long-term success. As part of the assessment process, the team looks at Simon as a whole person, acknowledging his weight gain may be a symptom of other issues and working to identify the root-cause. The dietitian evaluates his nutritional needs and establishes a diet plan. He will also be assessed for diabetes. If he has diabetes, the team at Banner Gateway will provide the necessary diabetes support and education. Lee communicates the diet plan to the ALH staff to make sure appropriate meals are prepared in the home and the ALH staff assist him in maintaining a healthy diet. The Banner Gateway team works with Simon to develop a reasonable exercise plan. He also receives metabolic testing, body composition analysis and diagnostic testing. Clinical support is available to answer all his questions and concerns. If the specialists at Banner Gateway determine bariatric surgery is a viable option, Lee and the ALH team will provide active support to assist Simon to meet prior authorization requirements and maintenance steps. In addition to working with Banner Gateway, Simon and Lee work together to visit a variety of health promotion and physical fitness programs. Simon agrees that Ability 360 is a good fit, as they have the Assistive Technology he needs to help with his limited mobility while enabling him to slowly increase his strength and mobility. Ability 360's supportive staff have experience helping people with a variety of disabilities, including those with bariatric needs. Ability 360 also offers Simon a social outlet, and when he is ready, they can assist him with vocational rehabilitation programming. B-UFC already has contracts in place with Ability 360 – the Center for

Independent Living serving the greater Phoenix area and offering a variety of programming to individuals with disabilities, including: advocacy, employment services, Social Security Work Incentives consulting, reintegration from SNFs, life skills instruction, peer support, and physical fitness and health promotion through their fully accessible *Ability 360 Sports and Fitness Center (SpoFit)*. The SpoFit staff are skilled in working with individuals with limited mobility. His natural supports are included in the exercise routines to motivate and educate, so when services are no longer funded, natural supports can continue. **Goals:** Simon engages in physical exercise for 30+ minutes, five to seven days per week. Simon follows a diet plan as outlined by his nutritionist. Simon loses the recommended amount of weight and body fat percentage as outlined by the team at Banner Gateway.

Issue 3: Need for Ongoing Primary and Preventive Care. **Plan:** B-UFC offers a flexible approach to the delivery of primary care services – whether Simon needs to utilize telemedicine or physician home visits (through our Primary Care at Home program) due to his limited mobility, access a Patient Centered Medical Home, or work with one of our contracted physicians with a strong connection between physical health and neuro-rehabilitation through Banner Health Network's (BHN's) Accountable Care Organization (ACO). Simon works with Lee and his care team to evaluate his primary care options – he considers using Geriatric Solutions for in-home PCP services, but ultimately decides to select a PCP within BHN's ACO. His selected PCP specializes in the connection between physical health and neuro-rehabilitation. The PCP agrees to work closely with the team at Banner Gateway Weight Loss Center to support Simon's weight loss goals in addition to caring for his whole health, including his TBI. The PCP will assess for other potential co-morbidities associated with his bariatric concerns, such as diabetes, hypertension and/or sleep apnea. **Goals:** Simon achieves improved health as evidenced by reduction in risk assessment scores.

Financial Independence through Gainful Employment. **Issue 1:** Need to Understand Available Strengths and Skills. **Plan:** Lee authorizes a full neuro-psychological evaluation to assist in the vocational rehabilitation process. This evaluation helps to provide insights into Simon's strengths, skills and learning style. His cognitive rehabilitation therapy program helps him to review what is learned through the neuro-psychological evaluation while exploring his own new-found insights to develop a vocational goal that matches his strengths and interests. **Goals:** Identify job goal that matches strengths and interests within next 120 days. **Issue 2:** Need to Learn New Skills and Identify Job Opportunities. **Plan:** The cognitive rehabilitation therapy program aids in gaining new skills. Meanwhile, Simon decides to wait until he makes greater progress towards his weight loss goal before taking additional steps to obtain employment. Lee utilizes motivational interviewing to increase his commitment to work and assists him in utilizing the web-based, Arizona specific Disability Benefits 101 (AZ.DB101.org) program to learn how returning to work will impact his benefits, so he can make an informed decision about earning an income while accessing local and national work-incentive programs. When he is ready, Lee will assist him in connecting with the state Vocational Rehabilitation program to begin job development and placement activities. At that time, Lee will also confirm long-term job coaching supports are available to assist Simon in maintaining employment and achieving maximum satisfaction at his new job. Lee will consult with B-UFC's Supported Employment Liaison as needed. **Goals:** Obtain competitive, community integrated employment that matches Simon's skills and interests.

SIMON GETS HIS LIFE BACK

Simon's pressure ulcer is healing. He is residing in an ALH with the goal of moving into his own home with Member Directed Services soon – especially with the skills, insight and motivation he is gaining through his cognitive rehabilitation therapy program. Through his cognitive therapy program and associated TBI support group, he is beginning to re-enter the social world and decrease isolation. In partnership with his team at Banner Gateway Weight Loss Center, he is working towards his weight loss goal, including following a new diet and exercise plan. He is making new friends at Ability 360, which is furthering his motivation to be physically active. He is happy with the holistic approach taken by his PCP and relieved that Lee is providing coordination across all his care providers. Simon is informed about his self-directed options early because of his goal to live in his own apartment and because he is very active in his care. This allows him ample time to identify people who may be good employees for him down the road. Finally, Simon has been found eligible for the Rehabilitation Services Administration's Vocational Rehabilitation (VR) Program and is working with his VR counselor to solidify his job goal. We look forward to the opportunity to meet and exceed AHCCCS' expectations as an ALTCS plan, assisting members like Simon to achieve independence and wellness.

6. A YOUNG MALE VETERAN WITH A SERVICE CONNECTED SPINAL CORD INJURY AND POST TRAUMATIC STRESS…

The University of Arizona Health Plans (UAHP) will build upon our extensive experience, efficient operations and long-standing community partnerships to respond to the strengths and needs of this member, Jerome. Our approach to case management will honor ALTCS values of choice, dignity, independence, individuality, privacy and self-determination while Jerome engages in effective, evidence-based and self-directed services designed to treat the whole person. We are uniquely qualified to help Jerome achieve his whole health goals through our local orientation and collaborative partnerships. Jerome is eligible to receive many services through the Veteran's Administration (VA). One of the most important factors in serving him will be coordination of both benefits and services with the VA.

UAHP has established a collaborative partnership with the Arizona Coalition for Military Families (ACMF), focused on building Arizona's capacity to care for and support all service members, veterans and their families. Currently, 25 of our employees are certified Resource Navigators through the ACMF Military/Veteran Resource Navigator program – equipping them with the knowledge, information and skills to connect service members, veterans and family members to an array of resources. To better serve members like Jerome, Resource Navigator certification will become a part of the onboarding process for all Banner – University Family Care (B-UFC) ALTCS Case Managers (CMs). Additionally, 125 of our employees have completed the military culture training provided by ACMF. We encourage our network of providers to get involved by providing information about upcoming ACMF events and trainings, offering access to the ACMF network of resources and hosting collaborative provider forums. We send our employees and leaders to participate in the ACMF Statewide Annual Symposium each year and will become a sponsor and presenter of the 2017 symposium and all future symposiums throughout the life of the ALTCS contract, in an effort to make positive impacts on the system of care available to our veterans. Additionally, we will establish a scholarship fund to send at least three Direct Care Workers per region to the Annual Symposium for each year of our ALTCS contract. The scholarship will include a stipend to make up for loss in wages. Before October 1, 2017, we will become an AZ Veteran Supportive Employer as part of the AZ Roadmap to Veteran Employment, creating local, competitive employment opportunities for veterans and establishing opportunities for veterans to provide support to other veterans. Creating this opportunity for peer-to-peer support allows us to build relationships of trust and respect with our members in a way few plans can.

ASSESSMENT AND PERSON-CENTERED PLANNING

When Jerome first enrolled in B-UFC, his CM, Dan, realized Jerome did not yet have a serious mental illness (SMI) determination. In line with AMPM policy 320-P, Dan helped Jerome navigate the SMI determination process and made the necessary referral for evaluation. Following the evaluation, Jerome received the SMI determination. Dan, a Behavioral Health (BH) CM and certified Veteran Resource Navigator, is Jerome's primary point of contact. Dan has expertise in BH resources and is trained in trauma-informed care, person-centered planning and self-directed philosophy. Dan empowers Jerome to set and obtain meaningful and measurable short- and long-term goals. Dan will work jointly with the VA CM. Having Dan as his primary point of contact will eliminate the frustration Jerome might face dealing with the VA himself, avoiding fragmentation and possible duplication of services. Dan lives and works in Jerome's community – meeting Jerome where he is and working to build a relationship of trust while fostering hope. Dan spends time identifying support people who Jerome knows and trusts that he would like on his care team. Dan is part of a regional Case Management Team and has access to and support from other specialized CMs, such as Community Specialists with in-depth knowledge of local housing, education and retraining, vocational and local community resources; and RN CMs who provide advice when complex medical issues arise. As part of every Case Management Team, there is a Qualified BH Professional (QBHP) responsible for quarterly BH consultations, identifying individuals appropriate for BH reinsurance, monitoring BH tracking requirements, and offering BH related consultation and training for all ALTCS CMs and providers. Honoring choice as an important self-direction concept, if a member expresses dissatisfaction with CM services and dissatisfaction can not be resolved, we will agree to assign a new CM.

Dan coordinates benefits with the VA and builds a strong relationship with the VA CM. Additionally, he works with our Network Department to best align networks, eliminating any potential disruption to services based on payer. As the VA provides coverage for service related injuries, we will fill the gaps by offering health care for covered, non-military

service-related needs in a highly coordinated manner. This includes helping him access community-based programs and learn about other comparable benefits available to fill gaps when desired services are not covered by the ALTCS plan or are not deemed medically necessary – including identifying grant opportunities, such as the VA Independent Living Grant, to enable use of assistive technology like Amazon Echo to help Jerome become more self-sufficient.

Dan will spend time with Jerome in the Assisted Living Facility (ALF) to conduct a detailed assessment, employing a systematic approach to assessing his strengths and needs as they relate to functional abilities, medical conditions, BH, social, environmental and cultural factors, existing support system, language and health/safety risks. Dan will partner with Jerome to complete assessments in a manner sensitive to his needs and within manageable segments of time. Support people that Jerome identifies are invited to be a part of this process as well, so all life domains are addressed. Our needs assessment and care planning process includes these components:

- B-UFC's Strengths and Needs Assessment (SANA) gathers in-depth bio-psycho-social-spiritual information about Jerome in a strengths-based, member-centered manner and includes a health risk and BH risk assessment with corresponding risk scores.
- Uniform Assessment Tool (UAT) – to be completed by Dan with information gleaned from the SANA.
- AHCCCS-required HCBS Member Needs Assessment (HNT) for members receiving Attendant Care (AC), personal care and housekeeping services (once he is able to live independently in his own home).
- Member-specific goal sheet and ALTCS Member Service Plan signed by member/representative and copy provided to member. Goals are established based on strengths and address Jerome's hopes and dreams, consistent with person-centered planning. Supports needed to achieve his goals are clearly demarked.
- Other AHCCCS forms when required: contingency planning, spouse attendant care acknowledgement, agency of choice, self-directed AC, managed risk agreement, assisted living documents and Notice of Action.

All assessments and supplemental tools are pre-loaded in Dan's hand-held tablet so they are available during the visit. The assessment process will consider how Jerome's spinal cord injury and PTSD impact ADLs such as mobility, bathing, dressing, toileting, brushing teeth and eating; and IADLs such as cooking, driving, using the telephone or computer, shopping, keeping track of finances and managing medication. Dan will work with the VA CM to determine Durable Medical Equipment (DME) needs and primary payer, and will coordinate with B-UFC's DME Specialist to identify appropriate DME to enable Jerome to get around his home and community. If we are deemed primary payer, final decisions regarding the purchase of new DME or repair of existing DME will follow all guidelines and requirements outlined in AMPM policy 1250-F Customized DME and AMPM policy 310-P Covered Services. All purchases more than $5,000 will be sent to a DME Review Committee to confirm medical necessity, explore alternatives and approve/deny as appropriate – with the primary goal of increasing member independence and safety while being cost effective. As the suicide rate is high among veterans with PTSD, Dan will make sure a crisis plan is in place and Jerome has access to necessary crisis numbers and supports. Dan will also provide coordination of benefits. If Jerome is having a difficult time getting any necessary medication from the VA, B-UFC will cover the cost of medications as a bridge service during any gaps/waiting periods, with medical director approval. Dan also functions as an advocate to help Jerome get the appropriate care. Being member-centered, B-UFC sees the benefit in providing such bridge services. Applying the *9 Guiding Principles for Recovery-Oriented Adult BH Services and Systems,* Dan initiates person-centered planning activities. With Jerome's consent, the planning process engages his support network, including the ALF staff, VA CM, family and friends. Following the in-person visit, Dan conducts a cost effectiveness study, documents the service plan in Acuity Care Management System and uploads all required information into CATS within 10 days.

MEETING JEROME'S NEEDS AND ASSISTING HIM TO ACHIEVE HIS GOALS

Dan must consider and integrate non-ALTCS covered community resources as appropriate. Since Jerome's disabilities are service-connected, his care planning is complex due to the availability of similar programs through the VA and other veterans' organizations, such as the Paralyzed Veterans of America, the Wounded Warriors Project and the National Center for PTSD. Through his Navigator training, Dan will be aware of which provider (VA or ALTCS) has the more extensive program to meet Jerome's needs and will modify his care plan accordingly, determining the primary payer and coordinating the services. Dan explains the ALTCS self-directed service options available to Jerome – co-

employer/agency with choice and fiscal management services. While the VA also has these options, the number of people participating is controlled and small. Providers are reluctant to sign aboard due to ongoing reimbursement issues and report it is difficult to navigate the VA bureaucracy.

Independent Living. Issue 1: Limited independent living skills. **Plan:** B-UFC empowers Jerome to live in the least restrictive environment possible while maximizing independence and individuality. Since Jerome has become more independent in ADLs and IADLs per the most recent assessment, he is ready to move on to mastering increasingly complex skills in preparation for the independent living he desires. Dan works with the ALF to outline advance skill assistance to be provided in the short-term to teach him the necessary skills to move to a less restrictive environment. Dan prioritizes connecting Jerome with the right community-based providers and/or self-directed care to continue skill mastery once he has moved into his own home. Jerome already completed a Comprehensive Interdisciplinary Inpatient Rehabilitation Program through the VA, offering intensive services and life skills training during the early phase after his spinal cord injury. However, once Jerome is living in his own home, in-home skills training and ADLs and IADLs support through a community-based VA program or a provider Jerome hires himself through a self-directed option will be critical to setting him up for success. Dan will make certain a contract or single-case agreement is established with the VA provider to avoid disruption of services and seamlessly coordinate benefits. If Jerome's BH condition becomes a barrier to achieving the necessary life skills, B-UFC also has established contracts with integrated providers (such as COPE) who have BH expertise and utilize evidence-based strategies to teach necessary life skills to individuals with BH challenges – including community-based in-vivo assessment of skills and areas for improvement, taking time to clarify goals and identifying motivating factors to enhance Jerome's dedication to learning the skills, orienting him to the new skills, breaking skills down into steps (e.g. task analysis), demonstrating successful completion of the skill and providing real-life practice with coaching and feedback to build towards skill mastery. **Goals:** Jerome will achieve and utilize daily a minimum of six new life skills within the next six months.

Issue 2: Jerome has limited mobility due to spinal cord injury. **Plan:** Dan works with the VA CM to determine primary payer for mobility assistance and weighs the benefits of working with the Paralyzed Veterans of America program. B-UFC has established contracts and/or Letters of Interest with all local Independent Living Centers to provide a variety of services to members through all awarded GSAs, including but not limited to assistance assessing and implementing home modifications that increase mobility, independence, safety and comfort. The Home Access Program at DIRECT, the local Independent Living Center in Tucson, may be a viable option for Jerome. Through this program, Jerome is assisted in identifying specific features that will be important to have in his new home – such as: barrier-free entrance, full extension drawers, accessible tub and shower, lever handles on doors and faucets, wider hallways and doorways, higher electrical outlets, non-slip tile and low pile carpet, and environmental controls including voice assisted home controls (i.e. A/C and heating, security system, lights and communication devices). The Home Access Program also helps him discover simple ways he can further his independence and mobility through eliminating clutter, putting reaching devices in every room, relocating furnishings and changing where activities occur for ease of access. Once a home is identified, the Home Access Program will help him outline important modifications and put together a plan for how these will be accomplished, including assistance identifying funding sources. While the ALTCS program and the VA cover the cost of the medically necessary modifications, there may be a need for alternative funding sources for modifications that will increase comfort level, but may not be medically necessary. Dan will assist Jerome in working with the Home Access Program to identify and follow up with community resources like Rebuilding Together, a nonprofit providing home repair and modifications to people with disabilities, veterans and military families. Additionally, Jerome continues to participate in outpatient physical and occupational therapy (PT/OT) through a VA program, with benefits augmented through B-UFC as needed. Because ALTCS only provides a limited amount of OT and PT, Dan will make sure Jerome continues to have VA benefits for therapy. **Goals:** Identify and prioritize home modifications and simple organization strategies within the next 30 days. Increase mobility as evidenced by PT/OT assessment.

Issue 3: Need for affordable housing with supports. **Plan:** Dan will work with the B-UFC Housing Liaison and VA CM to identify Permanent Supportive Housing (PSH) options. The Housing Liaison oversees B-UFC's PSH program available for members with SMI determination, complying with ALTCS requirements and making certain all contracted housing providers follow the SAMHSA model for evidence-based practice in PSH. Dan helps Jerome identify available housing,

understand lease agreements and financial responsibilities. B-UFC will operate a *Move-in Assistance and Emergency Housing Fund* to assist members with move-in fees (application, first/last month's rent, security deposits, etc.), emergency eviction prevention and utility payments when eligible. Dan will first try to identify funding and/or comparable benefits through the VA and/or ACMF. If VA funding is unavailable, Jerome will utilize the *Move-in Assistance and Emergency Housing Fund*. B-UFC will offer contracts to all HUD-Veterans Affairs Supportive Housing (HUD-VASH) providers while maintaining a robust network of housing providers that apply the following standards: Housing Quality Standards inspections, fair housing laws, the AZ Residential Landlord Tenant Act, Use of the Vulnerability Index Serve Prioritization Decision Assistance Tool, SAMHSA PSH evidence-based practice and other best practices. B-UFC's Housing Liaison will provide behind the scenes support to Dan. The Housing Liaison works closely with the Network Department to develop, support and monitor a network of Housing Providers and maintains knowledge of affordable housing options – serving as an expert resource. The Housing Liaison also establishes and manages the *Move-in Assistance and Emergency Housing Fund*. In coordinating with the VA and under the guidance of the Housing Liaison, Dan will connect Jerome to the VA home buying programs and assistance, including the Specially Adapted Housing Grant and Special Home Adaptation Grant offered through the VA. These grants are for veterans with permanent service-connected disabilities to purchase or construct a home, or modify an existing home to accommodate a disability. Dan helps Jerome assess eligibility and apply for relevant HUD programs, such as Section 8, Shelter Plus Care and HUD-VASH to obtain housing assistance. Jerome selects to work with La Frontera, a Tucson-based and B-UFC contracted supportive housing provider who offers a new program designed specifically for veterans. **Goals:** Short term – Jerome will move into his own apartment within the next six months. Long term – Jerome will own his own home.

Meaningful Community Engagement. Issue 1: Needs motivation and assistance identifying accessible social/recreational opportunities. **Plan:** Dan helps Jerome compile a list of interests and reviews providers that may be a good fit for Jerome and who offer psychosocial rehabilitation services to increase coping skills, promote healthy lifestyles, support groups, peer support, and other meaningful and outdoor activities. With Dan's assistance, Jerome explores an array of options – including engagement with the Special Olympics, Disabled Veterans Off Road Adventures, The Independence Program and Project Odyssey, to name a few. Jerome is thrilled about engaging with the Disabled Veterans Off Road Adventures program, feeding his love of the outdoors while providing him the opportunity to socialize with peers. Jerome also decides to get involved in the Special Olympics. Dan sets Jerome up to become trained as a volunteer and future mentor. Becoming a volunteer and mentor for the Special Olympics helps him begin to solidify his vocational goals and develop work experience. Jerome identifies a friend from the VA who is willing to accompany him on many of these activities, and Dan helps Jerome make the necessary arrangements for his friend to become a paid support. *As a long-term sponsor of the Special Olympics of AZ, UAHP contributed $45,700 and 173 volunteer hours in 2016 alone.* **Goals:** Identify social and recreational activities and engage in minimum of one activity per month, beginning in the next 30 days.

Employment. Issue 1: Jerome cannot return to his previous employment due to his disability and needs assistance identifying a new employment goal and developing necessary skills. **Plan:** Jerome and Dan will work with our Supported Employment Liaison who has received training from the Work Incentive Informational Network. The Supported Employment Liaison fulfills all AHCCCS required activities, including training CMs on incorporating the Arizona Disability Benefits 101 resource tool into personal goal development. B-UFC CMs will receive advanced training in Supported Employment, understanding how to engage in vocational discussions, navigating the resources available to best understand SSA Work Incentives (including Ticket to Work), and connecting members with Supported Employment providers and the Vocational Rehabilitation program. Based on DB101, AHCCCS Freedom to Work, SSA Work Incentives and VA pension, Dan will work with Jerome to make an informed decision about returning to work. Jerome will be given the necessary education to help him fully understand how earning an income impacts his benefits and take advantage of all available work incentives – including connecting him with DIRECT for assistance setting up a Plan to Achieve Self Support (PASS) account through Social Security and Individual Development Account, a tool designed to enable individuals and families to save towards a targeted amount usually used for building assets, to help him save money (without affecting his benefits) to purchase his own home. Initially, Jerome's biggest fear about returning to work was

losing his benefits, but after Dan helps him understand the available work incentives, including Medicaid buy-in options, he is confident he can achieve employment without losing his benefits, especially health care. Dan will work in conjunction with the VA CM to help Jerome access the VA Vocational Rehabilitation (VR) program so he receives the necessary supports, assessment, guidance and counseling to assist him in developing an employment goal and determining any training needs and/or vocational skill building. Jerome would be able to use his post 9/11 GI bill for education if desired. He may also choose to access Operation PAVE, the Paralyzed Veterans of America's vocational program. **Goals:** Identify a job goal that matches his strengths and interests within the next 90 days.
Issue 2: Jerome needs help understanding the labor market, seeking a job, identifying necessary job accommodations, acclimating to the job and maintaining the job. **Plan:** Once Jerome's job goal is determined, the VA VR program will help him obtain any needed job training. The VA VR Counselor will provide or contract pre-job training, job development and placement services to help Jerome land a job that matches his goal. The VA VR program will also provide time-limited job coaching to help Jerome understand his job duties, acclimate to the job, and request accommodations to maximize his productivity and success on the job. Due to the nature of his PTSD, Dan will make certain Jerome has access to time-unlimited follow-along supports to help him maintain his employment long after the VA VR program closes his case. For continuity of care, B-UFC will contract with Supported Employment providers who are mutually contracted with the VA VR program – allowing Jerome to continue working with the same job coach regardless of payer. We also make available to Jerome the *Hiring our Heroes program*, a U.S. Chamber of Commerce organization that works with veterans and their spouses**.** Our parent company, Banner Health, is helping military veterans obtain meaningful employment through Hiring our Heroes Corporate Fellowship program. This program matches service men and women with an employer partner where they spend three months working and meeting people throughout the organization. The program has an 80% successful placement rate and has assisted thousands in finding employment. **Goals:** Obtain a job he is proud of and feels successful in within the next 12 months.

Emotional, mental and physical health. **Issue 1:** Needs assistance managing his PTSD and coping with the changes from his spinal cord injury. **Plan:** Although Jerome is aware of the VA PTSD support groups and programs, since he is already involved with COPE, he selects to utilize the COPE integrated BH/PH program to assist him in managing his PTSD and coping with the changes from his spinal cord injury. He receives psychiatry and peer support through COPE. He also participates in group counseling, health promotion classes and individual counseling services to build coping skills and resilience. As the suicide rate is high among veterans with PTSD, Dan will work with the team at COPE to address any potentially worsening symptoms and establish a crisis prevention plan. **Goals:** Identify and utilize at least two new coping skills to manage PTSD, within the next 90 days**.** Maintain whole-person health, as evidenced by integrated health assessment.
Issue 2: Jerome needs ongoing primary care and preventative physical health care services. **Plan:** Jerome is thrilled to receive his physical and BH services through one agency (COPE) and location. He is happy his team will work closely as one interdisciplinary team; he won't be required to go through multiple intakes and, because COPE participates in a B-UFC Value-Based Purchasing agreement, is paid based on their ability to improve his overall health and wellbeing. **Goals:** Maintain whole-person health, as evidence by integrated health assessment.

CARE COORDINATION HELPS JEROME ACHIEVE HIS GOALS

By building upon our extensive experience, efficient operations and long-standing community partnerships, we are able to help Jerome achieve his goals of living in his own home, becoming employed and engaging in meaningful community activities – including reconnecting with his love of the outdoors. The person-centered planning approach utilized keeps Jerome at the center of the planning process. He feels listened too and is satisfied because his hopes and dreams are coming to fruition. Further, Jerome is given control and choice over what services and supports he wants, who provides them and when they are provided. He is empowered to select caregivers who are veterans to provide personal care services and accompany him on social activities. Not only is he satisfied, but veterans who were struggling to find work are given an employment opportunity. Jerome's situation is an excellent example of how coordinated, collaborative care can eliminate fragmentation and result in the best outcomes for members.

7. IT IS ESTIMATED ONE IN FOUR ARIZONANS WILL BE OVER THE AGE OF 60 BY 2020. IT IS REPORTED THAT THIS…

The paraprofessional workforce is vital to helping ALTCS members achieve the highest degree of independence while maintaining their health in the least restrictive environment possible. Paraprofessionals fulfill many important roles within ALTCS: from Alternative Home and Community Based Services (HCBS) settings (such as Assisted Living Facilities and Skilled Nursing Facilities), personal and Attendant Care (AC) in HCBS settings, to community-based health promotion, peer support, rehabilitation, life skills training and more. Creating clearly defined roles for paraprofessionals and a financially secure place within our system of care will address workforce shortages and help us meet the increasing health care needs of our aging population and changing demographics. As a locally owned and operated non-profit health plan, we reinvest in our community through workforce development efforts and the creation of more local jobs. As a part of the AHCCCS required workforce development plan, The University of Arizona Health Plans (UAHP) will proactively identify potential threats to the workforce, analyze the potential impact of said threats, develop and implement interventions to prevent or mitigate threats, and measure and monitor workforce sustainability.

CURRENT PARAPROFESSIONAL LABOR MARKET AND ANTICIPATED LABOR NEEDS TO SERVE ALTCS MEMBERS

The need for increased skill-set amongst the paraprofessional workforce is prevalent. AHCCCS public comment from our community called for increased training and support for HCBS providers who are offering services in the member's home as Direct Care Workers (DCWs), which supports the need for development of advance training modules. During the public comment period, the local AZ community also made clear the need for new initiatives related to End of Life (EOL) care. The community has acknowledged a need for workforce development and community education targeting families and providers as it relates to EOL care. This need will affect the current and future ALTCS paraprofessional workforce.

According to the Bureau of Labor Statistics, employment of health care occupations, including "health care support occupations" (such as home health aides, community health workers and other paraprofessionals), is projected to grow 19% from 2014 to 2024. This faster-than-average growth will add about 2.3 million new jobs across the country. Health care occupations are expected to add more jobs than any other group of occupations.[i] The occupational outlook in AZ from 2014 to 2024 for paraprofessional roles in health care delivery is as follows:

- Health care support workers will grow 14%, adding an additional 230 jobs.
- Home health aides will grow 30%, adding an additional 4,960 jobs.
- Community health workers will grow 22%, adding an additional 200 jobs.
- Community and social service specialists will grow 24%, adding an additional 440 jobs.[ii]

Based on this labor market research, our ALTCS enrollment projections, the Health Affairs' projection that 180,000 Arizonans will be receiving long-term support services by 2021, and the assumption that 40% of those will be ALTCS enrollees[iii], we anticipate the need for about 588-1,272 paraprofessional positions across our ALTCS provider network.

STRATEGIES FOR RECRUITMENT, HIRING, DEVELOPMENT AND RETENTION OF PARAPROFESSIONAL WORKFORCE

UAHP understands the needs of ALTCS members, providers and stakeholders, and will direct our workforce development strategies specifically towards paraprofessionals working within the ALTCS system. To assist with these needs, we will hire a full-time Workforce Development Administrator no later than 1/1/2018 focused on recruitment, hiring, development and retention of the paraprofessional workforce. The Workforce Development Administrator will also make certain UAHP complies with all requirements outlined in A.A.C. R9-10-1006 and AMPM policy 1060 in the same manner as required of the Regional Behavioral Health Authorities, including the creation, implementation and management of a comprehensive system of workforce training and development programs. Such programs will be designed to develop a qualified, knowledgeable, skilled and culturally competent subcontractor workforce that consistently provides high-quality services to members. The primary way to impact the paraprofessional workforce is through support of our network of providers. As such, our Workforce Development Administrator will work closely with our contracted network of providers and in conjunction with the UAHP Network and Provider Relations Departments. It has been our experience that meaningful, effective and long-lasting workforce development and capacity building efforts cannot happen within the vacuum of one single program or system; therefore, we are excited to coordinate our efforts with those larger, statewide workforce development efforts targeting paraprofessionals throughout the health care industry. As a long-standing member of the Community Health Worker (CHW) Workforce Development Coalition and Leadership Council and as a partner with the University of AZ (UA), we bring unique resources, ability and depth of knowledge to truly impact workforce issues across our state in a way no other health plan can. We are excited to leverage these resources in a manner that positively impacts the ALTCS community and health care delivery system

statewide. Our approach includes six strategies: 1) establish and implement a comprehensive DCW provider monitoring and training plan; 2) establish a Workforce Development Advisory Council; 3) develop and implement specialty advanced training programs, 4) identify new labor pools and engage in coordinated recruitment efforts; 4) align efforts with the statewide AZ CHW Workforce Coalition and Leadership Council; and 6) take a collaborative approach to workforce development.

Strategy 1: Establish and Implement a Comprehensive DCW Provider Monitoring and Training Plan

UAHP will support AHCCCS' training and testing requirements for DCWs. Beginning on 1/1/18 and during the term of our ALTCS contract, in close collaboration with our Workforce Development Advisory Council, we will develop and implement a comprehensive DCW Provider Monitoring and Training Plan, with input from our network of providers, paraprofessionals in the field, members, family members, advocates and others vested in solving DCW workforce development issues, such as the AZ DCW Association and the AZ Geriatric Workforce Enhancement Program. The plan will include these elements:

- Conduct an environmental survey of current DCW workforce within our provider network, Approved DCW Training and Testing Programs (Approved Program) and current AHCCCS audit results, curriculum review of all non-standardized curriculum, test scores and competency reports, and Approved Program rate of participation in the AHCCCS online database (dcwrecords.azahcccs.gov). After completion of baseline survey, develop regularly occurring survey requirements (e.g. annual or bi-annual) and include in provider contracts.
- Establish a mechanism by which DCWs are incentivized to participate in workplace culture surveys.
- Develop a *Speakers Bureau* to present information about DCW workforce needs and employment opportunities to high schools, community colleges, unemployment programs, veteran employment programs, refugee relocation employment programs, churches, DES unemployment offices and other labor pools. Recruit paraprofessionals and provider agencies to participate as speakers in the Speakers Bureau, sharing personal stories, offering more information about DCW training programs and job opportunities, and inspiring the pursuit of a career as a paraprofessional serving ALTCS members.
- Establish a shadowing program, providing DCWs an opportunity to shadow a variety of health care professionals while encouraging their exploration of career growth within the health care industry.
- Increase provider participation in job fairs. Collaborate with One Stop Resource Centers throughout the state, AZ at Work, Vocational Rehabilitation, LINKAGES, Centers for Independent Living, Area Agencies on Aging, community colleges, and other regional and statewide workforce development groups to collaborate in the development, promotion and advertising of job fairs, especially the creation of local job fairs in rural areas.
- Conduct post-initial and ongoing onsite audits of Approved Programs, 180 days post-AHCCCS approval and annually thereafter. Engage in ongoing monitoring of Approved Programs who scored below average on their audits, offer financial incentives for those Approved Programs with higher than average scores and other activities as deemed necessary and appropriate.
- Develop financial incentives and other strategies to promote provider innovation related to recruitment, training and retention of DCWs – especially as it relates to employee satisfaction, frequency of supervisory visits, demonstrating improved retention, competitive pay, employee benefits, offering full-time hours, paid vacation, childcare reimbursement, stipends for advanced training and the development of a career ladder.
- Work collaboratively with our providers to develop a compassion fatigue and grief management program – providing an outlet for DCWs to process feelings of loss and reduce compassion fatigue in a supportive setting.
- Collaborate with our provider network and other stakeholder groups to establish and make available through our web-based learning system a series of ongoing training and advanced training modules to compliment and build upon the initial required DCW training, allowing DCWs to advance within their field. As an example, we will develop a training series related to EOL care and a series related to legal matters affecting ALTCS members (to be implemented on or before 12/1/18).

Strategy 2: Establish an ALTCS Workforce Development Advisory Council

The UAHP ALTCS Workforce Advisory Council (Council) will be established on or before 1/1/18, chaired by the UAHP Workforce Development Administrator and made up of: ALTCS providers representing each GSA served, paraprofessionals working within a variety of ALTCS programs, ALTCS members and/or family members, advocates, educational institutions and other stakeholder groups. The Council will meet at least quarterly to provide boots-on-the-ground perspectives on potential threats, challenges and opportunities related to workforce development in local

communities throughout AZ, including an analysis and comparison of the unique needs in rural versus urban communities. Council members, along with the Workforce Development Administrator, will assist in the development and distribution of an Annual Provider Workforce Survey, review survey results and assist UAHP in devising and implementing response plans. Our providers will be contractually required to participate in this survey. We will also invite other ALTCS plans to participate on our Council to build collaborative solutions to AZ's workforce gaps.

Strategy 3: Develop and Implement Specialty Advanced Training Programs

We will implement a DCW/CHW webinar series on or before 12/1/18. It will consist of five, 45-minute webinars providing educational information on culturally competent advanced care planning, Advance Directives (ADs) and other EOL care planning matters facing ALTCS members and their families. UAHP will host the webinar series on our learning management system platform, advertise the availability of the series and manage participant tracking. DCWs who complete the series and pass the required competency tests will obtain UA TFAP/UAHP Certification as a DCW with advanced knowledge in EOL care planning. On or before 12/1/18, we will also develop a legal services education model for DCW and CHW education, along with resources for significant life transitions. The content will include culturally competent advanced care planning, ADs, Powers of Attorney and other topics relevant to those facing EOL decisions. On or before 12/1/18, UAHP will award Capacity Building Grants to six community-based organizations throughout AZ to become Master Trainers in EOL decision-making and the associated legal considerations. Grantees will receive travel and administrative expenses, five-day live training series and monthly technical assistance and coaching sessions offered through the UA.

Strategy 4: Identify New Labor Pools and Engage in Coordinated Recruitment Efforts

Peers and Family Members Represent a Viable Labor Pool for ALTCS Providers: As paraprofessionals, peers and family members improve service delivery as they are inherently more interested in the well-being of the member and naturally very member-centered. Throughout the term of the ALTCS award, we will notify members and their families of opportunities to become employed as DCWs, peer specialists and other paraprofessional roles within the ALTCS system. Our partnership with the UA Family and Community Medicine Workforce Development Program is pertinent to further developing the peer workforce. UA's Workforce Development Program established a Recovery Support Specialist (RSS) Institute with the commitment to train, certify and find employment opportunities for individuals with lived experience in the behavioral health, substance abuse and disability services realm, and is an AHCCCS Approved Peer Support Employment Training Program. The first RSS Institute was taught in early 2005. Since then, the program has certified 1,035 paraprofessionals and 189 this past year. Most individuals who go through the RSS Institute and other Approved Peer Support Employment Training Programs will be screened for appropriate employment by Vocational Rehabilitation prior to admission into the training program. This means they are appropriate for employment within the ALTCS system and, if needed, can pass a background check/obtain a fingerprint clearance card. Based on the success of the RSS Institute and its graduates, the UA Workforce Development Program established advanced training opportunities for peer paraprofessionals interested in integrated health care settings (including ALTCS settings) through their Integrated Health Institute. Training began in October 2014, and has since certified 342 paraprofessionals across the state, 189 this past year. We already have contracts in place with six other Approved Peer Support Employment Training Programs and will establish contracts with all other existing programs within the awarded GSAs on or before 10/1/17, and will assist with job placements for graduates to fulfill ALTCS paraprofessional workforce needs.

Veterans Represent a Viable Labor Pool for ALTCS Providers: We will leverage our partnership with the AZ Coalition of Military Families (ACMF) to recruit and train veterans as paraprofessionals. We encourage our network of providers to get involved with ACMF by providing information about upcoming ACMF events and trainings, offering access to the ACMF network of resources and hosting collaborative provider forums related to paraprofessional workforce development needs impacting our veterans. UAHP employees will participate in the ACMF Statewide Annual Symposium each year and we will sponsor and present at the 2017 symposium (and all future symposiums through the life of our ALTCS contract) in an effort to tap into the labor pool of veterans and their families. Additionally, we will establish a scholarship fund to send DCWs to the Annual Symposium for each year of our ALTCS contract. Within the next six months, we will become an AZ Veteran Supportive Employer as part of the AZ Roadmap to Veteran Employment. As such, we will create local jobs for veterans and establish on roads for veterans in the paraprofessional workforce.

Through our partnership with AZ's unique Hiring our Heroes program, UAHP will leverage the veteran labor pool. Our parent company, Banner Health, is helping military veterans obtain meaningful employment through the Hiring our Heroes Corporate Fellowship program. Hiring our Heroes is a U.S. Chamber of Commerce organization that works with veterans and their spouses. This program matches service men and women with an employer partner where they spend three months working on projects, meeting people and preparing for their new field of choice. The employer can then hire the fully trained and certified veteran or spouse. We will establish internships within our provider network on or before 10/1/17 to create opportunities for veterans to become paraprofessionals. The Hiring our Heroes program, which is free to transitioning military, veterans and spouses, has an 80% successful placement rate.

Refugees Represent a Viable Labor Pool for ALTCS Providers: During year two of the contract, UAHP will build collaborative partnerships with the AZ Refugee Resettlement Program (RRP) and the International Rescue Committee to identify employment and training opportunities for refugees receiving employment services through the RRP who are interested in a health care career. These programs are seeking business partners to employ new refugees. UAHP will work with these programs to match new refugees with training and provider-based job opportunities to further develop our system-wide paraprofessional workforce. All refugees participating in the RRP are registered refugees, have passed comprehensive security screening conducted by five separate federal security agencies, have passed face-to-face interviews with the U.S. Citizenship and Immigration Service and are qualified for legal employment in the U.S. Outreach to this labor pool also helps develop a diverse workforce that reflects the diversity of the members we serve.

Strategy 5: Align Efforts with the Statewide AZ CHW Workforce Coalition and Leadership Council

Our partner, the UA College of Public Health Prevention Research Center, worked closely with ADHS to initiate the statewide AZ CHW Workforce Coalition (Coalition) and Leadership Council in March 2015, as a statewide initiative to help strengthen the role of CHWs as a structured and sustainable workforce. This Coalition addresses paraprofessional workforce development issues and strategies to mitigate these issues – including responding to many of the workforce development issues and strategies laid out in the AZ State Health Care Innovation Plan. UAHP has been an active member of this Coalition since its inception, and is the *only* health plan representative to date on the Leadership Council. We have helped inform the Coalition through our cutting-edge work in team-based care and Value-Based Purchasing (VBP). In 2001, our partners, the UA Area Health Education Centers Program and the College of Public Health, provided the initial establishment funding for the AZ Community Health Workers Association (AzCHOW). The association offered the first statewide CHW training conference in AZ, founded the AZ CHW Network, and continues a movement to unite and strengthen the CHW workforce through training, advocacy, partnership building and policy development.

CHWs are known by many names, such as paraprofessional, health advisor, home health aide, patient navigator, peer support specialist, wellness coach, housing aide, nutrition educator and more. The Coalition, Leadership Council and AzCHOW focus on ways to conduct unified workforce development efforts related to all of these roles, instead of categorizing them out into different systems and roles. These paraprofessionals have important roles, including offering community outreach; increasing access to culturally appropriate care; offering member education and health promotion; teaching self-management strategies; enabling individuals to live independently through providing AC services, life skills training and ongoing coaching; and helping members navigate the complex health care delivery system while advocating for them and linking them to appropriate services to reduce their needs and avoid hospitalizations. Most importantly, they work hard to build a trusting relationship with the member while fostering hope and independence. They create links between medical expertise and community comprehension to help members understand and follow medical recommendations. Throughout the term of the ALTCS award, we will continue efforts of the Coalition to define, accept and disseminate core competencies and scope of practice by:

- Accepting, promoting and advocating for statewide acceptance of the CHW Core Competencies. Disseminating Core Competencies within our contracted provider network. As a member of the Coalition and Leadership Council, we helped author the Core Competencies based on research, best practices, review of curriculum, stakeholder input and consensus building.
- Seeking legislative support for the establishment of a voluntary certification among CHWs and implementation of a CHW certification board to review training programs and confirm consistency in education of our CHW workforce.

UAHP will adopt *and* build upon the statewide strategic goals of the ADHS Office of Chronic Disease, the Coalition and Leadership Council once finalized and approved. In line with these efforts, we will establish paraprofessional certification

and paraprofessional supervisor training programs through offering live trainings to our providers and making web based training modules available through the Banner Learning Center. Additionally, we will utilize UAHP's Healthy Together Care Partnership (HTCP) team and provider-based Short-Term Assistance Teams to offer support, consultation and in-vivo coaching to paraprofessionals while working side-by-side to support members during times of acute need and transition – this will address retention and decrease staff burn-out as many staff leave the field due to feeling unprepared for the job, a lack of support and being overwhelmed by demands of the job.

Strategy 6: Take a Collaborative Approach to Workforce Development

UAHP will partner with our providers, members, families, advocates and stakeholders – taking a collaborative approach to workforce development. Beginning within 60 days of contract award and on an ongoing basis, we will build both formal and informal partnerships with stakeholders who are already engaged in workforce development efforts, such as AZ Direct Care Alliance, AZ Health Care Association, AZ DCW Association, Ability 360, Foundation for Senior Living (FSL), Area Agencies on Aging, Brain Injury Alliance of AZ and more. On or before 9/1/17, we will become a member of the National Association of Health Care Assistants, working through their local chapter to support their mission of elevating professional standing and performance of Certified Nursing Assistants (CNAs). On or before 3/1/18, we will promote existing and newly developed paraprofessional certification and training programs, including but not limited to AZ Health Care Association's CNA/Caregiver Leadership Academy, UA's CHW certification program through the College of Public Health, Pima Community College's Behavioral Health Services Certificate program and San Luis Rural Health Center in Yuma, which offers a certification program for CHWs. As an ALTCS provider, we also commit to employing a statewide trainer of trainers for Mental Health First Aid training on or before 1/1/18. Throughout the term of the ALTCS award, UAHP will build partnerships with organizations with strong caregiver training programs. One such organization is FSL in Maricopa County. FSL provided more than 28,000 hours of training last year, including certification courses and educational series for both formal and informal caregivers. FSL provides ADL and IADL training in their centrally located Caregiver House and in outlying areas through use of a mobile van.

Our partner, UA Center on Aging was awarded a Geriatric Workforce Enhancement Grant by the U.S. Department of Health and Human Services. The grant totals $2.5 million over three years. UAHP's Dr. Nancy Wexler played a lead role in developing the strategic plan: mapping out how the grant will best be utilized to support statewide efforts to provide ongoing education and training to a variety of health care professionals serving the geriatric population in AZ. This strategic plan particularly highlights the use of paraprofessionals – CHWs, DCWs, CNAs and family caregivers.

Finally, throughout the term of the contract, we will continue to partner with the UA Prevention Research Center to expand upon current research which we were a part of co-authoring and to identify opportunities to transform practice. We participated in the *Community Health Worker Utilization and Impact in the Primary Care Setting Survey* (under review), assessing provider perspectives on CHWs impact on member outcomes, costs and provider time as well as how providers integrate CHWs into primary care.[iv] We will work with our partners, the UA Prevention Research Center and the UA Center on Aging (especially through the efforts of the Geriatric Workforce Enhance Grant) to glean information from current research and identify strategies for translating research to practice, including informing provider training.

UAHP HAS THE KNOWLEDGE AND INSIGHT NEEDED

Paraprofessionals are pivotal to the UAHP mission, especially as it relates to simplifying the impersonal and complicated world of health care. As a locally owned and operated managed care plan in existence since 1985, we have a solid reputation when it comes to recruitment and understanding of current workforce needs in AZ. Our existing partnerships with local training programs and educational institutions offer us insight into the workforce and access to a large pool of talent to help fulfill ALTCS system-wide paraprofessional workforce needs in collaboration with our provider network.

[i] Bureau of Labor Statistics, Occupational Outlook Handbook. 2016. www.bls.gov/ooh
[ii] Projections Central, Long Term Occupational Projections by State Report. 2015. www.projectionscentral.com/projections/longterm
[iii] Kaye, H. S; Harrington, C.; LaPlante, M.P. Long-term Care: who gets it, who provides it, who pays, and how much. Health Affairs 29, no. 1 (2010): 11-21. Doi: 10.1377/hlthaff.2009.0535. Retrieved from http://content.healthaffairs.org/content/29/1/11.
[iv] Sabo, S; Ingram, M; Wexler, N; Flores, M; Dreifuss, H; de Zapien, J. CHW Clinical Impact Survey: Health care provider perspectives on the impact of community health workers as members of the health care team. Submitted for review October 2016.

8. A 16-YEAR-OLD MALE WHO IS PARAPLEGIC SECONDARY TO A GUNSHOT WOUND TO THE SPINE IS CURRENTLY…

By prioritizing and addressing the care needs of this member, Patrick, Banner – University Family Care (B-UFC) will deliver on our mission to make a difference in people's lives through excellent care while also honoring *Arizona's Vision for Children*. As an experienced plan serving Arizona's most vulnerable, we realize the challenge of finding accessible out-of-home treatment options experienced with maladaptive sexual behavior while helping Patrick achieve academic success, maintain close connections with his natural supports, avoid delinquency and become an independent adult. However, we have built trusted relationships across the provider community and will create more partnerships to conquer the challenge of offering placement choices as part of Patrick's treatment intervention. We will tailor our approach and work closely with Patrick and his family in a transparent manner while respecting their cultural heritage to build trust and address their needs in the most appropriate setting, in a timely fashion and in accordance with best practices. Throughout, we will conduct ourselves using *Arizona's System of Care for Children 12 Guiding Principles* and utilize the *Children's Out-of-Home Services* Practice Tool. Furthermore, B-UFC is committed to increasing the number of options available in Arizona for other children with integrated physical and Behavioral Health (BH) needs through active engagement with community partners.

To create an accessible, high-quality network and address gaps, such as for Patrick, the B-UFC Network Development (ND) staff meets regularly with other health plan departments and external stakeholders. Our Contracts Committee includes Case and Medical Management along with other departments to review and address perceived gaps. Network gap analyses are conducted at least quarterly and address membership growth, linguistic and cultural needs, utilization, geographic accessibility and appointment availability as well as input from Case Managers. Gaps are corrected swiftly to prevent care interruptions and dissatisfaction. Immediate gaps may be reported to AHCCCS, such as compliance with the 20% threshold of members residing in alternative HCBS settings, with Corrective Action Plans (CAPs). All CAPs and results are overseen by Compliance and QMPI Committees, with results sent to AHCCCS. We will also work with other plans to develop creative solutions for Arizona's most challenging network needs.

Patrick enrolled with B-UFC more than a year ago after a gunshot injury left him paraplegic. He subsequently perpetrated inappropriate sexual behaviors against a sibling. In addition to physical and BH treatments, Patrick was assigned a Juvenile Court Probation Officer (PO) with his care being overseen by a Child and Family Team (CFT). Patrick's B-UFC Case Manager (CM), Joe, has participated in the CFT with support from his regional Case Management Team, which includes a Registered Nurse (RN), a Qualified Behavioral Health Provider (QBHP), Community Specialists and the support of our Justice System Liaison. Patrick's CFT, run by a trained facilitator in B-UFC's network, consists of Patrick, his parents, Behavioral Health Residential Facility (BHRF) staff, his PO, Joe and a Department of Child Safety (DCS) representative who represents the rights of the victim during discharge planning. The CFT, as appropriate, has also included his psychiatrist, physical therapist, teacher and court-appointed lawyer to make certain his needs are being met. Recently, Patrick's aunt joined due to her willingness to provide a kinship placement. The PO keeps the Juvenile Delinquency Court Judge apprised of Patrick's progress and treatment. Joe made sure the chosen BHRF meets Patrick's physical and BH needs as he needs assistance with bathing, dressing, catheter and bowel care. Joe has come to understand Patrick's strengths, goals and hopes for the future to identify treatment interventions, such as a mentoring program with the Arizona Spinal Cord Injury Association and a provider utilizing the Transition to Independence Process treatment model – to help Patrick adjust to life with paraplegia while preparing for transition to adulthood. These interventions along with Joe's continued encouragement built a foundation of trust that gave Patrick hope and improved his engagement in counseling to address growing up in a chaotic household with substance abuse exposure. During treatment, Patrick did well in school, reaching his grade level. He worked hard to become as physically independent as possible and kept all appointments following EPSDT guidelines. Throughout his care, Patrick was given choice, dignity, independence, individuality, privacy and self-determination. The sexually maladaptive behavior was a major setback. During Patrick's BHRF stay, Joe staffed each of his visits with a QBHP as part of the ALTCS quarterly BH consultation requirement. In addition, his stay was reviewed monthly with the B-UFC Psychiatric Medical Director to make certain it is medically necessary and he is progressing toward his goals. Every 90 days, Joe completed a formal reassessment per ALTCS Case Management Standards.

COLLABORATIVELY IDENTIFYING PLACEMENT OPTIONS TO MAINTAIN PATRICK'S CONNECTION TO HIS SUPPORTS

Joe began discharge planning proactively upon Patrick's arrival to the BHRF by focusing on four options: Return to his home, Kinship, Home Care Training to Home Care Client (HCTC) and group settings. He communicated Patrick's anticipated needs to his supervisor, who in turn discussed the potential need for out-of-home placement options at the

Contracts Committee. As Patrick's stay progressed the CFT felt a return home was unlikely, hence Joe worked with the CFT to identify kinship placement options while the ND Department identified Arizona agencies, such as Intermountain, Deveraux, Providence, Lateef and Community Provider of Enrichment Services (CPES), capable of meeting Patrick's whole-person needs. Joe and the Provider Services Manager identified non-kinship HCTC and group placement options with these agencies to accommodate Patrick's ADL abilities and maladaptive sexual behavior. The CFT (including Patrick and his family) reviewed all outpatient placement considerations and needs as part of his treatment intervention. A kinship placement was preferred, with HCTC as an alternative. A group home setting was considered, but would not allow him to be in the least restrictive setting or in as natural and home-like setting as possible. **BH needs:** In all of these settings, Patrick will receive outpatient BH treatment, including individual and family therapy. **Physical needs:** He will need assistance with bathing, dressing and grooming, and has skilled needs for bladder and bowel care. If Patrick lives with a relative or in an HCTC setting, this person must provide this care under Self-Directed Attendant Care (SDAC) or be willing to have RNs and Attendant Care Workers (ACWs) address his physical needs. He will also need PT/OT for him achieve the highest level of independent functioning possible. **Educational needs:** The CFT will help him enroll in school and coordinate with the school and his parents regarding an Individualized Education Plan, if needed. Joe will also collaborate with the school to arrange a health aide for personal care services. **Financial situation:** Payer sources will be assessed, including the family's finances, as Medicaid funds cannot be expended on room or board in alternative HCBS settings once he no longer meets criteria for the higher level of service in the BHRF.

B-UFC negotiates higher rates with our contracted providers to build the capacity necessary to meet the complex needs associated with maladaptive sexual behaviors and to deliver integrated care coordination needs. When no in-network options are available to meet our members' needs, the Provider Services Manager will extend the search to non-contracted providers. Any facility considered for a single case agreement or as an addition to the network must have accessibility modifications, be licensed by ADHS/DLS, be registered with AHCCCS, have staff trained in BH treatment modalities and possess the required liability coverage for sexual abuse and molestation. A single case agreement is then executed and, if on-going needs for the provider are anticipated, discussions ensue regarding joining the B-UFC network. Only when a member's needs cannot be met within Arizona are out-of-state options considered. In these rare circumstances, B-UFC follows AMPM policy 1620-J and works in coordination with AHCCCS to sufficiently evaluate all in-state options in order to definitively exclude them as treatment interventions.

Ultimately, through collaboration with Patrick, his family and the other members of the CFT, the following out-of-home treatment interventions were considered as appropriate choices. **Kinship home:** Patrick's aunt lives with her husband in Phoenix, and they are willing to have Patrick live with them. Their children are adults and no longer live in the home. SDAC is an option and there is no requirement to pay room and board. If not SDAC, HCBS will provide ACW and skilled nursing for his physical needs. Patrick's aunt is willing to complete any required training to make this possible and a successful experience for the family. **HCTC settings:** Patrick's aunt has been informed of the benefits of becoming licensed as an HCTC provider, which includes training, payment for the service she provides and access to respite. We go above and beyond by providing access to our B-UFC Employment Liaison, to help caregivers navigate the licensing process. An alternative is living in an HCTC setting with a non-relative. Joe reported to the CFT that CPES and Providence are contracted with B-UFC and have HCTC sites to accommodate Patrick's needs and required services. Due to the scarcity of such sites, B-UFC will arrange for a hold to be placed on either of these places if chosen. **Out-of-home group settings:** If Patrick is unable to be placed in a private home or HCTC setting, a group home will need to be considered. The Youth Development Institute in Phoenix and CPES in Tucson were identified as willing and able to accommodate Patrick. These homes must be accessible for his needs and must agree to provide or allow the ACW and therapies he will need. The CFT suggested the family visit these available placements and report their preferences.

We built a trusting relationship with Patrick by appropriately framing his choice of providers using *Arizona's System of Care for Children 12 Guiding Principles* – focusing on his whole-person outcomes. We educated his family on the benefits and risks of each service option along with their covered benefits in a transparent manner. This approach creates an environment in which creative care planning can succeed. Of the options listed above, the CFT thought the most beneficial would be living with his aunt in Phoenix or an HCTC site in Tucson where Patrick and his parents live. These options align with the ALTCS principle of members living in the least restrictive, most integrative environment while acknowledging the importance of family visits and the possible reconciliation with his sibling victim, when appropriate. Patrick has experienced great loss, including the loss of bodily function and separation from his family. Since he has made progress in treatment, it will be very important to provide continuity and stability in order to extinguish sexual

maladaptive behaviors and achieve greater self-esteem, confidence and independence as he approaches adulthood. Being placed closer to home will allow Patrick to gain increasing degrees of independence with his natural supports who he will continue to live amongst as an independent adult, which is his ultimate goal.

Addressing Parents' Current Request for Out-of-State Placement

In spite of this prior planning, Patrick's parents (his legal guardians) request his placement in an out-of-state group home as his discharge approaches. The CFT acknowledges the request and explores the advantages and disadvantages of this provider. During this dialogue, the parents tearfully express their guilt and shame of the situation along with their fear for their other child's safety as driving factors in wanting Patrick "as far away as possible." While acknowledging their distress, the parents are reminded that request may not be in the best interest of his recovery. Additionally, they are reminded that there is no medical need for Patrick to be placed out of state since his needs can be met in Arizona. Joe further explains they will bear more financial responsibilities for such a placement. However, due to their concerns, it is suggested that the CFT reassess all options so all parties agree we have properly balanced the best care for Patrick with the safety concerns of his family and community. While Patrick is a minor, his input with and assent to the discharge plan is vital. Furthermore, the court will be involved in the placement decision due to his involvement with the Juvenile Justice System. Ideally the Department of Child Safety (DCS), probation and any attorneys involved will agree with the CFT's proposal before the judge orders treatment and agrees to the placement, which must ensure community safety.

A subsequent CFT meeting is scheduled to discuss the out-of-state facility alongside the in-state options. The B-UFC Psychiatric and Physical Health Medical Directors attend to address any clinical or administrative questions. The CFT members respectfully listen as the parents express their concerns and discuss the perceived benefits of the out-of-state facility. The Medical Directors and other CFT members respectfully review the recently completed psychosexual assessment, Patrick's attained goals, reasons he no longer has a BH or physical health need to remain in a facility or out-of-state group home and the multiple options within Arizona that can meet his needs. Although the CFT recommends Patrick be located close to the family so they can be natural supports involved in his recovery, consideration is made for an initial placement in another part of Arizona, which will provide more distance between Patrick and his sibling as long as the parents are willing to travel for counseling sessions and other recommended visits important for Patrick's continued recovery. The CFT continues to recommend a kinship home with continued outpatient aftercare for sexually maladaptive behavior treatment as the optimal placement and follow-up care for Patrick. The PO and attorneys review the restrictions Patrick will have in place to ensure the sibling's and community's safety. Following this discussion and weighing the factors involved, the parents are more comfortable with the in-state options. The CFT completes its reassessment of placement options and all parties agree with the treatment intervention of Patrick living with his aunt and uncle in Phoenix.

Alternative Case Scenarios

While B-UFC is confident this case will be resolved amicably, we are prepared for different scenarios when addressing the parents' request for out-of-state placement. In each scenario, Joe will be critical to expediting services because Patrick is ready for discharge from the BHRF. Patrick's continued stay might no longer be medically necessary and it is in his best interest to move to a less restricting environment expeditiously.

1. Patrick will not assent to his parents demand for out-of-state placement: Since Patrick has met his treatment goals and is ready for discharge, it is unlikely B-UFC would consider an out-of-state placement as medically necessary. Should Patrick disagree with his parents then his legal counsel, as a CFT member, would likely involve the Juvenile Court Judge assigned to Patrick's case since he is an advanced adolescent where his assent to treatment decisions is expected. Joe will offer family counseling as this would be in the best interests of Patrick. Other legal alternatives are available, such as court mediation services within the Juvenile Court. Lastly, if the Juvenile Court Judge felt the parents were not acting in Patrick's best interests, s/he could appoint a Guardian Ad Litem on his behalf.

2. Patrick agrees with his parents in demanding out-of-state placement: In this case, the CFT would review why such a placement is not medically necessary and discuss with the family the legal, financial and ALTCS regulatory requirements and barriers to such a placement, as outlined in AHCCCS AMPM policy 1620-J. This includes but is not limited to the requirement that all in-state options must be ruled out, which has not occurred in the opinion of the CFT nor B-UFC, and for written authorization from AHCCCS for such a placement. Since Patrick no longer requires out-of-home care, the CFT would clarify financial responsibility related to room and board.

3. The CFT agrees out-of-state placement is the best option for Patrick: Patrick no longer requires out-of-home care, so

the CFT would clarify financial responsibility for this placement, as it is not the responsibility of B-UFC to cover room and board costs of this placement. In spite of this decision, it remains unlikely B-UFC would agree this placement is medically necessary because Patrick's needs can be met by existing providers in Arizona; therefore, B-UFC would be prepared to defend its denial of such a placement to the Juvenile Court Judge and/or Administrative Law Judge as necessary. If Patrick must be placed out-of-state, then B-UFC would follow AMPM policy 1620-J by preparing the required information for AHCCCS to document why in-state options have been ruled out along with the name and location of the out-of-state facility, description of Patrick's medical and behavioral condition that necessitates this placement and his plan for return to Arizona.

As part of the latter two alternate scenarios, it is likely a Notice of Action (NOA) will be issued denying the out-of-state placement. The CM will follow the procedure outlined in the AHCCCS Contractor Operations Manual (ACOM) Section 414. She will consult with her supervisor and the Medical Director about the request and an expedited decision will be made within three days due to his impending discharge. Once the family is issued the NOA explaining the decision to deny out-of-state placement, they can file an appeal if they do not agree. Information about how to file an appeal and the time limits is included in the NOA letter and Joe will assist the family with the process. B-UFC will expedite this process to the extent possible in the best interests of Patrick. Additionally, the CFT will create a clearly outlined plan at the time of the denial that will adequately address Patrick's needs, including a crisis plan.

TAILORING PATRICK'S SERVICES TO MAXIMIZE OUTCOMES, INDEPENDENCE AND CONNECTIONS TO SUPPORTS

Since Patrick moved from Tucson to Phoenix, the case is transferred from Joe to a Phoenix-based CM, Ed, and Patrick agrees to the change. Within two business days of arriving at his aunt's Phoenix home, Joe and Ed meet with Patrick. Joe and Ed conduct the visit jointly to ease the transition for Patrick and his family. The CMs complete the Strengths and Needs Assessment (SANA) in his new setting in compliance with B-UFC's standard procedures and consistent with ALTCS policies in AMPM Chapter 1600. Ed helps Patrick identify a new PCP and specialists along with Attendant Care (AC) needs, therapy, DME and home modifications. Through person-centered planning, the CFT identified his main needs, how they would be met, along with meaningful and measureable goals. The UAT, HCBS Needs Assessment Tool (HNT) and Contingency Plan forms are completed as part of developing the care plan with service needs below.

Issue 1: Paraplegia limits Patrick's ability to perform all ADLs. He is able to transfer independently but needs assistance with bathing, dressing, grooming, bowel and bladder care. **Plan:** Patrick will receive AC services to assist with ADLs. PT/OT will be provided to promote further independence and strength. Skilled nursing will provide bowel and bladder care. **Goal:** Patrick will reach the highest level of independence possible as demonstrated by PT/OT notes.
Issue 2: Patrick exhibited maladaptive sexual behaviors in the past. He has made progress and attained his goals at the BHRF but will need ongoing treatment to extinguish these behaviors. **Plan:** Patrick will receive individual and family therapy with a number of excellent options available to him, including programs for sexually maladaptive behavior such as the Arizona Center for Change, The Resolution Group or Grossman and Grossman. The Youth Development Institute also has a chaperone program that serves their outpatient program as well. It is important his natural supports and care program continue to address safety, make certain his behaviors are not minimized, he continues to be held accountable and his medical needs are met. Such programs offer interventions based upon ongoing assessments of abusive dynamics, sexual dysfunction/deviance, growth and development, co-occurring psychiatric diagnoses, and ecological strengths and deficits. Family psychoeducation through Marc Community Resources, Inc. will be encouraged to help Patrick's new family unit to function optimally. He will continue to be followed by the Juvenile Court and a PO. **Goal:** Patrick will demonstrate appropriate sexual boundaries as a result of developing effective coping skills.
Issue 3: Patrick experienced the trauma of being shot in the spine. **Plan:** Patrick will receive individual and family therapy to address his trauma and other behaviors. He will learn about peer support groups and be encouraged to attend. Patrick will re-engage with the Arizona Spinal Cord Injury Association peer mentoring program in his new community. The mentors are volunteers who have accepted their situation, developed healthy coping strategies and have the intense desire to help others. They also have wheelchair skill training classes and other resources that may help. Patrick's new CM will also help him and his aunt explore options for supervised day programs or a therapeutic day program. **Goal:** Patrick will learn at least three new coping skills to deal with emotions related to his injury and losses. He will be able to express his emotions appropriately. He will attend at least one Spinal Cord Injury Support group.
Issue 4: Patrick will continue his education. **Plan:** Patrick's new CM, Ed, and his CFT will help him enroll in a local school and arrange any necessary personal care services for the school day as outlined in ALTCS AMPM Chapter 700. Charter

schools and online options will also be explored. Ed will coordinate his enrollment and provision of services with the school, such as BH, nursing, OT/PT, personal care services and specialized transportation. **Goal:** Patrick will attend school in line with attendance requirements and complete all requirements for his GED or graduation from high school. **Issue 5:** Growing up, Patrick was exposed to his parents' regular substance abuse in the home. Patrick and his sibling witnessed many drunken fights and were at times left without proper meals. Patrick's parents have begun 12-step meetings and report being sober for several months. **Plan:** Patrick's parents will be encouraged to continue meetings at least once a week and remain sober. Patrick will address the impact of having grown up in a household where drinking and drug use were common in his individual counseling and encouraged to attend Al-Anon meetings for teens. Patrick will also receive a substance abuse assessment to track his ongoing risk of developing a substance abuse disorder. **Goal:** Patrick's parents will maintain abstinence. Patrick's substance abuse risk assessment scores will decrease.

The CMs confirm Patrick and his aunt have the B-UFC Member Kit with Member Handbook, relevant contact information and that all documents have been signed with copies distributed per protocol. Afterwards, the B-UFC CM will complete the ALTCS Electronic Member Change Report to notify the local ALTCS office and AHCCCS of Patrick's change in residence. All necessary information will be entered into the B-UFC Acuity Care Management System and updated in the CATS system within 10 business days. The CA161 screen and Service Plan are updated to reflect changes in placement and services. The CM initiates all required and agreed upon referrals for services and makes sure they are started. Based on the results of the HNT and before services have begun, the CM completes a Cost Effectiveness Study, calculates the cost of the services authorized and determines what percentage of this would cost if Patrick were in a Skilled Nursing Facility. She staffs the need for the adaptive equipment with her supervisor and the Medical Director, needing to make a decision about approval within 14 days. When approved, she contacts Patrick's new PCP for orders and then completes the referral and authorization for the selected providers so services begin within 30 days.

INCREASING ARIZONA OPTIONS FOR ALL CHILDREN WITH INTEGRATED BEHAVIORAL AND PHYSICAL HEALTH NEEDS

Foundational to providing choice of appropriate placement options for our members is the B-UFC ND Department. B-UFC continually monitors our network to meet the requirements of Medicaid and Medicare as well as the needs of our covered populations. Furthermore, B-UFC's ND Department is responsive to not only changes in regulations (such as is expected from AHCCCS to align with Medicare requirements), but also the immediate needs of each member as they arise. In CYE 2015, B-UFC successfully contracted with the top 100 Pima/Rural county BH providers to accommodate the new requirements to cover the Medicaid BH needs for the GMH/SA dual population. Seven provider onboarding webinars were conducted for these providers. Internal and external training were ongoing and the Director of BH developed a quarterly newsletter for B-UFC staff. Ongoing internal trainings are provided to all staff providing updates to the BH benefits available to members. Additional providers continue to be added throughout the state to improve access and choice for the GMH/SA dual membership.

B-UFC will utilize this same successful approach to improve access to whole-person care by collaborating with community partners critical to the delivery of person-centered integrated care coordination for our members living at home. We commit to support families and caregivers with an emphasis on improving families' access to education and resources, strengthening Family Run Organizations and furthering existing parent advisor programs. We will be an annual sponsor and presenter of the AZ Caregiver Coalition's annual conference beginning in 2018, including partnering to develop tracks focused on caregivers of youth, kinship placements and grandparents as caregivers. On or before 1/1/18, we will establish contracts with Family Run Organizations such as the Family Involvement Center, MIKID and the Pascua Yaqui Youth Group, including funding healthy lifestyle programming for families and assisting in the organization of a Whole Health Forum. We will provide financial and administrative support to increase the number of specialty services available to members with both behavioral and physical integrated health needs. This includes support with Value-Based Purchasing along with having our BH staff assist potential kinship and HCTC providers to complete the licensing process, working with BH agencies to provide administrative support to complete the HCTC licensing process, providing clinical physical health expertise to BH agencies and providers to assist them to become integrated providers, and working collaboratively with AHCCCS to implement *Arizona's Systemic Assessment and Transition Plan* to make certain HCBS providers are adequately oriented, trained and supported on their respective roles and responsibilities in helping members have full access to the benefits of community living. Through these activities, B-UFC commits to addressing the needs not only of Patrick, but also others who share his whole-person needs in order to achieve *Arizona's Vision for Children*.

9. THE OFFEROR HOLDS AN ALTCS E/PD CONTRACT FOR BOTH CENTRAL AND NORTH GSAS AND RECEIVES…

Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' vision to shape tomorrow's managed care from today's experience, quality and innovation. Implementing meaningful VBP arrangements is vital to bending the cost curve and improving health outcomes. Our VBP program includes financial and quality performance accountability that employs an evidence-based Quadruple Aim focus to improve: health outcomes, health care utilization, access to whole-person-centered care and the provider experience. Since launching more than two years ago, we have implemented 18 VBP agreements with primary care, hospitals, dental care, specialty care, Behavioral Health (BH) and integrated provider entities. Current University Family Care (UFC) and University Care Advantage (UCA) VBP arrangements are in place with safety-net providers, including those with Patient-Centered Medical Home (PCMH) recognition, as well as integrated physical/BH providers. While AHCCCS required 20% of acute care prospective payments in VBPs by September 30, 2016, UFC has exceeded expectations with more than 45% in such arrangements. Additionally, there is no current mandate to convert Dual Eligible Special Needs Plan (D-SNP) prospective payments into VBPs, yet UCA has already moved more than 40% into VBP agreements. Through these combined efforts, UFC and UCA have made demonstrable improvements including more than doubling our 2016 D-SNP VBP annual wellness visits; decreasing acute care VBP Emergency Department (ED) visits by 50%; and, by end of year one, an across the board reduction in the Medical Loss Ratio (MLR) for all seven inaugural UFC VBP agreements. Also under the VBP umbrella, our Centers of Excellence (COE) approach includes our recent selection by The Center for Medicare and Medicaid Innovation (CMMI) to participate in its innovative Oncology Care Model (OCM), an initiative focused on more coordinated cancer care.

VBP efforts require diligent study and evaluation, and we are at the forefront of supporting and contributing to the Health Care Payment Learning and Action Network (LAN) activities. LAN brings together payers, providers and government partners to accelerate Alternative Payment Models (APMs) transition. A committed LAN partner, we are one of only 28 Medicaid health plans to contribute detailed data to LAN's 2016 national data collection survey and, as such, were designated a Premium Level Contributor. UAHP is currently achieving a LAN category 3a, and through our OCM partnership, we will advance to a 3b payer. We also participate in trainings and learning collaboratives with LAN, Catalyst for Payment Reform, Bailit Health and other industry leaders for continuous learning and quality improvement. As members of the Arizona Alliance for Community Health Centers (AACHC), we are active participants in activities that have facilitated VBP innovation, such as statewide PCMH development, primary care behavioral integration efforts and oral health access work groups. Additionally, Banner Health Network's (BHN's) Accountable Care Organization (ACO) participates in the Centers for Medicare and Medicaid Services (CMS) APM initiatives such as the CMS Pioneer ACO, providing UAHP with valuable insight as an "early adopter" of the APM movement.

To create our VBP strategy, we formed a cross-functional committee led by Nancy Wexler, D.B.H., our Director of Innovation and Collaborative Care. The committee develops goals to promote the inclusion of large and small providers; to provide ongoing, in-person support; and to offer seamless electronic reporting to improve the provider's experience. For example, we developed electronic-prescribing reports which led to increased e-prescribing rates for all VBP providers. While exceeding a Minimum Performance Standard (MPS) is the goal, we also measure and report improvement over time to recognize the efforts of our providers to move up the value continuum. We will bring the same energy and commitment to the ALTCS program, and have a solid plan to remain compliant with ACOM policy 318 on or before September 30, 2019. Our VBP strategy will result in these conversions by CY19:

Contract Type	Year One Conversion % of Prospective Payments	Year Two Conversion % of Prospective Payments
ALTCS VBP	53%	59%
D-SNP VBP	48%	52%

HOW UAHP WILL MEET AHCCCS VBP REQUIREMENTS

UAHP has implemented LAN category 2 and 3 APMs, including Total Cost of Care (TCOC) shared savings agreements with providers such as the following health centers: Sun Life in Pinal County, Marana in Pima and Sunset in Yuma County. These arrangements measure inpatient readmissions and ED visits, while incentivizing access to comprehensive care management and medication adherence for key chronic conditions. We will expand these LAN 2 and 3 APMs to serve ALTCS members by targeting Primary Care Providers (PCPs), Home and Community Based Services (HCBS), Skilled Nursing Facilities (SNFs), Long-Term Care Hospitals (LTCH) and Home Health Providers (HH). We will initially engage

comprehensive care providers who serve a large volume of ALTCS members, including integrated physical/BH providers. These TCOC agreements will initiate transformation, increasing provider accountability by incenting proactive care within and beyond their clinical specialties. To address small attributed populations and/or limited measure sets, we will introduce Partial Cost of Care (PCOC) agreements with other providers such as HCBS.

In year two and beyond, we will develop demonstration projects for LAN category 3a and 3b bundled and clinical episode ALTCS arrangements. Partnerships will be offered to facilities already experienced in the peri-hospitalization period, with a track record of better than average readmission and hospital-acquired condition rates. For bundled payment demonstration arrangements, we will engage SNFs and Assisted Living Facilities. Finally, as BHN's ACO and UAHP are Banner Health (Banner) subsidiaries, we plan to leverage our close relationship and enter into LAN category 3 or 4 ALTCS agreements, up to full population-based payments by 2019. The ACO model places the highest level of control and accountability in the providers' hands and appropriately incents providers to achieve improved care coordination and integration across the delivery system.

SIMILARITIES AND DIFFERENCES IN VBP CONTRACTING APPROACHES FOR MEDICAID VERSUS MEDICARE

In considering the development of VBP agreements, it is important to note Medicaid and Medicare distinctions, such as distinct population segments with differing target goals and variations in types/levels of health care benefits and coverage. While Medicaid has a large maternal and child health population and an emphasis on preventive health and acute care intervention strategies, Medicare's focus is on elderly and disabled populations with chronic conditions. A key similarity for ALTCS and D-SNP members is dual eligibility. UCA's sole focus is on dual eligible enrollees, with more than 70% of our UFC eligible members aligned to UCA. This alignment enhances service integration between the two programs and is a strategy we will pursue with ALTCS. Although some contracting variation is necessary to reduce fragmentation and improve provider experience, we bring comparable approaches for each business line. UFC and UCA members seek services from the same clinicians; therefore, we target provider groups who already serve our dual eligible members.

UAHP contracts with providers serving all our populations under a Master Service Agreement (MSA) that includes separate VBP amendments with scopes of work for each program that delineate population-specific metrics, targets and variances. The amendment describes the collaborative processes, expectations for each party, financial agreement, and details the mutually agreed upon metrics and targets for each covered population/program. The amendment includes an MLR financial goal for the provider's identified cohort benchmarked against the practice's historical performance in order to develop a customize a risk-based target. Our data-driven approach helps us identify appropriate and non-redundant performance measures. Those measures which apply across both Medicaid and Medicare but vary based on population cohort will be included in both agreements. Such an arrangement maintains the practice's focus on our entire population, regardless of member category.

Given the importance of integrated physical and BH, we will continue to engage our partners in VBP strategies that improve integration as well as population de-segregation for both Medicaid and Medicare members. Additionally, the increased attention on quality of life and independence will require more integration between UAHP and providers to capture key measures of these domains and achieve success. UAHP believes this aligned approach will ultimately result in improved whole-person outcomes and financial performance across all lines of business.

THE URBAN/RURAL DICHOTOMY

Both urban and rural providers and their associated members experience unique socioeconomic and geographic-specific challenges, which can impede a provider's readiness and ability to succeed in APMs. In Arizona, rural areas have higher rates of diabetes, coronary heart disease, chronic obstructive pulmonary diseases, members with serious mental illness (SMI) and other health inequalities such as higher incidence of tobacco and alcohol abuse. Rural Arizona tends to be more isolated, covering larger land areas with fewer roads and modes of transportation. Facing ongoing health care professional shortages, the ratio of patients to PCPs, mental health providers and general dentists is statistically lower than urban areas. Rural providers also experience lower service volumes, which limit economies of scale and reduces their ability to invest in the staff and technology to transform from volume to value.

Given the challenges facing rural providers, it is significant to report that seven of UFC and UCA's VBP agreements have been successfully implemented with providers in rural locations across Central, Southern and Northern Geographic Service Areas (GSAs). To address some of the barriers, we have found that offering more direct, face-to-face support increases rural provider engagement. Rural Arizona providers have informed us that they view VBP as a mechanism to develop new programs to improve care coordination for their challenging populations and circumstances. In many cases, we were the first health plan to engage these remote providers in a PCMH and VBP partnership. This includes a large multi-location practice in the ALTCS program's central GSA who was attempting to gain NCQA PCMH recognition, but had no true Electronic Health Record (EHR) for data collection and analysis purposes. Through our partnership, we delivered baseline utilization and health outcomes data needed to obtain Level 3 PCMH recognition. Our actionable reports have also supported our rural providers' rapid performance improvement, and we have seen remarkable results. For example, one of our rural border-area PCMHs, Sunset Health Center, entered into a VBP agreement and initially struggled to meet any one of the performance measures. By the end of the year, the PCMH improved in eight of the 10 measures, including:

Performance Measure	2015 Rate	2016 Rate	MPS	% Improvement
E-prescribing	88%	91%	90%	4%
Readmissions	13.10%	8.33%	11.5%	36%
Diabetes Retinal Eye Exam	43%	93%	49%	116%
D-SNP Annual Wellness Visit	13.53%	18.68%	N/A	38%

Additionally, we partnered with a provider in the ALTCS program's Northern GSA, the Community Health Center of Yavapai, who has three locations across a large geographic span and had no previous VBP experience. Despite multiple barriers, the provider conveyed eagerness to partner and we opted to extend a VBP amendment in quarter two of the contract year. In only three quarters, they experienced a significant improvement in e-prescribing (9%), readmission rate (11%) and adult ED utilization (9%).

Urban area providers also face challenges such as high volumes and transitory populations, which can impede meaningful medical home engagement. Our PCMH partners in Arizona urban areas, including Phoenix and Tucson, serve as a safety net for refugees and homeless populations, and tend to provide a significant volume of HIV and Hepatitis C services as well as integrated behavioral care. They are also more experienced in population health management and need less hands-on but more targeted support to assist with their own performance improvement initiatives. They have experience with ACOs and VBP arrangements so we work to create focused efforts around any measure not meeting the target. With this support, the Phoenix and Tucson area provider groups realized improvements of between four and six of the quality outcome measures and had the most significant improvements in the financial marker of MLR, realizing a 10% combined drop in this measure of cost of care.

UAHP'S VBP CONTRACT IMPLEMENTATION STRATEGY AND COMPONENTS

As a key component of our VBP strategy, UAHP will continue to focus on reducing provider burden and account for the unique needs of both rural and urban providers. We will design each VBP contract to address our partner's health care focus, member characteristics, geographic location and internal capacity. While some providers are advanced along the LAN continuum, we have learned others have little infrastructure or understanding and need our close partnership through an initial development year to succeed. Through our experience, we have learned the following strategy results in a greater likelihood of achievement:

1. **Use aggregate population data to identify outcome drivers.** Our first step is to employ population-health data analysis, supported by our partnership with UA Center for Population Science and Discovery. In an effort to control TCOC, we identify key drivers of increased costs through sophisticated analytic techniques to determine key population segments and drivers of health care spending. For example, in our UCA D-SNP population, the prominent drivers of health care costs are: chronic conditions, BH, social determinants and End of Life (EOL) care.
2. **Develop meaningful outcome measures.** UAHP utilizes a population-based approach to determine provider-specific metrics. Through analysis we identify underlying drivers of desired outcomes, improvement interventions, metrics to monitor the effectiveness of implemented interventions and providers positioned to implement change. For example, we currently include an Advance Directive (AD) metric in our OCM agreement because the completion and accessibility of ADs may facilitate referrals to palliative care and hospice. This metric is driven by evidence such as our

Banner home-based palliative care program significantly decreasing costs by more than 70% in the last three months of life. Therefore, we will include ADs and timely referrals to hospice as a metric for ALTCS VPB agreements.

3. **Identify viable provider partners and assess level of readiness.** UAHP utilizes performance data to identify viable VBP candidates and then deploys a readiness assessment to gauge population health capabilities and evolution along the pay-for-value continuum. The assessment includes survey questions pertaining to the following categories, enhanced for ALTCS provider types:
    - Population health management infrastructure, including EHR capabilities
    - Experience with VBP and APMs (types and levels)
    - PCMH recognition status
    - Barriers to transformation as well as identified leverage points
    - The provider's unique approaches to team-based, integrated care specific to senior and disabled populations
4. **Design a VBP agreement to include meaningful metrics and level of risk.** Provider groups with demonstrated expertise in team-based, integrated care and population health management are given high priority and, after analysis of baseline quality and performance metrics, engaged to develop mutually beneficial VBP agreements. In addition to the ALTCS critical core metrics, we will focus on patient-centric indicators of quality of care, quality of life, care transitions, integrated care and EOL care.
5. **Provide meaningful, actionable reporting.** UAHP supplies VBP providers with customized and actionable reports. This will be enhanced through Banner's population health platform, which uses best-in-class business intelligence and visualization software to create provider-specific, clinically actionable disease registries and provider scorecards. VBP providers can easily access the scorecards and registries via an internet connection. The registries are used to identify care opportunities, with the ability to view key quality metrics at the population, practice, provider and member level. This is accomplished by using both clinical and claims data in a single dataset defined by national standards.
6. **Provide ongoing, in-person support.** During quarterly joint operating meetings, performance data are reviewed and actionable care enhancement strategies are developed. Additionally, Jacqueline Adams, our RN Senior Manager of Clinical Practice Integration, meets regularly with provider's clinical teams to develop targeted initiatives. For practices early in the transformation phase, this close partnership helps identify barriers and support rapid evolution.
7. **Progress through the LAN continuum.** UAHP seeks opportunities to place more accountability for care management into the hands of providers. Those demonstrating high capacity in population health management and achieving consistent success in VBP targets are engaged in discussion and action planning to proceed to the next LAN level. We will create opportunities for ALTCS providers to develop demonstration projects of new VBP models.

ALTCS AND D-SNP VBP CONTRACTING – RELEVANT OUTCOME MEASURES

UAHP will continue to include performance accountability elements in our VBP agreements. Financial performance will be aligned to appropriate MLR benchmarks, based on the provider's unique population and location. Given the 92% MLR in this response scenario, UAHP has identified areas of cost management opportunity for Inpatient Hospital (IP). UCA has demonstrated success in optimizing IP utilization, with a current IP utilization rate of 25% compared to national Medicare FFS levels of 34%. Given this scenario's IP experience of 37%, UCA would aim to decrease the MLR to 90% by reducing IP expense by 5%, or $1.2M within two years. Based on our D-SNP experience, we also project savings in physician expenses as described in the table below:

Service Category	National Medicare FFS Expense Percentages	Response Scenario Annual Expense	Opportunity
IP Hospital	34%	37%	$1.2M
Physician	20%	22%	$300,000

UAHP established a menu of relevant core health outcome measures, aligned with state and national measure sets for the ALTCS population. We will work with VBP providers to select achievable goals from the menu. Some partners will achieve a minimum set, while others, with sophisticated processes, may surpass the MPS on most measures. The more measures reached, the greater the reward. The core measure set is endorsed by the National Quality Forum and designed to accommodate a variety of ALTCS provider types, including:

Core Measure Menu	ALTCS E/PD VBP Agreements				D-SNP VBP Agreements		
	HCBS	SNF/ LTCH	Integrated PH/BH	PCP/ PCMH	Integrated PH/BH	PCP/ PCMH	Hospital
Annual Flu Vaccine Rates		X	X	X			
Follow-Up After Hospitalization (Including Mental Health)	X	X	X	X	X	X	
Diabetes HbA1c Testing/Management		X		X			
Depression Screening		X	X	X	X		
Annual Wellness Visit with Functional Assessments					X	X	
Annual Monitoring for Persistent Medications	X	X	X	X	X	X	
Advance Directive Discussion		X	X	X			
Pneumonia Vaccine Rates		X	X	X			
Chronic Disease Medication Adherence Management	X	X	X	X	X	X	
Adult Access to Ambulatory Health Care			X	X	X		
Reduction of Avoidable Readmissions	X	X	X	X	X	X	X
Emergency Department Utilization	X	X	X	X	X	X	
High Dosage Opioid Use from Multiple Providers	X	X	X	X			

As providers demonstrate comfort and capacity with this core set, we will integrate enhanced measures to focus on key ALTCS drivers. One critical driver is the appropriate and timely use of hospice at EOL. We will add a measure of the proportion of patients dying in hospice care who were admitted three or more days prior to death. A major cause of hospitalization and the leading cause of hip surgery in the ALTCS and D-SNP populations are fall-related injuries, thus we will test incentivizing HCBS teams and home care attendants to conduct fall and safety risk assessments. For both HCBS and SNF settings, we will also measure elements highly influenced by social determinants. Based on national reports of 23% of seniors not seeing a dentist within the last five years, we posit that ALTCS members may be at risk for poor dentition and will include a measure around preventive dental services. Additionally, via UAHP internal analysis, we discovered, among our D-SNP members who completed a health risk assessment, 16% reported a concern regarding food security. Medical expense was 37% greater among this group, primarily due to increased hospitalization and ED visits. However, no such difference existed when these enrollees were provided low-cost interventions, such as food assistance. Thus, we will develop nutrition screening measures. Finally, we will create a customized "experience of care" survey for all ALTCS provider types. The enhanced measure menu is summarized below:

Enhanced Measure Menu	ALTCS E/PD VBP Agreements				D-SNP VBP Agreements		
	HCBS	SNF/ LTCH	Integrated PH/BH	PCP/ PCMH	Integrated PH/BH	PCP/ PCMH	Hospital
Preventive Dental Services		X	X	X	X	X	
Fall Risk Assessment	X	X	X	X			
Home Safety Screening	X						
Nutrition Screening	X		X	X			
Experience of Care	X	X	X	X			

UAHP HAS THE EXPERIENCE AND CAPABILITY TO IMPLEMENT EFFECTIVE ALTCS VBP AGREEMENTS IN ARIZONA

UAHP's VBP contracting model will improve our member's health and experience, and drive increased ALTCS/D-SNP integration while reducing provider burden and programmatic costs. We are committed to drawing on our experience to build a meaningful and innovative VBP program to benefit Arizona. We possess in-depth APM knowledge, deploy creative solutions, and adapt to address a provider's unique circumstances. Our proven and practical approach will lay the foundation for our ALTCS and D-SNP provider's seamless and sustainable transition from volume to value.

10. THE OFFEROR RECENTLY RECEIVED AN AUTHORIZATION REQUEST FOR AN INCREASE IN ATTENDANT CARE…

This response outlines the interactions between Grace, our ALTCS Case Manager (CM); the member, Mr. Stevens; his spouse and representative, Mrs. Stevens; as well as the actions taken by Banner – University Family Care (B-UFC) to resolve the situation described in this scenario. Before receiving the request for 45 hours of Attendant Care (AC) and notification about Mrs. Stevens' complaint, our efforts to provide care and service to Mr. Stevens began with our case management program. Within two days of notification that Mr. Stevens had been enrolled in B-UFC, the designated Case Aide (CA) reached out to Mr. or Mrs. Stevens by phone. During the initial call, the CA welcomed the Stevens to B-UFC and conducted a brief assessment of Mr. Stevens' situation and immediate need for services. *B-UFC uses the following Priority System coupled with clinical judgment to determine when the timing of the initial visit should be less than the AHCCCS standard of 12 business days: Priority 1-Urgent need for services and the CM makes appointment within one business day; Priority 2-Routine Home and Community Based Services (HCBS) member living in their own/family home and CM makes appointment within seven business days; Priority 3-Member residing in an Assisted Living Facility (ALF) or Skilled Nursing Facility (SNF) and the AHCCCS standard of 12 business days from date of enrollment is followed.* Mr. Stevens did not have any urgent needs and was not in a SNF, so he was identified as a Priority 2. After the initial telephone call, the CA created a member electronic record in Acuity, our comprehensive case management system, and sent it to a CM Supervisor for review and assignment. We prefer to match members with CMs who live in the member's community. Grace, with more than five years of CM experience, was assigned to Mr. Stevens based on his Pre-Admission Screening (PAS) information, geographical location, placement and demographic needs, such as language and cultural preferences. As a Priority 2, Grace met with the Stevens at their home to complete the initial on-site assessment and service plan within seven business days of enrollment. During the initial on-site assessment, Grace reviewed the B-UFC program components including the benefits, covered services, placement and service delivery options as well as the grievance and appeals process. She also provided Mr. and Mrs. Stevens with a B-UFC New Member Kit, which includes a Member Handbook and Quick Reference Guide; her personal business card via a customized refrigerator magnet (if the member agrees); the Advance Directive (AD) booklet; 5 Wishes; and a written copy of the Member's Rights. Mr. and Mrs. Stevens signed appropriate forms acknowledging they received a clear explanation of the program and a written copy of the Member's Rights.

INITIAL ASSESSMENT

Using a person-centered planning approach, Grace assessed Mr. Stevens via the Strengths and Needs Assessment (SANA), a B-UFC proprietary assessment tool and the Uniform Assessment Tool (UAT). Using these tools, Grace can assess functional abilities, medical conditions, existing supports systems, the social environment, preferred language, cultural customs in the home and dietary needs. The UAT helps determine the institutional rate for completing a Cost Effectiveness Study (CES). Grace also completed the HCBS Needs Assessment Tool (HNT) to determine the amount and scope of (AC Mr. Stevens will need. Once the assessments were complete, the Stevens and Grace jointly developed the Service Plan, focusing on the Stevens' preferences and service needs. Based on the information provided, Grace and the Stevens determined 20 hours of AC would succeed in providing the help Mr. Stevens needed to remain safely in his home. Both Mr. and Mrs. Stevens agreed they would like Mrs. Stevens to be the paid spousal caregiver.

INITIAL SERVICE PLANNING AND AC OPTIONS

Grace, along with the Stevens' input, developed a person-centered Service Plan with the specific services to be authorized, the provider agency, frequency, start and end date. Throughout the process, Grace made certain her interactions with Mr. and Mrs. Stevens respected their dignity, self-determination and choice with regards to the types, amount and delivery of the services Mr. Stevens required to remain at home – the least restrictive, most integrated setting. In addition, Grace reviewed the member-directed care options, such as the Agency with Choice (AWC) and Self-Directed Attendant Care (SDAC), with the Stevens plus the requirements and limitations of each, as described in AMPM Chapter 1300. Grace also reviewed the Spouse as Paid Caregiver option and the potential impact this option could have on Mrs. Stevens' eligibility for other publicly funded programs, such as food stamps. Grace explained Mrs. Stevens would have to provide Mr. Stevens' AC under the following conditions and limitations: Mr. Stevens must reside in his home and is informed he may choose an Attendant Care Worker (ACW) other than his spouse. The services provided must meet the definition of "extraordinary care" –care that exceeds the range of activities a spouse would ordinarily perform in the household, such as housekeeping, cooking and shopping. Grace also explained if Mrs. Stevens becomes Mr. Stevens' paid caregiver, she cannot be authorized to provide more than 40 hours of services in a seven-day period. If she is unable to provide the entire 40 hours, another agency or ACW may provide the balance of the authorized hours. The

total hours of AC services cannot exceed 40 hours. This applies only in situations when the spouse is the paid caregiver and does not preclude receiving other medically necessary, community-based services. Mrs. Stevens must be employed by a contracted agency and meet all training and employment requirements before she can become her husband's paid caregiver. Mr. and Mrs. Stevens agreed to have Mrs. Stevens as the ACW who will provide 20 hours of AC services each week. Both signed the Spouse Attendant Care Acknowledgment of Understanding and the ALTCS Member Service Plan. Grace completed the CES to verify the cost of 20 AC hours did not exceed 80 – 100% of what it would cost to care for Mr. Stevens in a SNF. Once she calculated and found the service plan to be cost effective, Grace arranged for services to be provided temporarily by an agency, (the same agency that was selected for contingency planning) per the Stevens' request, until Mrs. Stevens completed all her training and was cleared to begin work. Grace notified the couple that services must begin within 30 days, but she would advocate with the Home Care Provider (HCP) to start them as soon as possible. Grace entered her completed CES into the Client Assessment Tracking System (CATS) within 10 business days from the date of the initial on-site visit.

MEMBER'S DISSATISFACTION WITH APPROVED ATTENDANT CARE HOURS

Seven days following the start of AC services, Grace called the Stevens to find out how things were going. Mrs. Stevens reported being quite satisfied with the help her husband was receiving and started her ACW training. Although the Stevens received Grace's contact information and instructions on how to contact her with any issues or concerns, two months later, we received notification from their assigned AHCCCS Operations Compliance Officer that Mrs. Stevens had formally complained to five separate entities, including the legislature, regarding her dissatisfaction with the current allocation of hours. She requested 45 AC hours for Mr. Stevens due to his declining condition. AHCCCS requested a full investigation into the matter and a written response within **five business days**. Our point of contact for member issues referred by AHCCCS is our Medicaid Program Director. Within three hours, the Medicaid Program Director notified the Director of Case Management, the ALTCS Administrator and the Grievance and Appeals (G&A) Department. We use our established G&A process to investigate all grievance and appeals. Also, we received a separate expedited service authorization request for 45 hours of AC services, from the HCP employing Mrs. Stevens.

In this situation, the Case Management Department is responsible for responding to Mrs. Stevens' request and complaints, which could extend to expressing dissatisfaction with the current CM. Honoring choice, we may also assign a new CM if the member's dissatisfaction can not be resolved. Throughout the resolution process, the G&A Department works closely with the Case Management Department and B-UFC leadership, as appropriate, to address all issues within the regulatory timeframes per the Arizona Administrative Codes, Title 9 Chapter 34. The G&A Manager notifies and discusses the grievance allegations with the Director of Quality Management to identify and investigate any potential quality of care issues by the Quality Management Department. If a media inquiry associated with this situation occurred, we would initiate its media inquiry protocol as applicable. Regardless of who receives a media inquiry within B-UFC, all employees are required to gather the requested information from the caller and notify the CEO's Executive Assistant. Leadership reviews the information and determines appropriate further actions. In addition, the Government Programs Department would notify AHCCCS that we received a media inquiry and confer with AHCCCS on the planned response**.**

CASE MANAGEMENT REASSESSMENT OF MEMBER

After notification of the grievance and the request for 45 AC hours, Grace immediately contacts Mrs. Stevens and schedules a follow-up visit within 24 hours to evaluate the situation and reassess Mr. Stevens' condition. Grace informs Mrs. Stevens that B-UFC received an expedited authorization request for 45 hours of AC and the authorization decision will be made within three working days from the date of receipt of the service request. Standard authorization requests allow up to 14 days to make a determination with a possible 14-day extension if criteria for services authorization extension is met and both parties agree per ACOM 414. The goal of the follow-up visit is to identify any change in condition or needs; determine what led Mrs. Stevens' to call five agencies with complaints about the number of hours her husband was authorized; and create a workable solution and service plan acceptable to both, which meets the needs of Mr. Stevens and is cost-effective. Using a person-centered approach, Grace seeks to understand Mrs. Stevens' perspective on her husband's declining condition and conducts a full reassessment to identify any change in needs and/or condition that would require more AC hours. Before the home visit, Grace reviewed her last assessment of the member, which was completed approximately two months ago and any other important health information recently documented in the member record. She notes the AC hours currently in place correspond to the needs identified on the HCBS Needs Tool (HTN) completed at the initial assessment. Also, Grace contacted Mr. Stevens' Primary Care Provider

(PCP) to identify any potential changes in his health, including new diagnoses, changes in medications or other pertinent health information.

Grace arrives at the Stevens home and acknowledges their concern and frustration with the current service plan. Focusing on the member and his spouse, Grace encouraged them to talk about the events that led them to call five agencies. Grace employs a member-centered approach and active listening skills, making it clear she is there to understand their perspective. Grace reminds Mrs. Stevens about the Guidelines for Spousal AC, emphasizing no more than 40 hours a week can be authorized when the spouse is providing the care and the spouse can only be paid for "extraordinary care" as previously discussed. Grace explains she will complete a reassessment, using the HNT to determine Mr. Stevens' current level of functioning and needs. The HNT helps Grace establish what extraordinary care Mrs. Stevens needs to perform for her husband and the length of time it takes to perform each task. These tasks include assisting with ADLs such as bathing, dressing and grooming, both in the morning and at night. Mr. Stevens needs moderate assistance in setting up his meals, cutting his food and transferring from his wheelchair to his bed or the toilet. As Grace questions the couple about Mr. Stevens' current abilities, she observes his overall physical appearance and evaluates his mental status by asking questions about his orientation to person, place and time. She also assesses Mrs. Stevens' stress level and continued ability to provide the care her husband requires. Since there is a report of declining condition, Grace will complete a new UAT to determine if Mr. Stevens' Level of Care (LOC) has changed and recalculate the CES to determine if he can continue to remain safely and cost-effectively in his home. She also performs another home safety evaluation to identify any new home modification or Durable Medical Equipment needs. After completion, she determines Mr. Stevens has declined and requires 30 hours of AC each week. Together with the Stevens, Grace develops a new service plan to reflect the increased needs. Mrs. Stevens wants to provide these extra hours and agrees she may benefit from respite care to give her some relief from her caregiving duties. Grace provides Mrs. Stevens with information about caregiver support groups and services available through Title III of the Social Security Act that funds extensive caregiver services through the local Area Agency on Aging. She also gives Mrs. Stevens a list of local caregiver support groups, including a resource guide titled *Being a Resilient Caregiver*, compiled by the Caregiver Consortium, a local non-profit group. Grace encourages Mrs. Stevens to attend a support group and explains an ACW from an agency will come and provide care for her husband while she is away.

RESPONSE TO REASSESSMENT AND NEW SERVICE PLAN

There are various possible responses the Stevens could have to Grace's reassessment findings and recommendation for 30 hours of AC and eight hours of respite care for Mrs. Stevens. Our approach to each is as follows.

Stevens Agree with New Service Plan

If the Stevens agree with the new service plan, as described above, no further action would be required. Even though Grace denied the request for 45 hours, if the Stevens agree to the new service plan, the situation would be resolved. In that case, Grace will authorize the additional hours and enter the new CES into CATS within 10 business days from the date of the decision. Grace will provide an update to her supervisor, noting the change in service plan and the Stevens acceptance of the additional hours, including respite hours for Mrs. Stevens. The CM Supervisor will notify the G&A Manager and provide any required documentation to demonstrate all Mrs. Stevens' concerns were resolved and Mr. Stevens' needs are being met with the new Service Plan signed by both Mr. and Mrs. Stevens. Within the five business days allotted by AHCCCS to complete the investigation, the Medicaid Program Director notifies AHCCCS verbally and in writing, and provides a detailed report outlining the outcome of the investigation, including the use of the appeal and State Fair Hearing (SFH) process as applicable.

Stevens Disagree with the New Service Plan

If after completing the reassessment and proposed care plan, the Stevens still do not agree with the plan and continue to ask for 45 hours of AC, Grace will explain that a spousal caregiver cannot be authorized to provide more than 40 hours a week, even if an ACW from the agency provides some of the hours. She will also remind Mrs. Stevens that only "extraordinary care" can be paid for when the spouse is the caregiver. If the Stevens still do not agree to the proposed revised care plan, Grace will explain their right to appeal the decision and tell them they will receive a letter called a Notice of Action (NOA). The NOA will be sent within **three calendar days** of receipt of the expedited service authorization request for 45 hours of AC. The NOA provided to the Stevens will be in accordance with the AHCCCS rules, by using the form (ACOM policy 414, Attachment A) and the *Guide to Language in Notices of Action* (ACOM policy 414,

Attachment C). The NOA will explain the reason for denial, how to file an appeal and the required timeframes. Once the draft NOA is completed, it must be reviewed and approved by a Case Management Supervisor and/or the Medical Director before being mailed. Grace also offers to assist the Stevens with filing the appeal if needed.

APPEAL PROCESS

If Mrs. Stevens files a standard appeal in writing within 60 days from the date of the NOA, the G&A Department will acknowledge the receipt of Mrs. Stevens appeal in writing within five business days. If Mrs. Stevens had filed an expedited appeal, the acknowledgment would be made in **one business day** in accordance the AHCCCS rules. We resolve standard appeals within 30 days from the receipt date unless an extension of up to 14 days has been agreed to and is in place for the benefit of the member. The G&A Manager will offer Mrs. Stevens a reasonable opportunity to present evidence and allegations of facts related to the denial of services and will be offered a face-to-face or telephonic meeting to present her evidence. Any information received during the resolution process is date-stamped and entered into Siebel, our customized Customer Relations Management (CRM) system, allowing us to track and trend grievances, appeals, claim disputes and SFHs. Our G&A Manager will assemble all background information from the CM, obtain relevant clinical information and forward it to a Medical Director for review.

The Medical Director or other appropriate B-UFC employees reviewing the case and making the appeal decision could not have participated in any prior review or decision-making actions related to this appeal. After completion, the G&A Manager will issue a written Notice of Appeal Resolution (NOAR) to Mr. and Mrs. Stevens via certified mail within 30 days from receipt of the appeal. The NOAR includes the legal citations or authorities supporting the determination, along with the completion date. If the appeal decision does not favor Mr. Stevens, the NOAR would include: (1) his right to request a SFH, including the requirement of filing for a hearing in writing no later than 30 days after the date he receives the NOAR and how to make the request; (2) the right to receive continued benefits pending the hearing and how to request continuation of benefits; (3) information explaining the Stevens may be responsible for the cost of benefits if the hearing decision upholds the denial as applicable; and (4) they may also file for a SFH if the NOAR is not completed within required timeframes.

STATE FAIR HEARING

If the denial is upheld, and the Stevens choose to appeal our decision and request a SFH in writing no later than 30 days after the date they received the NOAR, our G&A Manager will forward the case file, cover letter, their written request for hearing, copies of the entire file with supporting documentation, copy of the NOAR and other information relevant to our decision to the Office of Administrative Services (OALS) at AHCCCS, no later than **five working days** from receipt. To resolve this issue before the SFH, a senior leader from the Case Management Department along with the Chief Medical Officer (CMO) will review the case file again. While this additional review by the CMO before proceeding to a SFH exceeds AHCCCS expectations, it has been an instrumental part of our standard procedure to resolve appeals.
As appropriate, the Director of Case Management will contact the Stevens to discuss our position and determine if a resolution is possible. If deemed not appropriate or no resolution is agreed upon, the SFH will proceed with each party providing their evidence. Subsequent to both parties providing testimony in the SFH, the Administrative Law Judge (ALJ) will deliver his/her decision to the Director of AHCCCS, who then provides a final determination of appeal outcome to all parties involved. Upon receipt, the G&A Manager will notify the Medical Director/CMO and the Director of Case Management of the decision. If the Director's decision overturns B-UFC's denial of services, B-UFC will effectuate the decision within the regulatory timeframes, otherwise the appeal is closed without additional actions. We maintain member appeal files in accordance with 42 CFR 438.416 for a period of 10 years.

ADDITIONAL REASSESSMENT OUTCOMES

We recognize there are other potential outcomes of Mr. Stevens' reassessment, including a need for 45 AC hours, a significant change in condition and the potential need for a change in placement. Our approach to each is described below.

Need for 45 hours of AC

If the reassessment of Mr. Stevens had indicated a need for 45 hours of AC and ***was*** cost-effective, all the AC hours would need to be provided by an ACW from a provider agency**.** Grace reviews the AWC option (AMPM policy 1300), saying Mr. Stevens could remain safely at home if he chooses Mrs. Stevens as his Individual Representative (IR) and

enters into a co-employment agreement with the provider agency per AMPM Exhibit 1300-2. As IR, Mrs. Stevens must sign the AWC–IR Form (AMPM Exhibit 1300-3). Under this option, the provider agency serves as the legal employer of the Direct Care Worker (DCW). The member or IR may choose the DCW who will provide the AC and direct the day-to-day provision of care, as outlined in the co-employment agreement. The Stevens will participate in the service planning process, including signing the Service Plan. The provider agency trains the DCW, completes and authorizes all tax, billing and payroll documents, and is available to assist the Stevens with DCW supervision, conflict resolution and implementing a contingency plan when necessary. Grace will also be available to assist and support the Stevens if they choose this option (per AMPM 1312-C). This could be a feasible option for the Stevens if 45 hours of AC are required. Although Mrs. Stevens would not be providing the care, she would have oversight and management of the DCW. Grace will complete a Member Change Report (MCR) reflecting the change in income resulting from the closure of Mrs. Stevens as the paid spousal caregiver.

Significant Change in Level of Care

If the need for 45 hours of AC were found to be warranted per the results of the HNT but **was not** found to be cost-effective, the CM would explain the cost-effectiveness limits and how they are determined. For example, if only 35 hours of AC (the assessed need) can be provided cost-effectively and the member insists upon remaining at home, they must be willing to accept the 35 hours of AC and assume the potential risks of remaining at home without all the care assessed as needed. The CM must complete a Managed Risk Agreement (MRA) with the member to document this situation. This agreement describes the HCBS service and placement options offered, the member's decision, the risks associated with this decision and any plans the member has to address these risks. In this situation, if Mr. and Mrs. Stevens do not want to accept the placement options Grace offers them because they do not want Mr. Stevens to reside in a SNF or ALF, they can agree to sign the MRA, indicating that Mrs. Stevens can provide the additional needed hours. Once Grace completes the MRA, she would increase the number of AC hours to 35 and enter the data into CATS, indicating an increase in the cost of services and complete a MCR to reflect the change in income resulting from the closure of Mrs. Stevens as the paid spousal caregiver.

RESOLUTION AND GRIEVANCE FOLLOW-UP

The G&A Department, in collaboration with the Case Management and Government Program Department, prepares the follow-up communication required by AHCCCS and submits it within the designated timeframe (five business days). Our detailed response and timely follow-up makes certain AHCCCS has the information necessary to close the loop with the legislature and five agencies to which Mrs. Stevens initially expressed concern, and we are available to contact community stakeholders directly as requested by AHCCCS. The communication content is based on the outcome of the reassessment, and the Stevens' response to the recommended changes to the service plan. The communication explains the actions taken to resolve Mrs. Stevens' complaints. These include the reassessment of Mr. Stevens to determine any changes in his condition, discussing the alternative options available to meet his needs and the assistance provided to Mrs. Stevens regarding her caregiver responsibilities, such as the addition of respite hours. Also included is information informing them of their appeal and SFH rights throughout the process, assisting them with filing an appeal as needed, and a plan to contact the Stevens more frequently for the next several months to verify the new service plan is effectively meeting their needs.

We embrace the ALTCS program values and make certain our members are given, choice, dignity, independence, individuality, privacy and self-determination as we partner with them to provide services that allow them to live in the least restrictive, most integrated setting. To that end, we will conduct an after-action review of the Stevens' situation to determine the root cause that prompted Mrs. Stevens to call five agencies rather than calling Grace for assistance. Depending on the outcome of the review, we will implement systemic corrective actions and/or additional training for CMs as appropriate. We approach each member and family with an individual, person-centered approach, seeking to meet their individual needs. We strive to consistently be available and ready to resolve members concerns at the earliest opportunity to minimize the escalation of complaints and grievances. In situations where issues have been escalated outside the plan, we will immediately take action to correct the issue and provide a rapid response to AHCCCS and other agencies as required.

11. A PROVIDER WHO IS A SPECIALTY SURGEON FILED A CLAIM DISPUTE CONTESTING THE OFFEROR'S RECENT…

The University of Arizona Health Plans (UAHP) realizes that positive provider interactions have far-reaching impact for our members. As the only locally owned health plan in Arizona and in alignment with our member- and provider-centric philosophies, The University of Arizona Health Plan's (UAHP) has efficient processes in place that minimize provider burden. We prioritize excellent customer service, which is evidenced by high levels of member and provider satisfaction. We pride ourselves on building trusted relationships with our providers and will continue this with ALTCS.

UAHP consistently follows the established process for the recoupment of a claim per ACOM policy 412. However, based on the facts provided in this scenario, it appears we did not follow ACOM 412, which requires AHCCCS authorization prior to recoupment of a claim paid greater than 12 months ago. In addition, because the notification sent to the provider was not in compliance with ACOM 412, it appears UAHP did not seek or receive approval on the required provider notification. At some point during the recoupment and subsequent claim dispute process, it is likely our omission would have been discovered (either internally or externally). If we had internally discovered our error, we would have immediately self-disclosed the situation to AHCCCS. Depending on the circumstance associated with the oversight discovery, AHCCCS may very well have notified the plan of the errors. Because we did not follow the requirements outlined in ACOM 412, we would anticipate that AHCCCS may prohibit UAHP from recouping the monies paid 26 months prior, and we would have reprocessed the claim as originally submitted.

To make certain AHCCCS approval is solicited and granted in advance of any recoupment more than $50,000 or more than one year from the date of the initial payment, UAHP will take the following actions:

1) Initiate a Root Cause Analysis (RCA) to find the cause of the breakdown in our process that lead to the errors.
2) Using the Plan, Do, Study, Act (PDSA) model for improvement, develop a Corrective Action Plan.
3) Test and implement the identified corrective actions needed to eliminate future errors.
4) Establish those actions deemed successful as our standard practice for claims recoupment and update associated policies and procedures accordingly.
5) Establish on-going monitoring and auditing to confirm the new processes are effective.
6) Monitor our claims, prior authorization and concurrent review processes to confirm they work in collaboration to minimize the likelihood of having to recoup already paid claims.
7) Apply continuous quality improvement efforts to ensure our internal on-going claims audit functions verifies provider contracts are loaded correctly and measures the accuracy of payments against the contract terms.

Concurrent with the PDSA process, in accordance with the contract requirements, UAHP will continue to perform regular and periodic audits of our provider contract terms. Audits will consist of a random, statistically significant sampling of all contracts in effect at the time of the audit. The audit sampling methodology is documented in policy. UAHP reviews the contract loading of both large groups and individual practitioners at least once every five-year period in addition to any time a contract change is initiated during that timeframe. The findings of these audits are documented and any deficiencies noted in the resulting reports are addressed through the corrective action process**.**

Additional Scenario Assumptions

The following sections outline the steps and activities UAHP would take to properly initiate the recoupment and process the subsequent claim dispute per ACOM 412 and Section F, Attachment F3, of the Agreement. The dates and timelines used in our response are consistent with the date of the original claim payment date being greater than two years ago and are based on the following assumptions:

- The provider is non-contracted but registered with AHCCCS.
- The non-contracted surgeon billed unlisted code 53899 (unlisted procedure, urinary system) for total billed charges of $5,232.00.
- For unlisted CPT codes, AHCCCS pays 58.66% of billed charges and the provider received payment of $3,069.09.
- AHCCCS granted approval to recoup the claim based on waste and approved our provider notification.
- The payment was recouped and the claim was denied for not a covered service/unauthorized treatment by our Claims Department.
- The provider did not seek prior approval for surgical procedure.
- The related hospital authorization was approved for surgical procedure nephrostomy billed under CPT 50040.
- The 2014 AHCCCS Physician Fee Schedule allowed for CPT 50040 is $780.18.

- The 2014 AHCCCS Physician Fee Schedule allowed for unlisted code CPT 53899 is By Report (BR) or 58.66%.
- The surgeon is appealing the denial of unlisted CPT 53899.

Correct Process for Recoupment of Claim

In this case, Dr. Cutter, a specialty surgeon, billed an unlisted code CPT 53899 while the hospital received authorization for CPT 50040. Based on a retrospective review of the unlisted code, the Medical Claims Review Team clinically reviewed the operative report and discovered the surgeon had billed the unlisted CPT code and the procedure was done robotically. Robotics can be used, but AHCCCS does not reimburse over and above the incisional equivalent to the physician. After identifying the overpayment, per ACOM policy 412, the Medical Claims Review Team sent the Claims Department an electronic file containing the claims that were eligible for recoupment. The Claims Manager reviewed the file and identified the claims that required AHCCCS approval, which included the claim submitted by Dr. Cutter, (Claim recoveries greater than $50,000 and those with an original payment date of greater than 12 months.) The Claims Manager prepared the AHCCCS Claims Recoupment Request (per Section F, Attachment F3, of the contract and ACOM 412) and submitted the request to our Operations Compliance Officer via the FTP server and email notification. The request included a detailed letter with the following information:

- How the need for recoupment was identified
- The systemic causes resulting in the need for a recoupment
- The process that will be utilized to recover the funds
- Methods to notify the affected provider(s) prior to recoupment
- The anticipated timeline for the project
- The corrective actions that will be implemented to avoid future occurrences
- Total recoupment amount, total number of claims, range of dates for the claims being recouped and total number of providers impacted

UAHP also provided AHCCCS with an electronic file containing the following information:

- AHCCCS Member ID
- Date of Service
- AHCCCS Original Claim Number
- AHCCCS CRN, if available
- Date of Payment
- Amount Paid
- Amount to be Recouped

Along with the request letter and electronic file, UAHP included a copy of the proposed recoupment prior notification for AHCCCS approval (Attachment 1). The communication included:

- How the need for the recoupment was identified
- The process that will be utilized to recover the funds
- The anticipated timeline for the recoupment
- The provider's right to file a claim dispute
- Total recoupment amount, total number of claims and ranges of dates for the claims being recouped
- Listing of impacted claim numbers

UAHP obtained AHCCCS approval, and with this approval, UAHP recouped the monies previously paid to Dr. Cutter.

CLAIM DISPUTE PROCESS

UAHP follows the established processes for contracted and non-contracted providers outlined in the Grievance and Appeals (G&A) section in the AHCCCS contract and in the AAC Title 9 Chapter 34 Article 4 when AHCCCS is the primary payer. In situations where Medicare is the primary payer, UAHP follows CMS Managed Care Manual, Chapter 13, §60.1.1 – Non-Contracted Provider Appeals, which permits a non-contract provider to file a standard appeal for a denied claim only if the non-contracted provider completes a Waiver of Liability (WOL) statement. The WOL makes certain the non-contracted provider will not bill the enrollee regardless of the outcome of the appeal. For Medicaid, contracted providers, UAHP follows the AHCCCS claim dispute regulations. UAHP processed this claim dispute using the AHCCCS protocol for a standard claim dispute.

Upon receipt of the claim dispute, the G&A Coordinator reviewed the submitted documentation to verify the provider included all required items, such as the claim, remittance advice, medical records and any additional information that would support the claim dispute. The G&A Coordinator date stamped and entered the claim dispute information into Siebel, our secure Customer Relationship Management System for managing, tracking and trending claim disputes. Within ***five business days*** of receipt, an acknowledgment letter was sent to Dr. Cutter notifying him the claim dispute had been received (Attachment 2).

The claim dispute is researched and reviewed per the UAHP claims dispute policy and in accordance with the Arizona Administrative Code (AAC) Title 9, Chapter 34 Article 4. The G&A Team, which includes the Clinical and Claim Analysts, reviewed any coverage limitations, previous claim payment history, relevant medical records and applicable regulatory, statutory and policy provisions associated with this claim denial. Those involved in the review were required to comply with all timelines for information and written response requests pertaining to this claim dispute. If there had been a need for more than ***30 days*** to investigate and issue the Notice of Decision (NOD), UAHP would have sent Dr. Cutter a written request for an additional ***14 days*** to complete the investigation. In this case, UAHP did not seek an extension for this claim dispute, and no extension letter was sent to Dr. Cutter. UAHP upheld the denial of the claim because not all services are covered. The Claims Dispute Analyst contacted Dr. Cutter's billing office to educate them that Dr. Cutter could submit a clean claim with the reimbursable code. The NOD was then sent to Dr. Cutter within **30 calendar days** from the date of receiving the claim dispute; the notice contained a detailed explanation of why the claims dispute was upheld and Dr. Cutter's right to request a State Fair Hearing (Attachment 3).

STATE FAIR HEARING

A request for a State Fair Hearing (SFH) must be submitted in writing and received by the health plan within **30 calendar days** from the date the provider received the NOD. Dr. Cutter chose to exercise his right to request a SFH and submitted a written request within 30 calendar days of receiving the NOD per the requirements AAC Title 9 Chapter 34. The SFH request was acknowledged within **five business days** from the date of receipt (Attachment 4).

The G&A Coordinator filed documentation with the Arizona Office of Administrative Hearings (OALS), no later than **five business days** from receipt of Dr. Cutter's written request for hearing. The file included a cover letter, which contained:

- The provider's name
- The provider's address
- The member's name and AHCCCS identification number
- The provider's phone number (if applicable)
- The date the claim dispute was received by the contractor
- A summary of the actions undertaken by UAHP to resolve the claim dispute and basis of the determination

The case file to the OALS contained:

- The written request for hearing filed by the provider
- The NOD letter
- An original appeal request
- A copy of the claim

The G&A Coordinator received a notice of hearing from OALS via U.S. mail. This notifies UAHP of the date and time of the hearing. The G&A Coordinator notified our Chief Medical Officer (CMO) and Director of Medical Management Systems of the hearing. The UAHP CMO and Director of Medical Management Systems conducted a final review. The CMO and Director of Medical Management Systems agreed to maintain their position to uphold the denial for the services not reimbursable by AHCCCS. They reached out to the provider again before the hearing to discuss a possible settlement. Because no settlement was reached, they consulted with legal counsel to prepare to present their legal arguments before the Administrative Law Judge (ALJ). The facts and legal arguments presented before the ALJ include:

- In regards to UAHP's right to recoup these billed fees at this time following the actual surgery, UAHP cites AHCCCS ACOM policy 412.
- Since Dr. Cutter does not hold a contract with UAHP, guidance regarding payment for services rendered is from Arizona Administrative Code (AAC), Arizona Revised Statute (ARS), AHCCCS policies and procedures along with nationally recognized payment methodologies.

- In regards to guidance on the claims payment process to use for a non-contracted provider, we cite AHCCCS ACOM policy 203 that states, "Claim payment requirements pertain to both contracted and non-contracted providers."
- In regards to the rate at which UAHP, an AHCCCS Contractor, will reimburse Dr. Cutter as a non-contracted provider, UAHP cites AAC R9-22-705 Payments by Contractors that states, "…in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties."
- In regards to UAHP, as a Contractor with AHCCCS, requiring Dr. Cutter to use specific claims methodologies, we cite AHCCCS ACOM policy 203 that states, "The Contractor must include nationally recognized methodologies to correctly pay claims…"
- UAHP, along with AHCCCS and CMS, use the AMA Health Care Professionals Advisory Committee recommendations as the nationally recognized methodology to process claims.
- In regards to our disagreement with Dr. Cutter using an unlisted code to bill for use of robotics, UAHP cites both the AMA recommendations and AHCCCS policy (Fee-for-Service Provider Manual, Chapter 10 Professional and Technical Services) which state, "All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code…" Furthermore, the nationally accepted methodology to bill for use of robotics during surgery is noted to be the use of HCPCS code S2900 (or more specific CPT code for specific procedure).
- Dr. Cutter's obligation to resubmit a clean claim in order to be reimbursed as per ARS § 36-2904.

The obligation to provide payment only for applicable covered services and non-covered services based on the medical records provided as per AAC R9-22-202(B)(1) "Only medically necessary, cost effective, and federally and state reimbursable services are covered services." The complete Arizona Administrative Codes can be found on the internet at http://apps.azsos.gov/public_services/Title_09/9-22.pdf.The facts developed by UAHP's review, including Dr. Cutter's contract status, the services Dr. Cutter billed for, the medical records and any other information from Dr. Cutter.

UAHP's conclusions, based on the comparison of the facts and the legal requirements for payment of covered services under the AHCCCS program, are that:

- The hospital was authorized to perform nephrostomy surgical procedure (CPT 50040), and as per the April 2014 AHCCCS Fee Schedule, the allowed amount is $780.18.
- Dr. Cutter billed for his services, using an unlisted CPT code of 53899, while the medical records show Dr. Cutter performed the surgery using robotics. AHCCCS does not reimburse for the use of this equipment.
- Therefore, Dr. Cutter has the option to rebill with the approved CPT 50040 for reimbursement of $780.18.

Subsequent to both parties providing testimony in the SFH, the ALJ will deliver his or her decision to the Director of AHCCCS, who then provides a final determination. Upon receipt of the final determination, the G&A Coordinator will notify all affected parties within UAHP of the decision. If the decision by the Director of AHCCCS overturns UAHP's denial of payment, UAHP will effectuate the decision within **15 calendar days**, and would issue Dr. Cutter with payment and associated remittance advice (attachment 5) otherwise the claim dispute is closed without additional actions. Our database is updated with the date and final disposition of the claim, dispute and SFH, and the case is closed. UAHP maintains claim dispute files for a period of 10 years and in accordance with 42 § CFR 438.416. If the Director's decision reverses our decision, it is closely reviewed to determine if a potential opportunity exists for operational performance improvement.

INTERVENTIONS/STRATEGIES TO RESOLVE DISPUTES WITHOUT RESORTING TO THE HEARING PROCESS

Because there are limited Medicaid funds, we focus on reducing administrative costs so the greatest amount of funding goes toward serving vulnerable members. SFH escalation results in increased administrative costs for AHCCCS, our providers and UAHP; as such, we strive to minimize the volume of claims disputes that go to hearing. To accomplish this, we first recognize that many departments are responsible for accurate and timely payment. To support this, we have comprehensive training programs in place to thoroughly train all employees who either support or process claims. We have robust practices and automated processing systems to evaluate all incoming claims and apply vigorous system edits to realize the greatest degree of payment accuracy. Once claims are processed, we deploy additional methods to

consistently evaluate accuracy. This occurs both through retrospective claims review by highly trained clinicians within our Medical Review Unit as well as through monthly audits of high-dollar claims by the Compliance Department. In compliance with the False Claims Act, overpayments are recouped. Further, because of the profound impact Fraud, Waste and Abuse (FWA) has on health care financing, UAHP has a fully implemented FWA plan that includes utilizing our Special Investigation Unit, FWA Specialist and state-of-the-art FWA data analytic tools in order to prevent, detect, research, report and correct FWA, such as unusual or inappropriate billing patterns.

To reduce unnecessary claims disputes, The Grievance and Appeals Reporting Committee (GARC) meets monthly to review: (1) The top 10 providers filing claims disputes (12-month rolling trend) and (2) The top 10 claim denial trends. Review of these reports helps us to identify trends and act as a catalyst to prompt the Provider Relations Representatives and/or Claims Educator to reach out to the provider to identify the root cause, develop an intervention to address the issues and identify an alternative to filing claims disputes. The GARC is an intra-departmental meeting with representation from departments such as Network Development, Quality Management, Medical Management, Claims and Member Services to promote organization-wide collaboration to minimize claim disputes and request for SFHs. All trended concerns and potential action plans are reported on at least a quarterly basis to the Quality Management Committee (QMC), which monitors the quality of care and service delivered to our members via our contracted providers and subcontractors. As required, UAHP implements a process improvement plan using the PDSA model for improvement, which includes, for example, examining system set-up and audit validating to confirm that any identified systemic issues are corrected. Once addressed, UAHP will notify affected providers of the actions taken to improve the system and assist them with correcting any claim payment errors. Process improvement outcomes are reported to and monitored for completion by the Quality Management and Compliance Committees. Recoupment as a component of waste reporting is also discussed at the Utilization Management/Finance Committee, which serves as our FWA Committee.

In addition, UAHP holds weekly meetings with the Appeals Case Review Team, led by the CMO, to review new hearing requests. The goals are to determine whether an issue can be resolved without the need for a hearing and to foster provider satisfaction. The CMO may make a peer-to-peer call with the provider to determine if additional medical information would provide an opportunity for overturning the decision. The team may determine a negotiated settlement could occur and would propose this solution to avoid a hearing. Through this process, UAHP has also developed a tool/guide for claims dispute escalation. If G&A identifies an anomaly on a claims dispute, this is immediately escalated to the CMO to follow-up with the provider to avoid a hearing. With these interventions, this team has greatly reduced the number of cases that need to be resolved using the hearing process, and combined interventions have resulted in avoiding 339 hearings from 2012 to 2016. The table below shows that UAHP resolved more than 99.6% of hearing requests in the last four years, with only one claim dispute being forwarded to a hearing.

Claims Dispute/ Hearing Trends	2013	2014	2015	2016
Total Claims Disputes Filed	3219	4319	5375	4164
Total Hearing Requests	38	45	129	75
Total Claims Disputes Forwarded to Hearing	0	0	1	0
% of Total Claims Disputes Forwarded to Hearing	0.00%	0.00%	.019%	0.00%

This approach of using team dialogue to arrive at fair, yet appropriate decisions followed by proactive provider outreach is at the core of UAHP's strategy.

UAHP HAS IMPLEMENTED PROCESSES WHICH REDUCE PROVIDER BURDEN

UAHP will continue to use robust processes and systems in order to realize the highest level of claims payment accuracy possible. Through our tracking, trending and reviewing processes as well as pre-hearing peer-to-peer discussions, we have successfully improved and sustained a low rate of claim disputes and SFHs. We remain committed to successful provider partnerships that result in quality care and service for our ALTCS members, as well as a collaborative approach to resolving provider concerns, including those associated with the payment, denial and recoupment of claims –which should ultimately result in continued high-levels of provider satisfaction.

Banner
University Health Plans
Banner – University Family Care

2701 E. Elvira Road, Tucson, Arizona 85756
(520) 874-5290 • (800) 582-8686 • Fax (520) 874-5555
www.ufcaz.com

ATTACHMENT 1
Provider Recoupment Notification

August 6, 2016

Robert Cutter, MD
1234 Lifeline Way
Phoenix, AZ 85034

Member Name: John Smith
Member ID#: A0000008
Date of Service: June 9, 2014
Date of Denial: August 13, 2016
Denied Claim Reason: Not all services are a covered benefit; no prior authorization obtained

Dear Sir or Madam,

Banner – University Family Care (B-UFC) has completed a review of the operative report, other medical records and supporting documentation related to the payment of claim 3475893. B-UFC is denying this payment because the services rendered were billed with an unlisted CPT code. After review, it was determined the procedure was done robotically. Per AHCCCS, robotics can be used but additional payment over and above the incisional equivalent is not covered. The hospital authorization approved surgical procedure CPT 50040 – nephrostomy. B-UFC will recoup the full payment of $3,069.09 on the next payment cycle scheduled for August 13, 2016. The date range for the one claim(s) being recouped is June 9, 2014.

If you do not agree with this decision, you have the right to file a claim dispute.

You may submit your claim dispute to:
Banner – University Family Care, Attention: Grievance and Appeals
2701 East Elvira Road
Tucson, AZ 85756
Fax: 866-465-8340

B-UFC will review the claim dispute and will notify you of the review decision within 30 calendar days, unless a 14-day extension is needed and agreed upon. If you need assistance with the claim dispute process, please contact the Customer Care or Appeals Department at 1-800-582-8686.

Sincerely,
Claims Manager
Banner – University Family Care

Banner
University Health Plans
Banner – University Family Care

2701 E. Elvira Road, Tucson, Arizona 85756
(520) 874-5290 • (800) 582-8686 • Fax (520) 874-5555
www.ufcaz.com

ATTACHMENT 2
NOTICE OF ACKNOWLEDGEMENT

October 20, 2016

Robert Cutter, MD
1234 Lifeline Way
Phoenix, AZ 85034

Claim Dispute #: 012457
Member Name: John Smith
Member ID#: A0000008
Date of Service: June 9, 2014
Date of Denial: August 13, 2016
Denied Claim Reason: Not all services are a covered benefit; no prior authorization obtained
Date of Claim Dispute Receipt: October 18, 2016

Dear Sir or Madam,

This letter is to confirm Banner – University Family Care (B-UFC) has received your request for a claim dispute on the denial for the payment of your claim.

B-UFC will review the claim dispute and will notify you of the review decision within 30 calendar days, unless a 14-day extension is needed and agreed upon.

You have the right to request to review your claim dispute case file and to present evidence or information regarding your claim dispute prior to a Notice of Decision by B-UFC. This request must be made timely so B-UFC will be able to meet regulatory timeframe requirements.

You may present information regarding your claim dispute in writing, by telephone or in person. Please contact the Appeals Department at 1-800-582-8686 or fax to 1-866-465-8340 if you have information you wish to present. It is important that B-UFC receives this information promptly to stay within the timeframe requirements.

If you need assistance with the claim dispute process, please contact the Customer Care or Appeals Department at 1-800-582-8686.

Sincerely,
Grievance and Appeal Coordinator
Banner – University Family Care

Banner
University Health Plans
Banner – University Family Care

2701 E. Elvira Road, Tucson, Arizona 85756
(520) 874-5290 • (800) 582-8686 • Fax (520) 874-5555
www.ufcaz.com

ATTACHMENT 3
NOTICE OF DECISION

November 14, 2016

Robert Cutter, MD
1234 Lifeline Way
Phoenix, AZ 85034

Claim Dispute #: 012457
Member Name: John Smith
Member ID#: A0000008
Date of Service: June 9, 2014
Date of Denial: August 13, 2016
Denied Claim Reason: Not all services are a covered benefit; no prior authorization obtained
Date of Claim Dispute Receipt: October 18, 2016

Dear Sir or Madam,

Banner – University Family Care (B-UFC) has completed a review of the operative report, other medical records and supporting documentation related to your request. B-UFC is upholding the decision to deny claim number 3475893 due to the claim being billed with an unlisted CPT code. Also, after review it was determined the procedure was done robotically, which is not reimbursable by AHCCCS. Per AHCCCS, robotics can be used but additional payment over and above the incisional equivalent is not covered. The hospital authorization approved surgical procedure CPT 50040 – nephrostomy**.** The obligation to provide payment only for applicable covered services and non-covered services based on the medical records provided as per AAC R9-22-202(B)(1) "Only medically necessary, cost effective, and federally and state reimbursable services are covered services." The complete Arizona Administrative Codes can be found on the internet at http://apps.azsos.gov/public_services/Title_09/9-22.pdf.

If you are not satisfied with our decision, you have the right to file a Request for State Fair Hearing. This request must be in writing and received no later than 30 calendar days from the receipt of this notice. A copy of this notice MUST be sent in with your written request.

You may submit a Request for State Fair Hearing to:
Banner – University Family Care Attention: Grievance and Appeals
2701 East Elvira Road
Tucson, AZ 85756
Fax: 866-465-8340

Once your request has been received, a copy of the entire file will be sent to the State of Arizona AHCCCS Administration, who will set a hearing date. If you need assistance with the State Fair Hearing process or need translator services, please contact Customer Care or the Appeals Department at 1-800-582-8686.

Sincerely,
Grievance and Appeal Coordinator
Banner – University Family Care

Banner
University Health Plans
Banner – University Family Care

2701 E. Elvira Road, Tucson, Arizona 85756
(520) 874-5290 • (800) 582-8686 • Fax (520) 874-5555
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ATTACHMENT 4
STATE FAIR HEARING ACKNOWLEDGEMENT

December 4, 2016

Robert Cutter, MD
1234 Lifeline Way
Phoenix, AZ 85034

Claim Dispute #: 012457
Member Name: John Smith
Member ID#: A0000008
Date of Service: June 9, 2014
Date of Denial: August 13, 2016
Denied Claim Reason: Not all services are a covered benefit; no prior authorization obtained
Date of Claim Dispute Receipt: October 18, 2016
Request for State Fair Hearing: December 1, 2016

Dear Sir or Madam,

This letter is to confirm Banner – University Family Care (B-UFC) has received your written request for a State Fair Hearing regarding the denial of claim number 3475893.

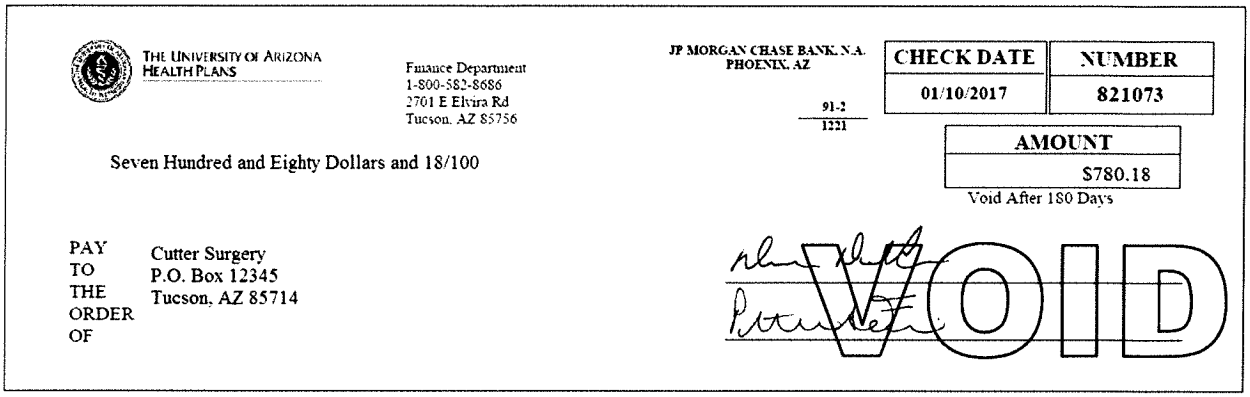
B-UFC will forward your entire case file to AHCCCS, who will schedule a hearing date. You will receive a Notice of Hearing. This notice will contain information about the time of the hearing as well as additional information about the hearing. You will have the opportunity to present information to the Administrative Law Judge at the hearing.

You have the right to request to review your case file prior to the hearing. This request must be made timely so B-UFC will be able to meet timeframe requirements. If you need assistance with the appeal process or need translator services, please contact Customer Care or the Appeals Department at 1-800-582-8686.

Sincerely,
Grievance and Appeal Coordinator
Banner – University Family Care

Attachment 5
Check and Associated Remittance Advice

ACCORDING TO AZ REGULATORY STATUTE (ARS) 36:2903.01 (B)(4) GRIEVANCES CHALLENGING CLAIMS DENIALS MUST BE FILED IN WRITING WITH UAHP NO LATER THAN 12 MONTHS FROM THE DATE OF SERVICE. 12 MONTHS AFTER THE DATE OF ELIGIBILITY POSTING. OR WITHIN 60 DAYS AFTER THE DATE OF DENIAL OF A TIMELY SUBMISSION. WHICHEVER IS LATER. RESUBMISSIONS OF INITIAL CLAIMS ARE NOT GRIEVANCES.



THE UNIVERSITY OF ARIZONA HEALTH PLANS

Finance Department
1-800-582-8686
2701 E Elvira Rd
Tucson, AZ 85756

JP MORGAN CHASE BANK, N.A.
PHOENIX, AZ

91-2
1221

CHECK DATE	NUMBER
01/10/2017	821073

AMOUNT
$780.18

Void After 180 Days

Seven Hundred and Eighty Dollars and 18/100

PAY TO THE ORDER OF
Cutter Surgery
P.O. Box 12345
Tucson, AZ 85714

VOID

01/10/2017 12:38 PM

UAHP
2701 E ELVIRA RD
TUCSON, AZ 85706

PAGE 1

Cutter Surgery
P.O. Box 12345
Tucson, AZ 85714

Check Number: 821073
Master Vendor: 9182736455
Vendor Number: 1928374600

Name	Member #	Referral #	Referral Type	From to date	Claim#	Post Date	Account number	S/f
Jordan, Jacabo	**A123456789**			**12/7/14-12/7/14**	**9876543**	01/04/17	88275	N

Claim Vendor **Cutter Surgery** **N373178459** *** Payment went to master vendor ***

Proc Code	Proc Description	Service dates From	to	S/f	Amount Billed	Amount Rejected	Deduct Amount	Copay Amount	Amount Approved	Amount Withheld	Interest Amount	Net Amount
50040	**Nephrostomy, nephrotomy w/drainage**	12/7/14	12/7/14		$5,232.00	$4,415.82			$780.18			$780.18

Adj to Allowed Amt $4,415.82
Approved for Payment $ 780.18 **Approval Fund for HMO XX**
Patient Deductible 0.00

** Claim Totals ** $780.18
* Vendor Refund Totals **
** Net Claim Payment ** $780.18

According to AZ Regulatory Statute (ARS) 36:2903.01(B) (4) grievances or claims disputes challenging claims denials must be filed in writing with University of Arizona Health Plans no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. When filing grievances, appeals or claims disputes, each claim should be identified with the words grievance, appeal or claims dispute. Please mail grievances, claims disputes and/or appeals to UAHP, ATTN: Grievances/Appeals, 2701 E. Elvira Road, Tucson, AZ 85756 Resubmissions attempting to achieve clean claim status must be received within 12 months from the date of service, or 12 months from the date of eligibility posting, whichever is later and must include the words "resubmission" or "reconsideration". Please mail claims resubmissions to P.O. Box 35069, Phoenix AZ 85069

Information Technology (IT) Systems Demonstration

For this Submission Requirement, the Offeror shall provide written acknowledgement as follows:

Banner - University Family Care acknowledges that its participation in the IT Systems Demonstration beginning on **January 24, 2017**, constitutes fulfillment of Submission Requirement No. 11. Banner - University Family Care acknowledges that it will comply with the stated guidelines and calendar for this process. Banner - University Family Care acknowledges that the IT Systems Demonstration will be scored as part of the Banner - University Family Care's Proposal.

AUTHORIZED SIGNATORY

Authorized Signatory for Banner - University Family Care
[OFFEROR'S Name]

James V. Stover [INDIVIDUAL'S Signed Name] Chief Executive Officer
[INDIVIDUAL'S Typed Name] [Title]
is the person authorized to sign this contract on behalf of Offeror.

OFFEROR'S MAILING ADDRESS

AHCCCS should address all notices relative to this offer to the attention of:

Mary Consie	Chief Administrative Officer
Name	Title
2701 E. Elvira Rd.	623-385-0884
Address	Telephone Number

Tucson	AZ	85756
City	State	ZIP

Banner
University Health Plans
Banner – University Family Care

2701 E. Elvira Road, Tucson, Arizona 85756
(520) 874-5290 • (800) 582-8686 • Fax (520) 874-5555
www.ufcaz.com

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

Mary Consie
Chief Administrative Officer

Silvia Parra
Interim Chief Operating Officer

Seth Dubry, MD
Chief Medical Officer

Tom Ball, MD
Medical Director

Kristin Frounfelker
Behavioral Health Director

Julie Bubul
Project Manager - ALTCS

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

2701 EAST CALLE LOS ALTOS • TUCSON, ARIZONA 85718 •

520-874-3362

THOMAS.BALL@BANNERHEALTH.COM

PROFESSIONAL BACKGROUND

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

ACCOMPLISHMENTS

Publications (selected from over 30) as follows:

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

EXPERIENCE

2015-Present University of Arizona– Banner Health Plans Tucson, AZ

Medical Director for Population Health

Includes all responsibilities of Medical Director for Population Health.

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

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

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

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

2006-2011 Casa de los Niños Tucson, AZ

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

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

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

1991-1996: Thomas-Davis Medical Centers Tucson, AZ

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

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

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

1986-1990: National Health Service Corps Nogales, AZ

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

EDUCATION AND TRAINING

1994-1997 University of Arizona Tucson, Arizona

M.P.H., Epidemiology

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

Pediatrics Internship and Residency

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

M.D.

1974-1978 Johns Hopkins University Baltimore, MD

B.A., Natural Sciences

CERTIFICATIONS

AZ #16198 since 1986

Pediatrics, Board Certified since 1987

PROFESSIONAL AFFILIATIONS

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

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

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

2008-2012: Member American Academy of Pediatrics Section on Epidemiology

2007-2010: AZ AAP Liaison for Child Care & Early Childhood Education

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

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

1997-2010: Journal reviewer for multiple health care journals

SETH M. DUBRY, MD

2701 E. ELVIRA ROAD • TUCSON, ARIZONA 85756 •

520-874-5204

SETH.DUBRY@BANNERHEALTH.COM

PROFESSIONAL BACKGROUND

I am a Board-Certified Family Physician with significant Administrative Medicine experience in the Medicaid, Medicare and defined-benefit Insurance industries. Having worked in both well-developed and developing Plans has given me a great deal of experience in creating new and innovative strategies for improving the delivery of health care in the most cost-appropriate manner. Academic experience allows me to appropriately utilize, evaluate and implement evidence-based guidelines.

ACCOMPLISHMENTS

- Medical Director during successful 2013 AHCCCS Bid/Expansion
- Development of Interdisciplinary Care Team Model
- Facilitated development of integrated care programs

EXPERIENCE

05/15 to Present: University of Arizona Health Plans Tucson, AZ

Chief Medical Officer

- Responsible for the Medical and Administrative Oversight of Medical Management
- Oversee Quality and Peer Review
- Physician Liaison for Clinical partnerships

06/10 to 05/15: University of Arizona Health Plans Tucson, AZ

Medical Director for Health Services

- Responsible for Health Services areas of Medical Management
- Credentialing and Pharmacy Oversight
- Developed Interdisciplinary Care Team

01/09 to 06/10: Managed Health Services Milwaukee, WI

Chief Medical Officer

- Responsible for Medical Oversight of Plan
- Provided Executive Oversight in URAC Accreditation
- Maintained University of Wisconsin faculty position
- Volunteer Physician, Walker's Pointe Community Clinic

10/00 to 01/09 Aurora Health Care Milwaukee, WI

Attending Physician/Faculty

- Clinical Assistant Professor, University of Wisconsin School of Medicine: 10/00 to 06/10
- Family Medicine Residency Program Director: 2005-2009
- Medical Student Director: 2002-2005
- Medical Director, Aurora Wiselives Clinic: 2001-2002

04/98 to 07/00 Anchor Medical Group Chicago, Il

Attending Physician

- Assistant Medical Director
- Clinical Instructor, Rush Medical School

03/97 to 04/98 Cigna of Arizona Mesa, AZ

Staff Physician

08/96 to 02/97 Casa Blanca Clinic Mesa, AZ

Staff Physician

EDUCATION AND TRAINING

1993-1996 Shadyside Hospital Pittsburgh, PA

- Family Medicine Residency
- Completed, Board Eligible

1989-1993 University of AZ College of Medicine Tucson, AZ

- Doctor of Medicine

1988-1989 University of Arizona Tucson, AZ

- Graduate Studies, Immunology and Microbiology
- Awarded Graduate Recruitment Fellowship, 1988-89

1983-1987 Grinnell College Grinnell, IA

- Bachelor of Arts in Biology
- Dean's List Designation

CERTIFICATIONS

American Board of Family Medicine; 1996-2003; 2003-2009; 2009-2019

Medical Licensure: Arizona, Wisconsin

PROFESSIONAL AFFILIATIONS

American Academy of Family Physicians

Arizona Academy of Family Physicians

American Association for Physician Leadership

National Association of Managed Care Physicians

JULIE A. BUBUL, MSW

1430 W. CALLE TIBURON • TUCSON, ARIZONA 85704 •

520-971-8415

JULIEBUBUL@GMAIL.COM

PROFESSIONAL BACKGROUND

For the past 30 years, I have been committed to serving older and vulnerable adults in our community. Because of my experience in diverse settings from psychiatric in-patient facilities, nursing homes and community based services, I have achieved an in-depth understanding of service, treatment and placement options.

ACCOMPLISHMENTS

Beginning as a volunteer in the Soviet Jew resettlement program to responsible leadership positions, I have reached a high level of expertise in my field of geriatric social work. I received one of seven national research fellowships from the Gerontological Society of America. I presented a paper outlining the history and benefits of the Arizona Long Term Care System at an annual American Society on Aging/National Council on Aging Conference.

EXPERIENCE

2016 to Present: University of Arizona Health Plans Tucson, AZ

Project Manager - ALTCS

- Responsible for ALTCS project management activities, including developing project plans and advising on long-term care program components.
- Provides expertise including leadership and consistent use of standard tools and methodology.
- Consults on the development and implementation of UAHP's integrated ALTCS work plans, especially in the area of case management and care coordination.

2015-2016: Care Partner Prog., Interfaith Community Services Tucson, AZ

Program Coordinator

- Responsible for the final development and implementation of a new grant-funded program in collaboration with Banner UMC, ICS, and six congregations to provided support and
- Planned and chaired monthly meetings and training sessions for the volunteer Care Partners
- Participated in the development of all procedures, forms and policies for the program

2009-2011: Pima Health Systems Tucson, AZ

Case Management Supervisor

- Responsible for the supervision of eight Arizona Long Term Care System (ALTCS) Case Managers
- Participated in the training and ongoing education of over 80 ALTCS Case Managers
- Assisted in the development and implementation of ALTCS quality improvement projects

2007-2008; 2011: Pima Council on Aging Tucson, AZ

Director of Services

- Responsible for the overall performance of Caregiving Services, Intake, Elder Rights and Benefits and Medicare and Health Insurance programs, supervising a staff of 16
- Act as PCOA liaison to Pima Health System Community Services System, Community Partnership of Southern Arizona, the Caregiver Consortium
- Member of the Management Team, participating in developing policies and procedures
- Directed the transition of the Community Services System from Pima Health to PCOA

2008-2009: Pima Council on Aging Tucson, AZ

Caregiver Specialist

- Provided information about caregiving issues and community resources
- Give community presentations about caregiving issues
- Participate as requested on community boards and projects

2003-2009: Pinal/Gila Long Term Care Tucson, AZ

Director of Case Management

- Responsible for the overall performance of the Arizona Long Term Care System (ALTCS) Case Management Section in compliance with County, State and Federal requirements
- Responsible for performance of Case Management Staff of 33, directly supervising four Case Management Supervisors and an Administrative Assistant
- Responsible for quality and utilization management within the Case Management section, including monitoring the budget, implementing interventions as needed to maintain quality and cost-effective services to more than 1300 hundred members
- Develop and implement systems, policies and goals for the program
- Member of the P/GLTC Management Team
- Represent the program at state AHCCCS meetings
- Responsible for leading the development of a new state-wide ALTCS program for Self-Directed Attendant Care after P/GLTC was awarded a grant by ALTCS for this project

EDUCATION AND TRAINING

1968 Colorado University Boulder, CO

- Bachelor of Arts, Russian

1972 Brown University Providence, RI

- Master of Arts, Russian Literature

1989 Arizona State University Tempe, AZ

- Master of Social Work

CERTIFICATIONS

American Board of Family Medicine; 1996-2003; 2003-2009; 2009-2019

Medical Licensure: Arizona, Wisconsin

PROFESSIONAL AFFILIATIONS

2007: Presenter, American Society on Aging/National Council on Aging Conference

2005-2006: Pinal County Elder Abuse Annual Conference Planning Committee

2001-2004; 2007-2009; 2011-Present: Caregiver Consortium, Board of Directors

1999-2001: Parish Nurse Council; Co-Leader

Pima Council on Aging Advisory Board

1989: GSA Fellow, Gerontological Society of America, Washington, DC. Awarded one of seven national student fellowships to conduct research on in-home therapy with homebound depressed elderly.

1989-1995: National Association of Social Workers, Arizona Chapter

1993-1999: Pima Community College, Community Advisory Committee, Social Services Dept.

KRISTIN FROUNFELKER

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PROFESSIONAL BACKGROUND

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

ACCOMPLISHMENTS

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

EXPERIENCE

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

Director, Behavioral Health

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

implement strategic initiatives to achieve the organizational goals and metrics.

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

Medical Management Administrator

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

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

Assistant Director of Quality and Integration

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

09/2010-07/2013 AHCCCS Phoenix, Arizona

Administrator, Behavioral Health

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

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

EDUCATION AND TRAINING

1982-1985 Wright State University Dayton, Ohio

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

CERTIFICATIONS

Arizona Licensed Professional Counselor (LPC) Active- #2437

Certified Professional in Healthcare Quality (CPHQ) Active

PROFESSIONAL AFFILIATIONS

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

MARY CONSIE

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MARY.CONSIE@BANNERHEALTH.COM

PROFESSIONAL BACKGROUND

Over 22 years' experience, including over 18 years' experience in Medicaid and Medicare managed care. Have held multiple leadership roles in strategic planning, business development, compliance, government programs oversight (Medicare and Medicaid), network development, contracting, and provider relations.

ACCOMPLISHMENTS

- Created and implemented an integrated health plan compliance program and compliance infrastructure to support compliant Medicare, Medicaid and Marketplace Government Programs.
- Led successful $400 million re-award of Arizona Medicaid product for both University of Arizona Health Plans and Maricopa Integrated Health Systems. Awarded expansion to 11 Arizona Counties.
- Led joint partnership venture between UAHP and Cenpatico Integrated Care (CI). Through this joint partnership, bid and won AHCCCS integrated bid for Southern Arizona.
- In support of Medicare D-SNP bids, led two successful Arizona provider network expansions in 2010 and 2014.

EXPERIENCE

2015-Present University of Arizona Health Plans Tucson, AZ

Chief Administrative Officer

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

compliance, as well as with the triple aim of improving the experience of care, quality of care and efficiency of care. Sets clear expectations and holds team members accountable for producing desired outcomes. Motivates and develops team members and promotes teamwork.

- Develops and maintains positive relations with all health plan stakeholders and facilitates implementation of health plan cultural initiatives. Ensures and fosters a high level of collaboration within a highly matrixed team environment in order to coordinate activities, review work, exchange information and resolve problems.

2014-2015 University of AZ Health Network Tucson, AZ

Interim Chief Compliance Officer

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

2013-2015 University of AZ Health Plans Tucson, AZ

Vice President, Compliance & Audit

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

2011-2013 University of AZ Health Plans Tucson, AZ

Director, AHCCCS Programs & Compliance

- Acted as UAHP's Compliance Officer for Medicare and Medicaid, including compliance with all federal and state statutes, regulations and contract compliance.
- Oversight of the Health Plan's operational and contractual oversight of the Medicaid program including audit project management and assuring optimal contractual

performance in all areas of the health plan, establishing and maintaining positive relationships with Medicaid regulators.

2008-2011 University of AZ Health Plans Tucson, AZ

Director, Network Development

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

EDUCATION AND TRAINING

1998 University of Phoenix Phoenix, AZ

- Bachelor of Science, Business Administration
- Summa Cum Laude

2006 Arizona State University Phoenix, AZ

- Bachelor of Fine Arts, Sculpture
- Summa Cum Laude

CERTIFICATIONS

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

SILVIA L. PARRA

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PROFESSIONAL BACKGROUND

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

ACCOMPLISHMENTS

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

EXPERIENCE

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

Interim Chief Operations Officer

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

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

Director of Operations

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

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

Customer Care Director

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

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

Member Services Manager

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

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

Chief Administrative Officer

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

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

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

Executive Director of Health and Human Services

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

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

Hospitality Director

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

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

Education Manager

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

EDUCATION AND TRAINING

1999-2001 University of Phoenix Tucson, AZ

Master's in Business Administration

1980-1985 University of Arizona Tucson, AZ

Bachelors of Science in Business Administration

CERTIFICATIONS

1995-1996 University of Phoenix Los Angeles, CA

Total Quality Management Certification

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

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

As defined by A.R.S. §35-393.01:

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

All Offerors must select one of the following:

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

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

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

Banner - University Family Care	
Company Name	Signature of Person Authorized to Sign
2701 E. Elvira Rd.	James V. Stover
Address	Printed Name
Tucson AZ 85756	Chief Executive Officer
City State Zip	Title