EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror must complete the Offeror's Checklist. The Offeror's Checklist must be submitted with the Proposal and shall be the initial pages of the Proposal. The Offeror's Checklist includes all submission requirements for the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the RFP notwithstanding the items included in the Offeror's Checklist.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its Proposal where AHCCCS may find the Offeror's response to the specified requirement. Refer also to the **Submission Requirements** outlined in RFP Section H: Instructions to Offerors.

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
Offeror's Bid Choice Form	RFP Section I, Exhibit B Refer to Bidders' Library	3
Offeror's Completed and Signed RFP Solicitation and Offer Page	RFP Section A Refer to Bidders' Library	4
Offeror's Signed Signature Page(s) for **each** Solicitation Amendment	Refer to Bidders' Library	5-6
Capitation Non-Benefit Costs Bid Submission		
Signed Agreement accepting capitation rates	RFP Section H, Instructions to Offerors	7
Non-Benefit Costs Bid Submission workbook	RFP Section H, Instructions to Offerors	8-13
Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	14
Executive Summary and Disclosure		
Executive Summary	RFP Section H, Instructions to Offerors	15-17
Moral or Religious Objections	RFP Section H, Instructions to Offerors	18
Narrative Submission Requirements		
1.	RFP Section I, Exhibit C	19-20
2.	RFP Section I, Exhibit C	21-27
3.	RFP Section I, Exhibit C	28-32
4.	RFP Section I, Exhibit C	33-39
5.	RFP Section I, Exhibit C	40-44
6.	RFP Section I, Exhibit C	45-49
7.	RFP Section I, Exhibit C	50-56
8.	RFP Section I, Exhibit C	57-61
9.	RFP Section I, Exhibit C	62-66
10.	RFP Section I, Exhibit C	67-71
11.	RFP Section I, Exhibit C	72-76
12.	RFP Section I, Exhibit C	77-81
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	82-86
14.	RFP Section I, Exhibit C	87-91
15.	RFP Section I, Exhibit C	92-96
16. A (North) *If applicable*	RFP Section I, Exhibit C	97-99
16. B (South) *If applicable*	RFP Section I, Exhibit C	100-102
17.	RFP Section I, Exhibit C	103-107
18.	RFP Section I, Exhibit C	NA
Oral Presentations		
Names and Titles of Participating Individuals	RFP Section H, Instructions to Offerors	108
Resumes of Participating Individuals	RFP Section H, Instructions to Offerors	109-130
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit D Refer to Bidders' Library	131
Affiliated Organization Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	132
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	133-135

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EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

BID CHOICE FORM - PART 1

Health Choice Arizona, Inc.
(Steward Health Choice Arizona)
OFFEROR'S NAME

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

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

	GSA	Priority Choice
☒	**Central**: Maricopa, Gila, and Pinal Counties	1
☒	**North**: Mohave, Coconino, Apache, Navajo and Yavapai Counties	2
☒	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties	3

Authorized Signature — January 23, 2017 Date

Shawn Nau Print Name — **Chief Executive Officer** Title

BID CHOICE FORM - PART 2

Offerors requesting to participate in the evaluation for expansion of services as described in *RFP Section H, Instructions to Offerors, Paragraph 20*, shall indicate their request for participation below. An Offeror must complete the Bid Choice Form - Part 2 in order to be considered for participation in the future expansion of services. **Failure to complete the Bid Choice Form shall preclude the Offeror from participation in the future expansion of services.**

Health Choice Arizona, Inc.
(Steward Health Choice Arizona)
OFFEROR'S NAME

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

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

Authorized Signature — January 23, 2017 Date

Shawn Nau Print Name — **Chief Executive Officer** Title

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

OFFER

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

NPI No. (*optional*)

62-1796494

Federal Employer Identification No.:

n/a

Dun and Bradstreet (DUN) No.

For clarification of this offer, contact:

Name: Shawn Nau

Title: Chief Executive Officer

E-Mail Address: Shawn. Nau@steward.org

Phone: (970) 759-5330

Health Choice Arizona, Inc. (Steward Health Choice Arizona)

Company Name

410 N. 44th Street, Suite #900

Address

Phoenix Arizona 85008

City State Zip

Signature of Person Authorized to Sign Offer

Shawn Nau

Printed Name

Chief Executive Officer

Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

AHCCCS
Arizona Health Care Cost Containment System

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

SOLICITATION AMENDMENT #1		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: **January 25, 2018** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

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

This Solicitation is amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 22, 2017	DATE:

AHCCCS
Arizona Health Care Cost Containment System

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

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

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

This Solicitation is amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: January 22, 2017	DATE:

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Steward
Health Care Network

HEALTH CHOICE
ARIZONA

January 23, 2018

Meggan Harley
AHCCCS Chief Procurement Officer
801 E. Jefferson Street
Phoenix, AZ 85034

RE: Statement of Acceptance of Rates (Solicitation # YH19-0001)

Dear Ms. Harley:

The purpose of this correspondence is to provide a statement confirming acceptance of the actuarially sound capitation rates computed prior to October 1, 2018.

Health Choice Arizona, Inc. (Steward Health Choice Arizona)	
Company Name	Signature of Person Authorized to Sign Agreement
410 N. 44th Street, Suite #900	Shawn Nau
Address	Printed Name
Phoenix / Arizona / 85008	Chief Executive Officer
City / State / Zip	Title

North GSA			
Member Months to Use for Bidding	990,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 26.04		
% of Admin PMPM that is Fixed	54.57%		
% of Admin PMPM that is Variable	45.43%		
Detail Admin Break Out			
Compensation	$ 15.78		
Occupancy	$ 1.37		
Depreciation	$ 0.87		
Care Management/Care Coordination	$ 3.22		
Professional and Outside Services	$ 1.63		
Office Supplies and Equipment	$ 0.61		
Travel	$ 0.18		
Repair and Maintenance	$ 0.40		
Bank Service Charge	$ -		
Insurance	$ 0.01		
Marketing	$ 0.17		
Interest	$ -		
Other Administrative	$ 1.79		
Total Admin PMPM	$ 26.04		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.01%	0.01%	0.01%

8

Central GSA			
Member Months to Use for Bidding	3,170,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 20.52		
% of Admin PMPM that is Fixed	27.28%		
% of Admin PMPM that is Variable	72.72%		
Detail Admin Break Out			
Compensation	$ 13.30		
Occupancy	$ 0.54		
Depreciation	$ 0.34		
Care Management/Care Coordination	$ 3.11		
Professional and Outside Services	$ 1.45		
Office Supplies and Equipment	$ 0.46		
Travel	$ 0.21		
Repair and Maintenance	$ 0.16		
Bank Service Charge	$ -		
Insurance	$ 0.01		
Marketing	$ 0.17		
Interest	$ -		
Other Administrative	$ 0.77		
Total Admin PMPM	$ 20.52		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.01%	0.01%	0.01%

9

South GSA			
Member Months to Use for Bidding	1,630,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 23.94		
% of Admin PMPM that is Fixed	42.18%		
% of Admin PMPM that is Variable	57.82%		
Detail Admin Break Out			
Compensation	$ 15.73		
Occupancy	$ 1.03		
Depreciation	$ 0.65		
Care Management/Care Coordination	$ 3.43		
Professional and Outside Services	$ 1.67		
Office Supplies and Equipment	$ 0.57		
Travel	$ 0.22		
Repair and Maintenance	$ 0.30		
Bank Service Charge	$ -		
Insurance	$ 0.01		
Marketing	$ 0.19		
Interest	$ -		
Other Administrative	$ 1.37		
Total Admin PMPM	$ 25.18		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.01%	0.01%	0.01%

10

North and South GSAs			
Member Months to Use for Bidding	2,620,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 21.70		
% of Admin PMPM that is Fixed	31.22%		
% of Admin PMPM that is Variable	68.78%		
Detail Admin Break Out			
Compensation	$ 13.93		
Occupancy	$ 0.66		
Depreciation	$ 0.42		
Care Management/Care Coordination	$ 3.20		
Professional and Outside Services	$ 1.51		
Office Supplies and Equipment	$ 0.48		
Travel	$ 0.21		
Repair and Maintenance	$ 0.19		
Bank Service Charge	$ -		
Insurance	$ 0.01		
Marketing	$ 0.18		
Interest	$ -		
Other Administrative	$ 0.91		
Total Admin PMPM	$ 21.70		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.01%	0.01%	0.01%

11

North and Central GSAs			
Member Months to Use for Bidding	4,160,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 19.17		
% of Admin PMPM that is Fixed	22.23%		
% of Admin PMPM that is Variable	77.77%		
Detail Admin Break Out			
Compensation	$ 12.57		
Occupancy	$ 0.42		
Depreciation	$ 0.26		
Care Management/Care Coordination	$ 3.00		
Professional and Outside Services	$ 1.38		
Office Supplies and Equipment	$ 0.42		
Travel	$ 0.21		
Repair and Maintenance	$ 0.12		
Bank Service Charge	$ -		
Insurance	$ 0.00		
Marketing	$ 0.17		
Interest	$ -		
Other Administrative	$ 0.61		
Total Admin PMPM	$ 19.17		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.01%	0.01%	0.01%

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Central and South GSAs			
Member Months to Use for Bidding	4,800,000		
Administrative Bid Component			
Total Admin PMPM (All Admin Expenses)	$ 18.62		
% of Admin PMPM that is Fixed	19.86%		
% of Admin PMPM that is Variable	80.14%		
Detail Admin Break Out			
Compensation	$ 12.28		
Occupancy	$ 0.36		
Depreciation	$ 0.23		
Care Management/Care Coordination	$ 2.96		
Professional and Outside Services	$ 1.35		
Office Supplies and Equipment	$ 0.41		
Travel	$ 0.21		
Repair and Maintenance	$ 0.11		
Bank Service Charge	$ -		
Insurance	$ 0.00		
Marketing	$ 0.17		
Interest	$ -		
Other Administrative	$ 0.55		
Total Admin PMPM	$ 18.62		
Underwriting Gain Component			
	Year 1	Year 2	Year 3
Underwriting Gain	0.01%	0.01%	0.01%

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OLIVER WYMAN

Actuarial Certification
Steward Health Choice Arizona
CYE 2019 Complete Care Non-Benefit Cost Submission

I, Glenn A. Giese, am associated with the firm of Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman). I am a Member of the American Academy of Actuaries and have been retained by Steward Health Choice Arizona (the Company) with regard to non-benefit costs and underwriting gains for the Medicaid (Title XIX) population. I am familiar with the requirements for preparing Medicaid bid submissions and meet the Academy's qualification standards for doing so. The non-benefit cost and underwriting gain bid submissions have been prepared for the Arizona Health Care Cost Containment System (AHCCCS) in CYE19.

I hereby certify that, to the best of my knowledge and judgment:

- The non-benefit costs bid submission and the underwriting gain, submitted by Steward Health Choice Arizona as part of its response to AHCCCS RFP YH19-0001, meets the requirements of 42 CFR 438.5(e)
- The development of the non-benefit component of the rate includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services identified in §438.3(c)(1)(ii) to the populations covered under the contract

The impact of unanticipated events subsequent to the date of this bid submission is beyond the scope of this certification.

In forming my opinion on the liabilities listed above I relied upon data prepared by Mr. Jeff Butcher, CFO, of the Company as certified in the attached statement. I evaluated the data for reasonableness and consistency. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary.

The actuarial methods, considerations and analyses used in forming my opinion are in conformance with the appropriate Standards of Practice and Compliance Guidelines as promulgated by the Actuarial Standards Board and the American Academy of Actuaries.

Signature of Actuary

Glenn A. Giese
Printed Name of Actuary

411 East Wisconsin Ave, Suite 1300, Milwaukee, WI 53202
Address of Actuary

414-223-7987
Telephone Number of Actuary

January 22, 2018
Date Opinion was Rendered

Executive Summary

It is our privilege to introduce Steward Health Choice Arizona (Health Choice) as the Offeror for AHCCCS Solicitation No. Y19-0001. Health Choice, as the Offeror, will contract with AHCCCS for the Complete Care program and as the Regional Behavioral Health Authority for Northern Arizona. Health Choice continues, and will enhance, the partnership between two of Arizona's premier health care organizations: The NARBHA Institute and Health Choice, a subsidiary of Steward Health Care System, LLC (Steward).

Organizational Overview. To address the emerging needs of the state of Arizona, Health Choice will merge the operations of Health Choice Arizona's legacy physical health plan with Health Choice Integrated Care's (HCIC) legacy behavioral health plan to establish an integrated, "behavioral health led" Complete Care program. Collectively, Health Choice serves more than 350,000 members today across nine counties in Arizona. The Health Choice executive team will be led by HCIC's current Chief Executive Officer, Shawn Nau, and Chief Medical Officer, Dr. Teresa Bertsch. Health Choice will remain headquartered in Phoenix with additional operations in Flagstaff, Yuma, and Tucson. Our additional locations reinforce our commitment to the communities we serve, and facilitates our ability to obtain an in-depth understanding of issues impacting all aspects of each respective community landscape. Health Choice will be accountable for the administrative and clinical integration of physical and behavioral health services for our Medicaid members and will continue to coordinate Medicare and Medicaid benefits for dually eligible members.

> "Through our participation in AHCCCS Complete Care, we will extend and evolve our innovative relationships and integrated care management approach developed over years between Health Choice and the NARBHA Institute. Our value-based provider performance model will align incentives to improve member and provider satisfaction, contain costs, and improve the health outcomes and quality of life for the members we serve."
>
> ***— Shawn Nau***
> ***Chief Executive Officer***

Health Choice's recent acquisition by Steward in September of 2017 has already proven beneficial to advancing Health Choice's strategy for AHCCCS Complete Care. Steward's current approach is Health Choice's vision for the future: A provider led organization committed to the highest quality of care for our members, containing costs by working collaboratively with our Integrated Health Home and Accountable Care Organization (ACO) based provider network, and utilizing an innovative, integrated physical and behavioral health care management model. Through significant cross-pollination of leadership and clinical expertise as our collective teams work together, Steward's experience and demonstrated successes in ACO programs will directly enhance our Arizona strategy to serve members utilizing our newly expanded person-centered, Integrated Health Home and Integrated ACO network.

Relevant Experience. Health Choice's approach is grounded in our history. The NARBHA Institute and Health Choice have been working, both individually and collaboratively, to meet the needs of Arizona Medicaid members for many years. The two entities have partnered over the past decade to increase member access to providers and to improve health outcomes. Through the formation of HCIC in 2015, the two organizations formalized this collaboration through a joint venture to develop, implement, test, and refine new care integration models. As best practices from the collaboration emerge, we will adopt them statewide. This collaboration has also given us a full appreciation of the importance of transitioning to integrated care in a manner that ensures members receive timely services — and has enabled us to develop the tools to do so effectively and efficiently.

Health Choice understands the challenge of providing integrated health care to members across Arizona's incredibly diverse urban, rural, and frontier regions. Based on our combined experience and appreciation of the unique needs of our members and families, providers, Tribal Nations, and communities, cities, counties and other stakeholders, Health Choice has tailored our integrated approach to serve our members and providers in each region. Additionally, Health Choice's continuing collaborative efforts with the NARBHA Institute offer a cohesive approach to engaging our communities in a way that has proven successful in

our past experience in soliciting meaningful and actionable member, provider, stakeholder, and community feedback on programs and initiatives.

Steward has been widely recognized as a national leader in implementing value based payments in integrated health care delivery. Steward has nearly 80 percent of its Massachusetts members in risk-based alternative payment models. By delivering and managing health care services in a coordinated and efficient manner, Steward controls costs while improving quality, eliminating care fragmentation and reducing duplication of services. For example, the Centers for Medicare and Medicaid released data that recognized Steward as the top system in the Medicare Pioneer ACO program (using combined quality and cost metrics) in Massachusetts, and in the top two nationally. We reduced annual per beneficiary spending by three percent while continuing to achieve high quality performance. In addition, in our risk contract with Blue Cross Blue Shield of Massachusetts, Steward increased our overall quality score every year since entering the contract in 2008, which has resulted in an overall quality score increase of more than 100 percent since the program's inception. Steward is committed to supporting Health Choice's adoption of our strategies and tactics that have led to our success in both quality and total cost of care management.

Our Integration Approach. Health Choice's current physical and behavioral health networks throughout Arizona will be the platform upon which Health Choice's tightly integrated, comprehensive model of care will operate. Our model continues to evolve from our existing robust Integrated Health Home approach toward an Integrated ACO model, aligned with the Health Care Payment Learning and Action Network's Category 4B shared risk model of comprehensive population based payments. We will effectuate this evolution through providers who participate in the AHCCCS Targeted Investment Program to develop Integrated ACOs. Health Choice will further develop our ambulatory care model to encompass a broader provider transformation that will include our hospital partners, mirroring the outline of AHCCCS' original 2016 Delivery System Reform Incentive Program proposal. To support this transformation, Health Choice will leverage our established partnerships with state educational institutions, including population health research and provider development efforts with Northern Arizona University through the NARBHA Institute, and our collaborative programs around provider integration with the Arizona State University's Center for Applied Behavioral Health Policy.

From a care management perspective, Health Choice will develop an enhanced integrated care management strategy based on the success of Health Choice Integrated Care's "Top Tier" program. This program deploys Integrated Care Managers to support integration at the delivery system level. Health Choice's Integrated Care Managers will be responsible for ensuring that integrated care management plans also coordinate with housing, employment, and peer/family supports. The Integrated Care Managers will in turn be supported by Health Choice's team of Population Care Leads who analyze our health data to identify trends and help Integrated Care Managers develop strategies to address them. Population Care Leads will have a range of expertise in disease management, special health care needs, maternal health, pediatrics, behavioral health, jail and prison transitional services, court ordered treatment, tribal services, peer and family supports, and other specific population needs.

In the event a member needs or desires to seek primary or specialty health care outside of an Integrated ACO or Health Home, Health Choice's full physical and behavioral health care network will be available to members, and Health Choice's Integrated Care Managers and Population Care Leads will meet the member's needs using a person centered, whole health approach.

Health Choice will continue to support the development of peer and family recovery support specialists as a significant element of Health Choice's integration strategy. Health Choice will assist in utilizing their services at our Integrated ACOs, Integrated Health Homes, and through Peer and Family Run Organizations like NAZCARE. Health Choice will continue to support training of peer and family members through its Project ECHO program, Peer Lay Leaders for the Stanford Chronic Disease, Diabetes and Pain Self-Management Programs, and peer certification programs.

Health Choice will support this integration model, as well as our continued quality and compliance efforts, through the use of our collective data and technology infrastructure. This will include our enhanced nationwide Zoom™ telemedicine system, proprietary data warehouse and Integrated Individual Care Planning software, Milliman's MedInsight™ population health tools, and Johns Hopkins Adjusted Clinical Groups (ACG)

predictive analytics system. We will implement HCIC's existing QNXT claims and encounter systems for both physical and behavioral processing to ensure stability throughout the contract cycle. Information from these systems will be coupled with a new cloud based version of EXL Landa's CareRadius™ integrated care management system to create enriched, member-centered, actionable data for our providers. We will also leverage this technology to continue evolving our quality management program to be a proactive, outcome oriented system, designed to identify potential quality issues early and implement appropriate interventions. Lastly, our new relationship with Steward also brings exciting opportunities in many forms, including resources to support the development of fully Integrated ACOs and access to a nationwide database of community-based social determinants of health resources to support real-time member referrals for services.

Value-Adds and Enhanced Services. Health Choice is exceptionally well positioned to employ a value based, "quality gated" system of shared savings and risk with providers in our network. We will target attribution of 75 percent of all members to integrated organizations with value-based arrangements within five years. We will also use this model to target specific, data-driven quality improvement opportunities so provider incentives align with quality and cost targets. As described above, Steward has seen much success using our value-based payment model to achieve specific quality and total medical expense targets in Massachusetts, and will support Health Choice in adapting best practices for this AHCCCS Complete Care program. We are confident in our ability to rapidly effectuate this transition, as Health Choice has been working with our physical and behavioral health provider network to prepare providers for more than a decade.

Health Choice will also enhance delivery of services to children, justice transition populations, and Tribal Nations. Supporting individualized, person-centered treatment planning has allowed Health Choice to effectively work with individuals with developmental disabilities and their families through both Behavioral Consultation Services of Northern Arizona (originally affiliated with Northern Arizona University) and the family focused services of providers across Arizona, such as Child & Family Support Services, CODAC, MIKID, Intermountain, Compass, and Terros. Transitional services for individuals who are released from incarceration will be improved through our continued expansion of peer-run organizations such as Hope Lives – Vive La Esperanza, as we continue and expand our extensive work with jails and prisons.

Health Choice will also expand on HCIC and NARBHA's extensive efforts to establish solid relationships and offer services to Tribal Nations. This will be facilitated through the continued development of tribal memoranda of understanding, expansion of our traditional practitioner network, and our annual tribal summit programs, and the development of ongoing collaborative efforts between the tribal entities, AHCCCS' American Indian Health Plan, and our local provider network.

Finally, Health Choice has partnered with axialHealthcare to implement an extensive Pain Care Management Program to identify and actively work with patients through the use of newly developed education tools and integrated pain management centers of excellence. These programs will help members self-manage their pain through all stages of their journey to recovery.

Medicare Advantage Special Needs Plan. Health Choice also operates Health Choice Generations, a Medicare Advantage Special Needs Plan (D-SNP) serving beneficiaries who are eligible for both Medicare and Medicaid through AHCCCS. Health Choice Generations has submitted its intent to expand coverage to all of Arizona so that regardless of service area, we will be able to provide Health Choice's members access to the most comprehensive D-SNP benefit program in Arizona.

Conclusion. Health Choice offers a unique and innovative approach to managing integrated care across Arizona. Our integrated approach is grounded in our experience and present successes, and is poised for significant, innovative evolution into the future. We will continue our tradition of turning challenges into customized, care delivery solutions to meet the unique needs of our members, providers, and stakeholders. We will leverage new technologies and models of care to deliver high quality, accessible services across Arizona. Above all, we will be dedicated to "doing the right thing" for our members, families, providers, communities, and for the State of Arizona.

Steward
Health Care Network

HEALTH CHOICE
ARIZONA

January 25, 2018

Meggan Harley
AHCCCS Chief Procurement Officer
801 E. Jefferson Street
Phoenix, AZ 85034

RE: Statement Confirming No Moral or Religious Objections (Solicitation # YH19-0001)

Dear Ms. Harley:

The purpose of this correspondence is to provide a statement confirming that Health Choice Inc., (Steward Health Choice Arizona) has no moral or religion objections regarding the provision or reimbursement of any covered services [42 CFR 438.102(a)(2)].

Health Choice Arizona, Inc. (Steward Health Choice Arizona)	
Company Name	Signature of Person Authorized to Sign Agreement
410 N. 44th Street, Suite #900	Shawn Nau
Address	Printed Name
Phoenix Arizona 85008	Chief Executive Officer
City State Zip	Title

Narrative Submission 1

Steward Health Choice Arizona (Health Choice) brings together the collective experience of Steward Health Care System, LLC (Steward), Health Choice's Medicaid and Medicare health plans in Arizona, Utah, and Massachusetts, and the NARBHA Institute, to implement an innovative approach to AHCCCS' Complete Care program and transition members to integrated care in a seamless manner. Health Choice's new integrated organizational structure reflects our behavioral health led approach to the merged operations of Health Choice Arizona's legacy physical health program with Health Choice Integrated Care's legacy behavioral health and SMI Integrated programs.

Steward's current approach is Health Choice's vision for the future of care for Arizona members: A provider led organization committed to the highest quality care for our members, containing costs by working collaboratively with our Health Home and Accountable Care Organization (ACO) based provider network, and utilizing an innovative, integrated physical and behavioral health care management model.

To support our narrative response submissions, we will reference our experience gained through our two current Arizona Medicaid contracts and two additional plans: Our Arizona Medicare Dual Eligible Special Needs Plan, Health Choice Generations, and our most recent contract with the Commonwealth of Massachusetts's Medicaid program, Steward Health Choice.

	Geographic Coverage	*Population Served and Enrollment*	*BH/PH Integration status*	*Years in Program & Contract Status*
Health Choice Arizona	Central, Pima, and Northern Arizona	250,000	Integrated for Dual Eligible members	27 years
Health Choice Integrated Care	Northern Arizona	165,000	Integrated for Individuals w/ SMI	50 years (including NARBHA)
Health Choice Generations	Tucson, Central and Northern Arizona	10,000	Integrated for All Beneficiaries	12 years
Steward Health Choice	Massachusetts	120,000	Integrated for all members	1 Year; Contract through 2022

Arizona Medicaid Contracts. Health Choice has had the pleasure to serve our home state of Arizona's Medicaid program since 1990. Beginning as a small AHCCCS Acute Plan associated with St. Luke's Hospital in Phoenix, **Health Choice Arizona** has grown to manage physical and behavioral health services for over 250,000 members in eight counties throughout southern, central and northern Arizona. For the last 15 years, our geographic coverage has included both the heavily populated and competitive urban health care market of the Phoenix and Tucson metropolitan areas, as well as the 93,000 square mile rural expanses of Northern and Eastern Arizona. As a result, Health Choice Arizona has developed extensive capabilities to address the needs of both urban and rural members as well as the provider network that serves them. Health Choice Arizona continued to develop its integration and care management approach through the addition of services for dual eligible members needing general mental health or substance abuse services. These services are provided in close coordination with Health Choice Generations and Health Choice Integrated Care.

In one sense, **Health Choice Integrated Care** represents a recent addition to the Health Choice family, beginning operations in 2015. As an innovative joint venture, Health Choice Integrated Care brought with it the 50-year history of the Northern Arizona Regional Behavioral Health Authority (NARBHA). NARBHA began in 1967 as an administrative service organization serving the needs of community based non-profit behavioral health providers throughout the rural and frontier region of Northern Arizona. NARBHA then transitioned to a Regional Behavioral Health Authority (RBHA) when Arizona implemented the RBHA system. In 2015, Health Choice Integrated Care began the evolution of its unique behavioral health care network and care management approach to serve both the physical and behavioral health needs of members living with Serious Mental Illness on a fully integrated basis.

Health Choice Integrated Care's experience and expertise is the foundation of our Complete Care strategy for the future: A behavioral health led, fully integrated, person-centered Integrated Health Home and Integrated Accountable Care Network, supported by an extensive health plan-based integrated care

management team, to ensure that members safely and smoothly navigate the transition to Complete Care and receive services they need.

Health Choice Generations. Over our history, Health Choice has evolved and adapted with the Arizona Medicaid environment. One example of this is Health Choice's entry into the Medicare Advantage Dual Eligible Special Needs Plan market in 2006, following AHCCCS' strategic direction to better align services for dual eligible members. Health Choice's Medicare plan, Health Choice Generations, has served approximately 10,000 members, including members living with Serious Mental Illness, for the provision of behavioral and physical health services, including general mental health and substance abuse services for the past 12 years. These services are provided in close coordination with Health Choice Arizona, Health Choice Integrated Care, and Steward's four Arizona based hospitals and accountable care organization.

Steward Health Choice. Steward began piloting its Medicaid ACO program in the Commonwealth of Massachusetts in 2016 with 30,000 members, which quickly evolved into a multiyear health plan contract with Massachusetts to participate as a Primary Care ACO, known to members as Steward Health Choice**.** Steward Health Choice has since enrolled nearly 120,000 non-dual, under 65 year old Medicaid members in the program, and has begun to integrate physical and behavioral health care, as well as services that support social determinants of health, in a manner similar to AHCCCS' strategy for Complete Care. Steward has been widely recognized as a national leader in implementing this new model of integrated health care delivery, including in its Medicare ACO program. Steward Health Choice deploys a comprehensive, integrated population health management strategy that includes programs tailored to address impactable quality and cost for high need, high cost members, including chronic and complex care management for physical and behavioral health, transitional care management, and social services supports. All programs have integrated, multi-disciplinary teams delivering services and manage to specific, measureable utilization and quality targets such as reductions in emergency department visits, inpatient admissions, and readmissions.

Steward Health Choice has also begun developing new technologies and services for our Medicaid population supported by Massachusetts's Delivery System Reform Incentive Program. Steward will adapt best practices from this effort for Arizona, which will include leveraging common quality reporting and care coordination tools, as well as deploying tools to support access to community-based resources to address social determinants of health.

Steward Health Choice has adapted best practices from Medicare and commercial risk programs and has now deployed successful population health strategies to its Medicaid population, including embedding social workers and care coordinators in participating practices. Steward Health Choice is available to members statewide, however Steward primarily serves communities that are in economically disadvantaged cities and towns with a high density of Medicaid enrollees compared to other communities throughout the Commonwealth of Massachusetts, including Fall River, New Bedford, Brockton, and Dorchester. Implementing an accountable care program for these members enables Steward to strengthen and deepen our commitment to the health and economic well-being of all of the communities we serve.

Conclusion. Health Choice's experience in integrated Medicaid and Medicare contracts brings a unique mix of experience and innovation that remains Arizona-based while supported and working in concert with other state Medicaid programs such as MassHealth.

Health Choice offers our stable executive and management team, organizational structure, and integrated health design associated with Health Choice Integrated Care's current operation, provider network and member service model. Using this existing platform for our operations across Arizona, Health Choice can assure a seamless transition for members as they move from a separate physical and behavioral health managed care environment to the new AHCCCS Complete Care world.

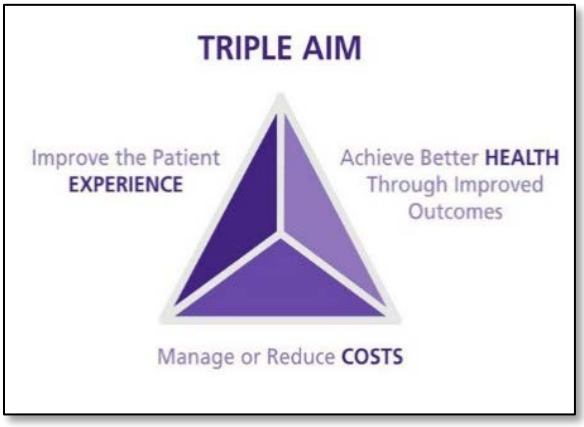
Health Choice will evolve our model further in concert with Steward's experience to enhance the member's experience through improved quality, a fully supported and engaged provider network, and with the active involvement and assistance of the NARBHA Institute. By delivering and managing health care services in a coordinated and efficient manner, we can control costs and improve quality, eliminate care fragmentation and reduce duplication of services. Health Choice looks forward to continuing our long-term partnership with AHCCCS to serve the integrated, complete care needs of our members.

Narrative Submission 2

Steward Health Choice Arizona (Health Choice) recognizes that integrated, person-centered, and team-based health care achieves cost-effective, high quality outcomes and an excellent experience for Medicaid members in Arizona. The stakes are high and solutions are typically very complex. Nationally, mental illness is more than twice as prevalent among Medicaid recipients as it is in the general population, and roughly 49 percent of Medicaid beneficiaries with disabilities have a psychiatric illness. In addition, Medicaid recipients are impacted disproportionately by Social Determinants of Health (SDOH) like poverty, unemployment, homelessness, food insecurity, chronic stress, lack of transportation and social or geographic isolation. These SDOHs significantly impact Medicaid members' health and help explain why these disadvantaged populations consistently have poorer health. In fact, in Arizona, it has been often reported that people living with Serious Mental Illness (SMI) die on average 32 years younger than other Arizona residents. Behavioral health care is therefore an important driver of Medicaid costs and outcomes.

Health Choice's behavioral health led approach to administering AHCCCS' comprehensive behavioral and physical health benefit package recognizes these challenges. As described in detail below, we operate all aspects of our health plan in accordance with the latest clinical guidelines and evidence-based practices. Given our long tenure as an AHCCCS Plan and that of our leadership, including our Chief Medical Officer for the past 25 years, Dr. Teresa Bertsch, we have actively and consistently participated in and led many of the statewide committees and workgroups that developed the state's clinical guidelines, toolkits, clinical programs, policies and formulary. We will also leverage our experience as the Regional Behavioral Health Authority (RBHA) in Northern Arizona to guide the evolution of our physical and behavioral health service delivery system to address these inequities effectively and maintain a high standard of care. Our Continuous Innovation Committee will be responsible for reviewing evidence-based best practices in addition to developing and recommending additional best and promising practices. Our care management design will be based on Health Choice Integrated Care's (HCIC) innovative and successful RBHA program which gained national recognition as a "Best in Class" model of integration for Medicaid programs by the National Council for Behavioral Health.[1] Our model will also adapt best practices gained from experience in Steward's transformative Massachusetts Medicaid program, and Health Choice Arizona's successful implementation of an integrated Medicare Dual Eligible Special Needs Plan.

Our data-driven approach is informed by our understanding of Arizona's unique populations, health dynamics, and cultural environment. For example, Health Choice partnered with the Northern Arizona University Center for Health Equity Research and the NARBHA Institute to complete a Regional Health Equity Assessment. This resource gives Health Choice access to data and trends in local and regional patterns of disparity, causes of mortality, children's health patterns and SDOH, which has allowed us to pinpoint challenges facing our members to inform our network and clinical program design.



An Integrated Design in Every Sense. Grounded in the Institute for Healthcare Improvement's Triple Aim, Health Choice has designed an administrative structure, care management approach, information systems, and an integrated provider network to directly address our members' needs. Our system of care will be transparent, efficient and effective, and ensure mental health parity. Our approach will also facilitate access to quality care and improved outcomes based on the AHCCCS System Values and Guiding Principles, Adult Service Delivery System Nine Guiding Principles, and the Arizona Vision Twelve Principles for Children's Behavioral Health Service

[1] "Best in Class: Addressing the Challenges of Bidirectional Integration -- You Get What You Pay For: An Arizona Medicaid MCO Incentivizes Behavioral Health Providers to Integrate Care." National Council for Behavioral Health Annual Conference. Las Vegas, NV. April 2013"

Delivery. We also work with our provider network to disseminate and adopt evidence-based best practices to promote member recovery and to guide decision making regarding appropriate, high quality, cost-effective health care for specific clinical circumstances.

Health Choice's model of care will ensure that members have access to a comprehensive network of physical health (PH) and behavioral health (BH) providers who are aligned with Health Choice both through a shared model of care and financial incentives. As part of our model of care, we will ensure that services are culturally competent, evidence-based, and provided in a manner that respects member choice in providers, services, and outcomes.

Over the past century, the Primary Care Provider (PCP) has typically been seen as the "center" of the outpatient experience. Patients visited their PCP first, who directed them to other resources based on the PCP's assessment of the patient's needs. Health Choice will employ a different approach: One that pairs the PCP with BH outpatient service providers to form a team-based model of "ambulatory care," similar to AHCCCS' Targeted Investment design, that supports access to fully integrated health care services. (See Figure 1.) Health Choice will facilitate this transition through the use of an expanded network of patient centered, Integrated Health Homes (IHHs) and Integrated Accountable Care Organizations (IACOs). These providers will have primary responsibility for managing the overall health of their panel, providing most services and coordinating care, and will receive substantial assistance from the Health Choice care management team for members with high need/high costs or special health care needs.

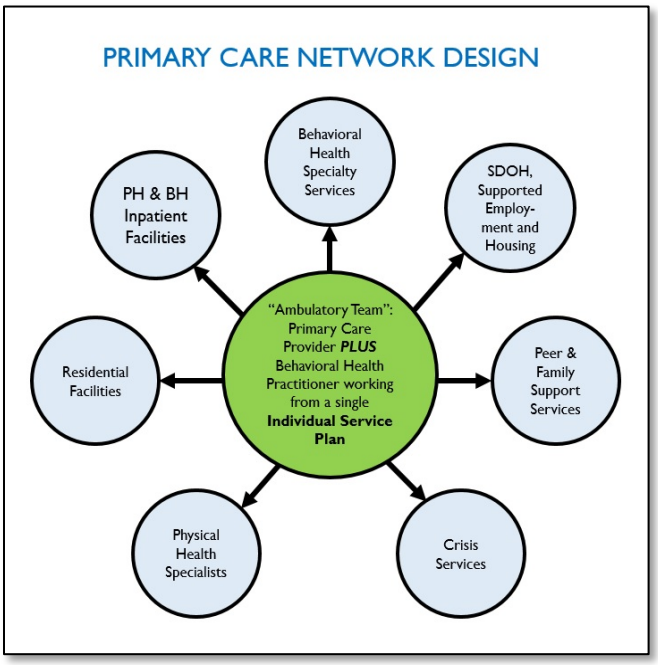


Figure 1

Health Choice has experience transitioning members to IHHs based on our recent, successful experience working with Spectrum Healthcare, Encompass Healthcare, and West Yavapai Guidance Clinics as they followed our model toward integration. More recently, HCIC successfully transitioned members in Gila County to our IHH model with South Eastern Arizona Behaviorial Health and Canyonlands Healthcare's innovative, integrated clinic program in Globe.

Our Phased Approach. The first step toward achieving this design is encouraging members with high acuity behavioral health needs to choose one of Health Choice's patient centered IHHs or IACOs with expertise in the type of care they need, and if the member is under 21 years of age, a dental home as well. Consistent with Health Choice's strategy of "behavioral health led integration," the first phase of our plan is designed to ensure that members with significant behavioral health needs are able to smoothly navigate the transition to integrated care. Over the course of 2017, Health Choice held an extensive series of discussions with both advocacy groups and our current, and potential, new IHHs that have affiliations with primary care providers. In Northern Arizona, all of HCIC's members are already attributed to either an IHH, or a Behavioral Health Home paired with a primary care practice, thus largely obviating the need for any transition. However, allowing for the required six month transition period, Health Choice will in all other regions begin by attributing or transitioning children and members in the General Mental Health/Substance Abuse (GMHSA) group to a contracted IHH or IACO for at least behavioral health services. Based on our initial research, approximately 90 percent of members who will likely be affected already obtain behavioral health services through our contracted or expanded IHH or IACO network. In these instances, members will remain with their current BH provider, although members are always afforded "choice" and may change providers at any time.

For members not already utilizing the services of an IHH or IACO, Health Choice will provide an extensive member education program around the benefits of the specific Health Homes in our network, and offer the

opportunity to select one for future BH needs. If members choose not to select a Health Home, they will be auto-assigned to an IHH or IACO based on their residential zip code, in the same manner that HCIC has done for several decades.

Our primary goal in this "first phase" is to ensure that vulnerable members receive all needed behavioral health services during the transition to integrated care, thus dramatically reducing the possibility that members will "fall through the cracks" in the system. Our secondary goal is to assist members (and again, especially those members with higher acuity behavioral health needs) to develop a relationship with integrated providers, thus easing the member's transition to fully integrated services. We have discussed this approach with providers and with advocacy groups, including the National Alliance on Mental Illness (NAMI), who both strongly support it. Given the required six-month transition period for members to continue using their current providers, we anticipate that full implementation of the above process will take approximately twelve months.

The second phase of our transition will assist remaining members to transition *both* physical and behavioral health services to an IHH or IACO. As noted above, we will use the first phase process to assist in migrating members with high acuity behavioral health needs to appropriate provider resources. This second phase will complete that task by providing marketing and educational materials to members about the benefits of obtaining their physical care through the same IHH or IACO as their behavioral health care. Using the SAMHSA Four Quadrant Clinical Integration Model, members identified through our MedInsight™ and Johns Hopkins ACG™ population and predictive analytics tools as Quadrant 3 (high behavioral health, low physical health needs) and Quadrant 4 (high behavioral health and high physical health needs) will be the focus of this effort.

The third and final phase will be to transition our remaining IHHs into full IACOs, including integration with inpatient facilities, SDOH programs, and high volume specialists. This will effectively complete the task of transitioning our provider network into IACOs that resemble AHCCCS' conception of "DSRIP entities."

Health Choice recognizes that the above represents a major transformation of the delivery system. As such, Health Choice will form a new Practice Transformation Team, which will be dedicated to assisting our current network as they move toward IHH, and ultimately, IACO status. Health Choice will also develop a model leadership series and disseminate it through videoconferencing so that all new and existing providers can learn about our practice guidelines, protocols, value-based incentives and shared risk model.

Ensuring High Quality Services Consistent with Clinical Guidelines and Best Practices. As we make this transition to fully integrated health care, Health Choice will ensure that members receive high quality services consistent with both clinical guidelines and best practices through several distinct, interrelated strategies: (1) Data-driven provider performance, quality management, and utilization management programs; (2) Early interventions based on assessments, standardized screenings and referrals; (3) Continued use of integrated treatment and service plans; and (4) Continuous adoption and adaptation of clinical guuidelines and evidence based best practices.

Data-Driven Provider Performance, Quality Management, and Utilization Management Programs. We will deploy a provider performance program for IHHs, IACOs, and other organizations where providers are accountable for the quality and total cost of care for attributed members with a value based, "quality gated" system of shared savings and risk. We will also use this model to target specific, data-driven quality improvement opportunities, aligning provider incentives with quality and cost targets. Steward has had success using a value-based payment model to achieve specific quality and total medical expense targets in its Massachusetts contracts, and will support Health Choice in adapting best practices for AHCCCS Complete Care.

Under the direction of the Chief Medical Officer, Health Choice has already begun to scale HCIC's high performing quality management (QM) program to all Health Choice plans to address current gaps and opportunities and to prepare for our Arizona Complete Care program. To ensure that we continuously assess and improve the quality of member care and integrate a quality focus throughout Health Choice, we have added additional quality management staff, modified reporting structures, and developed improvement new strategies. Our QM program is structured on the U.S. Department of Health and Human Services (HHS) National Quality Strategy priorities. Our QM program will continue its use of a Plan-Do-Study-Act performance improvement model, and principles from Lean Six Sigma's "Define, Measure, Analyze, Improve, Control" ("DMAIC"). Our QM program promotes objective and systematic measurement, monitors and evaluates services

and work processes against clinical guidelines, and implements continuous quality improvement activities based upon the outcomes. Findings from quality of care concerns, routine and targeted provider reviews, member and provider satisfaction surveys, and grievances and complaints are used to target improvement activities that address individual member concerns, provider level performance and trends for systemic improvements. Provider report cards on performance measures will help providers modify their practices to achieve better member outcomes and are used for credentialing and contract performance review. Health Choice's peer review process improves the quality of professional care delivered to members. Providers who do not practice in a consistent manner with clinical practice guidelines are subject to performance improvement activities including technical assistance, training, letters of concern, quality of care reviews, corrective action plans, financial sanctions, and contract terminations.

Health Choice's utilization management (UM) approach employs the American Medical Association's Prior Authorization and UM Reform Principles as adopted by numerous national and state professional organizations including Association for Community Affiliated Plans (ACAP), American Academy of Family Physicans (AAFP) and the American Hospital Association (AHA) to practice patient-centered utilization management in order to improve timely access to care and reduce administrative costs to the health system. Under these principles, UM programs must be based on clinical criteria, and never on cost alone, and the criteria must be readily available to providers and members. The UM structure and approach accommodates the transition of our plan design to our value based, quality-gated, sub-capitated performance program.

Early Intervention Based on Screening and Referrals. Once a member has established a relationship with Health Choice and a Health Choice provider, Health Choice and/or the provider will conduct an assessment including referrals to other appropriate services. Providers, and in particular our IHHs and IACOs are selected for their willingness to share Health Choice's emphasis on placing the member's whole-health needs above all else through care that is culturally competent and linguistically appropriate. This ensures that a full continuum of covered services are accessible, offer choice to members, are wellness and recovery-oriented, and include specialty services. Because depression, anxiety, substance use disorders and trauma are especially common in Medicaid populations and because people with BH disorders are at risk for chronic conditions and early morbidity and mortality, both PCP and BH providers are required to regularly screen members using standardized and validated screening tools. Health Choice trains providers on evidence based protocols and toolkits for the PCPs or BH providers to treat and/or refer within their scopes of practice, such as the AHCCCS Toolkits for ADHD, Depression, Post-Partum Depression and Buprenorphine; Screening Brief Intervention and Referral to Treatment (SBIRT) and the AHCCCS Behavioral Health Practice Tools. Regular age-appropriate screening of infants and children/youth less than 21 years old is also required through our Early and Periodic Screening, Diagnostic and Treatment (EPSDT) child health program. Based on recommendations by the Arizona Medical Association and the American Academy of Pediatrics, this program prevents, identifies, treats, corrects, and improves PH and BH conditions for children and youth. Using a population based medical care approach, PCPs are required to provide EPSDT ("well-child visits") to all their empaneled children in order to identify early hearing, dental, vision and nutritional problems, developmental delays, autism spectrum disorder, BH disorders, and special health care needs. The PCP must assess children's health needs, provide preventive screening and all required immunizations, initiate needed referrals and complete recommended medical treatment and coordinate care.

Required Screening Tools:

Health Risk Assessment: Initial & Annual whole person screening

Depression and anxiety: PHQ-9, GAD-7, Edinburg Perinatal Depression Scale

Developmental needs: EPSDT, ECSII, CASII, M-CHAT, ADOS, PEDS, ASQ.

Substance use: AUDIT, DAST,ASAM

Trauma: Adverse Childhood Events

For children or adults with special health care needs, referrals can be made directly to a specialist or PCP so that care is comprehensive and can maximize health outcomes. Health Choice ensures that the network includes additional experts who are Masters and Doctoral level clinicians in the fields of social work, counseling, and psychology trained in implementation of best practices for medically and behaviorally complex conditions

such as intellectual/cognitive disabilities, trauma-related disorders, substance use disorders, sexual disorders, and special age groups such as transition age youth and birth to five year old members.

If additional assistance is needed, Health Choice will have a dedicated referral line similar to one used by Steward's Massachusetts program, where referrals will be made preferentially to our highest quality providers and Centers of Excellence. Second opinions are also always available free of charge for members. Providers can call the Health Choice Medical Directors or Clinical Directors for additional assistance with complex concerns, like pain management, autism or substance use disorders. Health Choice will also work closely with providers who are part of AHCCCS' Targeted Investment program in order to be a "force multiplier" for the alignment of child and adult PH and BH integration efforts, which includes standardized screenings, well-child and adult preventive visits, best practices, follow-up after hospitalizations and use of the Health Current Health Information Exchange data feeds.

Integrated Treatment and Service Plans. The service plan acts as our "promise" to the member and identifies the covered services that are medically necessary based on an assessment and the member's preferences and needs. For members engaged in services with an IHH, IACO, or who have special health care needs, the multi-disciplinary team will be responsible for coordinating a comprehensive service plan that ensures members receive regular PH and BH appointments, health prevention screenings, wellness programs that promote and support healthy lifestyles like smoking cessation, weight reduction, exercise and stress management, management of conditions, health coaching & education to promote lifestyle goals and self-management, community and peer/family support, and other resources. The service plan is available to all members of the team to facilitate well-coordinated, interdisciplinary care.

Adult Recovery Teams and Child and Family Teams will jointly participate in the development of service plans. The service plan informs the member as to what services they can expect to receive, by whom and at what frequency. The service plan also documents which services and referrals the IHH or IACO will coordinate and cover, and communicates the member's diagnoses, needs, treatment goals and expected services to providers who are treating the member for the purposes of coordination, billing and reassessment.

Continuous Adoption of Clinical Guidelines and Evidence Best Practices. Under the direction of Health Choice's Chief Medical Officer, we will continue to research established national guidelines, and review current peer-reviewed scientific literature to develop best practices to guide Health Choice's contracted practitioners in improving quality of care and reducing variations in care. Health Choice also solicits feedback from members, providers, and stakeholders to obtain input and consensus, and incorporates peer-reviewed research findings into the analysis.

As Health Choice adopts clinical guidelines and evidence-based practices, we incorporate them by reference in provider contracts, into the Health Choice Provider Manual, and on our website. When new guidelines are adopted or existing guidelines are updated or revised, we will notify providers through our website, mass mailings and blast faxes. Providers who would be impacted by the changes or recent additions will receive follow up with site visits or are offered education. Members may view guidelines on Health Choice's website, or request a hard copy through our Member Services Department. Guidelines are also discussed in our member and provider newsletters.

Past Implementation Successes. The most recent and significant examples of Health Choice's successful past implementation of the above concepts are represented by our 2015 transitions to integrate care for members living with SMI and for dually eligible GMHSA members. The strategies identified above were employed during these two transitions. In both instances, the transitions were completed with minimal member and provider issues. HCIC experienced no member or provider complaints related to the transition process, and unlike many other Acute Health Plans, HCA had no BH provider complaints related to claims payment issues during its GMHSA dual transition.

Most significantly, our experience as the Integrated RBHA in Northern Arizona has demonstrated impressive results for high need/high cost members in our Integrated Care Management Program that are scalable to this new program, including decreasing emergency department visits by 27 percent, decreasing all-cause inpatient admissions by 65 percent, and decreasing total costs by 21 percent.

Another example of a successful program we implemented was Screening, Brief Intervention & Referral to Treatment (SBIRT), an evidence-based prevention and treatment practice based on our five year SAMHSA grant with the State of Arizona Governor's Office of Youth, Faith & Families. Since 2013, we have delivered SBIRT services to identify and treat substance use/misuse at Flagstaff Medical Center emergency department, six primary care sites and NAU student health to more than 47,000 adults. Likewise, our "Parent Support Now" program, which provides family peer support to families with Department of Child Safety involvement, has increased the number of successful reunifications of children with their family, and decreased reunification time by half. This is a value based incentive program with MIKID, a family run organization that provides services to families of children with emotional and behavioral challenges in Mohave county, and with Family Involvement Centers in Yavapai county, a family run organization in Phoenix and Northern Arizona.

Health Choice also implemented HCIC's High Risk Suicide Attempt Prevention Protocol (SHOUT), Stanford Disease Self-Management Programs for Chronic Conditions, Pain and Diabetes; and HCIC's Benzodiazepine and Opioid Warning Signs Prevention Protocol based on the CDC Chronic Pain Guidelines. Health Choice has also developed and contracted with Centers of Excellence for integrated PH and BH care, for integrated care for members with substance use disorders, for members with opioid use disorders, and for integrated pain management centers. Health Choice will promote our Centers of Excellence on our website so that members can choose providers with the best outcomes. Each of these Centers of Excellence are required to utilize evidence based practices and provide high quality care. Health Choice will extend all of these successful programs throughout our entire service area, and across all populations.

Innovative Strategies Health Choice Will Implement Under this Contract. Health Choice prides ourself on continuous, rapid-cycle innovation. Specific innovations we will implement include: (1) Integrated care management, (2) Technology-enabled pain management program, (3) 24 hour telemedicine, (4) Enhanced member engagement, and (5) Innovative provider and staff development.

Expanded Integrated Care Management. We will expand HCIC's innovative "Top Tier" care management program to all eligible Health Choice members. Our care management design promotes and supports seamless care coordination across the entire delivery system by establishing a central point of contact at Health Choice for member outcomes. Data and support are shared between the providers and Health Choice in order to eliminate blind spots and gaps in medically necessary care. We achieve this through a step by step approach that begins with an initial assessment to determine the member's specific care coordination or care management needs and the development of an Integrated Individual Care Management Plan for members who have high needs/high costs or special health care needs. Health Choice uses both real-time and predictive analytic data feeds to support care management, population health analytics, risk stratification and performance benchmarking from Health Current, Health Choice's pharmacy benefit manager, Johns Hopkins ACG™ Predictive Modeling program and Milliman's MedInsight™. All member contacts, authorizations and care management plans are contained in CareRadius, our suite of care management functions platform. Our care management strategy will also continue the use of Integrated Care Managers, supported by committed and experienced Health Choice Medical Directors who have a public health and member-centered perspective, and provide PH and BH expertise and oversight, increased system coordination, and resources for members in care management. The care management team assists treatment teams and stakeholders in developing a holistic approach to understanding and organizing members' PH and BH needs and services based on member/guardian/family preferences and evidence-based practices or guidelines. Given the challenges of Arizona's expansive geography and the need to transform the delivery of health care, Integrated Care Managers are specifically assigned to high volume practices and IHH and IACO provider sites by region. They learn the resources, needs, culture, tribes and community partners in their region so that they can become a virtual part of that community.

Technology-enabled Pain Management Program. We will develop Centers of Excellence for integrated pain management and medication assisted treatment providers through axialHealthcare. We will use proprietary algorithms to detect opportunities to implement evidence based best practices and achieve exceptional clinical outcomes at appropriate costs. In addition, axialHealthcare will establish a local scientific advisory board with us to provide clinical oversight of our pain and opioid solutions, including but not limited to, reviewing Arizona and national clinical guidelines, physician engagement strategies, and access to care.

24 hour Telemedicine. Most services including specialty services may be provided on-site or through the telemedicine network we established in 1996 for BH services. Our telemedicine system received a substantial upgrade in 2016 when Health Choice, in partnership with Northern Arizona Health Care, North County Health Care, and other rural Arizona providers, migrated our telehealth platform to Zoom Technologies™. This allows us to work directly with providers from these organizations and provide remote access to multiple specialty type services all on a single, secure platform. We are currently working with Indian Health Services to extend the use of this system throughout tribal lands, with an initial focus on providing expanded telehealth services to the Havasupai Tribe at the bottom of the Grand Canyon. Additionally, Health Choice will implement a "tele-doctor" mobile health application available 24 hours per day in 2018, and will implement an enhanced pediatric telehealth nurse line (with 24 hours pediatrician support) in 2019.

Enhanced Member Involvement. Health Choice recognizes and values member, peer, and family input and involvement in the design, evolution, and oversight of our system of care. Health Choice will build on HCIC's extensive experience inviting and utilizing peer/family input at the RBHA and provider level, including developing peer and family run organizations (PFROs) and membership in state and local affiliates such as the National Alliance on Mental Illness (NAMI). Health Choice has member and family membership on our governing board and committees. Our Member Engagement Committee and regular peer/family forums will provide input to all levels of the Health Choice organization, including our executive management team. Since members, peers and family members with lived experiences of PH and BH challenges offer meaning, support and hope to so many of our members, Health Choice will also maximize their influence throughout our system of care, by offering peer/family support to every member, peer led health promotions and self-management classes, forensic peers, peer recovery specialists, PFROs and parent support.

Innovative Focus on Provider and Staff Development. Health Choice will continue to emphasize the importance of training and competency development in its mission to provide superior health care throughout our region. Our training program's content will be adult-learning focused and evidenced based. Health Choice requires that all subject matter experts deliver their trainings from a trauma-informed, culturally proficient, recovery based, perspective. Live in-person trainings are provided at Health Choice facilities, provider sites and many community sites such as detention centers, schools, churches, county facilities, hotels, libraries, restaurants, tribal community centers, casinos and veterans' centers. Through Zoom Technologies' video conferencing software, the Health Choice telemedicine department supports remote trainings with immediate and free resources for individual or group training sessions, including to tribal nations. We utilize Relias Learning's online community with thousands of customizable training modules available on-demand for provider staff and PFROs.

Health Choice also participates in several University of New Mexico Project ECHO programs, an innovative, evidence based program over a secure web-based video-conferencing platform, for improving the competency of primary care and rural providers to manage complex care that would have been referred to a specialty provider. Since 2013, we have granted $135,000 for primary care providers, pain management specialists, and psychiatrist, to participate in pain management training programs. Health Choice has also developed a new ECHO Opioid Use Disorder telementoring program to train care coordinators and peer recovery support specialists. Since 2015 Health Choice has participated in Project ECHO for Autism and sponsored Health Choice's Elevate Autism System of Care in Arizona 2017, a highly acclaimed all-day conference attended by over 150 medical and community providers.

Conclusion. Health Choice has been developing our model of care over many years using practical, evidence based solutions responsive to the needs of our members and communities. As a partner with members, providers and stakeholders, we have designed systems that address the unique cultural and geographic needs of our frontier, rural and urban areas so that care is responsive and high quality. Based on our recent experience in successfully implementing transformative programs, and our comprehensive strategies to manage and monitor the transition process, Health Choice, as a behavioral health led organization, is well positioned to implement and manage AHCCCS' comprehensive behavioral and physical health benefit package throughout Arizona.

Narrative Submission 3

Steward Health Choice Arizona (Health Choice) understands the myriad of complexities involved in transitioning members from our current delivery system to a newly structured system, and the importance of extensive implementation planning and effective self-monitoring to ensure members receive access to timely and appropriate health services.

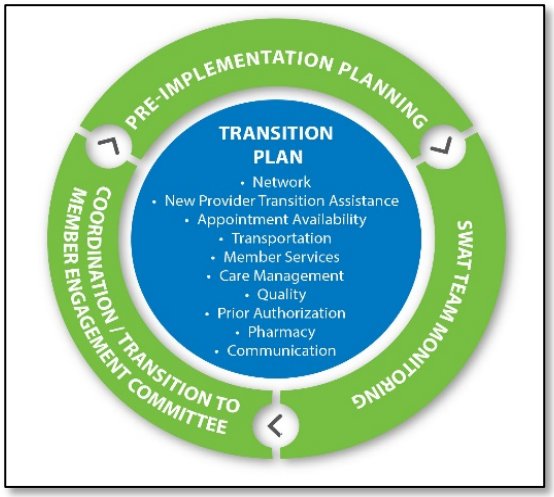
Our 25 years of experience in acute care management, and over 30 years of experience in behavioral health managed care, have afforded us the opportunity to participate in several major transition events and initiatives within Arizona. Our most notably and recent event was Health Choice Integrated Care's transition to Integrated Care in 2015, where Health Choice managed a highly successful transition for the integration of both physical and behavioral health services in Northern Arizona. This implementation effort featured intensive planning and monitoring to ensure all members, particularly those with complex needs, did not experience interruptions in care during and after the transition. We will incorporate many of the successful strategies utilized in our previous transitions for the implementation of the AHCCCS Complete Care program.

2015 Integration Successes

- Met all contractually required call center statistics
- Significant expansion of a physical (in Yavapai County) and behavioral network (in Gila County) without issues or complaints
- No transition-related grievances

We will monitor staffing adequacy, and immediately address needed changes. Our approach will include pre-implementation planning and monitoring, establishing a transition team, and ongoing monitoring and evaluation post-implementation. Our plan, detailed below, addresses the following components of our effective self-monitoring to ensure members can access and receive needed services post-implementation: Proactive outreach to members and providers, network adequacy, access to care, member call center metrics, transportation, pharmacy, prior authorization, care management, quality management (QM), communications and all other operational areas within the health plan.

Pre-implementation Planning and Monitoring. The integration of physical and behavioral health services, as well as associated member transitions, must be carefully and skillfully planned and monitored. Our plan will reflect both intuitive and proactive approaches in regard to member and provider communications and responses to identified vulnerabilities or gaps at the earliest opportunities. We will achieve this through focused and consistent monitoring throughout the life of the contract. Health Choice will develop a transition plan during the pre-implementation phase with oversight by a coordinated SWAT (Specialized Workgroup and Tactics) transition team. We will leverage best practices developed from prior transitions for the plan to maximize success. In addition, Health Choice's experienced Member Advocacy Administrator, Laura Hartgroves, will lead an inter-departmental Member Experience Committee to guide the development of pre-implementation member engagement activities, and monitor and improve member experience. This Committee will coordinate with the SWAT team during the implementation phase, and will continue the SWAT team's work for the duration of the contract.



Transition SWAT team. The post-implementation transition planning will start immediately upon contract award. With oversight from our Chief Executive Officer, Health Choice's Transition Coordinator will lead the development of the transition plan with the approval and monitoring by the SWAT team and in coordination with the Member Experience Committee. The transition plan will identify action items, objectives, responsible

parties, and timelines for completion of tasks. We have highlighted below several key areas of focus as part of the transition plan. Effective self-monitoring to ensure members are able to access and receive needed services post-implementation will be conducted through Health Choice's implementation and deployment of our transition SWAT team, which will be responsible for pre-implementation planning, the transition plan and post-implementation monitoring through the first six months of the contract go-live. The activities of the Health Choice SWAT team will transition to the Member Experience Committee for ongoing monitoring thereafter to continue through the contract cycle. Health Choice's Chief Executive Officer will directly lead the SWAT team with support from the Transition Coordinator, and will include a representative from each operational and clinical area of the organization. Trained service-centric member service representatives will also be prepared to serve both members and providers in need. As part of the transition, the SWAT team will use daily dashboards with continuously updated data from our nationally recognized analytics tools, our Pharmacy Benefits Manager, transportation vendor, call center, grievance reporting, network reporting, care management reporting, and quality metrics to track member access to care, provider/member/community concerns and grievances, authorizations, network adequacy, and high risk member outcomes. Health Choice will share information with providers, coordinating health plans, members and AHCCCS as needed. SWAT team members will be required to report into the SWAT team weekly on the current and cumulative status of health plan required metrics, triaging and assessment of issues, gap closures, updated processes, successes, and challenges.

Member Experience Committee. Our Member Experience Committee is grounded in the principles of the AHCCCS Complete Care program. Our Member Advocacy Administrator will coordinate efforts across all member-facing functions of the organization to ensure that no member "slips through the cracks." The Member Advocacy Administrator will also coordinate the Member Experience Committee, which will be responsible for driving a consistent message across the organization. Committee members will provide feedback from all areas to drive a positive member experience. During the transition, this committee will work in coordination with the SWAT team for self-monitoring of member experience and member access to care during the transition period, and will continue to provide a focused monitoring of member experience on a permanent basis post-transition. A Member Experience dashboard will be reviewed monthly with the committee to identify trends and develop initiatives for improvement. The Committee will review information from calls, surveys, appeals, grievances, and community feedback. The Committee will be comprised of representatives across the organization, in addition to members, peers and family representing all corners of our geographic service areas. Sources used during the implementation phase to gather information, along with the efforts of this committee, will be shared with the Member Advocacy Council, also led by the Member Advocacy Administrator.

Proactive Outreach to Members and Providers. Prior to October 1, 2018, Health Choice will proactively outreach to our current provider network and to all members assigned to us to alert members and providers of upcoming changes and assure them of a smooth transition. All members transitioning to Health Choice will receive a welcome packet with an identification card and information about our new plan, integrated network, and benefits. Providers will receive updates about any changes in network composition as well as an update of our overall vision to transition to Integrated Accountable Care Organizations (IACOs) during the course of the AHCCCS Complete Care contract. We will also have a web page dedicated to updates on the transition process available to members and providers during the transition to streamline communications and FAQs.

Importantly, Health Choice will work directly with high risk members to ensure a smooth transition for them. Health Choice will combine all available data, including but not limited to, current claims and pharmacy information, information shared via relinquishing contractor, blind spot data, and Health Current data, into our nationally recognized predictive analytics programs to identify high needs/high cost members who may be at risk during the transition. Health Choice has developed an array of reports that enable us to identify utilization trends early. Health Choice has invested in Milliman MedInsight™, an industry-leading health care analytics tool

that identifies core drivers of utilization. MedInsight is a cloud based tool used to perform longitudinal analysis and multi-level modelling of population health data which is leveraged to identify trends and opportunities to improve health outcomes and operational performance. Health Choice will use industry leading risk adjustment models [Milliman Advanced Risk Adjustment (MARA) and the Johns Hopkins Adjusted Clinical Groups (ACG)™] for predictive analytics at a member level to help identify members with high needs and/or high levels of medical spending. High need/high cost identification factors include members at risk for avoidable admissions and readmissions, unnecessary emergency and crisis utilization, morbidity and mortality due to over or under-utilization of services (including pharmacy) and the presence of multiple active co-morbid chronic conditions, among others. These integrated methodologies will allow us to identify high need/high cost members who exhibit these factors and therefore require Top Tier Care Management services during and post transition.

Network. Members currently enrolled in Health Choice will not be required to choose new medical or behavioral health providers given that they will simply continue to participate in the Health Choice network. They will also utilize the same member service phone numbers, case managers, and pharmacies they utilized before the transition. We will contractually require our Integrated Health Homes (IHHs) and IACO providers to contact high risk members prior to October 1, 2018 to engage and establish appointments, and share back confirmation of successful contact. Transitioning members will be able to access providers as described in Exhibit G, “Transition Requirements for All Populations” in AHCCCS’ “Request for Proposal Solicitation” and also have the option of choosing an in network provider.

Health Choice will use a full court press approach to contract with new providers leading up to October 1, 2018. We will deploy Network representatives into the community to meet with providers and assist them in preparations. We will engage in frequent communications with our providers and create several communication pathways for them to utilize pre and post-implementation. For continuity, our provider network team will identify non-contracted providers utilized by our transitioning members and attempt to contract with them. Should these providers choose not to contract with us or if we determine they do not meet quality standards, we will work with the member to transition them to a provider who can meet their specific needs.

Health Choice will monitor enrollment and utilization expectations against actual enrollment. These data points and systems will be used pre and post-implementation to determine number and types of providers needed in order to meet or exceed established AHCCCS standards. We will also have staff outreaching to our larger providers on a daily basis for the first week to identify any issues they might be experiencing. Network staff will be deployed to visit our IHHs, IACOs, and each Multi-Specialty Interdisciplinary Clinic. Other staff members will be on standby in cases where physical meetings with other providers are necessary.

Access to Care. Starting no later than August 1, 2018, Health Choice will outreach to any newly transitioned high needs/high cost members to ensure they have their needed appointments scheduled, timely and through their current providers. In accordance with AHCCCS standards, we monitor appointment availability to ensure members are able to access their providers in a timely manner. Health Choice's Network Services Department is skilled and experienced in monitoring network capacity and appointment availability. Health Choice plans to meet or exceed AHCCCS appointment availability requirements. We will use various methods to actively monitor appointment availability as tracked and reported through a site visit tool, through focused QM audits, appointments offered and appointment scheduled reviews, and review and resolution of complaints and quality of care concerns. Health Choice will conduct additional focused audits during the implementation period to audit and monitor the appointment scheduling process of our provider network. Provider issues will be reviewed and communicated through phone or in-person meetings and additionally through our Provider Profile reports which detail performance measure data sent to providers quarterly.

Transportation. Based on past transition experiences, we will require our transportation vendor to have additional call center staffing the 30 days pre and post transition. We will monitor vendor performance daily during the transition. We will trend data to provide insight to overall metrics and statistical compliance, including call center performance, trip performance and grievance reporting. Trended items will incorporate all service areas, both urban and rural. We will conduct daily calls with the vendor to address any immediate issues. We will also host a vendor representative at our Phoenix call center to coordinate real time assistance for members as needed. Our calls and on-site vendor representation will continue until we determine that all

performance is within established service level agreements and performance is maintained at that level. Our member services leadership, QM and vendor representatives will communicate daily on any grievances or complaints reported. The grievance/complaints data will be sorted by type (e.g., late arrival, no-show, missed appointments). We will also use data to identify potential quality of care issues. We will partner with the vendor to investigate such issues swiftly and identify any process improvements or corrective actions that will be taken as a result of the complaints or grievances.

Upon receipt, we will review all transitioning member data for past transportation utilization, and contact those members who had received transportation services within the prior 90 days to discuss setting up transportation for future appointments. New members will be able to begin scheduling transportation 45 days in advance of October 1st.

Member Services Call Center. The assurance of member support begins with our local, Arizona-based member services call center. Specially-trained Behavioral Health Member Service representatives will collaborate with our Medicaid, Dual Eligible and Behavioral Health members as well as our provider population. We will provide education and support to our customers. Consistent with our past track record, we are able to resolve 98 percent of inquires during the first call to the plan. Representatives will receive transition training beginning 90 days prior to go live. Training will continue until go live through classroom and computer based training as well as electronic communications at least weekly through go live. We will manage additional staff, cross utilization of workforce and flexibility of resources regularly to ensure that all vendor service level agreements are met or exceeded during and after transition. Utilizing our call management system (Avaya), we monitor inbound call volume real-time. Reported service levels include number of calls received, abandonment rate, average speed of answer and hold times will be reported to the SWAT team and senior leadership four times a day. Call reasons, representative briefing, and quality monitoring will occur to quickly identify and address trends from provider and member questions and concerns.

Care Management. We will deploy case managers (at the provider level) and care managers (at the health plan level) in the field to reach out to high need individuals and special populations. They will also contribute to overall monitoring efforts. We will assign integrated care managers (ICMs) who have complex behavioral health/physical health experience to health home provider sites by region, and will support implementation by working closely with high needs individuals. We will also assign care managers to follow up with clinics and providers to develop transition plans for members identified as high need, at-risk, on court ordered treatment, or at the Arizona State Hospital. We will conduct daily check-ins between the field based care managers and the Director of Quality Management, who will report any identified issues back to the SWAT team detailing the issue and ongoing remediation efforts. The Health Choice care management team will assist treatment teams and stakeholders in developing an integrated approach to understanding and organizing members' physical and behavioral health needs and services based on member/guardian/family preferences and evidence-based practices or guidelines. Integrated Care Management Plans for high need/high cost members will identify the member's entire care team/providers, call out gaps in services, promote care coordination and evidence based interventions; and monitoring outcomes at the member and provider level.

Quality Management. The implementation SWAT team will use a Quality Management Implementation Dashboard, stratified by members impacted by the transition, to ensure leadership oversight of proactive and swift responses to all quality and case management concerns. Our robust reporting exists to monitor trends related to integrated quality of care, member grievances and appeals, patient safety, member satisfaction, care coordination, service provision and timely access to care. We will use findings from quality of care concerns, grievances, and complaints to target improvement activities that address individual member concerns, and aggregated data at the provider level to identify trends for systemic improvements. We will deploy rapid cycle improvement teams to provider site locations as improvement opportunities are identified. Interventions will include: Member advocacy, internally initiated Quality Improvement Plans, issuance of a letter of concern, and Corrective Action Plans. Specific strategies will range from staff and provider education, peer review, and policy and procedural changes to sanctions or recoupment, legal action, provider termination or suspension, or referral to a state agency or licensing body among other actions. We will continue to follow performance improvement actions taken to ensure effectiveness and to prevent the concern from reoccurring.

Prior Authorization. We use data elements such as diagnosis, drug, lab and prior authorization data to ensure members are transitioned smoothly with no disruption in care. We will honor prior authorizations from relinquishing contractors as per contract and policy. The prior authorization operations center will work in concert with medical services and network to ensure a smooth and seamless transition for all members. All prior authorizations will be managed and monitored utilizing our medical management software program, CareRadius. The prior authorization operations center will collaborate with medical services to assist in coordinating care and authorizing medically necessary services. Additionally, the Prior Authorization Operations Center will provide feedback to the SWAT team and network services for potential gaps, non-contracted providers in underserved areas, and areas where we have noted limited providers.

Pharmacy. To prevent member eligibility issues that could result in members not getting needed medications, Health Choice will begin sending daily eligibility files to our Pharmacy Benefit Manager (PBM) for immediate uploading into the pharmacy system as soon as data is available. Health Choice will monitor new member pharmacy rejects and review Electronic Data Interchange medication information on a daily basis to identify and enter overrides to allow new members access up to a 90 day transition supply of non-formulary drugs and drugs requiring prior authorization, with the exception of controlled substances. This will allow members time to transition into Health Choice without a break in therapy. Health Choice will then generate a letter to inform the member of the transition fill and the need to work with their provider to submit a prior authorization or change therapy to a formulary drug.

Over the past six months, Health Choice implemented a new PBM and experienced a very smooth transition. Health Choice and the PBM will generate daily reports and review current claims processed for the purposes of placing overrides and correcting any errors in claim processing to ensure that members do not go without access to needed medications. The Pharmacy Department will monitor vendor performance daily during the transition. We will also trend data to provide insight into overall metrics and statistical compliance, including pharmacy rejects, eligibility issues, and grievance reporting. We will conduct daily calls with the vendor to address any immediate issues. We will also host an on-site vendor representative to coordinate real time assistance for members as needed. These calls and the on-site vendor representative at Health Choice will continue until the plan determines all performance is within and is maintaining all set service requirements. The Pharmacy Department, quality management and vendor representatives will communicate daily on any grievance/complaints reported. The plan and vendor will partner to investigate the issues swiftly and identify any process improvements or corrective actions that will be taken as a result of the complaints/grievances.

Communications. Health Choice will monitor communications received by members, providers, AHCCCS relinquishing contractors, and advocacy groups. Outbound communications will allow Health Choice to provide updates, outreach, and disseminate information to members, providers, advocacy groups and other stakeholders. There will also be collaborative communication between AHCCCS and relinquishing contractors to avoid access to care pitfalls and ensure needed information is exchanged for a successful transition. We will monitor inbound communication to identify issues from all sources. We will remediate identified issues through the identified department, SWAT team and/or Member Experience Committee to determine root cause issues and update processes as necessary. We will also conduct monthly meetings between Health Choice's CEO and an Arizona-based consultant with strong ties to the provider and member advocacy communities to help identify problems and implement mitigation strategies during the transition. This will allow us to obtain feedback that we may not be able to garner from other formal channels.

Conclusion. Health Choice understands the importance of monitoring, triaging, assessing, updating and realigning processes to ensure that member's needs are met. Timeliness and the accuracy with which we make decisions are of the utmost importance. We will achieve this by aligning accountability for these efforts across dedicated staff and resources. As learned from our prior transition experiences, utilizing standardized tools, systems, appropriate communication and authority will be foundational components of our successful transition. We aim to ensure all members have access to and receive needed services during the transition, and that we can establish and sustain a high degree of member and provider satisfaction.

Narrative Submission 4

Overview. "If only…" These are common words across all levels of health care today. "If only I could remember which doctor I was supposed to see." "If only I knew which prescriptions my patients were actually filling." "If only I knew which of my patients are due for a mammogram or an immunization." "If only I knew the phone number for the pain management specialist." "If only I had transportation to get to my appointment." "If only her doctor had known she had a previous suicide attempt." Steward Health Choice Arizona's (Health Choice) population health and care management approaches are designed to answer questions like these for members and providers that significantly impact health outcomes.

Health care systems have historically been fragmented and confusing to navigate, even for individuals who are not hampered by the social determinants of health (SDOH) that can create additional barriers to understanding, accessing and self-managing health conditions. Health Choice's population management approach simplifies, educates, organizes, supports and monitors health care delivery. Our decades of health care experience in Arizona, including our successful implementation of integrated physical health (PH) and behavioral health (BH) managed care for our most vulnerable and complex members — those with serious mental illness (SMI) and disabilities complicated by poverty — gives us the understanding, motivation, and experience to partner with AHCCCS to transform the health of Arizona residents, including in rural and frontier regions where access to care may be limited. It is what informs our behavioral health led approach to integration.

Health Choice's care management program promotes and supports "seamless" care coordination across the entire delivery system so that members experience health care, and their membership with Health Choice, as a single system treating the whole person. Data and support services are shared with providers in order to eliminate blind spots and gaps in medically necessary care. Opportunities for members to engage in their healthcare and improve outcomes and satisfaction are encouraged through our use of condition-specific education, social media, our member portal, telehealth and mobile applications.

Administering Integrated Benefits. Health Choice will build on its current operating structures serving integrated populations enrolled with our dual eligible Medicare Advantage plan (Health Choice Generations) and our Integrated Regional Behavioral Health Authority (RBHA), Health Choice Integrated Care (HCIC). Both of those plans already administer PH and BH benefits for members in a fully integrated manner at the health plan level, provider level and member level. As we expand our integrated populations, Health Choice will bring our best programs, processes and protocols to the new contract, such as QNXT® for claims processing and provider contract management, and CareRadius® upgrades for contact management and care management. Supported by the Specialized Workgroup and Tactics (SWAT) team, we will train our member services, medical management, quality management, claims, and contracts staff on the new populations and benefit structures prior to contract implementation.

Integrated Care Management. Health Choice's "Member First" Integrated Care Management program is designed to improve quality, decrease costs, and reduce hospital admissions and unnecessary emergency department (ED) visits and crisis services through care management, member education and provider monitoring, and to effectively transition members from one level of care to another, including the Arizona State Hospital and justice systems. To do so, we will: (1) Prospectively stratify all members into levels and types of health care needs using predictive analytics and standardized, evidence-based assessment tools to identify "Top Tier" high risk/high cost members for member-first care management; (2) Use a "no wrong door" approach for care management referrals; (3) Deploy integrated, interdisciplinary care teams organized around the SAMHSA Four Quadrant Model to outreach to members about health care conditions that require follow-up and to assist members with self-management strategies for care adherence; and (4) Establish a single, integrated care management plan that care teams monitor and adjust based on service gaps, progress and outcomes.

<u>Prospective stratification of all members into levels and types of health care needs</u>. The foundation of population health is understanding holistically the characteristics and needs of all members for whom we care by assessing current status and conditions as well as emerging risk so that we can engage in both preventive and active interventions. Health Choice has years of experience with, and access to, multiple data sets and data analytic programs critical to supporting our providers to manage their empaneled membership effectively. These tools are not typically available to providers due to costs or complexity. Members may be identified for

care management through predictive analytics, health risk assessment (HRA) results, provider referrals, or real-time alerts through Health Current admission, discharge, and transfer alerts.

Health Choice has been actively using Milliman MedInsight™ and Johns Hopkins ACG™ Predictive Modeling analytic tools for member risk stratification for many years. Our stratification tools take into consideration PH and BH utilization, but also include SDOH which impact a member's care and risk. Health Choice frequently sends "emergency response registries" to providers related to members living in disaster or evacuation-related zip codes who have affected conditions like chronic obstructive pulmonary disease, asthma or homelessness.

These risk stratification tools allow Health Choice to build population registries of members sorted by age, demographics, providers, chronic conditions and counts, inpatient hospitalizations, ED visits, medication fill gaps, predicted and actual costs, over and under-utilization bands, and frailty markers. Reports can be run at the individual and population level to inform us on gaps in care, over and under-utilization and outreach needs. Additional reports allow Health Choice to effectively manage members in pain and on opioids, including: Key clinical impact metrics (opioid patient count, polyparmacy prescribing, average dose, multi-prescriber, opioid use disorder), cost savings, and monthly portal utilization and clinical outreach. Health Choice will use the following criteria to prospectively identify members for care management:

Real Life Success Story --

Two years ago, Health Choice received a "you saved a life" email based on our alert to providers.

A member with chronic obstructive pulmonary disease and congestive heart failure lived in a high smoke area during a forest fire and didn't answer her emergency outreach call. Her case manager immediately went to her home and found the woman "minutes" from full respiratory arrest. She was admitted to the hospital and survived.

- High Cost|Predicted: Members with high probability of being in the top five percent of high cost for the next twelve months or a high probability of persisting as a high utilizer over the next two years;
- High Cost|Established: Members with 3+ hospital admits or 4+ ED visits;
- High Risk|Predicted: Members with high probability of hospitalization or risk of unplanned readmission;
- High Risk|Established: Members prescribed opioids and/or benzodiazepines for chronic pain for more than 90 days; members with a diagnosis of CHF, HIV, Diabetes, COPD, high risk pregnancy, Hepatitis C on antiviral medications, Asthma, Hypertension, Hyperlipidemia, Complex Chronic Pediatric Conditions, Coronary Artery Disease, transplants, high risk suicide attempts; AHCCCS-eligible individuals transitioning out of the Arizona Department of Corrections (DOC) or Arizona State Hospital (AzSH); internal, provider or member referrals; Special Health Care Conditions; HRA score.

In addition to risk stratification, our HRA screens members for medical, behavioral, functional, cognitive and psychosocial needs. The HRA also includes up to date contact information, demographic and member satisfaction questions. HRAs are combined with analytic reports to further identify members with unmet needs and complex, chronic and/or serious PH/BH conditions needing further care management or coordination. We use a "no wrong door" approach to maximizing member completion of the HRA. HRAs are sent with a return envelope in every initial Member Welcome Packet. Members are also encouraged to complete the HRA electronically in the member portal. HRAs are uploaded into CareRadius®, our suite of medical management/care management software, where all care management activities are documented, as well as all incoming and outgoing contacts by or about the member. If the HRA is missing in CareRadius®, Member Services will outreach to members within the first 90 days of enrollment and at other care transitions as needed. In order to facilitate completion of HRAs, Health Choice will also leverage our successful requirement of linking HRA submission to the annual assessment process that is currently completed for members living with SMI, by requiring it for all non-SMI members beginning October 1, 2018. The member's case manager facilitates HRA completion at the Health Home intake and annually, and needs identified in the HRA are addressed in the member's service plan. Providers submit HRAs via the Health Choice Provider Portal. ICMs review HRAs using an HRA Risk Algorithm that flags responses requiring further clinical review like pregnancy, self-reported high blood

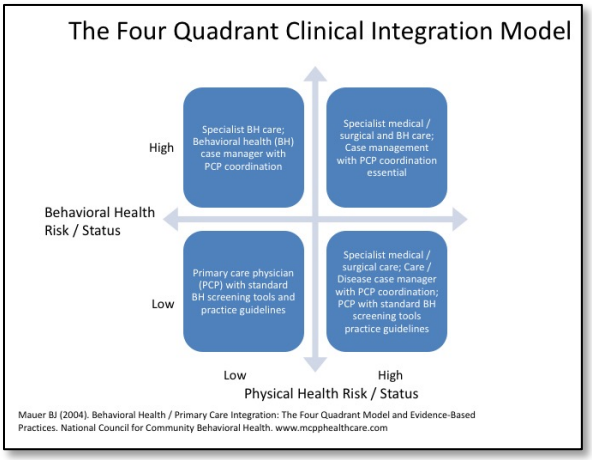
pressure, HbA1c, cholesterol, chronic conditions, multiple hospitalizations or ED visits, overall poor health status, abnormal BMI, assistance with daily living activities, or suicidal/homicidal thoughts.

Health Choice also leverages the Arizona Health Information Exchange, Health Current, to identify member needs. ICMs receive real time alerts on their members who present to the ED and/or are admitted to an inpatient facility, allowing proactive member and provider outreach to address preventable admits and barriers to care. The Health Choice ICMs also regularly use other information systems such as pharmacy fill data from Optum Pharmacy Benefit Manager, Arizona Controlled Substances Pharmacy Monitoring Program (CSPMP) database, direct access to electronic medical records from hospital systems, LexisNexis™ for missing addresses and phone numbers, and medical claims data to evaluate member utilization.

"No Wrong Door" Referrals. Health Choice has adopted a "no wrong door" strategy for referrals, which includes, but is not limited to accepting referrals from virtually any source to identify members in need of care management. Such sources include the member, their family, caregivers, providers, members with multiple complaints or who contact a governmental entity for assistance, community-based agencies, tribes, the Department of Corrections, Department of Economic Security/Division of Development Disabilities (DES/DDD), AHCCCS, internal health plan departments (prior authorization, quality, utilization review, maternal health), Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Tracking, the Arizona State Hospital, and the Psychiatric Security Review Board.

Health Choice proactively seeks out members in transition who require care management/care coordination from sources such as jails, Department of Corrections and hospitals, or those who are transitioning from the child to the adult system of care or other health plans. For members not engaged in services, Health Choice will contact the member to identify needs and barriers to receiving appropriate care. We will then assist with connecting the member to appropriate providers based on member choice and preference.

Deploy integrated, interdisciplinary care teams based on the Four Quadrant Model to conduct care management interventions. While the Four Quadrant Model (FQM) for Clinical Integration is typically used to describe levels of integration at the provider level, Health Choice has found it conceptually useful at the health plan level so that populations with both low needs and high needs are considered in program design. Health Choice will also have a Health Intervention Programs Division which will develop and manage the programmatic needs of our member populations and the communities we serve.



FQM programs are grouped by level of need or risk for PH conditions and BH conditions — Low PH/Low BH; High PH/Low BH; High BH/Low PH; High BH/High PH. Health Choice will have specific programs and interventions, and care management teams with specialized expertise or resources for each quadrant. For example, the High BH/High PH team will have lower caseloads and a higher percentage of nurses with BH experience. And while not all members require "Top Tier" care management, identifying and intervening on behalf of those with emerging risk, or who may not be currently engaged in needed services, can substantially decrease morbidity and mortality, improve health of the population and bend the cost curve. Therefore, the Low PH/Low BH team will have additional experience in prevention, use of screening tools to identify and respond to risk, patient activation strategies and facilitating time-limited transitions between health plans, levels of care or providers.

Each FQM care team will be led by an experienced Medical Director, who will be an Arizona licensed physician with experience in integrated care. Each team is supported by an Integrated Care Administrator (ICA), who is an experienced Arizona licensed Registered Nurse or Behavioral Health Professional. Each team includes Integrated Care Managers (ICMs) who are responsible for assisting with member needs, coordinating care and developing a single, integrated care management plan (ICMP) for each member. Finally, each team will include at least one Population Care Lead (PCL … pronounced "pickle") who are care managers responsible for

identifying population trends and implementing interventions. Both ICMs and PCLs are experienced Registered Nurses or Behavioral Health Professionals. PCLs have additional population health data trending and analysis experience for developing member registries and strategies to meet the needs of those with special health care needs, disease management and chronic, unmanaged conditions. All teams are supported by specially trained Member Services Representatives, called "Healthcare Buddies," who are available to make outreach or follow up calls to members. All ICMs and Buddies will have training in member self-management approaches, behavioral activation, member advocacy, navigating complex systems and communicating with a wide spectrum of professional and lay persons including family members, physicians, specialists, and other health professionals.

Most members will need a focused, one-time intervention for situations or conditions that can benefit from a brief alert, coordination or engagement with a provider. This may include assistance in scheduling appointments or transportation, contacting the member after an inpatient hospitalization to ascertain well-being and needs, re-engaging with a primary care provider (PCP) or BH provider, providing disease management information or reminders to attend EPSDT services or prenatal care, or offering information on housing, wellness programs or prevention.

Members in need of on going care management are referred to Top Tier Care Management for review against Health Choice's high need/high cost criteria which incorporates information from the HRA and Johns Hopkins ACG™ Predictive Modeling software. The assigned Health Choice ICM will complete an initial case review of the member's health conditions, service and pharmacy utilization including CSPMP data, social environment, support network, current functioning, and overall needs. If the member has not yet established care with a PCP, the ICM will ensure the member's provider case manager or a Healthcare Buddy will assists the member with setting up a new patient appointment. The Health Choice ICMs will oversee and assist members' clinical teams by:

- Effectively transitioning members between health plans, levels of care or providers;
- Streamlining, monitoring and adjusting ICMPs based on progress and outcomes;
- Providing teams and members with proper disease-specific self-management tools and education related to disease progression and importance of adherence to recommended treatment options;
- Identifying and communicating important clinical information and test results, such as discharge summaries, critical lab results, medications, ED visits, etc. to the clinical team;
- Updating the member's team on changes in member status, such as eligibility, court-ordered treatment, guardianship, Advance Directives, transition to adulthood, significant medication changes, incarceration, pregnancy, out of state treatment, all cause hospitalizations;
- Ensuring members are scheduled for preventive services, EPSDT/well-child visits, disease management and health promotion activities, based on identified needs;
- Analyzing predicted and actual outcomes and cost-effectiveness of a member's interventions and services based on best practices.

Members identified as high need/high cost have an Interdisciplinary Care Team (ICT) that is based on the member's needs. The ICT may consist of the member and family, provider case managers, peer/family supports, and PH and BH providers. The Interdisciplinary Care Team is supported by Health Choice's ICM. The ICT provides more intensive clinical oversight and coordination for the period of time when the member's need or risk is greatest, including development of an integrated care plan.

<u>Establish a single, integrated care plan that care teams monitor and adjust based on service gaps, progress and outcomes</u>. For each member enrolled in the Top Tier Care Management Program, the Health Choice ICM develops and implements a single, ICMP for the member and the member's ICT. The ICMP incorporates the member's PH, BH, and social needs. Additionally, the ICMP includes: The reason for high need/high cost; contact information for the entire clinical team including the PCP, specialists, BH providers, case managers and stakeholders, recommended clinical interventions, results from the CSPMP database, strategies for successful transitions, discharge planning and coordination of care gaps; delineation of responsibilities for involved providers for monitoring referrals and follow-up specialty care, monitoring of health metrics such as BMI, HbA1c, viral load, a schedule for routine health care services, prevention, EPSDT, disease management and

health promotion activities, strategies such as health coaching and wellness to facilitate behavior change and foster member self-management, a list of the last 90 days of medication fills, inpatient hospital and ED visit dates and diagnoses.

We will monitor all members receiving care management services on an ongoing basis for changes in their plan goals, risk factors or identified needs. Clinical rounds by the care management physician leader, PCLs and ICMs occur at least monthly to review care and update the clinical interventions or treatments. Members will be transitioned from the Top Tier Care Management Program to less intensive care coordination when their goals have been achieved, when they no longer have active, uncontrolled behavioral or chronic disease symptoms, or when they show demonstrated improvement in overall health and self-management outcomes.

Integrated Care Management. The Population Health and Health Intervention Programs Division will expand, develop and manage many of the health intervention programs important for member care coordination for these new contract populations. Building on the successes of Health Choice Integrated Care (HCIC), Health Choice will continue to address health status disparities through oversight of crisis, adult and child clinical services, trauma-informed care, supported housing, justice programs, cultural competency, prevention, tribal services and consultation, peer and family involvement, supported employment, court-ordered evaluation or treatment, jails, DES/DDD, DCS, Department of Education and local education authorities, veterans, Arizona Early Intervention Program (AzEIP), outreach, health plans, RBHAs, American Indian Health Medical Homes, Targeted Investments, training and grants administration.

Real Life Success Story –

"Peg says that she is doing good and wanted to thank you for caring about her."

Email from a family member. Peg had total medical cost of over $500,000 in the previous year. Following intensive care management, she has stayed out of the hospital for the last seven months.

Protocols. Health Choice requires coordination of care to occur both at the system level and the provider level to best address members' needs, goals and functional status. Health Choice ICMs and provider clinical staff work together to coordinate care with PCPs, specialists, health plans, AzEIP, DES/DDD, tribal nations, justice and law enforcement, peer and family run organizations, stakeholders, DCS and other child-serving organizations. Care coordination and collaboration ensures:

- Early identification of health risk factors and special health care needs;
- Coordination of covered services with community and social services;
- Timely and confidential communication of clinical information between providers on progress, services, labs, medications and member needs;
- Monitoring member health status and implementation/revision of service plans;
- Participation in transitions and discharge planning from hospitals, jails or other institutions to ensure timely services post-discharge, member engagement and avoidance of gaps in care;
- Referral management for providers, services and community resources; and
- Outreach and engagement of members who would benefit from services.

Monitoring. Health Choice's Quality Management Department monitors care coordination through retrospective case file review, peer review, grievances, quality of care concerns and provider audits. Our pharmacy team will monitor providers' and members' controlled substances utilization for aberrant prescribing patterns. Performance improvement processes will occurs when providers do not meet minimum performance standards. For example, HCIC monitors coordination of care of BH providers with primary care providers. In 2017 for all populations, care was coordinated by the BH provider with the PCP at least annually 91 percent of the time, and BH staff engaged other stakeholders, as appropriate, in the members' treatment planning 99.2 percent.

Tools. For all members, even those not in Top Tier Care Management, Health Choice has a comprehensive set of provider tools, which assist providers with individual member information and population

health management. Providers utilize the information for outreach campaigns or closing gaps in care. Health Choice Physician Toolkits and Performance Report Cards educate PCPs on CMS, HEDIS, AHCCCS and Health Choice metrics and performance measures. The Toolkit outlines other measures that affect provider performance, such as immunizations and member satisfaction. We generate the Member Registry Gap Report using our claims-based, attributed member registry with member detail, provider assignment, last office visit, member contact information, and gaps in care to close in the measurement year. We will make additional pain management tools available for providers to enhance referral to Centers of Excellence, monitor patient alerts, access care pathways, conduct risk informed surgical evaluations, invite patients to technology-enabled pain management program, and view reports comparing prescribing behaviors.

Our Health Choice provider portal also decreases administrative burden by assisting providers in easily obtaining critical member care information, submitting or checking on the status of prior authorizations, denials and claims, or uploading clinical records for claim reviews, or receiving patient alerts related to opioid risk factors. Health Homes will be able to use the portal to track member stays in "out-of-home" facilities. Providers participating in Health Choice Integrated ACO and Integrated Health Homes will also have access to care management plans and authorizations in CareRadius® with the implementation of a system upgrade in 2018.

Experience And Outcomes. Health Choice builds on our history of delivering evidence-based care management programs. Health Choice will continue to adapt and design new programs to address member needs in all quadrants based on member data throughout our participation in the AHCCCS Complete Care program. As the incumbent integrated RBHA for individuals living with SMI in Northern Arizona, Health Choice has demonstrated strong results for many populations, including for high need/high cost members in care management. These result include decreasing ED visits by 27 percent, decreasing inpatient admissions by 65 percent and decreasing total costs by 21 percent. Based on an analysis of current HCA members using similar high need/high cost criteria as currently used by HCIC for members living with SMI), Health Choice is confident that similarly significant results will be achieved through our established identification, methodology, ICM protocols, joint operating protocols, provider contracts, provider relationships and monitoring. Our care management and care coordination activities will give members a better health care experience, improve the health of our population and bend the cost-curve while improving quality. Some examples of protocols we will use include:

Results: Members in HCIC's Top Tier Integrated Care Management Program for 12 months:

- ED visits decreased 27%
- Inpatient admissions decreased 64.9%
- Total costs decreased 21% *(excluding pharmacy)*

Inpatient Discharge Calls**.** Within three days of discharge notification, our Healthcare Buddies call members to check on their well-being, ensure follow-up appointments have been set and medications filled, answer questions and ask about satisfaction with the hospital. Members who received post hospitalization Healthcare Buddy calls had readmission rates within 30 days that were approximately two times lower than those who could not be reached.

ED Utilization**.** An ICM develops a ICMP which identifies PH, BH, and SDOH factors to address possible causes for ED use for members with four or more ED visits in a six month period. Real-time ED alerts from Health Current are sent directly to the ICM for immediate outreach.

Readmissions**.** Health Choice's Transition of Care program uses ICMs to conduct outreach to hospitalized members, collaborate with discharge planners and follow members 30 days post-discharge. High volume Maricopa County hospitals have on-site ICMs, and all Mohave County and Phoenix hospitals have ICMs who outreach and care manage telephonically. Readmission rates average 3-4 percent less for involved hospitals.

Disease Management**.** For members with high need/high cost conditions, the ICM develops a ICMP. The member receives a disease-specific Health Promotion Care Plan Letter, which is also sent to the PCP and HH case manager, with self-management information, strategies for wellness, preventive care and local resources. All members with the lower risk/cost conditions, like high cholesterol, hypertension and unhealthy weight, receive disease-specific Health Promotion Care Plan Letters too.

Suicide prevention**.** Health Choice developed a research-based protocol with best practice interventions for members with high risk or multiple suicide attempts. The ICM develops a ICMP and conducts monthly staffings with the BH provider for one year post index attempt. In the past two years, for adult and child members on the protocol, 99 percent are still alive and only had 27 subsequent attempts (13.4 percent).

Benzodiazepine and Opioid Warning Signs (BOWS) Prevention Protocol**.** Based on the Centers for Disease Control's Chronic Pain Guidelines and other best practices, this protocol has different procedures for PCPs, Health Homes and Health Choice ICMs. The ICM develops a ICMP to immediately resolve risk. For members with an ICM, providers follow BOWS protocol 95 percent of the time resulting in members receiving improved, coordinated and safer care.

Use Of Technology And Social Media. In addition to Facebook, Linkedin and Twitter, Health Choice uses multiple technology strategies to increase member engagement. Health Choice's unique geographic service area led us to pioneer a telepsychiatry network to increase member access to BH services. Health Choice serves as a telemedicine training site for providers throughout the country and has helped draft national and AHCCCS standards and best practices for this service delivery technology. Today, Health Choice is a national leader with an award-winning telemedicine program that provides members in remote areas with access to psychiatrists, peer support and American Sign Language interpreters. With more than 236,000 patient telepsychiatry appointments since its inception, our telemedicine network includes 80 provider sites in Arizona and other states. In addition, Health Choice will be adding a new teledoc program with on-demand mobile application-enabled care will decrease avoidable utilization of hospital and ED visits.

High need/high cost members in pain and on opioids will be connected to a personalized mobile phone application. The Empower App from axialHealthcare provides educational resources on pain conditions, medications, and the benefits of specific care and lifestyle choices. The Empower App encourages members to engage in their own pain management and take an active role by completing surveys, reading articles, and watching videos that enable self-management with better understanding of pain and pain treatment.

Our online member portal is optimized for mobile use, and is available to all members. The portal promotes and encourages self-management through general and member-specific information and links to providers, community resources and secure messaging to Health Choice. Members can find a doctor, request a PCP change, update contact/dependent information, access the member handbook, complete their HRAs, print an identification card, receive newsletters, and more. Members can see their personal history of preventive services and gaps in care, track test results against goals, get tips on healthy lifestyle and contact their ICM. In addition to links to 2-1-1 resources, our member portal will be updated in summer 2018 to adopt a new proprietary program initiated by Steward's Massachusetts Medicaid program to connect members to community resources based on the members' SDOH needs. Results are shared with the ICM and member services electronically through CareRadius®. ICMs can use this information for care planning and member services can be informed about evolving community resources when members contact us. We track will member portal and Empower App outcomes to measure effectiveness of the program and member engagement.

For members without a phone, Health Choice promotes a subsidized (free to members) cell phone through SafeLink Health Solutions, a federal program for those on Medicaid, SSI, food stamps, Section 8 housing or with a veterans benefit. Availability of these phone is regularly promotes through our member newsletters, our website, and disease management letters sent to members by direct mail. Health Choice also uses CareMessage™, a secure cloud-based proprietary program that is an interactive and automated text and voice messaging application for engaging members and measuring member satisfaction. Health Choice messages members in each quadrant of the FQM to receive preventive and condition-specific information such as flu shots, prenatal care, staying cool during hot weather, and EPSDT.

Conclusion. Health Choice's existing population health programs are well-established and scalable based on enrollment. Health Choice has had a long standing presence in Arizona, and has vast knowledge of the needs of this population. Our rural and tribal experience is valuable as these are some of the most difficult service areas with limited resources. Our experience allows us to be nimble in developing new programs that are responsive to our population, so that no one will have to say "…if I only knew."

Narrative Submission 5

This member's situation is not uncommon for people with complex social circumstances, particularly when combined with chronic medical and behavioral health conditions. Complete care systems, like Steward Health Choice Arizona's (Health Choice) model, can provide needed care and support, decrease immediate suffering this woman experiences and improve her chances for achieving a healthy lifestyle and effective self-management of her physical and behavioral health. Based on our experience as an Integrated Regional Behavioral Health Authority (RBHA) for people living with Serious Mental Illness (SMI), we have developed the network, programs, and systems to achieve optimal outcomes for members based on the members' needs, preferences and culture.

This scenario raises challenges with transitions between levels of care, as well as between health plans. Our short-term focus will be on how we can assist the member as she transitions out of the emergency setting and into appropriate outpatient levels of care. Also Health Choice will assist with this member's transition to us as her new health plan, and then possibly to an Integrated RBHA if determined to meet SMI criteria. In addition, she has chronic physical and behavioral health conditions — schizophrenia, brittle diabetes, chronic pain and opioid use disorder — that will have acute exacerbations without comprehensive, immediate follow up. Without a safe place to live and loved ones to support her, she is at high risk for long-term complications from her disorders including unintended overdoses, diabetic ketoacidosis, psychosis, traumatic victimization in her vulnerable status, incarceration from her substance use and premature death.

Identification Prior to October 1, 2018. As part of our implementation transition plan, after receiving our list of anticipated members from AHCCCS in the summer of 2018, Health Choice will utilize a variety of data sources to identify members with special health care needs. All available data will be run through our Johns Hopkins ACG™ predictive analytics tools. Members who are identified with special health care needs, or other criteria, will receive outreach from Health Choice prior to go-live. This outreach will inform members of the transition, assist with any medication, appointment, or transportation transitions, and address any concerns. Based on the history of the member described, we would have attempted outreach prior to October 1st. As such, when we were notified of her emergency department (ED) stay, we may already have a record of her history and have developed transitional care.

Part of our analysis and outreach to members prior to October 1st will be to confirm that members are enrolled in appropriate services. We will determine if members need referrals to programs such as the Arizona Long Term Care System or for an SMI determination. For the member in this scenario, prior to October 1st, we would have identified that her schizophrenia may qualify her as meeting SMI criteria and reached out to her provider to begin the SMI determination process.

Transition Out of Emergency Department. While the scenario indicates that discharge planning began after the member had been in the ED for three days, based on our history of success in this area, this is an unlikely scenario. Health Choice employs several strategies for early identification of ED admissions such as direct information from EDs, Health Current alerts, notification from our providers or notification from Crisis Response Network (CRN) based on a crisis response. Due to a variety of alerts, Health Choice has the ability to react quickly and prevent extended ED stays.

> ***Results:***
> *Health Choice had zero adults who were in an ED waiting longer than 24 hours for inpatient BH treatment in 2016***.**

The scenario also says the member is stable for release from the ED, however, this member is at high risk for an opioid overdose and needs to be considered for medication assisted treatment (MAT) for opioid use disorder (OUD). Health Choice follows AHCCCS' Strategic Plan and the Arizona Department of Health Services Opioid Action Plan to reduce the prevalence of misuse and abuse, opioid use disorders and opioid-related deaths. If she is in an ED that is part of the AHCCCS Opioid State Targeted Response Emergency Department buprenorphine program, Health Choice would support her starting buprenorphine or receiving an injection of Vivitrol in the ED, if she chose, in order to decrease her risk of relapse. However, based on her history and current presentation, the ED physician and the Health Home's on-call behavioral health medical provider may

decide that MAT induction would best be done at a behavioral health inpatient or sub-acute facility, a crisis stabilization unit or chemical dependency (CD) residential facility.

Transition to Inpatient Psychiatric Facility. Our goal is to get the member to the most appropriate level of care without needless delays in the ED. Health Choice has an established statewide network of inpatient hospitals, sub-acute facilities, observation/stabilization units and CD residential services in order to provide accessible and available inpatient/residential treatment. With her agreement, this member would be transferred to the nearest facility with transportation provided by and/or arranged by the Health Home and mobile crisis team, assisted as needed by Health Choice. While inpatient, Health Choice's Medical Management unit will complete an inpatient concurrent review, and will be involved in her discharge planning ensuring that she is assessed for CD residential services and for MAT, a Health Choice adopted Substance Abuse and Mental Health Services Administration (SAMHSA) best practice, to include Vivitrol, buprenorphine or methadone. She would be able to start MAT in the inpatient facility and then be followed by Health Choice's established network of buprenorphine prescribers at all health homes, including a telemedicine buprenorphine prescriber program for some rural areas that may have access limitations. MAT is also available in our CD residential treatment facilities. Starting October 1, 2018, Health Choice will have primary care providers (PCPs) who can deliver MAT.

Transition to CD residential services. Health Choice providers are required to use the American Society of Addiction Medicine (ASAM) criteria for all members who use substances. The ASAM tool evaluates a member to create a holistic, biopsychosocial assessment for service planning and treatment on six dimensions. This member meets all six ASAM dimensions for inpatient care first, followed by CD residential treatment center (RTC) because of her IV heroin use and opioid use disorder which puts her at risk for withdrawal, her brittle diabetes which is hard to manage without access to medications, supplies, and healthy food, her chronic pain as a driver of opioid use; her thought disorder which might make it hard to understand the need for ongoing care and increase her social isolation, her high risk of relapse, and her lack of support and housing.

In order to address higher readmission rates and ED visits for members with comorbid physical, behavioral and substance use disorders, Health Choice Medical Management encourages inpatient facilities to have members remain at the inpatient level of care until a CD RTC bed has been secured when necessary. Health Choice has gender-specific CD residential services and all facilities have a trauma-informed perspective. Length of stay is not fixed, but will be based on her needs and preferences. CD RTCs do not require Health Choice prior authorization and can be secured directly by providers with assistance as needed from Health Choice.

Transition to Outpatient Providers. Like all new members transferring to Health Choice, we will allow her to continue seeing her previous providers and specialists if she is in an active course of treatment for the duration of her treatment or up to six months, whichever occurs first, even if they are not in our Health Choice network. Since she already has an established PCP, she can receive services through her PCP for up to 90 days even if her PCP is not contracted with Health Choice. To support this member, we will also reach out to the PCP and evaluate establishing a contract so this member can keep her PCP relationship beyond the transition period.

This woman will also benefit from Health Choice assigning her to a fully Integrated Health Home that has onsite behavioral and physical health care with a unified medical record and treatment plan so all of her behavioral health and physical health needs can be comprehensively addressed to her satisfaction. AxialHealthcare, our specialized opioid use disorder care solution program, with their Centers of Pain Excellence and Centers of Recovery Excellence, will identify a high quality Substance Use Disorder practitioner in her area so that her transition of care to an in network provider will be uninterrupted.

This member will be assigned a behavioral health professional (BHP) at her Integrated Health Home (if assigned) who would be responsible for engaging her and developing a person-centered treatment plan to increase personal self-determination and independence, and choose her treatment options. She will be able to choose who participates on her clinical team including family and natural supports. While the clinical team is responsible for identifying and securing her service needs through the assessment and service planning processes, her recovery is personal, self-directed and individualized.

Because the scenario indicates that she is lacking in natural supports, she will likely benefit from a Peer or Peer Recovery Support Specialist. Health Choice has numerous credentialed peer support options: she can receive peer support from a peer-run organization or from peers working at the Health Homes. Peer support

providers share the same mission as Health Choice to place the member's whole-health needs as a focal point of care. She would also be offered Health Choice's Stanford Chronic Disease Self-Management Programs, which are six week covered health promotion programs which are evidence based and proven to reduce ED utilization and improve health outcomes. They are led by peers trained by Health Choice as a Stanford licensee. She could choose from Chronic Conditions, Pain Management and/or Diabetes Self-Management.

Stanford Self-Management Program
Peers: Health Choice has trained 95 Peer Support Specialists to teach.
Awards: HCIC won the Health Innovation Award from Empowerment Systems in 2014 and again in 2017.
Outcomes: 17% of participants had improved confidence that pain wouldn't interfere with activities. 15% felt less distressed by chronic illness.

She cannot achieve good health if homeless, hungry or isolated. Therefore, Health Choice requires that her assessments and service plans include goals and interventions to achieve stable housing, vocational and educational support, good nutrition, social outlets and quality member care.

This member may also benefit from an Assertive Community Treatment (ACT) team. ACT teams are a SAMHSA evidence based practice that uses a team approach to deliver flexible, unlimited and comprehensive care. The ACT team could assist the member with attending her PCP and pain management visits, housing issues, applying for benefits, medication adherence and transportation. The ACT team's services would be delivered within her home or a community setting. The ACT team's goal is to make sure that she has a life that is not dominated by illness. These dedicated teams consist of a case manager, peer supports, employment specialist, psychiatrist, recovery support specialist, registered nurse, substance abuse specialist, and a counselor. Even if she did not wish to be assigned to an ACT team, her Interdisciplinary Care Team will develop longer term goals with her to improve her health outcomes and will monitor her progress and receipt of services, including addressing her diabetes and peripheral neuropathy.

Transition to Health Choice. Because she is in need of both behavioral health and physical health, she will be assigned to an Integrated Care Manager (ICM) who is a nurse with behavioral health experience to oversee her care. This will be especially important during the first six months after her transition to Health Choice so that she does not get lost as she transitions between levels of care and providers. The ICM will reach out to the previous health plan and obtain information and records about her prior treatment, if not already received as part of the contract change.

Using the Health Risk Assessment completed at the Integrated Health Home intake and other assessments from the ED, providers and the Arizona Health Current, the ICM will complete an Integrated Care Management Plan (ICMP) which will be shared with all of her providers. The ICMP includes all provider contact information (PCP, health home behavioral health medical practitioner (BHMP), pain management specialist, clinical liaison, MAT provider, housing, ICM, etc.), overarching goals and "Care Alerts" which identify immediate needs for health, preventive services, high risk areas such as her opioid use and Morphine Equivalent Daily Dosage (MEDD) score, medication fills and gaps in care, and her prior hospitalizations and ED visits.

Health Choice 2017 Case File Review Audit:

- 88 percent of service plans include meaningful activities and educational/ vocational goals.
- 85 percent of assessments had an ASAM when indicated.
- 100 percent of service plans included therapy for both co-occurring BH and SUD issues.
- 70 percent of the BHMPs checked the CSPMP when initiating a controlled substance, annually, or when member is known to be in pain management or on a controlled substance prescribed by another prescriber.

For example, the ICM would recommend that she receive a Narcan prescription, an opioid overdose rescue medication, which all of our health homes have as a value based measure for members on opioids. Based on her antipsychotic medication fill history, the ICM will recommend a long-acting injectable antipsychotic. The ICM will also recommend a mammogram given her age, and a flu shot.

Based on her diabetes history, she may benefit from an insulin pump or diabetes education. The ICM would also recommend that her case manager or peer support specialist help her apply for a SafeLink cell phone that she can use for emergencies, contacting the Health Choice 24 Hour Nurse Advice Line or Crisis Line, for targeted texts from Health Choice about her diabetes as part of our diabetes disease management program, and for ongoing contact with supports and autonomy. Health Choice partners with SafeLink and promotes this excellent resource in all of our ICMPs, newsletters, disease management letters and website.

Transition to Housing. Establishing stable housing may be of greatest importance to this member. The ICM would ensure that the clinical team will arrange housing options for her. Health Choice has adopted SAMHSA's "Housing First" Model, which uses housing as a tool for recovery. Housing is a basic human right, not a reward for clinical success, and once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occur faster and are more enduring. We need to make certain the member is situated in safe, affordable housing with wrap-around community services. Health Choice's very successful housing programs have permanent supportive housing to assist members who are homeless, $1,000 move-in-assistance grants, an eviction prevention program, bridge subsidy program vouchers and rapid re-housing funds that can assist her. Our housing programs focus on housing stabilization, reduction in length and episodes of homelessness, connecting to resources in the community to empower and gain independence, reduction of substance abuse, increased basic life skills, increased employability, increased support and stabilization for members leaving incarceration, increased housing stock and variety of housing models. Supportive housing units are owned by entities within Health Choice's provider/housing provider network, including Health Homes and the NARBHA Institute, Health Choice's joint venture partner.

Transition to Pain Management. In this scenario, the cause of the member's PCP refusing to continue her Percocet is multi-factorial but ultimately led to her engaging in high risk behaviors with her heroin use. Some of the reasons may have little to do with the member and more to do with the PCP's comfort level with prescribing opioids to a person who has brittle diabetes and is homeless. Health Choice has been responding to the opioid epidemic in Arizona for many years and has developed a robust response with excellent outcomes from which she will benefit:

ISSUE/GOAL	Health Choice SOLUTION	OUTCOMES
Unrecognized substance use or misuse in ED, university or PCP office and provision of immediate intervention or referral	SAMHSA SBIRT Grant recipient to implement SBIRT in primary care, emergency departments and university setting. 2012-present	Screened: 47,610 clients Brief Interventions: 3,339 Alcohol Reduced or Eliminated: 55 percent Marijuana Use Reduced or Eliminated: 60 percent
Improve competency of PCPs, pharmacists, pain management specialists and psychiatrists to treat pain	Incentivize UNM Project ECHO Chronic Pain participation through $135,000 community reinvestment grants. 2013- 2016	"Demonopolize" clinical expertise about pain management and OUD usually only available in university or specialty clinics. 17 Participants
Improve member experience and outcomes with best practices for OUD using competitive bid contracting for Coconino, Yavapai and Mohave Counties due to high dose methadone and polypharmacy	Developed Center of Excellence health home for SUD and assigned members with SUD to it (Southwest Behavioral & Health) for MAT, intensive outpatient, residential care, subacute facility, telemedicine, peer support. 2012	Prior to implementation, 22 percent of members were on >200mg methadone per day and the average was 150mg/day. Current average methadone dose is now 72mg
Align pain management criteria, network and best practices	HC Pain Management Committee with HC Medical Directors, pharmacists, community pain management specialists and MDs. December, 2015 - present	Adopted CDC Chronic Pain Guidelines, revised pain management authorization criteria, implemented limited quantities for opioids, required

		evidence of CSPMP and coordination of care by pain docs and PCPs with BHMPs on opioid prior authorizations
Align providers and psychiatrists with best practices and protocols through value based programs to improve outcomes for members with SUD and/or in opioid replacement services	VBP measures: Narcan Rx, engagement after ED visit, follow up after hospital admission, readmits, annual PCP visits for members on MAT, e-prescribing, total cost of care.	Participating: 6 health homes, 1 FQHC Required use of the CSPMP by all BHMPs. January, 2016.
Improve coordination for members for high MEDD Score ≥90 and/or a DEDD Score ≥30	Assigned ICM to care manage and develop an ICMP addressing risks and suggested interventions. We will also utilize axialHealthcare Pain Care Management Program for self-management of pain tools and education	In 2017, 198 members in care management for high MEDD/DEDD
Prevent unintentional/ intentional overdoses by immediately addressing benzodiazepines or opioids warning signs ("BOWS") Exampled of BOWS—nodding off, slurred speech, confusion, calls from family/stakeholders, falls, ED visits, overdoses, early refills, etc.	Required Incident/Accident/Death (IAD) reporting for incidents of "warning signs" [NEW Indication] for surveillance of members with high risk and for quality oversight of providers. January, 2017 Members assigned to intensive care management using "BOWS" Prevention Protocols (PCP, health home, internal). May, 2017	IADs: over 70 received; 50 assigned to care management After six months of active care management: MEDD average decrease: 21.2 mg per day. DEDD average decrease: 3.9 mg per day. No deaths or overdoses.

Transition to an Integrated RBHA. This member has a diagnosis of schizophrenia, although she apparently has not been determined SMI. A critical component of the service delivery system is the effective and efficient identification of persons who have special health care needs due to the severity of their behavioral health disorder and the possible need for Special Assistance. To ensure that persons living with SMI are promptly identified and enrolled for services, over the last 25 years Health Choice has developed a standardized process for the referral, evaluation, and determination for SMI eligibility. To make sure that members with psychotic diagnoses, like this member with Schizophrenia, don't fall through the cracks, we will send out bi-annually a registry of members with psychotic disorders for providers to complete additional clinical review and oversight. The final determination is completed by the state's contractor, Crisis Response Network. Members determined to be SMI are transferred to the integrated RBHA in the member's service area. If this member lives in Northern Arizona, she will not experience a change in her provider network or Integrated Care Management team since Health Choice is the RBHA. If she lives outside of Northern Arizona, we would work closely with the RBHA in the service area to transition the member.

Conclusion. Health Choice serves homeless and other high needs individuals using innovative, integrated, and collaborative approaches. We will quickly find housing for this member, leveraging our strong relationships and resources in the community and then provide the member with care management services while facilitating transition to new providers or a RBHA. In many respects, this individual represents the type of member who can benefit most from our Integrated Care Management program. The combination of staff supports, community relationships, technology, innovation and expertise will improve this member's outcomes, and the outcomes for all members facing similar challenges.

Incarceration of people with serious medical and behavioral health illnesses, such as is the case in this scenario, can result in compromised care and exacerbate poor outcomes. The results can in turn lead to unnecessary stress and trauma for both members and their families, and also significantly increases cost to the justice and health care systems. Steward Health Choice Arizona's (Health Choice) model of care is uniquely suited to ensure that the health of this young woman and her baby is supported by a full continuum of coordinated services that address her social, physical, and behavioral health needs during this particularly vulnerable time. She has multiple problems which are complex, overwhelming and possibly frightening to her. Our providers and Obstetric Integrated Care Managers (OB ICMs) will ensure a comprehensive and coordinated assessment and service plan to address her depression and substance use, adherence to the terms of release from jail, successful transition to adulthood and motherhood, connection with natural and community supports, completion of her educational and vocational goals, and prevention of substance use relapse. Our complex care management program will ensure that she obtains needed high risk prenatal care with good perinatal outcomes, specialty care for her sickle cell anemia, family planning services, participation in EPSDT, pain management, and avoidance of neonatal abstinence syndrome while achieving pain control.

Comprehensive Health Assessment. This young woman, who was in jail for three months, has five conditions that require immediate assessment and ongoing care — pregnancy, sickle cell anemia, episodic pain, depression, and substance use. We will ensure that she receives a thorough evaluation and screen her for any additional needs not mentioned. Informed by her evaluation, we will establish a comprehensive service plan that is culturally reflective of her preferences and needs, as well as trauma-informed, given the high likelihood that her conditions have worsened while in jail and have impacted her ability to function. This puts her at risk for relapse, being unable to complete her legal obligations, and limiting her ability to obtain the care she needs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that for youth in the juvenile justice system, like this young woman, 50 to 70 percent met criteria for a mental disorder and 60 percent met criteria for a substance use disorder. Of those youth with co-occurring mental and substance use issues, almost 30 percent experienced severe disorders that impaired their ability to function. Per SAMHSA, once in jail, many individuals don't receive the treatment they need and end up deteriorating. They also are in jail longer than their counterparts without mental illness, are at risk of victimization or exploitation, and often their mental health conditions worsen.

Recognizing that the period following release from jail is critical for her success, Health Choice promotes direct linkages between the member and her service providers through our Justice System Transitions program. Her assigned Health Home will schedule an initial outpatient appointment, which must occur as early as possible but at a maximum within seven days to prevent decompensation. Health Choice requires that a comprehensive behavioral health assessment includes standardized screening tools like the PHQ9 for depression, a GAD7 for anxiety, the Adverse Childhood Experiences Scale (ACES) for trauma, level of care determinations including American Society of Addiction Medicine (ASAM) for substance use treatment, seriously mentally ill (SMI) evaluation (if indicated), a Health Risk Assessment (HRA) and overall care planning. Her need for and coordination of care related to her OB care, sickle cell anemia, and pain management is part of her comprehensive assessment.

Health Choice's programs are also trauma-informed. She may also have a history of trauma that is affecting her and may impact her overall health and response to healthcare. Per the Health & Medicine Policy Research Group's Justice Brief — Juvenile and Criminal Justice Systems, the prevalence of trauma histories of those involved in the juvenile and criminal justice systems is high: Childhood abuse or neglect raises the chance of juvenile arrest by 59 percent, and the likelihood of non-violent and violent criminal behavior in adulthood increases by 28 percent and 30 percent respectively, 77-90 percent of incarcerated women have extensive histories of emotional, physical and sexual abuse, approximately 90 percent of juvenile detainees reported having experienced at least one traumatic event and 75 percent reported having been exposed to severe victimization, compared to youth in the general population, juvenile-justice involved youth have roughly three times more adverse childhood experiences.

One of the highest risk times for opioid overdoses and death is post-release from jail due to decreased tolerance to opioids. This young woman would benefit from an immediate assessment for Medication Assisted Treatment (MAT), like buprenorphine or methadone, to determine if MAT is appropriate now while she is pregnant or immediately post-delivery in order to improve the likelihood of a healthy birth outcome. All of Health Choice's Health Homes have buprenorphine-certified providers on staff. In addition, we have telemedicine buprenorphine providers and a specialty substance abuse health home in Maricopa, Yavapai, Coconino and Mohave counties and would expand as appropriate to align with our contract award. Additionally, Health Choice has contracted with addiction treatment centers such as Clean Slate.

Following the SAMHSA Guideline for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison, part of her assessment will be to determine what behaviors triggered the original arrest. The assessment will also explore the criminogenic dynamic and static risk factors that affect her risk for recidivism and that may influence the intensity of services and which can be a focus of treatment, such as antisocial attitudes, values, and beliefs, low self-control or impulsivity, association with criminal peers, substance abuse, or an unsupportive family.

Service Planning and Services. In partnership with this young woman, the Health Home's assigned clinician will convene a clinical team of this woman's choosing to assist her with developing a service plan based on the comprehensive assessment, the AHCCCS Transition to Adulthood Practice Tool, and the AHCCCS Support and Rehabilitation Services for Children, Adolescents and Young Adults Practice Tool. Her individualized service plan will help her access and schedule necessary services, including her OB care, depression management, pain management, MAT if needed, substance use treatment, and services to meet her educational and vocational goals. In addition, with her approval, family members, her probation officer, agency representatives and other involved parties as applicable, are invited to participate in the development of the service plan. The service plan must actively consider information and recommendations contained in her probation case plan, if she has one. Should re-incarceration occur, her clinical team will outreach to re-engage her in services and maintain care coordination and continuously work with her to reduce re-incarceration.

Peer Support. In order to assist her with the many details, appointments, accountability and transition to the community, and in addition to a case manager, Health Choice has developed and funded a number of different options for peer support where she is paired with a trained peer who has lived experience with similar struggles and who can provide hope, resources and support. These options include:

- Forensic peer supports (FPS): She can participate in forensic peer support through a Health Choice Peer and Family Run Organization (PFRO), such as Hope Lives, which is also available through telemedicine. Her FPS can attend Mental Health/Drug Court with her, organize transportation and accompany her to appointments with her probation officer, attorney or other stakeholders. The FPS can provide assistance in dealing with everyday problems, such as organizing appointments and providing support in coping with stresses from her legal situation;
- Peer-led Stanford Chronic Pain Self-Management Program: She could be offered this highly effective, six week, evidence-based program led by Health Choice trained peers on how to manage and live with chronic pain;
- Recovery peer support for substance use disorders: She may want to receive peer support for her substance use. This is available through PFROs and from her Health Home;
- Transition to Adulthood peer/family support: As a young person between the ages of 16-25 years old, she has special needs for learning about healthy family and romantic relationships, finding and accessing community resources, budgeting, doing taxes, renting and knowing housing rights, safe use of social media. Health Choice promotes using patience and positive behavioral support to help youth gradually transition to adulthood rather than removing supports in order to let them "experience what it is like to be an adult."

Supported Living Services. Given the complexity of her needs, we would recommend that this woman's clinical team consider referring her to Health Choice's Supported Living Services for Young Adults 18-25 years

old. Young adults have a combination of unique needs as they transition into adulthood. This is particularly true when they jointly include the areas of mental health, substance abuse, legal involvement, pregnancy, and housing. The transition stage is even more difficult for youth, like this young woman, who are coming from institutional settings where they have not had significant experiences with autonomy or independent living opportunities prior to becoming an adult. Health Choice believes our communities in Arizona have the resources and supports to help these young adults be successful, but they need assistance from their informal support system as well as from caring professionals that can help them complete this transition to adulthood successfully. This is the purpose of young adult supported living program.

While transition age youth can benefit from our focused outpatient programs available at all of our health homes, the combination of easily-accessible, individualized behavioral health support services and the opportunity to live in a subsidized housing setting provide an improved chance for success for her and her baby. The Supported Living Program for 18-25 year olds (for example, Emerald House in Flagstaff) is based on the philosophy that the best way for individuals to gain independent living skills, like a driver's license, completing school or getting a job, is to help them become active in the community and participate in hands-on activities based on an individualized development plan. Through this program, direct support staff will also partner closely with her to ensure she is attending prenatal care appointments and help her obtain her GED or finish high school. As she transitions to adulthood, it will also be important to help her connect to her family in a healthy manner to improve social support and receive assistance with raising her baby if she chooses, or support her if she chooses adoption. However, even post-delivery she will be able to live at Emerald House with (or without) her baby and work towards independence.

Access to Technology. Another important part of transitioning to adulthood is having a mobile phone to schedule appointments, remain in contact with service providers, legal representatives and family, contact Health Choice's twenty four hour behavioral health crisis line and twenty four hour nurse advice line for questions or concerns about emergency care needs or medical questions, receive appointment reminders and OB/EPSDT text messages from Health Choice care managers, and participate in telemedicine or Health Choice's mobile member applications. Health Choice works with SafeLink to give qualifying members, like this young woman, a free mobile phone with unlimited text messages and 350 monthly minutes. Calls or texts to or from Health Choice are no cost to the member, and do not use minutes.

Health Choice Justice Reach-In Program. Health Choice has already developed Memoranda of Understanding with most counties, jails, and the Department of Corrections to notify Health Choice when a member is incarcerated and when an individual with behavioral health needs is being released. While this question does not indicate that Health Choice was notified prior to her release, through the established Health Choice Justice Reach-In Program (a joint protocol for collaboration and services with all of the jails and prisons in our service area), she meets the criteria for reach-in care coordination (high risk chronic need—pregnancy, sickle cell anemia and substance use). The Health Choice Jail Liaison would have initiated outreach to the member and developed an individualized Justice Involved Risk Identification Plan (JIRP) similar to a HRA and would have notified the member's Health Home of the need to complete reach-in care coordination and begin services immediately if she agreed.

Health Choice Integrated Care Management. Because this young woman will need multiple specialty providers and focused, time-sensitive care, the real foundation of achieving good outcomes is Health Choice's integrated care management program, which will focus on both her acute and chronic needs ensuring that her care is coordinated across multiple providers and addresses both her physical and behavioral health needs, as well as those of her baby. As a result, we would also assign a Health Choice high risk OB ICM who is a nurse with expertise in high risk OB, neonatal abstinence risk, depression and special health care needs in order to assist all of her providers through identification of risks and needs, care management and care coordination.

Risk Assessment. The OB ICM will conduct a Maternal Risk Assessment using a tool from the American Congress of Obstetricians and Gynecologists to ensure all pertinent medical history, past treatments, past pregnancies and current psychosocial concerns are gathered for care planning purposes. The tool stratifies members into high, moderate, and low risk categories. This young woman has a very high risk pregnancy and we will need to make sure she is engaged (and stays engaged) in care. Her sickle cell anemia puts her at high risk for

renal failure, stroke, preeclampsia, eclampsia, sepsis and even death. The national maternal mortality rate for moms with sickle cell anemia is ten times higher than those without. 50-70 percent of women with sickle cell of anemia will require at least one hospitalization during pregnancy and 30-40 percent will need a transfusion. Her fetus is also at risk for fetal growth restriction, preterm delivery and stillbirth, and since women with sickle cell anemia cannot take most over the counter pain medications, most fetuses are exposed to opioids. The OB ICM will regularly incorporate updates into her Integrated Care Management Plan (ICMP) which will be shared with all of her providers, including the OB, her pain management specialist, her specialty providers and her assigned health home.

The member in this scenario also has a qualifying diagnosis for Children's Rehabilitation Services (sickle cell anemia), is under 21 years old, and will still need active treatment. As a result, the OB ICM will ensure that Health Choice has received all transition information from her previous health plan if she is transitioning to us October 1, 2018 as a new plan member. The OB ICM will reach out to her previous Multi-Specialty Interdisciplinary Clinic (MSIC) or specialty health care providers for past treatment information and to ensure continuity of care, evaluation, regular monitoring, and treatment.

Integrated Care Management Plan. The OB ICM will develop an ICMP for her providers through a comprehensive review of her demographics data, Electronic Transmission of Information (ETI) transition forms from when she was originally enrolled with us, utilization and authorization history through Milliman's MedInsight analytics platform, Johns Hopkins Adjusted Clinical Groups™ (ACG) System predictive modeling Member Profile, Health Current data, OptumRx pharmacy benefit manager reports (including the morphine equivalent daily dosage and diazepam equivalent daily dosage report), the Arizona Controlled Substance Pharmacy Monitoring Program data of controlled substance fills, any medications filled in the last six months, recent claims for OB care, ED utilization and history of any past medical care.

Health Choice has also developed a Healthy Pregnancy/Healthy Baby Diaper Rewards Program to engage pregnant members in achieving health outcomes. Members will receive diapers and baby wipes for achieving several goals during pregnancy, such as attending prenatal appointments. Health Choice would enroll this member in the Diaper Reward Program to help incentivize her to meet these goals.

In order to help her providers easily coordinate care with all involved providers or stakeholders and target her immediate needs through our "Care Alerts," her ICMP will identify and give the contact information for her Health Choice OB ICM, her PCP, her OB, pain management specialists, specialty providers, the Health Choice behavioral health crisis line, Health Choice 24 hour Nurse Assistance Line, Warmline for Peer Support, non-emergency transportation number, AHCCCS and Health Choice Member Services lines, provider and addictions treatment locater links, Health Choice Pharmacy Help Desk and ADHS Medication Disposal locations. Her ICMP also has "Care Alerts" indicating her last dates of care, whether or not she is already engaged in behavioral health services, the need for perinatal depression screening, OB care, EPSDT services like dental care, assessment of MAT and of risk for Neonatal Abstinence Syndrome and pain management. Her ICMP will list her medical diagnoses including those on previous claims such as her pregnancy, sickle cell anemia, as well as her incarceration dates and criminal charges via Public Database. It will include a "Care Protocol" section that has the behavioral health "tasks" needed such as intake, psychiatric evaluation, substance abuse services including MAT assessment, and their completion dates if already completed, and the primary care "tasks" such as establishing a PCP, member education on using the Nurse Assistance Line, her OB appointments, EPSDT gaps and her prescription fills.

Outreach and Engagement. The Health Choice OB ICM will conduct an outreach to engage her in treatment both directly and with the Health Home team. The OB ICM will ensure that she has a scheduled appointment with her previously established OB or with a new OB provider. Since the member has a number of high risk factors such as, sickle cell anemia diagnosis, behavioral health concerns, psychosocial stressors, legal concerns and history of substance abuse, the OB ICM will make sure that she is offered a Maternal Fetal Medicine OB and health home assignment with a fully integrated Health Home that can act as patient centered medical home and also address her special health care needs. She may also continue to receive services from her previous PCP and MSIC or specialty health care providers if she desires, with behavioral health wrap-around services through her health home.

Her OB ICM will ensure that her PCP and her Maternal Fetal Medicine provider discuss Advance Directives with her in the unfortunate circumstances that she becomes incapacitated and not able to make health care decisions for her or her fetus. The OB ICM will share the Advance Directives with her treatment team and PCP and upload it into CareRadius, our Member Portal and Provider Portal, so that it will be readily available to her and her treatment team. In this way she will be offered comprehensive, continuous medical care and extended access to services with the goal of obtaining maximized health outcomes.

The OB ICM will ensure there is coordination of care between the OB provider and the member's health home clinical team through pregnancy, delivery and six to eight weeks post-delivery or until the member is no longer high risk/high need, and that she completes perinatal and postnatal depression screening and receives information on family planning like long-acting contraceptives and breastfeeding. At that time, if she is still considered high risk/high need, she will be transferred to a non-OB ICM to follow her.

Pain Management and Opioid Use. Expert pain management will be an important component of her overall care. She would be an excellent candidate for Health Choice's new proprietary program partnering with axialHealthcare. This pain management and opioid use disorder (OUD) program includes pain management and OUD Centers of Pain Excellence (COPE) and Centers of Recovery Excellence (CORE). This program consists of certified, high-performing, multi-disciplinary and high quality pain and OUD treating providers selected based on an evaluation of their adherence to evidence based guidelines and ongoing participation in compliance standards. Whether or not she ends up going to a COPE or CORE provider, she will benefit from the Clinical Consult Services available telephonically and in-person to all our network providers for guidance on challenging cases and care coordination. She will be able to use axielHealth's proprietary comprehensive mobile application for pain management via the Empower mobile platform when she is having an exacerbation of her pain. This application provides enhanced support between office visits, educational content on pain treatments and risk of opioids in pregnancy, as well as assessments to identify risk exacerbation. If she needs urgent care or advice while having a pain crisis from her sickle cell anemia or any other condition, she could also access a medical provider 24/7 through our telemedicine program which will be available through her mobile cell phone or computer. Arizona licensed providers can directly evaluate and treat her, coordinate with her OB or PCP, or determine that she needs emergency care. 24-hour immediate access to a medical provider may decrease her risks for illicit opioid use during pregnancy. She can also call our 24/7 Nurse Advice Line or Crisis Line.

Also of concern regarding this member member's situation is the high likelihood that her baby could be born with neonatal abstinence syndrome or opioid exposure. Newborns on AHCCCS represent roughly half (51 percent) of the births in Arizona but 79 percent of the newborns with neonatal abstinence syndrome. Post-delivery, we will refer her to the Substance Exposed Newborn Safe Environment (SENSE) program so that she can receive in-home nursing services for moms and newborns who have been exposed to substances. This program will help her understand and respond to her newborn's developmental needs, monitor her baby for prolonged effects of substance exposure, connect her to community resources and develop good parenting skills so that both she and her baby have the best chance for healthy outcomes. Should she need residential substance abuse treatment, Health Choice has women's only chemical dependency treatment centers and sober living homes which she can attend with her baby.

AHCCCS recently awarded three million dollars to Health Choice to improve access to care and increase medication assisted treatment. Our Health Homes are aligned with Health Choice to increase 24/7 access to care, increase coordination of care with stakeholders and community partners, and increase jail diversion efforts. Ensuring that her providers are aware of her history and risks, the OB ICM will be instrumental in working towards preventing neonatal abstinence syndrome.

Conclusion. Our overall goal is to assist this young woman and her baby in achieving health, wellness and self-reliance/autonomy through advocacy, communication, education, identification of services and resources, and prevention of recidivism. Integrated care management ensures she will gain appropriate access to providers, facilities and other providers in the acute, home and alternative care settings in full collaboration with her identified clinical team, who together will provide necessary, cost effective and timely services to her and her baby's overall health.

Narrative Submission 7

Steward Health Choice Arizona (Health Choice) will improve member engagement, develop and implement best practices, and track and monitor outcomes for the identified populations by leveraging strategies and tools developed by Health Choice Integrated Care (HCIC) and Health Choice Arizona (HCA).

Overview. Health Choice's Chief Medical Officer will be responsible for the overall development of clinical initiatives based on best practices in the design of our delivery system. Each Health Choice clinical division will be physician led and report directly to our Chief Medical Officer in order to ensure program fidelity.

Given our long tenure as an AHCCCS Health Plan and that of our leadership, including our Chief Medical Officer for the past 25 years, Dr. Teresa Bertsch, we have actively and consistently participated in and led many of the state-wide committees and workgroups that developed the state's clinical guidelines, toolkits, clinical programs, policies and formulary. These groups included representatives from AHCCCS, Medical Directors, Clinical Officers, CEOs, and the Arizona Department of Health Services (ADHS), the Department of Economic Security's Division of Developmental Disabilities (DDD), the Department of Child Safety (DCS), members, peers, family members, Health Plans, providers and other stakeholders. In addition, HCIC has worked under mutually agreed upon protocols that are reviewed annually with all of the major stakeholders like DCS, DDD, the Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Juvenile Probation Offices and Adult Probation Departments for over a decade to ensure effective and efficient delivery of behavioral health services. These collaborative protocols define the respective roles and responsibilities of each stakeholder for engaging members, coordinating care and monitoring outcomes.

As we identify new needs of populations or clinical risk groups such as those in Question 7, Health Choice will develop and/or adopt evidence based or peer-reviewed guidelines to assist members and providers in making decision about appropriate, quality, cost effective health care. Guidelines are developed in consultation with our providers, clinicians, pain management specialists, members and peer and family run organizations. Health Choice uses the evidence based guidelines and best practices from the National Guideline Clearinghouse (a public resource for summaries of evidence-based clinical practice guidelines)**,** American Psychiatric Association Clinical Practice Protocols, American Child and Adolescent Psychiatric Practice Parameters, Substance Abuse and Mental Health Services Administration (SAMHSA), and AHCCCS Resources.

All guidelines will be reviewed and adopted prior to implementation by our Continuous Innovations Committee, Quality Management (QM) Committee and the Pharmacy & Therapeutics Committee, which are chaired by Health Choice's Chief Medical Officer, and comprised of multi-disciplinary staff, members and contracted providers. Health Choice will also monitor program fidelity through our medical management and QM committees based on random and focused case file review, site visits and audits.

Our integrated clinical operations will be grounded in the experience of HCIC and HCA, and will be organized into three major components for each population in Question 7: (1) Member and provider focused service delivery, which ensures each member receives the right care, at the right time and place, to include care management and utilization/medical management; (2) Population health and health promotion, which will address broader programmatic needs of specific populations, and best practices; and (3) Quality and utilization management, which will track and monitor outcomes and metrics across all programs, and establish improvement initiatives as appropriate as outlined below.

Justice Involved Populations. Health Choice aims to reduce recidivism, improve health outcomes, and facilitate a seamless transition back to the community for this population. Health Choice is committed to implementing justice reach-in services and coordinating care with jails and prisons using the SAMHSA Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison, and the Sequential Intercept Model for behavioral health and criminal justice collaboration (SAMHSA GAINS Center for Behavioral Health and Justice Transformation). Health Choice uses a person-centered approach to providing transitional services to incarcerated individuals to ensure that each individual is treated with respect consistent with their unique set of personal circumstances. We engage the criminal justice system directly to develop a collaborative approach to identify eligible members and develop procedures and protocols to facilitate member transitions into community based services to support their recovery. We build collaborative relationships with

key community stakeholders including county jails, state and federal prisons, related probation and parole departments, community providers for both physical and behavioral health needs, and community based social determinants of health (SDOH) providers.

Health Choice's Justice Liaison, provider Justice Liaisons and Integrated Care Managers (ICMs) engage members to coordinate access to Medicaid and other state funded services as permitted during the pre and post-release time period from jail, prison and during probation/parole. Health Choice will also continue to rely heavily on peer and family supports to provide assistance, particularly during the immediate transition phase as members leave an institutional setting and re-enter community life. Health Choice uses Hope Lives, a forensic peer run organization, to assist justice involved members with self-help and support which allows for personal growth and better adherence with the terms of their release, and health care to improve the member's long term prospects for continued recovery. Where available, we will prioritize the use of co-located integrated clinics in probation offices established through AHCCCS' Targeted Investment program.

Our assessment and service planning is designed to improve member outcomes and decrease recidivism through member engagement. For example, post release, the member's assigned clinician at the Integrated Health Home (IHH) or Integrated ACO (IACO) is required to complete an assessment which includes the behaviors that triggered the original arrest, and the criminogenic dynamic and static risk factors that can be the focus of treatment. Health Choice monitors that the service plan actively considers information and recommendations from the member's post release justice case plan. Should re-incarceration occur, the clinical team will outreach to re-engage the member in services, maintain care coordination and continuously work with the member to reduce further incarceration. We will assist members in accessing appropriate services in a timely manner such as supported housing, supported employment and other vocational support, psychiatric services, SAMHSA evidence-based practices, and Medication Assisted Treatment (MAT) for opioid use disorder (OUD). For transitioning members with OUD, Health Choice has piloted a program with the Yavapai County jail to administer Vivitrol to qualifying inmates prior to release, which if successful, we will expand to all counties within our service area.

If a justice involved member meets Health Choice's established criteria for integrated intensive care management, the member will be assigned to a Health Choice ICM. The ICM will work with the member's providers, peer and family supports, housing and employment supports, and other SDOH services. The ICM will also develop and distribute a single Integrated Care Management Plan (ICMP) to involved providers and resources, following up with them to ensure that the member actually receives the needed services.

Reach-In care coordination activities begin upon identification or notification of a member's anticipated release date. Health Choice will email a completed Justice Involved Risk Identification Plan, similar to a Health Risk Assessment, which contains demographic and available clinical information to the designated jail liaison at the assigned IHH or IACO, who will confirm receipt of the plan electronically. Within three business days of receiving a Justice Involved Risk Identification Plan, the IHH's designated jail liaison will contact the county jail or the Arizona DOC to initiate a professional visit with the member. In all cases, communication with the member will occur at least seven days prior to release, and will occur either in person, via phone, or via video-conference. Within 48 business hours prior to release, Health Choice will confirm with the IHH's jail liaison that a professional visit has occurred with the member. Health Choice will also support incarcerated members and our criminal justice partners by providing updated ASAMs, intakes, Serious Mental Illness determination evaluations and treatment plans during incarceration and upon a referral from the court system. These assessments serve as tools for the court system to release members into services based upon medically determined levels of care and divert the individuals away from the justice system.

Finally, we will continue to track and monitor outcomes for justice-involved members including post release re-arrests, emergency department (ED) utilization, health care cost, and employment status. Health Choice will also continue our value based incentive for providers who connect members to services within seven days of release through the provider performance model. In 2017, 50 percent of members in the Justice Reach-In program engaged with our Health Homes and received behavioral health services within seven days.

Court Ordered Evaluation and Court Ordered Treatment Populations. Health Choice has developed a full understanding of the complex State statutory and regulatory provisions surrounding both the court ordered

evaluation (COE) and court ordered treatment (COT) systems, through HCIC's experience managing care in both contexts. HCIC administers the COE contract for Coconino County. HCIC monitors and supports the COE processes throughout all other counties in Northern Arizona.

Court Ordered Evaluation. Health Choice recognizes that the COE process usually begins with a crisis response. As such, in Northern Arizona, our contracted crisis providers, IHHs, and inpatient psychiatric facilities are responsible for engaging members in the COE process. Our established registries, available through these contracted providers, facilitate our ability to identify individuals in each county's system. We have also developed ongoing relationships with each county's management to understand the unique components of each county's community behavioral health system. As a result, we have developed customized crisis response protocols for each county that address the needs of the communities, local law enforcement organizations, and other system partners. Health Choice will also continue to assist family members and the community with submitting a pre-petition screening application.

HCIC's experience with Coconino County has afforded us the opportunity to develop best practices for members undergoing the COE process and we will expand these best practices to all awarded counties. We recognize the need for constant and consistent oversight to address process concerns, to review and update long standing protocols and procedures, and to rapidly address any quality of care concerns that arise. The experience we have gained through our role in Coconino County has also taught us ways to help our other county governments. For example, the data gathered in Coconino County served as the basis for comparison when Mohave County asked us to complete a high level cost comparison of their contracted COE evaluation agency and inpatient COE provider in 2016. We have also been able to transfer several improved processes related to court filing and jail services in Coconino County into guidance to assist Gila County. HCIC currently validates each COE petition application, reviews court documents, monitors weekly patient logs, and conducts monthly retroactive reviews of claims for medical necessity and appropriateness of services for Coconino County. HCIC ensures that screening, evaluations and admission days meet statutory requirements, and provides technical assistance to the screening agency as needed or requested. Following best practices, for all counties in our GSA, Health Choice will continue to assist all COE members who are hospitalized with discharge planning. We will also continue to monitor their length of stay and readmission rates.

Court Ordered Treatment. When a person is referred for COT, we assist the court in determining whether the individual is already an AHCCCS member or, if with our assistance, could be enrolled in services. If the individual is not already an AHCCCS member, Health Choice will assist in submitting an application. If the individual is eligible, Health Choice will work with the member's assigned IHH to conduct an evaluation to determine if the person meets the criteria to receive services for individuals living with Serious Mental Illness, and conduct a comprehensive assessment to identify the member's service needs in conjunction with the member's preference, the recommendations of the clinical team, family members, court and other supports.

Additionally, for members pending release from inpatient care, Health Choice will ensure that the members' IHH or IACO arranges a priority appointment with a prescribing practitioner within seven days of the person's release. This best practice ensures stability, medication adherence, and helps prevent re-hospitalization. Additionally, each member typically receives a "safety plan" at this time, which is developed to address actions that need to be taken in the event that the member experiences a behavioral health crisis.

In order to assist with tracking members on COT throughout our system, Health Choice will continue to require all contracted IHHs and IACOs to submit a monthly report for each enrolled member receiving court ordered treatment. Health Choice will complete an Outpatient Commitment Monitoring Quarterly Report, which will synthesize performance on outcomes for this population, including inpatient utilization, emergency department utilization, physical health care cost, and employment status.

Services for High Need/High Cost Populations. Health Choice's model of care is designed to achieve a high degree of physical and behavioral health integration. Our system is designed to ensure that our providers cost-effectively manage care while meeting the needs of our members by aligning incentives between Health Choice and providers through our provider performance and shared risk model.

Our Integrated Care Management Program is informed by SAMHSA's Four Quadrant Model (FQM) for Clinical Integration with separate teams addressing the unique needs of high need/high cost members with

"high behavioral health/high physical health needs" (Quadrant 4), "high behavioral health, low physical health needs" (Quadrant 3), and "high physical health, low behavioral health needs" (Quadrant 2). Health Choice will also employ an additional team specifically for Top Tier High Need/High Cost children and adolescents. We deploy interdisciplinary care teams tailored based on the FQM to outreach to members about health care conditions that require follow-up and to assist members with self-management strategies for care adherence.

Each of our Integrated Care Management teams will be staffed in accordance with industry standard best practices. The teams will be led by an experienced Arizona licensed Physician and each team will also be supported by an Integrated Care Administrator (ICA), who will be an experienced Arizona licensed Registered Nurse or Behavioral Health Professional (BHP) with a Master's degree in Behavioral Health Field and/or current Arizona License in Social Work, Counseling, Marriage and Family Counseling or Substance Abuse Counseling. Finally, each team will include one or more Population Care Leads (PCL) who will identify trends and evidence-based interventions for each population, and a team of Integrated Care Managers (ICMs) who will be responsible for developing ICMPs for each identified member, addressing member's care coordination needs, and assisting with emergency member needs. Both PCLs and ICMs will be either experienced Nurses or BHPs based in Arizona.

All ICMPs include the reason for the member's inclusion in the Top Tier Program, contact information (phone numbers, fax numbers, email addresses) for each provider on the team, the member's service history based upon available claims and Health Information Exchange data, medication fill history, a list of identified care management needs, and a list of recommended preventive and care interventions based on AHCCCS, HEDIS and US Preventive Services Task Force preventative care measures. ICMs will also send letters to members based on disease management protocols about health care conditions that require follow-up and to assist members with self-management strategies for care adherence. Members with chronic diseases receive letters that invite them to sign up for self-management programs that are peer-led by their Health Home.

Health Choice will integrate our current proprietary ICMP tool into our current care management software, CareRadius, as well as into our provider portal so that all providers on a member's care team can access the most up-to-date information on a real time basis. Health Choice's provider portal will also be enhanced to meet the specific needs of IHH and IACO providers to support their performance on quality and total cost of care management for this program. Health Choice monitors the key quality and performance measures that are part of our high need/high cost integrated care management program which are designed to achieve: Reduced hospital admissions, unnecessary ED visits, and crisis services; member education, and member transitions from one level of care to another.

Substance Use Disorder Populations. Health Choice follows AHCCCS' Strategic Plan, ADHS Opioid Action Plan and CDC Chronic Pain Guidelines to reduce the prevalence of misuse and abuse, OUD, and opioid-related deaths. From a care management perspective, Health Choice will again use the SAMHSA Four Quadrant Model to engage members and achieve outcomes. Health Choice will require the use of American Society of Addiction Management's (ASAM) criteria for all member evaluations to help identify the treatment needs of members with SUD. Most high need/high cost members living with SUD will be assigned to ICMs within the Quadrant 3 and 4 teams, with pediatric and adolescent members assigned to the Children's team. Health Choice will leverage the Benzodiazepine and Opioid Warning Signs (BOWS) protocols that HCIC has developed over the past two years for high risk members with SUD.

Health Choice will also continue and expand our practice of assigning members with primary substance use disorder to an IHH Center of Excellence for SUD. Since 2011, we have implemented quality measures to improve prescribing practices based on SAMHSA's MAT with methadone, buprenorphine and Vivitrol to reduce risk to members through our primary Center of Excellence, Southwest Behavioral & Health. We will also continue to utilize the following best practices for substance use treatment, including Seeking Safety, The Matrix, Staying Quit, Thinking for a Change, Living in Balance, Acceptance and Commitment Therapy, and Cognitive Enhancement Therapy.

Health Choice also implemented a Pain Management Committee, chaired by Dr. Bertsch, for all health plans in 2015 to develop standards and strategies for best practices, authorizations, and provider network. In concert with this, Health Choice adopted the CDC Guidelines for Chronic Pain in 2016 and implemented new

provider and internal policies to include required "Incident/Accident/Death" reporting to us for surveillance of members displaying symptoms of aberrant substance use or drug interactions for illicit or prescribed medications so we can provide quality oversight through our BOWS Protocol. We developed and implemented distinct BOWS protocols for primary care providers (PCPs), behavioral health medical practitioners, and internal staff to immediately address and ameliorate the high risk warning signs of an impending overdose or death. Consistent with this, Health Choice will continue utilizing the Pharmacy and Provider Restriction Program to prevent members from obtaining controlled substances from multiple providers. Health Choice has also implemented value based incentives to improve outcomes for members with substance use disorder and/or in MAT through prescribing naloxone so that members and families can reverse accidental overdoses and increase annual PCP visits.

Health Choice supports the Department of Health & Human Service's National Pain Strategy to promote development of a system of patient-centered integrated pain management practices based on a biopsychosocial model of care that enables providers and patients to access the full spectrum of pain treatment options. For example, HCIC is the sole SAMHSA SBIRT Grant recipient with the Governor's Office to implement SBIRT in primary care, emergency departments and university setting for the past 5 years. We have also participated in and promoted the University New Mexico's Project ECHO Chronic Pain Program, winner of a CMS Healthcare Innovations Award, through community reinvestment grants to PCPs, pain management specialists and psychiatrists in Northern Arizona in order to improve the competency of rural providers to manage chronic pain.

Health Choice has, and will continue to, develop prescriber education on our website and direct communications to providers and members that explain the pharmacy benefit changes under Governor Ducey's Executive Orders regarding opioid prescribing practices. Many providers initially struggled with these changes. With additional explanation and education, however, provider resistance has diminished significantly.

HCIC also assisted in the drafting of AHCCCS' Opioid State Targeted Response grant, and has actively participated with AHCCCS to fully implement the program since its award. This grant will significantly increase care coordination, peer support, access to care and competency of providers to care for members with SUDs. Health Choice will also target populations for interventions including members who are opioid-naïve, chemically dependent and possibly diverting. Strategies include promoting responsible prescribing and dispensing policies and practices, enhancing harm reduction strategies to prevent opioid overdoses and deaths, and improving access to services and MAT like buprenorphine and methadone.

Health Choice's Chief Medical Officer, Dr. Teresa Bertsch, has been a leading supporter of adding buprenorphine on acute health plan formularies to allow PCPs to utilize MAT. HCA and HCIC added naloxone to their formularies in 2015, and championed getting it added to the acute and RBHA formularies in 2016. HCIC also provided assistance and content towards the development of AHCCCS' forth-coming Medication Assisted Treatment Tool Kit for PCPs. Based on these changes, Health Choice has, and will continue to expand the number of buprenorphine providers throughout the network, with a focus on rural providers first.

For moms and kids, HCIC developed the "Safe Mom, Happy Baby Program" – a pilot project that partners and trains OB/GYN practitioners to implement the evidence based practice, Adverse Childhood Experiences (ACEs), to pregnant women, provide urine drug screens to identify substance misuse, and refer to hospital-based "healthy families" programs that provide in-home support, nursing, and parenting tool kits for at risk mothers. These mothers will also be followed in our OB Integrated Care Management Program to prevent fetal alcohol syndrome and neonatal abstinence syndrome. In the same vein, HCIC has used grant funding in 2017 to support County Health Department nurses in providing in-home nursing services for families/newborns who have been exposed to substances as part of the DCS best practice, Substance Exposed Newborn Safe Environment (SENSE) program. HCIC's Community Reinvestment program has also developed evidence based, school-based prevention programs to reduce substance use among school-aged members.

HCIC ensures a continuum of SUD treatment providers exist in each region throughout the GSA so that members can engage in services when their motivation is high. As per ASAM and MAT, the treatment continuum for members with substance use disorders includes outpatient counseling, case management, intensive outpatient programs, MAT and access to medical practitioners. Health Choice has established designated Opiate

Replacement sites in each region that offer methadone and related behavioral health treatment and may also provide physical health services to ensure the member receives complete care.

Health Choice also supports Substance Abuse Transitional Facilities (also known as "social model detox") where members may safely recover from the effects of substance misuse or abuse. In Northern Arizona, these facilities were primarily developed in partnership with the Navajo Nation and are located in border communities to the Navajo Nation and other Tribal Nations. Health Choice also worked with our network to develop both co-ed and gender-specific Chemical Dependence (CD) Residential Treatment Centers, as per the SAMHSA best practice, Substance Abuse Treatment: Addressing the Specific Needs of Women. These services within the service region are "network purchased" (i.e., the cost is not attributed back against an IHH or IACO's sub-capitation) to incentivize their use for needed treatment. A new women's CD Residential Facility was recently developed in Payson to be a "sister facility" to the Albert Long Center in Holbrook.

Health Choice has developed in partnership with our IHHs, Crisis Stabilization Units in Flagstaff, Prescott Valley, Kingman, and Show Low, which allow an individual to be evaluated and, if needed, receive MAT on a twenty four hours a day basis. These specialized programs and facilities help divert people from hospital EDs, jail, and unnecessary inpatient treatment. Likewise, inpatient detoxification services are delivered through our inpatient hospital network. As these facilities have been developed, we have also collaborated with local first responders and law enforcement agencies to utilize them for individuals who are intoxicated or using substances to divert individuals from incarceration. Both HCA and HCIC have been strong supporters of the National Association of Counties "Step Up Program" to avoid unnecessary or inappropriate incarceration of individuals who are living with behavioral health or substance use conditions. Health Choice will also continue to utilize peer and family run organizations to assist members with resources and support in transitioning from these programs and into ongoing outpatient treatment. This community-based continuum of SUD treatment is supported by sober-living homes that are funded through HCIC's Community Reinvestment program. HCIC also utilizes Substance Abuse Prevention and Treatment Block Grant as well as Opioid State Targeted Response funding to provide substance use treatment to priority populations who do not qualify for Medicaid.

Children at risk of removal by DCS. Health Choice employs multiple strategies to provide families with the skills necessary to effectively parent their children. Our IHH and IACO model provides support to families in all areas, including in-home stabilization, intensive wrap-around services, such as the "Meet Me Where I Am" model (an ADHS best practice), pediatric care, EPSDT visits, and respite services. Consistent with the Meet Me Where I Am program, our IHH and IACO's assess families for risk and assign Dedicated Case Managers (DCMs) to families who have more complex needs. The DCMs provide additional support to the family with coordination of care through the Child and Family Teams, as well as identify resources available based on the needs of the family. Our providers utilize evidence-based best practices to provide parenting skills, which include the Strengthening Families program, Love and Logic model, the Positive Parenting Program, Cognitive Behavioral Therapy, Play Therapy (Parent Child Interactive Therapy), and Applied Behavioral Analysis.

In addition, Health Choice partners with stakeholders such as the DCS and county Juvenile Probation Offices in order to align with families who are running the risk of disruption or removal. We will meet with DCS and CMDP monthly to monitor outcomes, address system concerns, referral processes, and complex families. When DCS discovers a family that may run the risk of DCS involvement, the DCS case specialist immediately will refer the family to the IHH or IACO.

HCIC has also provided Community Reinvestment funding to support a positive behavior program best practice called "Healthy Kids and Classrooms" in the school systems. This program provides teachers with additional tools to manage problem behaviors that lead to suspension and ultimately expulsion. We closely monitor outcomes of this program, which has been proven to reduce emotional and mental disruptions. The program also assists with translating the learned skills into the family environment, so parents can manage negative behaviors more effectively, thus reducing chances of DCS involvement.

Health Choice's affiliate, the NARBHA Institute, has provided funding to create the Mindfulness Project based on emerging best practices for children with inattention and anger difficulties in a local elementary school. The project was designed to develop a "focus room" for children who need a "time out". The focus room is highly regulated, with muted lighting, swings, and comforting materials to decrease over-stimulation. In

addition, the project imbedded a “parent night”, one time per month, so parents can learn techniques provided in the focus room, and practice the skills at home. The project began in August 2017. The program resulted in no suspensions, compared to last year's first quarter, which saw 27 suspensions. The project will continue to be monitored and although in its early stages, we predict a substantial decrease in disruptions from the family unit.

As discussed previously, the “Safe Mom, Happy Baby” program has been piloted in Northern Arizona. The program has proven to be successful in decreasing the number of pregnant and substance using mothers, as well as successfully maintaining the family system, without the need to remove or involve DCS.

Finally, Health Choice will continue to work closely with the Juvenile Justice System to ensure appropriate services are provided to keep the family together. HCIC has partnered with the Family Involvement Center to create a program to have a family support partner immediately become involved when a child is placed on probation. The goal of the program is to assist the families in navigating the justice system, and training parents in more effective parenting and discipline techniques. Health Choice will continue to expand this program throughout our service region.

Children transitioning from Comprehensive Medical and Dental Program (CMDP) to Health Choice. Health Choice partners closely with CMDP to engage children and their families in receiving assistance needed to restore their family relationship. HCIC and CMDP communicate regularly via the DCS secure email address. We will meet monthly with CMDP to address any changes in eligibility or enrollment as part of system concerns and regularly review our joint operating protocols. We will ensure that we and our provider network use the Arizona Vision-Twelve Principles for Children Behavioral Health Service Delivery and the Behavioral Health Practice Tools, many of which we helped develop and test. These include the Child and Family Team (CFT) practice model and The Unique Behavioral Health Services Needs of Children, Youth, and Families Involved with DCS, which applies to CMDP children.

When a child transitions out of CMDP, Health Choice will engage CMDP to obtain medical information, latest EPSDT visit, dental visits, and other health information. Health Choice’s Transition Coordinator will be notified of the change in health plans and coordinate with the ICMs and DCS liaison to enroll the child into our health plan. Health Choice will ensure the PCP is engaged in the development of the child’s integrated service plan, and will encourage the family to utilize the IHH or IACO's pediatrician for any physical health related issues/EPSDT visits. We will use the AHCCCS clinical guidelines for Working with the Birth to Five Population, making sure that children’s services are developmentally sensitive, child and family centered, and respect the family’s strengths, culture and preferences.

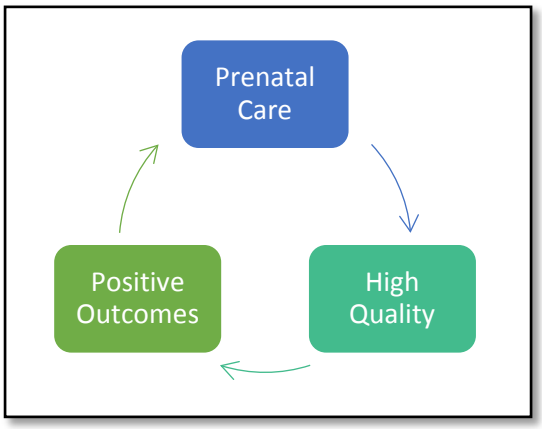
For adolescents "aging out" of DCS custody, Health Choice will use the AHCCCS Transition to Adulthood Practice Tool with support systems to assist with the transition. Teens and young adults (up to the age of 26) will be assigned a transition to adulthood case manager at the IHH. The transition case managers guide the members through the process of self-sustainability to include supportive housing (such as Emerald House in Flagstaff), employment coaching, vocational support, resume building, creating and maintaining a budget, and relationship development. As most children return to their biological family after turning 18, our IHHs work closely with adolescents transitioning out of DCS custody to help them establish appropriate relationships with their family of origin.

Lastly, Health Choice has partnered with the Coconino Coalition for Children and Youth (CCC&Y) to create a pilot mentorship program for adolescents “aging out” of the DCS system. CCC&Y works closely with community members to develop strong mentors for this population. The mentors create additional support with continuing education opportunities, safe relationships, and supportive living arrangements. If the program is successful in attaining these goals, we will expand it throughout our entire service region.

Conclusion. Health Choice brings a wealth of experience and resources to the challenges facing Arizona’s transition to “Complete Care.” Health Choice will use its unique population health and care management approaches to address these challenges head on through member engagement, employing best practices, and monitoring quality outcomes. We will continue to partner with AHCCCS and other state and local agencies to ensure that the unique needs of our diverse populations and communities are being met.

Steward Health Choice Arizona (Health Choice) understands that a strong maternal health program represents a tremendous value to pregnant women and their families. Building on our extensive experience in Arizona, we will expand our maternal health program to emphasize our focus on the importance of prenatal and post-partum care as the foundation for a healthy pregnancy, and a healthy baby.

Overview. Maternal health is the foundation for a woman's future health, as well as that of her child. Pregnant mothers who have access to high quality, timely, and maternal care, experience better outcomes at lower overall cost. Our approach to material health is also emphasizes the importance of additional programs for high risk pregnancies, including women with chronic conditions including diabetes, intractable vomiting, pain, behavioral health and substance use disorders, and those with impactful social determinants of health, like isolation, poverty, lack of transportation, poor nutrition or lack of family support. Family planning and preventive care are also important aspects of our maternal health strategy.



Health Choice developed our Maternal Health Program using evidence-based metrics serving as the compass for our decisions. Our goals for all maternal child health initiatives include: Improve birth outcomes, reduce neonatal intensive care stays, and decrease the number and incidence of low birth weight, pre-term labor, elective deliveries prior to 39 weeks, lower caesarian section rates, and reduced exposure to opiates in utero. To achieve these goals, we will use five strategies: (1) Early identification and outreach; (2) Assistance with member transitions; (3) Member engagement; (4) Intensive care management; and (5) Provider monitoring with aligned reimbursement incentives.

Early Identification and Outreach. One of the most prominent drivers for maternal health success is the ability to identify and engage with expecting mothers as early as possible. Identification usually occurs through referrals from AHCCCS, providers or the members themselves. However, we also use a variety of data sources including laboratory values, pharmacy data including prenatal vitamins, and medical claims data. Within one business day of identification or referral, a Maternal Health Care Coordinator will conduct an outreach call with the member to engage and build trust, answer any questions, and complete a Maternal Risk Assessment based on the American Congress of Obstetricians and Gynecologists which stratifies the member into high, moderate and low risk categories. The assessment focuses on risk, and pre-screening for perinatal depression. We document this information in our care management system, CareRadius® and it serves as the basis for the types of interventions and outreach we perform.

Member Transition Assistance. We anticipate that some women will become Health Choice members as a result of qualifying for AHCCCS based on their pregnancy, or as a result of AHCCCS Complete Care contractor changes. Health Choice has extensive experience transitioning members between contractors during contractual transitions as well as during member open enrollment. Health Choice ensures member transitions are smooth with little to no disruption or inconvenience to the member. Our transition plan will follow all requirements in AHCCCS Complete Care contract. Health Choice utilizes historical encounter data and data element files received from relinquishing plans to ensure members identified with special health care needs, including pregnancy, are enrolled into our care management programs. Health Choice's care management staff will reach out to the member, their providers, and the relinquishing health plan to obtain pertinent medical and behavioral health information. Health Choice will act quickly when member concerns are identified during the transition period to ensure needed services are provided timely.

Member Engagement. Health Choice recognizes that pregnancy can be a time of anxiety for many women and their families. We will engage the member and provide tools to inform and ease these concerns. After the initial outreach, each member receives a "stork packet" which includes education, resources, and other helpful information. Health Choice will use mobile applications to remind pregnant women of upcoming

appointments, provide tips related to the gestational age of their baby, postpartum concerns and early infant care. Members will also be encouraged to sign up for the Health Choice member portal which has a specific maternal health section. Through the member portal application members receive helpful tips related to having a healthy pregnancy, access to community resources and outreach to their obstetric Integrated Care Manager (OB ICM). Members may even request an OB ICM if one has not been assigned.

Health Choice has a 1-800 OB line for providers and members to ensure member issues are resolved quickly when a barrier to care is identified and to ensure members are triaged to a nurse when clinical questions arise. We also have FoneMed, our 24/7 nurse advice line, which has evidence-based clinical triage guidelines related to pregnancy to ensure members are triaged appropriately. We provide telehealth solutions for member care for non-obstetric needs, available through our provider network. Our ultimate goal is to meet our members' needs at the most appropriate level of care.

Diaper Rewards Program. We developed a new Healthy Pregnancy/Healthy Baby Diaper Rewards Program to engage pregnant members in achieving health outcomes. Members can earn diapers and wipes for completing the following during pregnancy:

- Early entry into prenatal care (first trimester or within 42 days from enrollment onto the plan)
- Sign up for online education via the member portal or text messages
- Attend all appointments as outlined by the attending physician
- Complete HIV testing
- Abstain from smoking, alcohol, and controlled substances (by personal attestation)
- Schedule postpartum appointment

Upon successful completion, Health Choice will send diapers and wipes to the mother around her expected delivery date.

Care Management Program/Activities. The Maternal Health Care Management Program offers members a high touch care management approach. Health Choice has adopted the SAMHSA Four Quadrant Model (FQM) for Clinical Integration to provide members with OB Integrated Care Managers (OB ICMs) who have experience as it relates to member needs. All first-time moms will be offered a Health Choice "Healthcare Buddy" (a specially trained Member Services Representative) from identification of pregnancy until two years after delivery. This Kaiser Family Foundation evidence-based practice gives first-time moms who may not have any identified high needs or risks, a contact at Health Choice to assist with questions about prenatal care visits, transportation, perinatal and postnatal depression screening, access to behavioral health care, newborn care, well-child visits, benefits, lactation services, or someone to call when "services just don't seem to be going right."

Real Life Story –

"I am grateful that I had her throughout my pregnancy, and had a great rapport with her. I appreciate that she helped me in so many ways, like finding a car seat and other resources."

Health Choice member feedback on her experience with her OB Integrated Care Manager.

High need/high cost members are assigned to either an OB ICM in Quadrant 4 (High Physical Health/High Behavioral Health) who is a nurse with OB and behavioral health expertise, or Quadrant 3 (High Physical Health/Low Behavioral Health) who is a nurse with OB experience but is supported by other Health Choice staff with behavioral health experience, depending on the member's needs.

Health Choice will build on the expertise developed by Health Choice Integrated Care's (HCIC) Integrated RBHA experiences when developing programs for high risk members with high behavioral health needs in Quadrant 4. For example, HCIC pregnant members living with Serious Mental Illness in Quadrant 4 (High PH/High BH) will be assigned to an OB ICMs who are nurses with OB and behavioral health expertise. Of the 52 babies born to members living with SMI in 2017, 90 percent had a healthy weight and only 17.7 percent were delivered by caesarian section — this is lower than the Arizona state average and a significant improvement from the 36 percent caesarian section rate during the first year of our RBHA contract.

The OB ICMs utilize the Health Choice Maternal Health Risk Assessment to assess member's past and present health status and pregnancy history. The assessment process allows the OB ICM to work with the member on treatment goals which will improve health outcomes for both her and her infant. The OB ICM develops an Integrated Care Management Plan (ICMP) that includes a review of all her obstetric, physical and behavioral health needs. The ICMP is shared with all of her physical health and behavioral health providers and includes the reason for classifications as "high risk," all contacts for providers, estimated delivery date, physical and behavioral health diagnoses and visits, 90 days of medication fills, information from the CSPMP database and recommended interventions. Members in our Top Tier Care Management (Quadrants 3 and 4) are contacted monthly at a minimum, and remain in the program eight weeks post-delivery. After a member has delivered, the OB ICM will conduct a perinatal depression survey to identify any early signs and then work closely with providers when a member is identified with potential perinatal depression. Members also receive education around infant care, breastfeeding, immunizations and infant/well-child visits. The OB ICM can assist with finding a pediatrician for the member and arrange transportation when appropriate for follow-up visits.

The OB ICMs work closely with the member's behavioral health team to ensure members with behavioral health conditions are receiving needed care. Behavioral health conditions not only affect the member but also affect fetal outcomes. During the assessment process members with behavioral health concerns will be offered and encouraged to seek services through an Integrated Health Home. This integration will allow for closer monitoring of the member's physical and behavioral health conditions.

Home Based Services**.** Health Choice contracts with Optum Homecare, who provides in-home and telephonic services to our most vulnerable members to improve birth and health outcomes. Optum provides close monitoring for members with diabetes, nausea and vomiting, special health care needs, and members with an increased risk of pre-term labor through all stages of their pregnancy. Optum has shown a 50 percent reduction in spontaneous preterm births and 62 percent reduction in antepartum hospital admissions. Health Choice's OB ICMs work collaboratively with Optum when a member is enrolled into one of the Optum programs. This collaborative approach ensures members receive needed care at the right time, in the right setting without barriers to care. Health Choice has seen the value they bring to our most vulnerable pregnant members.

OB Transition of Care Program. Health Choice developed an OB Transition of Care Team five years ago to add a hands on touch to members who recently delivered. The team visits members in our highest delivery volume hospitals in Maricopa and Pima Counties. The program is designed to provide members with education around postpartum care and newborn/infant care, especially about well-child visits and immunizations. The team offers to assist with locating a pediatrician and setting up the first newborn appointment prior to leaving the hospital. The team also discusses with the member the importance of postpartum follow-up and offers to assist with scheduling an appointment when necessary. The approach is centered around not only ensuring the mother has appropriate post-delivery care but education around the importance of early infant care and the impact this can have on a healthy start for their newborn. Community resources are also discussed during the face-to-face interaction to ensure the member is aware of programs such as Women, Infants and Children (WIC) which assist with supplemental foods, nutrition education, and breastfeeding support. Health Choice has a certified lactation specialist on the team who provides education to new nursing mothers on the importance of breastfeeding and the benefits it has for their newborn. The OB ICMs also promote breastfeeding to enrolled members during outreach activities. Providing this hands on touch enhances the member's experience and provides the sense that the health plan cares about their well-being and wants to see their family have a healthy life. We will expand the program to other high volume hospitals based on utilization data post-contract award.

Neonatal Abstinence Syndrome (NAS) Program. Substance use during pregnancy can have devastating consequences for both mom and baby. It is critical that mothers with substance use history receive early prenatal care, but this is a challenge due to the perceived stigma. The rising epidemic of newborn drug exposure has been a priority focus of Health Choice for the past two years. Our NAS rate in 2015 was 1.1 percent of all total deliveries and increased to 1.4 percent in 2016. Even more alarming, the average length of stay for newborns with NAS increased by 35 percent from 2015 to 2016. To address these trends, we implemented a new program which focuses on pregnant members who have been identified as potentially at risk for using

opioids. This program uses NAS-focused OB ICMs to conduct intensive care management, and has been successful due to early identification and member and provider education.

Through a variety of sources, Health Choice is able to have early indicators for potential opioid use. Data sources include documentation from providers, pharmacy reporting, Health Current data feeds, AHCCCS Active Care Roster, and review of the CSPMP. Members and providers receive education on the consequences of opioid use during pregnancy and the benefits of early intervention. This includes specialized resources for members and providers to contact for support. For example, Health Choice participates in the Arizona Substance Exposed Newborn (SEN) Taskforce. Recently the task force developed an educational toolkit for providers related to best practice guidelines for SENs. Health Choice incorporated the material into our educational OB tool kit which we take to providers during our on-site visits. The tool kit is also available on our website and through the provider portal.

Results: The strategies deployed via the Health Choice Neonatal Abstinence Program resulted in a 19 percent decrease in the average length of stay for newborns with neonatal abstinence syndrome when comparing 2016 and 2017.

In 2018, Health Choice will also add a specialized Care Management program through axialHealthcare for pregnant members with chronic pain. This program includes a mobile technology platform for member education and engagement. Our program educates members, and "meets them where they are" in their pain and behavioral health journeys. By offering education around pain, behavioral health, pregnancy, lifestyle modifications, complementary and alternative therapy, and substance use disorder, members receive a number of tools to help them successfully navigate complex conditions. Members are also connected with a care team of pharmacists, health coaches, and engagement specialist to support ongoing physical and behavioral health treatment to bridge the gap between primary and obstetric appointments.

Our program works to engage the member without stigma, blame, or embarrassment. The program is designed to reduce harm to the infant and, when possible, wean the member off of all substances prior to delivery. It uses a collaborative approach between the members, family, OB ICMs, providers and community based supports/programs. Health Choice will also develope centers of excellence with community based providers focused on addiction and recovery to work with OB providers.

Family Planning Activities. Family Planning is a key component in achieving desired outcomes related to birth spacing and family unit size, and improved health outcomes for infants, children, women and families. Ensuring providers are educating members on family planning services including receiving LARC after delivery and before discharge will be a focus for Health Choice. Health Choice has developed educational materials around family planning for network representatives to distribute when conducting on-site provider visits.

Provider Monitoring and Aligned Reimbursement. Health Choice will use a provider payment structure which aligns financial reimbursement with birth outcomes. We will have a consistent, simple approach to ensure provider understanding. The majority of providers will be compensated using a value based, bundled "OB pack" which provides a baseline payment for all prenatal visits and delivery. An additional payment will be made above and beyond the OB pack for timely post-partum visits. Payment will be scaled based on prenatal visits, early elective deliveries, and elective caesarian sections. We will monitor to ensure that all members are screened through the CSPMP once per trimester; and, for those members receiving opioids, appropriate intervention and counseling is provided, including referral of members for behavioral health services, as indicated, for substance use disorder assessment and treatment.

To ensure success for our providers, as well as positive outcomes for our members, Health Choice will facilitate the provision of necessary educational and analytic resources. Health Choice will provide no less than quarterly reporting to each provider to discuss their outcomes against targets. Health Choice continually evaluates covered services related to OB services and family planning to ensure members are receiving needed services without any barriers to care. Health Choice will conduct provider forums as a vehicle for providers to have a discussion about barriers they are experiencing related to member access to care and any suggestions to make the processes less burdensome but at the same time meet all contractual requirements. We know provider education is key to this initiative.

Results and Barriers Identified Through Implemented Strategies. Based on our 25 year history, and experience overseeing an average of 500 births per month, we have encountered a variety of barriers requiring prompt development of strategies to address the respective barriers. In many cases, these have either led to changes in our initial approach, or resulted or presented as an opportunity to implement new strategies. Our lessons learned and continuous improvement strategies form the foundation for our future maternal health program:

Barrier: Women do not always establish early prenatal care. Recognizing that our prenatal visit rate could improve, we enhanced and increased member outreach and education through Health Choice member Stork packets and OB toolkits for providers. While increased member and provider outreach showed improvement from this initiative, we recognized an opportunity to further increase our prenatal visit rate. As one of our challenges was only being able to contact members when we knew about their pregnancy, we compiled a variety of sources for early indicators, including pharmacy, laboratory, and medical claims data. Using these additional data points, Health Choice is now able to quickly identify and engage women earlier in their pregnancy.

Barrier: Provider notification of prenatal opioid exposure remained low. We identified an increase in NAS rates, and addressed this concern by establishing a strategy with our providers to notify us of all opioid exposed pregnancies. Shortly after implementation, we confirmed that we were not receiving all notification in a timely manner to enable us to refer the member for services. As a result, we adjusted our strategy to take on the responsibility of searching pharmacy and Arizona Controlled Substances Prescription Monitoring Program (CSPMP) data for any potential early indicators. In addition, we will implement a new data analytics program through axialHealthcare that will mine our pharmacy claims for controlled substances and medical claims by diagnosis and service type. This will help us identify members for our care management program for pregnant women with opioid use disorder.

Barrier: Post-Partum “Busyness.” In an attempt to outreach to members who have delivered to schedule post-partum visits, Health Choice implemented a call outreach campaign to women within two weeks after discharge. At a time so soon after this life-changing event, many women did not have the time to speak or think about scheduling an appointment. We completed a pilot in April 2016 and found that when our OB ICM assisted the member in scheduling a post-partum visit, 97 percent had a timely postpartum visit. Based on this pilot, we changed strategy to help schedule visits in advance of birth and to have OB ICMs in high volume hospitals visit the new mother in the hospital after delivery and ensure an appointment is scheduled.

Barrier: Billing methodology for Long Acting Reversible Contraceptives (LARC). In certain circumstances, the AHCCCS fee schedule rate for certain LARCs is well below the provider acquisition cost. Health Choice has historically reimbursed the provider at their actual acquisition cost through a reimbursement process. Feedback from providers indicated that this process was burdensome, and we were concerned that it may be a barrier to LARC services. Health Choice addressed that barrier by increasing the provider rates paid via claims instead of an invoice. This allows the provider to be reimbursed at their appropriate cost, in a less burdensome manner.

Conclusion. Health Choice understands the vital importance of a comprehensive Maternal Health Program as the foundation for health of women and their families. Understanding that the needs of women vary, we will employ a multi-faceted approach to improving maternal care. Through member engagement, provider reimbursement alignment, care management, and robust analytics, we will move the needle on improved birth outcomes. Kids are our future, and it’s our job to make sure they get off to a healthy start, so they can have a bright future.

Narrative Submission 9

Steward Health Choice Arizona (Health Choice) believes that all children should receive the care they need to be able to live the fullest life possible. Health Choice will accomplish this through our comprehensive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, outreach embracing parents, guardians and families as full partners in care, our integrated care management and ongoing monitoring and quality management strategies, and through our comprehensive provider network of physical and behavioral health providers. Although AHCCCS' Twelve Principles for Children's Behavioral Health Service Delivery were designed for behavioral health services, Health Choice believes the same principles should be followed for all children's services to achieve the best outcomes for children and their families. This is especially important for children with disabilities because an effective, family-friendly care delivery system can prevent conditions from worsening and prevent more costly conditions. Our experience managing the EPSDT program for over 25 years and managing children's behavioral health services through Health Choice Integrated Care (HCIC) gives us the ability to achieve excellent outcomes for children by integrating services at the managed care and provider level — especially for those with behavioral or developmental needs.

EPSDT Program. A fundamental component of addressing the developmental needs of young children is successful implementation of the EPSDT program, the comprehensive child health program of prevention, diagnostic and treatment services for AHCCCS members under 21 years of age. Health Choice requires that EPSDT services, also called "well-child" visits, occur at specific intervals in a child's life to help prevent, identify, and treat conditions early enough to achieve high quality care and healthier children at a lower overall cost. Our experience indicates that by identifying children with developmental or behavioral issues before the age of two years, early intensive behavioral interventions (EIBI) can greatly improve the chances of positive outcomes for children. These early services can assist the child with reaching developmental milestones, such as walking, talking, or interacting with others, as well as ameliorate more significant developmental conditions.

All contracted EPSDT visits must include a comprehensive health and developmental history, growth and development screening, and physical, nutritional, and behavioral health assessments. By requiring the AHCCCS-approved developmental screenings at the nine-month, 18-month, and 24-month visits using the Parent's Evaluation of Developmental Status tool and the Ages and Stages Questionnaire, babies and toddlers can be identified for early interventions. Health Choice requires that our providers not take a "wait and see" approach, so as to not miss a crucial developmental stage when effective early interventions can cause significant changes to a child's developmental progress. For example, Health Choice requires that pediatricians use the Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R), for toddlers 16-30 months old to screen for autism to identify suspected Autism Spectrum Disorder (ASD) earlier than Arizona's average age of diagnosis at four years and ten months. When a child is identified as having a special health care condition, such as those with ASD or at risk for ASD, the provider or parent can make a direct referral to needed specialists.

Parents as Partners. Every good pediatrician or child psychiatrist knows to take it seriously when a parent says there is "something not right with my child." Parents/guardians and families know their children best and can notice subtle delays or changes early, but not always. By partnering with parents to understand why children need to be seen regularly through the EPSDT program, we can achieve important outcomes. Since 2016, Health Choice has had a "Healthy Start, Bright Futures" parent campaign to promote annual well visits and covered services that includes six "pillars for a bright future"— annual well visits, immunizations, dental visits, education, exercise and nutrition. This campaign uses branded colorful posters, letters, birthday mailings, physician toolkits and an eight page brochure for parents with education and tips for each pillar.

Within ten days of their child's enrollment, a Healthy Start, Bright Futures New Member Information Packet, including a Welcome Letter with PCP assignment, is mailed to the parent or guardian. The Welcome Letter provides information about how to obtain a member handbook, sign up for the member portal and how to find the provider directory on the website. The Member Handbook explains the EPSDT program and EPSDT

covered benefits. We send colorful flyers eight times up to 23 months of age to remind parents and guardians of upcoming well child visits and vaccines as outlined in the EPSDT periodicity schedule. At least twice per year, Health Choice emphasizes the benefits of EPSDT in the mailed member newsletters, informing members of EPSDT services, changes to benefits, and organizations where additional services can be obtained.

Community Engagement. The Health Choice THANX (Think Healthy About Nutrition and eXercise) team also carries out the Healthy Start, Bright Futures mission by partnering with several school districts in underserved communities to improve pediatric health literacy and fight childhood malnutrition and obesity. Our THANX afterschool team offers health and wellness education and activities covering important topics such as nutrition, exercise, hygiene, bike, and water safety. Several THANX activities aim to not only educate and motivate the children involved, but equip them with knowledge and tools to share with their families. The THANX team also hosts Field Days with several schools that include educational and fun exercise activities.

Member Tools. We will continue to improve and add new enhancements to the Healthy Start, Bright Futures campaign as the data demonstrates which strategies are the most effective. For example, we noticed that the best time to engage members in using the new Health Choice member portal was at the initial point of enrollment. We are, therefore, enhancing the portal to give parents a history of completed or missed well visits and due dates. They can also look up providers based on quality star ratings, access the member handbook, update demographics, complete a pediatric health risk assessment, let us know their preferred communication method (phone, text, mail, email), and view their child's identification card. In 2018, we will add a proprietary platform to the portal that allows parents to enter their needs based on social determinants of health factor, as well as clinical needs or concerns, and receive a list of local resources to assist. Our website will also have resources on Autism Spectrum Disorder (ASD) including the EPSDT tools used by doctors to screen for ASD, a list of our contracted psychiatrists, psychologists, and developmental pediatricians who can diagnose ASD for Division of Developmental Disabilities (DDD) eligibility, the Arizona Early Intervention Program (AzEIP) for children under three years old, DDD available services, and family education resources like Project ECHO Autism toolkits, Autism Speaks, Raising Special Kids, Intermountain Centers for Human Development, and the Arizona Autism Coalition.

Comprehensive Provider Network. Health Choice has an already established network of pediatricians across all of our service area providing contract-required EPSDT visits where babies, children, youth, and young adults are screened for conditions or illnesses, such as developmental delays, autism, hearing loss, vision loss, dental needs and behavioral needs using AHCCCS-approved standard developmental screening tools. Health Choice ensures providers are trained to use the required screening tools, blood lead testing, and immunizations. Health Choice has also developed a Pediatric Physicians Toolkit designed to assist providers with understanding AHCCCS requirements. This toolkit includes the EPSDT Periodicity schedule, suggested codes for meeting HEDIS measures, best practice tips, important forms, phone numbers, websites, and useful information to help providers create a medical home for their patients. Health Choice distributes the AHCCCS PCP Toolkits on ADHD, Depression and Anxiety so primary care providers (PCPs) can treat these disorders within the scope of their practice. The information can also be found on the Health Choice website, provider portal, and is available in print through the Health Choice provider representatives.

Health Choice includes AHCCCS AzEIP providers in our network, and will still cover eligible AzEIP services by providers not in our network. These providers help identify and treat children 0-3 years of age with developmental disabilities. The services also focus on each child's natural environment with family education and support to optimize health and development. Since time is of the essence for these babies and toddlers, Health Choice ensures that medically necessary services are started within 45 days after Health Choice receives a request by the AzEIP service coordinator for an eligible child and are coordinated with other service providers including behavioral health. All multispecialty interdisciplinary care providers (MSIC) are also in Health Choice's provider network for children with Children's Rehabilitative Services (CRS) conditions, a frequent comorbidity with developmental and behavioral health needs.

The Health Choice Provider Network team ensures that providers have access to interpreters or interpreter services for families with limited English proficiency or other language needs through A Foreign Language Service, Valley Center for the Deaf, and Community Outreach Program for the Deaf.

Health Choice has already established a comprehensive network of children's behavioral health providers based HCIC's network across Arizona. Children from birth to 21 years will be assigned to a Health Home responsible for all developmental assessments, psychiatric care, case management, peer and family support, crisis services, inpatient psychiatric care, HCTC (therapeutic foster care) and Level I residential treatment. Health Choice even has a child-serving-only specialty Health Home, Child and Family Support Services, for families who prefer the additional programming and child focus it can offer. All Health Homes have early childhood expertise and focus on early developmental screenings for all children.

Like pediatricians, our Health Homes are required to use standardized screening tools such as Ages and Stages Questionnaire (ASQ) and the Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R) and must also routinely refer children to AzEIP, a developmental pediatrician or a behavioral health medical practitioner (BHMP), and DDD when needed. The Early Childhood Service Intensity Instrument (ECSII) or the Child and Adolescent Service Intensity Instrument (CASII) is used to assess every child's needs. Children with high service intensity needs, such as children birth through five years of age who are involved with AzEIP, the Department of Child Safety, and/or DDD, or children six through 17 years old with a CASII score of greater or equal to four, are assigned a high needs provider case manager and are identified as having special health care needs. Caseloads are monitored by Health Choice with a 1:15 desired target. Each child's care will be coordinated through the Child and Family Team (CFT) process. The treatment team focuses on individual needs of the member including speech, communication and socialization delays to promote cognitive and behavioral development. Health Choice ensures the service plan is consistent with the goals established by other stakeholders serving the child and/or family and that the team seeks active participation by other involved agencies in the planning process. Importantly, the CFT is required to begin appropriate services at the necessary frequency and intensity because any delays in care can negatively impact a young developing child. Health Choice will also recommend that all children with newly diagnosed or suspected ASD will be referred for a Functional Behavioral Assessment or Applied Behavioral Analysis within 45 days of identification.

> We currently have 99 percent of children with ASD actively engaged in treatment and successfully living with their family, due to the successful collaboration of HCIC, our Health Homes, and DDD.

Each Health Home has on staff psychiatrists who can conduct an assessment acceptable for DDD eligibility for ASD or if the parent/guardian prefers, can arrange an outside evaluation, either in person or over our telemedicine network. Health Choice is also contracted with providers who use evidence-based practice guidelines in treating children with special needs. Two of these providers include Southwest Behavioral & Health, one of our Health Homes, and Touchstone Health Services, both of which qualify as Centers of Excellence for diagnosing and treating children with ASD. Our Children's Medical Director, a Board Certified Child and Adolescent Psychiatrist with experience developing integrated pediatric clinics and with additional ASD training, is also available to consult with PCPs, psychiatrists, or CFTs.

Health Choice ensures a wide range of services including early intensive behavioral interventions (EIBI) are available for children, especially those with special health care needs, developmental delays, behavioral needs or ASD. An excellent example of this is Health Choice's development of providers through our Community Reinvestment program and financial start-up for Intermountain Centers for Human Development (ICHD), Yavapai County Health Department ASD program (Y-CARE), Project ECHO Autism and ongoing training to improve the provider network competency to care for children who need EIBI. The Y-CARE program, which started in early 2017, employs a registered nurse and an ASD-trained pediatrician to evaluate children who are experiencing symptoms of ASD. As an integrated program, the pediatrician reviews all medical reports to identify medical issues that may contribute to the reported concerns, as well as performs a comprehensive examination. The Y-CARE program has served 75 children to date. Y-CARE is currently collaborating with Northern Arizona University to expand the program within the next fiscal year. ICHD's Board Certified Behavioral Analysts (BCBAs) provide intensive in-home behavior modification techniques for high needs children throughout rural and frontier Northern Arizona and in partnership with Tribal Nations to ensure all populations have access to EIBIs.

Health Choice's Health Intervention Programs Division will also continue to develop annual collaborative joint protocols, with child-serving stakeholders and government entities such as DDD, AzEIP, DCS and the Arizona Department of Education and schools so that providers and stakeholders have a clear pathway for collaboration, coordination, responsibilities and reduction in duplication of services. In this way, we can maximize the use of community-based services for children and families. We post all protocols to our web site.

Provider Education. Health Choice will continue to work with our providers on evidence-based best practices such as play therapy, sand tray therapy, and the Positive Parenting Program (Triple P). Health Choice will also continue the ongoing ASD Lunch and Learn Mini Series for our Health Homes, DDD, and specialty providers over videoconferencing. The mini-series is taught by BCBAs, and covers Positive Behavioral Support, Applied Behavior Analysis, Behavior Extinction and Skills Training, and Treatment Fidelity.

Health Choice's Director of Health Intervention Programs, Jennie McMillian, was a member of the Arizona Governor's ASD Advisory Committee. Health Choice will continue its Autism Action Committee that acts on the recommendations to the state outlined in the 2015 ASD Advisory Committee Report, to strengthen the health care system's ability to respond to those with or at risk for ASD, including those with comorbid diagnoses. The key projects include: Parent and Provider Resource Guides available on our website, an Health Choice Autism Tool Kit for providers, Project ECHO Autism to provide resources and guidance to practitioners, and tracking and trending ASD members in the network through an ASD member registry that profiles PCP, health home assignment, demographics, service types, service frequency, receipt of applied behavioral analysis or BCBA services, and comorbid conditions to identify any gaps in care.

In 2016, Health Choice identified the need to improve the competency of Arizona providers to recognize, refer, diagnose and treat children birth to five years old with developmental disorders and ASD, so we organized and sponsored "Elevate Autism" on May 5, 2017, at Flagstaff Medical Center. The one-day conference focused on Arizona's system of care and early identification of ASD. The keynote speakers included Dr. Sara Salek, Chief Medical Officer for AHCCCS, Dr. Joanna Kowalik, Chief Medical Officer for the Arizona DES/DDD, Dr. Kristin Sohl, Director of Project Echo Autism from the University of Missouri, and Christopher Tiffany, Director of Family Support and Education for Raising Special Kids Parent Support and Advocacy. Over 150 pediatricians, psychiatrists, practitioners, therapists, and school personnel attended.

Integrated Care Management. Health Choice will provide integrated care management to all children for routine EPSDT services (Quadrant 1, Low Physical Health/Low Behavioral Health) through our EPSDT program and high needs children in Quadrants 2, 3, and 4 for physical health and/or behavioral health in our integrated care management program. PCPs are required to submit EPSDT required information to Health Choice's EPSDT Coordinator to ensure completeness. Based on this information, the Health Choice EPSDT/Health Promotion Specialist assists providers with referrals when children have needs outside the scope of the pediatrician or the behavioral health provider. For example, when we identify the possible need for a Head Start referrals through review of EPSDT tracking information, our EPSDT/Health Promotion Specialist will contact the parents to assist them in enrolling in the program. The EPSDT/Health Promotion Specialist will also assist with referring children to AzEIP, to a developmental pediatrician, to DDD, to a MSIC, or to behavioral health services.

We upload all EPSDT information into Health Choice's care management software, CareRadius®, which makes it available to member services and Integrated Care Managers (ICM) for identification of needs. The information is also available to providers on our provider portal. In addition to Health Choice conducting direct member outreach and engagement, Health Choice will also continue to give providers a registry of their patients who are due for EPSDT/Well Child Visits so they can conduct member outreach. For real-time member information, our web-based provider portal allows providers to access and pull member specific information for their member registry. We use claims data to identify the last date of service for EPSDT/Well Child Visits. Alert codes identifying specific program enrollment and diagnosis information are also identified, including Neonatal Intensive Care Unit (NICU) graduate identification.

Health Choice also manages and oversees the EIBI benefit through Health Choice's Top Tier Pediatric Integrated Care Management Program supervised by our Children's Medical Director. Using our "no wrong door" methodology, the Children's Population Care Leads identify children who could benefit from integrated care management by combining EPSDT information, referrals and risk stratification from our data analytics

software with our high needs/high cost criteria. Health Choice then assigns high need/high cost children with behavioral or developmental conditions to an ICM with pediatric clinical nursing and relevant developmental disorders and behavioral health experience. The ICM oversees and supports members and their families, especially during the birth to age five period when ensuring care from multiple agencies and stakeholders such as DDD, AzEIP, pediatricians, speech/occupational/physical therapists, BCBA and health home psychiatrists is critical to early success. The ICM will develop an Integrated Care Management Plan (ICMP) that identifies all providers and involved stakeholders including their contact information. The ICMP identifies services the member currently receives, and includes recommendations for additional needs such as EPSDT, lead testing, immunizations, speech therapy, applied behavioral analysis or family support from a Family Run Organization like MIKID. The ICM also provides educational material to parents and caregivers, connects them to services, and coordinates with the child's multidisciplinary team of healthcare providers. Children in Top Tier care management are registered with the Health Current's Health Information Exchange so ICMs can receive real-time notifications of ED visits and hospitalizations. All children will have an interdisciplinary team meeting at least monthly to review and monitor care and the ICMP recommendations.

Health Choice has also partnered with developmental pediatricians and AzEIP to assist with tracking and trending service delivery for this vulnerable population. The team staffs and reviews cases to address access to care, appropriate diagnosis, service planning, and coordination of care with the Health Homes, DDD, and other specialty providers. If an AzEIP team has been formed for the child, the ICM will ensure that the behavioral health provider and AzEIP coordinate so as to avoid duplicative processes between systems and make sure the family's experience of care is unified and seamless.

Quality Management Monitoring. Health Choice monitors receipt of EPSDT visit data at the health plan, provider, and member level. The EPSDT Coordinator tracks referrals and implements activities to improve member participation rates for age appropriate screening including, but not limited to, blood lead screening/testing, developmental assessments, BMI/growth percentile, unhealthy weight, immunizations and the need for behavioral health services. We monitor EPSDT/well child visit attendance through an automated claims review of each member to identify those without EPSDT visits within 90 days after a member's first notice. A letter to the parent is auto-generated from the Health Choice EPSDT database when there is a missed appointment identified via EPSDT Tracking or to the PCP when the incorrect form was used. The EPSDT/Health Promotion Specialist will also call parents to assist with rescheduling and address any barriers, such as transportation. They also provide education is provided regarding the importance of EPSDT visits and how to notify the provider in advance for cancellations. The EPSDT/Health Promotion Specialist will also follow up with the PCP about excessive no-shows. All letters and calls are documented in CareRadius®. Provider representatives also complete site visits to monitor appointment availability, educate providers and distribute Provider Report Cards with the toolkits which include provider-specific adherence to EPSDT, HEDIS measures, and a gap analysis of EPSDT services for each of the PCP's assigned members so PCPs can outreach to members. Behavioral health services are monitored through Case File Review. When providers do not meet performance standards, we initiate performance improvement oversight requirements, which may include education, technical assistance, corrective actions, quality of care reviews, peer review, or referral to credentialing or contracts for possible termination.

HCIC 2018 Case File Review Results

- 97% Completed Developmental History
- 100% Developmental Screening (Birth to 5)
- 100% Completed ECSII/CASII
- 90% met all CFT Process requirements

Conclusion. Health Choice is committed to meeting the developmental needs of young children through in a new integrated health approach that brings together the strengths and experience of our organization. We believe our member and family-centered care model can improve children's outcomes, improve the child's and family's experience, build on child and family strengths, decrease health care costs, lead to more effective use of health care resources and improve overall health and quality of life of the child.

Narrative Submission 10

Steward Health Choice Arizona (Health Choice) will utilize a series of strategies, developed through our 50 years of experience as a Regional Behavioral Health Authority (RBHA) and as a major inpatient provider for more than 40 years through our 124-bed St. Luke's Behavioral Health facility located in central Phoenix. This history, coupled with the many years of Arizona experience of our senior leadership team, gives us the capacity and "know how" to reduce emergency department (ED) holds, reduce psychiatric hospital admissions (including out of state admissions), and increase alternative community based services and follow up care.

Emergency Department Holds. There is no denying one of the worst environments for an individual with acute behavioral health needs is a hospital ED. EDs are loud, busy, and simply put, trauma inducing. In addition, individuals may be subject to mental illness stigma and poor understanding of behavioral health disorders, including substance use when entering the ED. Thus, the first and best strategy is to not have people with behavioral health crises come to the ED in the first place.

As Northern Arizona's RBHA, Health Choice Integrated Care (HCIC) has developed and implemented a five part strategy and provider network to support it, in order to avoid unnecessary and potentially damaging ED stays. Where possible, Health Choice will leverage this strategy across Arizona for this contract. Our strategy includes: (1) Enhanced centralized crisis call center; (2) Expanded community based mobile crisis services; (3) Sufficient hospital and subacute inpatient bed capacity to serve crisis needs; (4) A newly-developed network of 23-hour Crisis Stabilization Units (CSUs); and (5) Assignment of all eligible members to a Health Home responsible for managing or delivering a full continuum of behavioral health services, including peer and family support. Since 2015, HCIC has used this strategy to implement a crisis system design resulting in an average of zero instances of hospital ED per month, and no ED holds at all, as indicated in the most recent report submitted to the state legislature.[1] This outcome is the result of a great deal of hard work on the part of both HCIC staff and our crisis provider network.

> ***Results:***
> *HCIC had zero adults who were in an ED waiting longer than 24 hours for inpatient BH treatment in 2016***.**

Centralized Crisis Call Center. The first step in implementing this strategy was changing to a single, centralized crisis call center in 2015, when Crisis Response Network's (CRN) call center services "went live" for Northern Arizona's six counties. Within the first quarter after making this change, we saw a 20 percent increase in crisis calls that were stabilized without need of mobile crisis services, transport to the ED, or law enforcement involvement, thus avoiding a number of instances which would have likely resulted in an ED visit.

Mobile Crisis Services. The second step was the implementation of dedicated, provider mobile crisis services in Northern Arizona and in Maricopa County. Health Choice subsidized and recruited Terros Health to be the first response mobile crisis team, first in the Flagstaff area then in the Prescott/Prescott Valley and Kingman/Bullhead City areas — the three micropolitan population centers in Northern Arizona with catchment areas of over 75,000 square miles. At the same time, Spectrum Healthcare implemented similar services in the Cottonwood/Camp Verde area, the next largest catchment area, with a population of approximately 70,000 people, as well as Community Bridges, Inc. (CBI) mobile crisis services for Gila County. These services deployed dedicated, trained mobile crisis teams, supported by telephone-based clinicians, into the communities to address needs identified through 9-1-1 calls, calls from law enforcement, calls from jails or fire departments, and calls referred directly from CRN. By responding to and resolving these crises while the individual remains in a community setting, mobile crisis services are able to avoid many instances in which individuals would otherwise have been transported and treated in an ED.

Crisis Stabilization Units. The third step was to fund and develop 23-hour Crisis Stabilization Units (CSUs), first in Flagstaff (eight stabilization "chairs"), and later in Prescott Valley (also eight chairs). CSUs in Kingman (six chairs) and Show Low are about to opening. These CSUs serve essentially as "behavioral health crisis emergency departments," in which individuals are evaluated for up to 24 hours before transiting to

[1] Report to the Director of the Joint Legislative Budget Committee Regarding Inpatient Psychiatric Treatment Availability, Arizona Health Care Cost Containment System, February 21, 2017, p. 3.

outpatient care, other community based services or transferred to an inpatient psychiatric facility. As such, these facilities offer an alternative to the ED for individuals in crisis, thus again avoiding hospital ED utilization altogether. One additional important element is that in each instance, the CSUs that HCIC has developed are affiliated clinical operations of psychiatric inpatient facilities, and are either physically co-located or located nearby. The facilities are either an existing inpatient psychiatric facility (as with The Guidance Center in Flagstaff) or located with a new inpatient subacute facility (as is the case in Prescott Valley and Kingman). This practice make it easier to transition members with higher acuity needs out of crisis services and into longer term inpatient treatment. This system design element also has the effect of decreasing the possibility that an individual might leave the CSU needing inpatient care and end up in a hospital ED.

Psychiatric Inpatient Capacity. The fourth step was the development of sufficient psychiatric hospital and subacute inpatient bed capacity to serve crisis needs. In many respects, this is the most important element of our strategy, but it also takes the longest lead time due to the associated funding, licensure and accreditation requirements. In the absence of an adequate number of inpatient psychiatric beds — and in particular, inpatient beds that are contracted by their respective counties to provide court ordered evaluation (COE) services, the entire system can log jam — resulting in delays all the way up the line, including hospital ED holds.

For example, HCIC's predecessor, Northern Arizona Regional Behavioral Health Authority (NARBHA), noted that Mohave Mental Health Clinic's inpatient sub-acute facility in Kingman was consistently reaching capacity due to patients on court ordered evaluation in 2013, resulting in voluntary patients having to be admitted outside of Mohave County, including Las Vegas. Rather than using single case agreements which do not have the same rigor for medical management and coordination of care as contracts, HCIC began contracting with Las Vegas facilities, but also immediately began planning for additional inpatient resources in the region. While contracting for bed capacity in Nevada has increased out of state hospitalization rates in the short run, it dramatically decreased emergency room holds — the only such decrease noted in the statewide Arizona Hospital & Healthcare Association's 2015 report, "Waiting for Care: Causes, Impacts and Solutions to Psychiatric Boarding in Arizona." After three years of planning and funding by NARBHA and Health Choice, Southwest Behavioral Health & Services' new eight bed subacute facility in Kingman was opened in 2017, along with a similar new subacute facility operated by West Yavapai Guidance Clinic in Prescott Valley. The additional capacity offered by these facilities should decrease our out of state hospitalization rates.

Health Home Approach. The fifth step involves our Health Home network design. All members are auto-assigned to a Health Home, which has the clinical responsibility for facilitating and coordinating admissions and discharges from crisis and inpatient services. This ensures that all members regardless of whether they currently receive behavioral health care have a clinical team that will respond to CRN and the mobile crisis teams, and then follow up with member so that that members' needs are immediately addressed to prevent return trips to the ED. For example, in HCIC's 2017 Case File Review of 730 randomly chosen charts, Health Homes followed up 100 percent of the time with the member after a crisis episode (no later than 7 days).

Applying our Experience to Central & Southern Arizona's Needs. Health Choice recognizes that many of the solutions described above were possible because of HCIC's role as the region's RBHA. Outside of Northern Arizona, Health Choice may not have the same ability to directly influence crisis system design. However, Health Choice's leadership team, in partnership with that of St. Luke's Behavioral Health, has reviewed the available data from both the South and Central geographic service areas. We collectively believe that, as was the case in Mohave County, an undersupply of court order evaluation beds is the primary underlying cause of the increase in hospital ED holds in Southern and Central Arizona counties. This is particularly true in Maricopa County where ED boarding remains at an epidemic level. It should be noted that Maricopa County appears to have adequate mobile crisis, CSUs, and even non-COE psychiatric inpatient resources. Thus, Health Choice and Steward will continue to strongly advocate for the expansion of contracted COE inpatient resources in Maricopa County to help address the demand.

In addition, our experience managing Coconino County's COE program indicates to us many patients (and in particular, those who fall under the "persistently and acutely disabled" or "gravely disabled" categories) are often best treated through an outpatient program. Health Choice is committed to working with our network

to develop additional innovative programs like Crisis Preparation & Recovery's emergency room intervention program in Maricopa County and ConnectionsAZ's Integrated Transition Clinic.

Crisis Preparation & Recovery's (CPR) emergency room intervention program uses feeds from Health Current's Health Information Exchange to identify members who are in a hospital emergency room, and are exhibiting symptoms of a behavioral health condition. In response, CPR sends trained social workers, who are supported telephonically by licensed clinical staff, to the emergency room to evaluate the member for possible placement in an appropriate inpatient or outpatient setting. If outpatient services are appropriate, CPR's staff then works closely with Health Choice's medical management team and the member's assigned Health Home to set up an appointment to quickly initiate treatment. If residential services are appropriate for the member's condition, CPR and Health Choice typically work with Lifewell Behavioral Wellness in Maricopa County or other contracted residential services to assist the member in meeting their unique needs. Lastly, if inpatient psychiatric services are appropriate, we work closely with St. Luke's Behavioral Health to provide care in an environment that will both meet the needs of the member, and can be relied upon to work collaboratively with Health Choice within the constraints placed upon Institutions for Mental Disease. In all of the instances above, we work with the member to ensure that, to the extent possible, the level and location of treatment is appropriate to their condition and is provided as close to home as possible.

ConnectionsAZ's Integrated Transition Clinic program is another approach to addressing the same issue. However, this program uses a very different model to address the needs of members in an ED. ConnectionAZ's clinic will be physically located near St. Joseph's ED so they can help quickly transition members out of a hospital ED, and into court ordered evaluation in an outpatient setting if necessary. (Presuming, of course, an outpatient evaluation is approved by the County's evaluation agency.) Because the clinic provides both physical and behavioral health care, it also has the added advantage of serving as an introduction to integrated care for members who have physical health care needs which may impact their behavioral health condition.

Addressing Other Factors. In addition to our efforts to reduce ED visits, Health Choice educates providers about mental illness and provides them with tools to manage those who are at their most acute stage. One of the lessons learned by HCIC from our experience in Coconino County is that ongoing collaboration and educational outreach with both local hospitals and inpatient psychiatric facilities about community crisis services and the COE process is imperative to make the system work effectively. It also decreases the stigma associated with seeking behavioral health care in a hospital ED. On the psychiatric inpatient facility side, misconceptions existed regarding the need and value for "medical clearance" by an ED before a patient could be admitted to the psychiatric facility. This resulted in a large number of unnecessary ED visits, and delays with leaving the ED. HCIC was able to significantly reduce instances of this medically "wasteful" practice through provider education with literature reviews, changes in policy and screening protocols, and quality managing our contracted providers. Conversely, we found hospital EDs often unintentionally slowed the disposition of patients by denying mobile crisis staff access because of ED credentialing rules and unwarranted fears about liabiity. HCIC educated and worked with the hospital staff to permit mobile crisis staff access to patients in the ED. As a result, crisis staff can assist the ED in not having behavioral health crises negatively impact their CMS through-put quality metrics, by expedited appropriate discharge dispositions, identification and admission to psychiatric facilities, outpatient linkages and transportation. These tactics decreased the perceived burden of individuals in a behavioral health crisis.

A Health Current Win:
On the very first day HCIC had connectivity, a member who could not be located and was in our "Top Tier" High Risk Care Management Program (and was on court ordered treatment) was identified in real time at an out of area ED. HCIC's Integrated Care Manager was able to contact the ED, clarify her behavioral health presentation and facilitate transferring her back to a residential facility.

Health Choice recognizes that there is no single answer to conundrum of hospital ED holds. Health Choice believes that it will take a collaborative effort around end-to-end system design analysis, advocacy, education, and provider resource development to fully address the issue. Health Choice stands ready to assist AHCCCS in any manner possible to address these challenges.

Reducing the Number of Inpatient Admissions Including Out Of State Admissions. Reducing inpatient admissions is a challenging business, in large part because it is influenced by so many apparently unrelated factors over which both providers and payors have limited control. There are, however, some high influence strategies and tactics we will continue to use by developing a complete continuum of care, including the graded responses to crisis services as discussed above (i.e., a centralized crisis number, dedicated mobile crisis teams with hospital/ED privileges, 23 hour crisis observation units with affiliated inpatient facilities, an adequate number of court-ordered evaluation resources and psychiatric beds, and collaboration with stakeholders to meet the needs of the communities) and care management.

Expand Substance Use Disorder Services. Beginning two years ago, we recognized a trend in the data showing that a major reason for increasing inpatient services and readmission rates appeared to be directly related to unrecognized, poorly controlled or inadequately treated substance use issues, especially opioid use disorder (OUD). Many members with no previous behavioral health treatment now present in EDs or clinics with the request to "go to rehab or detox," as chemical dependency (CD) services are commonly termed in the media. In addition, the area most impacted by OUD is Mohave County, and with its proximity to Las Vegas, increases out of state admissions.

Based on ASAM guidelines and medical necessity criteria, our provider network approach has focused on outpatient treatment, reserving the smaller supply of CD residential beds for high priority members such as those who are pregnant or parenting, or have IV drug use, however the OUD epidemic has increased the need to have longer periods of supervised treatment in order to reduce frequent hospitalizations due to relapses and to improve member satisfaction with behavioral health's responsiveness and services.

Health Choice has worked quickly to expand the number and type of residential and program alternatives for our members. In Northern Arizona, NARBHA and Health Choice have worked with Community Bridges to convert an under-utilized clinic into the Albert Long Residential Treatment Center in Holbrook. This facility provides culturally competent CD residential services for American Indian members. Similarly, Health Choice has partnered with Mohave and Yavapai Counties, Southwest Behavioral & Health, and Spectrum Healthcare (most recently leveraging State Targeted Response Grant funding) to increase the number of CD residential beds in Mohave County and Yavapai County, including gender specific residential programs.

Health Choice has also initiated the expansion of medically assisted treatment (MAT) throughout our region, and most recently in Maricopa and Pima counties. In Northern Arizona, HCIC contracted with Southwest Behavioral & Health as our Center of Excellence for providing MAT. However, we recognized that this was insufficient to meet the total needs. Health Choice's Chief Medical Officer, Dr. Teresa Bertsch, has been a strong advocate for expanding the ability of primary care providers to prescribe buprenorphine to make this form of MAT more readily available, even in rural regions. With the AHCCCS Administration's recent adoption of this change, Health Choice is now working to implement programs to make it happen.

Our most recent addition is Clean Slate Arizona, with three locations in Maricopa County. Introduced to us through the NARBHA Institute's collaboration with former House of Representatives Member, Patrick Kennedy, Clean Slate offers a variety of alcohol and substance abuse treatment programs, including MAT with buprenorphine and Vivitrol programs. We will expand these strategies throughout Arizona.

Improve Member Satisfaction. Health Choice recognizes increased inpatient psychiatric utilization is not solely caused by factors surrounding substance abuse. Other factors, including member service patterns and member satisfaction with specific treatment modalities or facilities may also affect member decisions to seek inpatient treatment. One of our Health Homes, West Yavapai Guidance Clinic (WYGC), identified that their members were seeking inpatient services in Maricopa County rather than at their inpatient facilities. We conducted an in-depth review of member utilization data, and in October 2017 initiated a work group with WYGC. This resulted in the formation of a rapid response team, spearheaded by WYGC, to work with members to identify and address concerns. Health Choice is expanding this pilot project with other health homes bordering Nevada, Utah and New Mexico to determine if members are seeking care out of state due to ED referral patterns, convenience, satisfaction or lack of network understanding. Health Choice has added questions about referral sources, hospital satisfaction and prompts to educate members about local inpatient care and resources to our "Healthcare Buddy" Follow-Up After Discharge calls protocol. In addition, Terros, our

mobile crisis provider for Mohave County, is collecting region-specific data on why members are admitted out of state to determine if the reasons are due to ED referral patterns, bed availability or other barriers to admission.

Care Management. Health Choice has developed well-established care management protocols (as discussed in Narrative Submission 4) to reduce admissions and readmissions that focus on identifying high need/ high cost members who have frequent admissions/readmissions and ED visits by assigning them to Top Tier Care Management. Our Integrated Care Managers develop a focused Individual Care Management Plan addressing the causes of frequent admissions/visits to assist providers with appropriate interventions. High need/high cost members also receive an educational letter with information on the crisis system, 24 hour nurse advice, local urgent care resources, etc. so they can better self-manage. All members receive information in their welcome packet, member handbook, and member newsletters on appropriate use of EDs and in-network services.

Alternative Community Based Services, And Follow-Up Care. Our organizational DNA has its roots in NARBHA's history of developing new providers to meet emerging needs. Whether it is the formation of Little Colorado Behavioral Health in the late 60s, or more recently helping NAZCARE's peer and family services get off the ground a decade ago, Health Choice recognizes that being a health plan partner in rural Arizona means we must develop and support new provider and community based resources. Health Choice strongly believes the best resources to ensure member engagement and follow up come from peer and family resource organizations. Whether employed directly by providers, or working through a Community Service Agency such as NAZCARE or Hope Lives, peer and family members offer the credibility and hope associated with "lived experience" that no other resource can match. We are also improving the competency of our peer support specialists and care coordinators to improve linkages for members to connect to treatment through our implementation of the University of New Mexico's Project ECHO tele-mentoring. Peers and coordinators will learn to recognize, respond, engage, refer and inspire members to utilize the full range of community-based services, like Alcoholics Anonymous and Narcotics Anonymous, intensive outpatient, MAT, sober living and recovery homes.

Additionally, Health Choice has used its Community Reinvestment program, along with NARBHA Institute funding, to create new programs to expand community based services. These efforts resulted in the distribution of more than $1.7 million in 2017 to support new community based services. Health Choice has financially supported local food banks, supported housing, sober living, rent assistance, jail transition planning and county public health department efforts to provide health education and prevention training.

Developmental Disorders and Autism Spectrum Disorder (ASD). Many of our children who have needed out of state care have developmental disorders. Health Choice has, therefore, also developed additional specialty resources, including an ASD Toolkit. We have provided start-up and ongoing funding of Behavioral Consultation Services of Northern Arizona for children with developmental disabilities and ASD to provide functional behavioral assessments, applied behavioral analysis and positive behavioral supports early in a child's treatment course. These services are available across our region and on the Navajo reservation. We have also funded an ASD diagnostic clinic at Yavapai County Health Department for children not on Medicaid.

Direct Support. Health Choice requires discharge planning, including follow-up after discharge, in all of our inpatient hospital and provider Health Home contracts and policies. Our 2017 Case File Review shows that members received a follow-up service at a Health Home within seven days of discharge 97.3 percent of the time. Our Medical Management specialists conduct concurrent review, oversee, and participate in discharge planning, to ensure that post-hospital services are in place. Additionally, we provide support for members transitioning out of the hospital. Health Choice's specially trained "Healthcare Buddies" call members after discharge to ensure members have required discharge appointments and to check on their well-being, assist with medications, and inquire about satisfaction with their hospital experience. Our experience shows that Buddy calls result in a rate of readmission in rate of 30 day readmissions two time lower than those not reached and the odds of being readmitted were 47 percent less if contacted by a Healthcare Buddy.

Conclusion. Heath Choice's "behavioral health led" model of integration is unique. Because of it, we understand, and have already developed strategies to address, issues such as hospital ED holds, inpatient psychiatric utilization rate, and the development of community based resources. We will not, however, rest on history. We will continue to research and identify emerging trends, and in partnership with AHCCCS, work to develop new resources and strategies to address them.

Narrative Submission 11

Steward Health Choice Arizona (Health Choice) will build upon our current comprehensive provider network platform to ensure that it serves the unique and specific needs of our most complex members. We employ a proactive, partnership-based approach to maintaining an adequate network of specialty providers and behavioral health providers for both children and adults. Of the nearly 18,000 providers currently contracted with Health Choice in Arizona, more than two thirds are specialty and behavioral health providers.

Health Choice has over 50 years' experience in creating solutions to address network adequacy among specialty and behavioral health providers for both children and adults. Health Choice will continue to partner with providers and local communities to expand services as we identify needs. Specialty and behavioral health providers can be critical to a member's service plan in supporting their overall goals. Such providers may include specialty medical services such as cardiologists, pulmonologists, or oncologists, as well as behavioral health services such as peer supports, parenting classes, substance use disorder treatment, and services for autism spectrum disorder. Health Choice takes great care to ensure specialty and behavioral health services are available to serve our most vulnerable populations, including opioid treatment programs**,** opiate replacement services**,** Applied Behavior Analysis (ABA) for individuals with developmental disabilities (including Autism Spectrum Disorder)**,** residential treatment centers**,** peer-run and family run organizations, Multi-Specialty Interdisciplinary Clinics, and HIV/AIDs organizations.

We will contract with a network of specialty and behavioral health providers to meet the needs of our members. Services will be available locally and quickly. Our overarching goals are:

- Member choice of providers
- High provider satisfaction
- High member satisfaction
- High quality and clinical outcomes
- Cost containment
- Limit out-of-state utilization

Due to the ever-changing needs of the population Health Choice serves, we will use a data-driven approach to monitoring our network of specialty and behavioral health providers for adequacy and quality performance. We will monitor network adequacy through geo-access reports, out of network provider requests, member requests, and collaboration with our provider network and community organizations. Sometimes challenges can arise due to a lack of providers, lack of capacity with current providers, or quality improvement opportunities. We will overcome challenges through provider and community collaboration, financially incentivizing provider quality and cost performance, and expanding and promoting telehealth capabilities.

Network Adequacy. Health Choice's network development is driven by both qualitative and quantitative data. Health Choice will obtain data from members, providers, advocacy organizations, and allied government agencies such as AHCCCS, Department of Child Safety (DCS), and the Department of Economic Security (DES). Additionally, we will gather data from discussions with local stakeholders, member and provider satisfaction surveys, and through complaints and grievances. Quantitative data will reflect information pertaining to both members and providers about network accessibility needs which vary depending on factors such as when new members enter services, where members live, and their specialty and behavioral health utilization patterns. This will allow us to compare member data to the location and specialties of our provider network to determine if our providers have the capacity to meet the needs of our members. Health Choice will also incorporate results from completed network assessment activities, such as geo-mapping to identify network gaps, which will inform prioritization of network expansion activities.

To better understand the expanded services, populations, and geographic areas of the AHCCCS Complete Care program, Health Choice has already gathered qualitative and quantitative data on members, potential Health Home providers, and potential specialty and behavioral health providers in each region of the state. Health Choice currently maintains a sufficient physical health provider network in our current services area, including specialty providers, as well as an extensive network of behavioral health providers across Central, Northern, and Southern Arizona. Our primary focus regarding network analysis and preliminary network development is to address the needs of the populations who will be integrated into AHCCCS Complete Care, specifically the behavioral health needs of adults with General Mental Health and Substance Abuse and children,

as well as physical and behavioral health needs of children qualified through Children's Rehabilitative Services (CRS).

Post-award, Health Choice will immediately embark on an even more detailed analysis of our network to identify any potential gaps based on service area. This analysis will include a review by provider type, number, and location/distance for members to travel. We will evaluate utilization history of current members, data transmitted from relinquishing plans/RBHAs for new members, Health Current information, and blind spot data. In addition to this, Health Choice will also continue conversations with providers and community stakeholders to obtain information not found in data around any challenges members may be facing in their local communities.

Strategies for Ongoing Network Development. We will employ a variety of methods to ensure a robust network of specialty and behavioral health providers is in place: Provider collaboration, financially incentivizing provider quality and cost performance, and expanding and promoting telehealth capabilities.

Provider and Community Collaboration. Health Choice will continue to utilize strategies that we have historically employed throughout in Arizona to develop specialty providers in new regions, which include:

- Expand capacity among existing providers.
- Recruit providers from other regions.
- Develop new providers within existing communities.

Integral to each of these strategies is provider and community engagement through partnership, a deep and thorough understanding of the clinical needs, system values, provider regulatory and system requirements, and funding and contract terms that incentivize high quality care, collaboration, and coordination with specialty providers. Health Choice has extensive, successful, and Arizona Medicaid-specific experience in each of these strategies, and a vision for future specialty-provider development in other parts of the state, as discussed below.

Expand Capacity of Existing Providers. Often provider organizations have untapped internal expertise and/or interest in expanding into other specialty service arenas. We will discuss identified needs with existing providers, identify evidence-based practices that will fill the need, compile data related to volume, the specific services that could fill the need, and jointly establish a development plan with providers. If multiple providers express interest and aptitude, then we may initiate a competitive procurement to select one or more specialty providers. Our development plan will address funding and rates, contract terms, regulatory and licensure requirements, service standards, timelines, and communication protocols.

Health Choice has also supported Behavioral Health Homes to explore expanding into different models of integrated care. Our efforts have resulted in four Health Homes developing their own integrated physical health services to become Integrated Health Homes.

As an example, Health Choice successfully expanded the capacity of one of our Health Homes through a competitive bid process. The process resulted in selection of a specialty Medically Assisted Treatment (MAT) provider that would deliver a more holistic and integrated approach to methadone services. As a result of the selection process, which included peers and family members in the review panel, we selected an existing Health Home (Southwest Behavioral & Health) to provide methadone treatment throughout Northern Arizona. Based on their performance, Health Choice has established a value based contract for methadone services with Southwest Behavioral & Health, and designated the agency as a Center of Excellence for holistic and integrated MAT. We used a similar approach to streamline non-emergency transportation services related to behavioral health services. After exploring the continued use of a separate non-emergency transportation provider, we decided to fund the creation of a van pooling arrangement (managed through our Health Homes). This resulted in improved member satisfaction, and substantial cost savings.

Health Choice also supported expanding behavioral health provider capacity within our existing Health Homes by funding the creation of crisis stabilization units across Northern Arizona. Since becoming an Integrated RBHA contract in 2015, Health Choice has worked with four of its Health Homes to develop behavioral health crisis stabilization units in Flagstaff, Prescott Valley, Kingman, and Show Low. Three of the four Health Homes had never provided this type of service before. We partnered with other providers from around

the State, toured and learned about their facilities, worked with the Arizona Department of Health Services on rates, and worked jointly to address licensure limitations. Health Choice also worked with community stakeholders, who were eager to support crisis stabilization units to divert patients from hospital emergency departments, jail, and unnecessary inpatient services. To support our Health Homes in this specialty expansion, Health Choice entered into a consultation agreement with an experienced Arizona crisis provider, ConnectionsAZ, which afforded developing crisis stabilization units easy access to Arizona-specific expertise. As a result of this support for existing Health Homes to expand into specialty services, crisis stabilization units in Northern Arizona are available to provide a safe and caring response to persons in crisis, and diverting people from hospital EDs, jail, and unnecessary inpatient services.

Recruiting Providers from Other Regions. As an established managed care organization with experience in rural Arizona, Health Choice has benefitted from the extensive resources available in the urban parts of the State and has established many successful partnerships by recruiting specialty providers from Arizona's urban communities to rural Northern Arizona. Recruiting providers from urban regions to open locations or partner with Northern Arizona based providers has allowed us to become familiar with other specialty providers and understand how services are delivered in urban parts of the State.

For example, Health Choice identified a need for pediatric dental care in Northern Arizona and partnered with an existing dental provider to expand dental services for pediatric members. In order to provide high quality/cost effective pediatric dental care, we recruited a pediatric dental provider located in Central and Southern Arizona to open an office in Flagstaff. This provider was selected based on quality outcomes and willingness to partner on community engagement events and member outreach. This expansion has proven very successful, and the provider has expressed a willingness to expanding to other locations.

Recruitment Success Stories:

- *Child & Family Support Services: Community Bridges and Southwest Behavioral & Health*
- *Mobile Crisis Services: Terros*
- *CPES from Tucson for specialty services for members with DD/ASD*
- *HCTC/therapeutic foster care oversight: Pathways from Tucson*
- *Forensic peer support: Hope Lives*
- *Family support: MIKID and the Family Involvement Center*

Developing Providers within Existing Communities. Health Choice recognizes, values, and is engaged with the rich cultural, educational and "lived experience" of people and communities within the regions we serve. Discussing local problems with people living in our communities who know the local needs and resources, know the formal and informal systems of service delivery, and have passion and ideas and a willingness to partner are the foundation of specialty service development within our communities. Health Choice has extensive, successful, and Arizona specific experience developing specialty services within the communities we serve. Examples of these partnership activities include the development of Applied Behavioral Analysis, our Traditional Practitioner Program, and development of local National Alliance on Mental Illness (NAMI) affiliates across Arizona as described below:

- The NARBHA Institute and Health Choice Integrated Care worked with Northern Arizona University to take a budding academic program for Applied Behavioral Analysis, and assisted them in getting licensed and AHCCCS registered, as a Behavioral Health Outpatient Treatment Center. This agency, Behavioral Consultation Services of Northern Arizona, now has over 30 clinicians who are (or are in the process of becoming) ABA-licensed and are delivering Applied Behavioral Analysis with families throughout Northern Arizona and on Navajo, Hopi, and White Mountain Apache tribal lands.
- Our Traditional Practitioner Program draws from the unique expertise of recognized American Indian Traditional Practitioners who perform healing ceremonies for American Indian members. This program is funded through our Community Reinvestment program, maintains a database of screened Traditional Practitioners, and delivered over 100 healing ceremonies to our members in the past year.

- Health Choice, together with the NARBHA Institute and NAMI, have expanded critical community-based non-Medicaid services through the development of NAMI chapters throughout Northern Arizona. These free community-based services delivered by local volunteers with "lived experience" offer nationally-recognized education and support to all members of the community, raise awareness about mental illness, and reduce stigma. By employing these same strategies of community engagement and partnership, we have developed (or are developing) and are supporting new NAMI affiliates in Payson, Lake Havasu City, and the White Mountains.

Financial Incentives for Quality and Cost Performance. Health Choice will adopt funding and contract terms with providers that reduce barriers to specialty and behavioral health services while aligning incentives to achieve quality and cost targets. We will accomplish this through Health Choice's Integrated Health Home (IHH) and new Integrated Accountable Care Organizations (IACOs). In these models, members are attributed to a provider organization accountable for the total cost of quality and care of their members. The organizations will contract through a shared risk arrangement which aligns financial incentives to promote development of specialty and behavioral health provider organizations and services. Through this model, providers are highly incentivized to ensure that their members are getting the right care, at the right time, at the right place – and to ensure high quality and cost containment. We will also use this model to target specific, data-driven quality improvement opportunities, aligning provider incentives with quality and cost targets. Steward has been successful in using our value-based payment model to achieve specific quality and total cost of care targets in Massachusetts, and will support Health Choice to adapt best practices for AHCCCS Complete Care.

Following the six month transition period, all Health Choice members will be assigned to an IHH for behavioral health care services. Health Choice and the IHHs will share risk and clinical and financial responsibility for their entire assigned member panel. We will subsequently extend this model to both physical and behavioral care, and will thereafter evolve these to become IACOs. Our integration of physical and behavioral health will allow us to create an aligned financial model which supports whole-person care. We will ultimately attribute at least 75 percent of members across all service areas assigned to an IACO by the end of the fifth year of our contract. Already we have agreements with potential IHH providers across the state who have capacity to deliver both behavioral health and physical health services including specialty care.

Network Purchase Agreements**.** Another successful strategy of our Health Home model to ensure specialty and behavioral health provider network adequacy is the use of our "network purchase" agreements held directly by Health Choice. In these instances, Health Choice has a direct contract for services such as: Family support delivered by a family-run organization, Peer-delivered services offered through a Peer-Run organization, Applied Behavioral Analysis, Chemical dependency residential treatment, and Inpatient psychiatric/medical detox hospital/subacute services. These contract and funding terms prioritize certain specialty services, reduce any funding barriers that may limit referrals from Health Homes, reduce out-of-home placements, and strengthen and enrich the array of specialty services and supports in small towns and on tribal lands.

Telehealth. Health Choice's unique geographic service area led us to pioneer a telepsychiatry network which has operated since 1996 to increase member access to behavioral health services. Health Choice serves as a telemedicine training site for providers throughout the country and has helped draft national and AHCCCS standards and best practices for this service delivery technology. Today, Health Choice is a national leader with an award-winning telemedicine program that provides members in remote areas with access to psychiatrists, peer support and American Sign Language interpreters. With more than 236,000 patient telepsychiatry appointments since its inception, our telemedicine network includes 80 sites in Arizona. In addition, our new telemedicine program with on-demand mobile application-enabled medical care aims to decrease avoidable utilization of hospital and ED visits.

Future Development Opportunities, Concerns, and Strategies. Health Choice is excited about developing and expanding specialty services in parts of Arizona where Health Choice does not have a significant footprint today. Through our recruitment and interaction with specialty behavioral health providers in Maricopa and Pima County we have already become familiar with many local specialty providers in these regions and, through discussion with local stakeholders, we have become familiar with some of the pressing needs and issues related to developing local access to specialty services for our members. To expand specialty services in other

regions we will employ the same strategies we have successfully used in Northern Arizona, such as expanding capacity within existing providers, recruiting quality providers from other areas, developing providers within existing communities, and offering network purchase funding and contract terms for key specialty providers.

Both a concern and opportunity lies in integrating behavioral health and physical health services within provider organizations that presently may not have integrated capacity. While we will initiate our Integrated Health Home model first to Integrated Behavioral Health providers where the GMH/SA and Title XIX child populations are accustomed to receiving behavioral health, we recognize that the vast majority of the acute population are not receiving behavioral health services, are accustomed to receiving physical health services in non-integrated settings, but could benefit from the receipt of behavioral health services within the same location where physical health services are delivered. These convenient and easy to access behavioral health services for the non-RBHA acute populations will increase access to behavioral health services in physical health service locations, will "normalize" the receipt of behavioral health services and reduce stigma, and will help improve members' overall health and reduce overall costs of care.

Help primary care providers and other physical health providers to recognize that almost every family, at some point, will need and benefit from behavioral health services, will be critical to practice transformation. Changing long-existing patterns of service delivery, educating physical health providers about integrated care, and engaging and incentivizing physical health providers poses both a challenge and opportunity. We will approach this challenge – which is both a shift in practice and perspective – by utilizing a Practice Transformation Team and a specifically designed change management plan. Our change management approach will employ engagement strategies including discussion and research of needs and issues, equipping physical health providers with resources and skills so they feel comfortable discussing behavioral health issues and needs with families, and delivering behavioral health services within a physical health practice environment. We will select providers who are participating in AHCCCS' Targeted Investment program to help fund practice transformation. While we understand that many physical health practitioners embrace behavioral health as part of a person's overall health, we also recognize that this is not universally the case and opportunities exist for practice transformation throughout the physical health realm.

Starting in 2014, HCIC partnered with Arizona State University's (ASU) Center for Applied Behavioral Health Policy to assess our network's readiness as we planned the integration of physical and behavioral health service for persons living with Serious Mental Illness in Northern Arizona. ASU used an interview and survey process to complete this assessment. Through this partnership with ASU, we identified barriers and needs within behavioral and physical health providers at the local community level. ASU's work has served as a roadmap to supporting all our health care providers in moving forward together in integrated care. We will continue to work with each provider toward a common understanding and toward positive movement along the continuum of integrated care and equip them with the tools they need to recognize, embrace, and address behavioral health as integral to physical health and well-being. Health Choice will have a leadership training series, available over our Zoom Technologies telehealth system, for providers to learn about our model of care, network design, financing, and ways to address accessibility challenges.

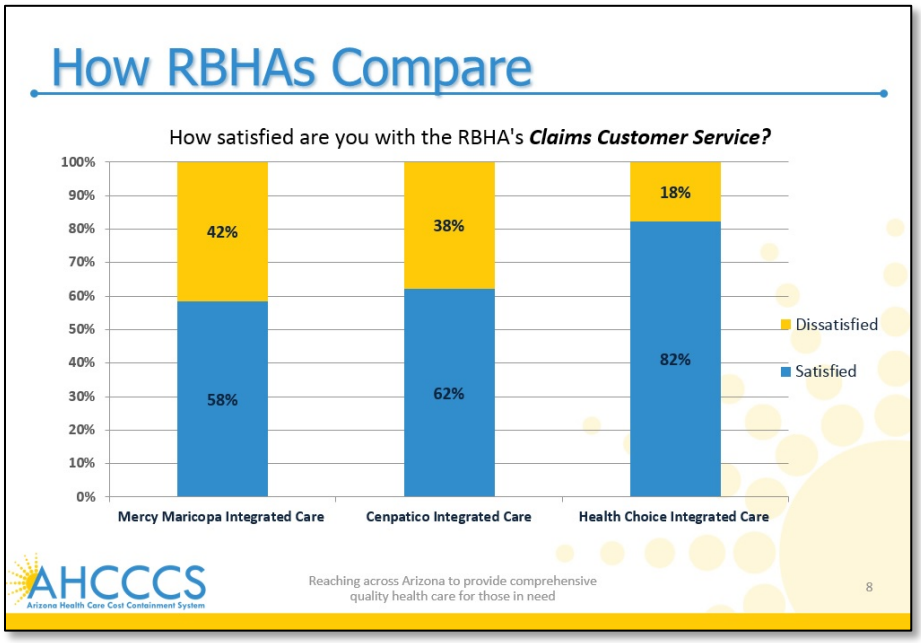
Conclusion. Health Choice will execute a variety of strategies to ensure a complete and adequate network of specialty providers and behavioral health providers to serve the needs of our population. This will be accomplished by building on past successes of provider and community collaboration, financially incentivizing provider quality and cost performance, and expanding and promoting telehealth capabilities. We will continually monitor and evaluate our network capacity via the use of a variety of data sources and feedback from members, providers, and community organizations. As the needs of our population change, we will have a structure in place to adapt and meet those needs ultimately leading to high member and provider satisfaction, high clinical and quality indicators, and an appropriate cost structure.

Narrative Submission 12

Steward Health Choice Arizona (Health Choice) recognizes that provider satisfaction is at the heart of the member's health care experience. Providers are the means through which health care services are delivered, so keeping them satisfied is vitally important. Conversely, a provider's unhappiness with a health plan can inadvertently color what and how they communicate with the member. We are, therefore, committed to building and maintaining strong provider partnerships and maintaining a high level of provider satisfaction.

Overview. We recognize that systemic change, such as integration of physical and behavioral care management, can place providers under great stress. Our goal is to give our provider partners the support they need, and deserve, to meet these challenges. We will accomplish this by providing tools and resources to help facilitate effectiveness and efficiency while reducing unnecessary administrative burdens. Health Choice will deploy a model which communicates upcoming changes in advance and works with providers to help navigate them. Changes such as the realignment of financial and quality incentives will emphasize our role in supporting providers throughout the process. Health Choice will partner with providers to support continuous practice transformation, and create a system which is built on value, not volume.

The guiding principles underlying our provider relations strategy have been developed through years of collaboration with a variety of Arizona providers. Health Choice will build on and expand the current provider partnership model which has been used by the Northern Arizona Regional Behavioral Health Authority (NARBHA) and Health Choice Integrated Care (HCIC) for the past 50 years. Provider satisfaction with this model has been demonstrated via AHCCCS administered provider satisfaction surveys, as well as feedback from the provider community. To date, HCIC's provider satisfaction results have exceeded all RBHAs. With the most recent satisfaction survey results from 2016, HCIC scored at the top in many categories, not only when compared to the other Regional Behavioral Health Authorities, but also against other AHCCCS contactors with respect to questions related to claims processing, resolution of claims issues, claims customer service, and satisfaction with provider relations staff members.



Our overall strategy for better serving our provider partners is built on HCIC's three guiding principles: Communication, Transparency and Partnership. Additionally, we recognize that several key operations processes directly impact provider satisfaction, such as assistance during times of transition, claims payment, prior authorization, credentialing, and regulatory and licensing support. Finally, we recognize the importance of monitoring our own performance so we can identify problems that will cause provider dissatisfaction before they turn into complaints. Each of these concepts is discussed below.

Communication. Health Choice believes communication is critically important to our providers, and a core component in achieving and maintaining provider satisfaction. While important on an overarching level at all times, this will be particularly so during the transition period prior to, and immediately following, "go live" on October 1, 2018. Drawing from our experience and lessons learned from prior transitions, as well as considerations of feedback received from providers across the state, Health Choice has developed a communication strategy which will be intuitive, proactive, and comprehensive. We will have methods for

providers to give frequent feedback as well as methods for quick internal analysis and action facilitating the ability for prompt adjustments based on input received regarding the transition process.

Transition Communications. The months leading up to October 1st will be a critical time for provider communications. Going live April 1st, we will have a page on our website (with a link on our provider portal) specifically dedicated to providing updates related to the transition. There will be an ability for providers to sign-up for a list-serve to receive emails as the website is updated. We anticipate updating this page with information on member communication from both Health Choice and AHCCCS and transition reminders leading up to October 1st. Even following go live, updates will be provided on any major issues identified and communication on how and to whom to direct questions. A twice daily bridge line will be opened for providers and community organizations to join, receive updates, and provide feedback during the first week of the transition. This communication strategy will be evaluated after the first week to determine its efficacy and changes made as identified. Extended service hours (7am – 7pm) will be established for incoming inquiries, and providers encouraged to call immediately with any concerns. Additionally, all provider representatives will be available via phone for support and on-site if needed.

Proactive Ongoing Communication. We understand that most providers are working with several different payors, and thus it is important for us to be proactive and consistent in our messaging. First and foremost, on-site meetings are important to building and continuing relationships. The frequency of on-site meetings will depend on the provider type. At the request of the provider, however, these may occur more frequently. Additional communication methods will be utilized such as newsletters, fax notifications, and provider forums.

One way that HCIC has been successful in gaining provider feedback is through regular monthly Provider CEO Meetings. Through this forum, we receive timely feedback on many topics including customer service and the timeliness and accuracy of our claims payment system. For example, we identified through this process that providers were unhappy with the claims processing system in use for acute claims. Health Choice is, as a result, making the investment to move all claims processing to the platform that HCIC currently uses – Trizetto's QNXT. This product is one of the most highly recognized in the healthcare industry, known for its accuracy and adaptability to ever-changing requirements. Health Choice has utilized QNXT to process behavioral health claims for over five years. Health Choice has been able to configure QNXT to auto-process 85 percent of claims with a 98 percent accuracy rate. This will be a key driver to provider satisfaction as we move forward.

Incoming Inquiries. For incoming inquiries, we will utilize a "24 hour/5 day/30 day" approach through which all provider inquiries received either telephonically or electronically are responded to within 24 hours of receipt. Our provider representatives will then communicate a process for resolution of the issue within five days of the initial inquiry, and resolution will be completed within 30 days. If a response indicates that resolution of an issue will take more than two weeks, a weekly communication will be offered to the provider – electronically, telephonically, or in-person. All inquiries received telephonically or electronically will be logged and reports will be reviewed by Provider Network Services management daily to ensure that service levels agreed to with the provider are met.

Health Choice was also the first AHCCCS plan to communicate a formal "escalation process" for provider concerns. This process includes contact emails and phone numbers for Provider Network Services management team members so that providers can quickly escalate issues up the management chain if their concerns are not being resolved by their assigned provider representative. The escalation process is posted on our web sites, and has been distributed by fax, email, and in person by provider representatives.

Transparency. Our approach with providers is to be open, candid, and fair in our actions and communications. This approach elicits trust from the provider community and enables a successful partnership. One of the main ways Health Choice demonstrates our commitment to transparency is through personal meetings. A variety of personal meetings and written communication will be utilized throughout the year, and throughout the organization. Our in-person approach is especially important given the norms and expectations of our rural providers. Information gathered from providers during these meetings will be utilized to analyze and implement improvements.

- As noted, we will continue to hold monthly Provider CEO Meetings held in different locations across the service area with Zoom video capabilities for those unable to attend in-person. (Despite its name, attendance at these meetings are not actually limited to provider CEOs — but calling it this works from a marketing perspective.)
- Quarterly provider forums;
- Quarterly 'What's Happening' Newsletter to offices;
- Monthly Provider Medical Directors Meetings;
- Monthly Provider CFO Meetings;
- Annual provider conference held to have presentations from Health Choice and the provider community to discuss trends, best practices, and opportunities for collaboration.

Another important aspect of transparency is openness around financial information. As Health Choice moves to a sub-capitated payment methodology where providers share risk, it is vital that we share provider financial performance information frequently, so that providers can understand how certain outcomes will impact their payment. This must be done at a detailed level so providers can understand areas of opportunity or risk, and discuss options for improvement if needed. Feedback from our current HCIC provider network is that this is one of the most satisfying aspects of working with us, and is not replicated by other managed care organizations across the state. We look forward to enhancing our reputation for transparency as we expand our payment model across Arizona.

Partnership. Provider partnership is far more than just lip service for us. Our history is founded upon the NARBHA legacy as a provider-built support organization. We see our provider network as part of us, as a collaborative partners — neither of us can deliver health care without the other. We have worked with providers across the state to gather input on our future network design and payment models so they can meet the needs of members. A consistent theme of these discussions was allowing the providers at the point of care to drive care planning and accompanying decisions. This is a cornerstone of our approach, and ultimately reduces provider administrative burden and improves provider satisfaction. It also expedites services for members, while reducing an additional administrative layer. Some of the past strategies we have utilized to partner with our providers, and would continue to use, include partnering to assist with connection to Health Current, and support in holding health fairs.

Practice Transformation Support. As the expectations of our provider network evolve, it is our responsibility to support providers in their practice transformation efforts. Our extensive work with providers in support of AHCCCS' DSRIP proposal and Targeted Investment program is a good example. We will continue these efforts through the use of a variety of tools to support practice transformation. As the health care system continues to shift to focus toward integration and outcomes, providers must change their operations to meet expectations. We will provide support through advanced predictive analytics, synthesized data, integrated Individual Care Management Plans, and making subject matter expertise available.

We will increase the number of providers receiving prospective sub-capitated payments through a shared risk arrangement. Our experiences in Arizona and Massachusetts indicate that this will improve satisfaction and ease the transition, particularly for behavioral health providers. We expect that this will also decrease the disputes related to payment and allows for more time to be spent discussing clinical and quality outcomes. Our sub-capitated, shared risk payment methodology also aligns incentives for providers and Health Choice as both parties play a financial role in the outcomes of the members to a considerably greater degree than in a fee-for-service system. The expectations we have for providers to drive outcomes, will be matched by the support given to modify operations and workflow.

Transition Support. The integration of physical and behavioral health services, as well as associated member transition process, poses concern for the advocacy and provider community. It is a high priority for us and for our provider community that we work closely during the six months before and after October 1, 2018. This support will be built on frequent communication and data/information sharing.

- **Practice Transformation Team.** Based on Steward's experience in Massachusetts, Health Choice will deploy a Practice Transformation Team, including clinical, legal, and organizational development

professionals to assist providers as they transition to an integrated practice environment. Or efforts will initially be focused on providers who are participating in AHCCCS' Targeted Investment program.

- **Transition 'SWAT' team**. As we did during the 2015 transition, we will monitor a variety of metrics and operations to ensure members are able to access and receive needed services post-implementation. We will partner with our providers to ensure that members receive all needed behavioral health, physical health, pharmacy, and transportation services in a seamless manner. Health Choice will form a transition Special Workgroup and Tactics (SWAT) team and command center to monitor member and provider needs on a daily basis for at least the first month of the contract. An assessment will then be made to determine if meetings should be moved to weekly through month three of post-implementation. The team will be led by the Chief Executive Officer and include a representative from each key operational and clinical area of the organization, in addition to specialized call center representatives that serve both members and providers. A transition plan will be utilized to monitor outcomes through real time data and dashboards. This data will also allow Health Choice the ability to share information with providers, other health plans, members, and AHCCCS as needed.
- **Data Sharing**. Once we receive enrollment information from AHCCCS, we will combine it with all other available member data, such as current claims and pharmacy information, blind spot data, information shared via relinquishing contractors, and Health Current information – into our predictive analytics model to identify members who may be at risk during the transition and generate integrated, Individual Care Management Plans for these members to be shared with their assigned primary care provider and assigned Integrated Health Home. We will require our providers to reach out to high risk members prior to October 1st to engage with them and establish appointments. This information supports providers as they continue or build new relationships.
- **New Provider Orientation**. Similar to the HCIC transition process leading up to October 2015 (which similarly involved integration of physical and behavioral health as well as an expanded service area), we will use a full-court press approach to onboarding new providers leading up to "go live". We will use a team model with representatives from a variety of departments to go meet with providers and assist them in preparations. For the HCIC transition in Gila County, a required two-day on-site training was completed for new providers. This model was so successful that we will duplicate it for this transition effort.

Claims and Prior Authorization Information. Our approach is to make things easy for our providers. Health Choice has made a significant investment in our upgraded provider portal as a tool for providers to use on a self-service basis. Providers can check claims status, review payment and denial information, and export or print information as needed. Additionally, the provider portal will include functions for submitting and checking status prior authorization requests. A live chat functionality will allow providers another communication for a quick responses to inquiries.

> **"HCIC has always been very easy to work with regarding claims and credentialing. The staff is always pleasant and we receive immediate responses to any inquiry."**
>
> *— Comment submitted 2016 Provider Survey Results*

Feedback from providers has been that the most important things we can do to support them are to pay their claims accurately and timely — and be available when there are questions. Our goal is to provide information on claims payment which meets the needs of the provider. In the event that additional information is needed, this will be at their fingertips 24/7 on the provider portal. In an industry engaged in constant change, it is important for our customer service staff to be well-educated and able to assist in resolving issues. We will update the training for our customer service team, and monitor service levels based on the information provided.

Credentialing. Credentialing has been a provider "dis-satisfier" in Arizona for many years. We aim to change that. We have identified ways to reduce duplication of processes and ensure that providers can begin delivering services as quickly as possible. For our Integrated Health Homes, Integrated Accountable Care Organizations, and large provider organizations, we are in the process of delegating credentialing and

overseeing that delegated function through on-site audits. Delegated credentialing enables large providers to begin providing care much more quickly. In our experience of auditing organizations where we have delegated credentialing, the outcomes have been very strong, including no compliance concerns, and the benefit to the provider and to the plan is significant.

Regulatory and Licensing Support. Health Choice understands that regulatory and administrative requirements are time consuming for providers, which is why we will minimize additional requirements beyond those established by regulatory entities. In addition to limiting additional requirements, we have the staff and knowledge to provide technical assistance related to regulatory compliance. We will focus on efforts to licensure and regulatory simplification by working with stakeholders, providers, community organizations to advocate for reductions in administrative burden.

One ongoing example is our ongoing advocacy for parity in training requirements among settings where personal care is delivered. Based upon an identified need, HCIC partnered to develop Behavioral Health Residential Settings (BHRFs) that also meet state licensing requirements for "personal care" and identified opportunities for regulatory alignment related to training requirements and is working with provider organizations, AHCCCS, and the Arizona Board of Examiners for Nursing Care Institution Administrators & Assisted Living Facility Managers (NCIA Board) to evaluate training requirements. This regulatory alignment will help ensure members throughout Arizona have access to community based behavioral health and personal care services – at a substantial cost savings compared to nursing facilites, and with improved member satisfaction and outcomes.

Internal Monitoring and Process Updates. Health Choice will use a team approach to monito our internal processes so that internal problems do not turn into provider complaints. The team will be led by our Vice President of Operations, Diana Alvarez. As noted previously, we recognize claims payment and credentialing are critical factors influencing provider satisfaction. Thus, an experienced claims liaison and an internal support representative (who assist with credentialing paperwork, provider loads, and other administrative functions) will also participate on the team. In addition, certified coders and providers claims educators will be made available for more complex billing questions and training.

Health Choice will use a thoughtful, collaborative, and continuously evaluated approach to how we serve the needs of our providers. We will employ staff who are service-focused, and partner with our providers to achieve these goals. Health Choice will utilize a provider satisfaction dashboard to monitor provider satisfaction. Metrics utilized to monitor provider satisfaction will include overall claims status inquires, first call resolution, prior authorization status inquiries, complaints and expressions of dissatisfaction, credentialing requests and status inquires, and contract status inquiries. These will be measured through our call/email tracking, as well as post call surveys offered on all calls.

The provider satisfaction dashboard will be reviewed with the cross-functional team that participates in the twice weekly "operational huddle" meetings, and our monthly Provider Relations Improvement Committee. This team will identify multiple initiatives for improvement each month. These initiatives will go through a LEAN Six Sigma program cycle which will involve planning, development, implementation, and evaluation. Additionally, quarterly internal provider satisfaction surveys will be conducted to monitor satisfaction and identify opportunities for improvement. We will also utilize our provider portal survey functionality to gain ad hoc feedback on specific topics or initiatives.

Conclusion. Change can be very hard on providers. Health Choice acknowledges this, and will work with our provider network to help them navigate the transition to AHCCCS Complete Care. We also recognize that provider satisfaction and engagement is imperative to achieving our goals of improved quality, member satisfaction and engagement, and to ultimately reducing costs to AHCCCS and the State of Arizona. Based on feedback from physical and behavioral health providers across the state, we know that satisfied providers also usually offer the best service. And service to our members is what we are all about. We look forward to continuing our long standing partnering with providers to expand our model to serve Arizona in an effective, transparent, and positive manner.

Narrative Submission 13

Understanding the member and provider "experience" is elemental to properly managing an AHCCCS Complete Care plan. Member satisfaction is important because it encourages members to engage in activities impacting their health, and thus resulting in better overall outcomes. Provider satisfaction is important because it impacts quality of care, cost of care, and member satisfaction. Health Choice recognizes that studies, such as the RAND study, have demonstrated a significant positive correlation between physician satisfaction and patient adherence to physician care recommendations among patients with major chronic conditions.[1] We recognize the importance of turning member and provider feedback into action.

Steward Health Choice Arizona (Health Choice) will continuously engage our member and provider communities to enhance the quality and accessibility of services for our members. We will use our provider-led governance structure to support our Integrated Health Homes (IHHs) and Integrated Accountable Care Organizations (IACOs), and augment this with stakeholder advisory councils. Health Choice will be consistently responsive to feedback from members, individuals, clinical teams, and providers to achieve high quality standard built on best practices and demonstrate financial stewardship.

Health Choice will employ continuous process improvement by gathering feedback, analyzing, creating strategies, and monitoring the effectiveness of the changes through feedback and data. We will use a "Plan, Do, Study, and Act" (PDSA) approach to performance improvement, as a component of our LEAN Six Sigma's "Define, Measure, Analyze, Improve, Control" ("DMAIC") team-based approach to quality management and performance Improvement. We will use this philosophy of improvement, monitoring quality of care, and implementing action steps to fuel successful interventions and the improvement cycle.

Member Feedback and Process Improvement. Health Choice will proactively obtain feedback from members, and incorporate that information into our planning and quality improvement efforts to improve the member's experience and help us drive quality health outcomes. These efforts will be done through a variety of processes as documented below.

- Committee Participation and Monitoring
- Complaints and Grievances
- Member Advisory Council
- Community Outreach
- Medical Director Meetings
- Tribal Relations Communications
- Member Newsletters and Surveys
- Integrated Care Manager Outreach
- Member and Family Involvement
- Evaluating Member Calls
- Member Portal Communications
- Member Satisfaction Surveys
- Member Focus Groups
- Member Engagement Committee

Member and Family Involvement. One of the most impactful ways that Health Choice integrates member input is by including peer and family members at all levels of our system. This starts at the top. At least 25 percent of our Health Choice governing board will be composed of peer and family members. Additionally, Health Choice will continue using Health Choice Integrated Care's (HCIC) current governing board, which includes both peer and family members, as a vehicle to specifically assess the needs of members living with Serious Mental Illness. Health Choice's Chief Executive Officer has lived experience as a family member, as do many of our employees. Peer and family members concerns will directly influence our priorities and activities, and will continue to result in a welcoming system of care that meets members' needs.

Health Choice is also affiliated with many local, statewide, and national advocacy committees. We encourage Health Choice members, their families, and residents of surrounding communities to share their voice. Members are encouraged to participate in our committees, and are offered support from the Arizona Peer and Family Coalition and the Community Engagement Committee. Our Office of Individual and Family

[1] Rand Corporation, *Physicians' characteristics influence patients' adherence to medical treatment: results from the Medical Outcomes Study* (Psychology Health, 1993).

Affairs will lead the effort to foster participatory engagement, ensuring peer and family involvement at all levels of our system. Health Choice's staff will drive our recovery program initiatives, and will work with members, families, communities, and stakeholders to build partnerships that promote recovery, wellness, and resiliency. This approach will further promote member and family voice in the delivery system. We will advocate for member wellness and work to remove barriers that impede service delivery.

Health Choice utilizes peer and family support in two ways. Our Health Homes directly employ peers and family members. Health Choice also contracts with Peer and Family Run Organizations (PFRO). Both are beneficial approaches, as individuals who are experiencing stability can "pay it forward" and also be gainfully employed. All members will be offered training and certified peer supports at the point of behavioral health intake – either through an Integrated Health Home or a PFRO.

Committee Input. Health Choice's committee structure will include members and family members in key roles to support our integrated quality management efforts, and provide feedback and direction. The multi-disciplinary integrated committees include the broad representation most critical for the successful attainment of each committee's purpose, including consumers, families, medical staff, providers and other stakeholders. We will have member and family participants at all levels of governance to ensure member and family experience is incorporated in Health Choice strategy and operations.

At the core of the member experience will be our Member Experience Committee which evaluates performance based on established benchmarks. This Committee will review member experience at multiple touch points including call center customer service, member satisfaction, transportation experience, grievances, and disenrollment/enrollment trends. This Committee will be led by our Member Advocacy Administrator, who will have lived experience, and will oversee initiatives for continuously improving member satisfaction. Additional sources of committee input include the following:

- The Member Advisory Council will be responsible for providing adoptive/kinship/foster families of members in out-of-home placement, advocacy groups, and Health Homes, with education and outreach materials to increase awareness, identify and reduce barriers, reduce stigma, and empower families to participate in the delivery of care and services.
- The Office of Individual and Family Affairs Committee will provide a forum for member, family members, community stakeholders, peer recovery support specialists and others to give input to Health Choice, provide feedback on services, receive education on advocacy and health education and wellness topics, and assist Health Choice in reviewing training materials. The primary goals are to ensure inclusion of recovery principles, non-stigmatizing language and that a variety of perspectives are heard related to decision-making processes, Health Choice committees' work, and training content.
- The Cultural Awareness and Diversity Committee ensures the integration of cultural and diversity needs into integrated health services through many perspectives and member input.
- The Northern Arizona Children's Council (NACC) is led by Family Run Organizations and provide insights from the member/family perspective.
- Members are also invited to the Adult/Child Clinical Committee, LGBTQ Committee, Deaf and Hard of Hearing Committee, Medical Management Committee and the Quality Management (QM) Committee to provide input on quality care delivery.

Member Feedback Resulting in Improvements. We take great pride in collaborating with members, identifying ways to improve, and implementing measures that increase their overall experience. The three examples which follow demonstrate our use of member feedback in developing improvements. These examples include: (1) the creation of our Traditional Practitioner Program based on feedback from tribal community outreach; (2) our updated interactive voice response (IVR) system that allows members to reach our transportation and our Medicare Over the Counter (OTC) products vendor, and (3) expansion of the "Parent Support NOW" Pilot (a parent-to-parent connection that provides support, education, and assistance for families involved with DCS) based on initiatives identified through our Member Advisory Council.

Traditional Practitioner Program. Health Choice's Tribal Services Team works closely with the tribal community to collaborate on efforts to create and enhance personalized and culturally relevant healthcare services that result in positive outcomes. Through this collaboration, tribal members communicated to us the importance of traditional Native American ceremonies in helping American Indian members benefit from all forms of treatment. As a result, we created a Traditional Practitioner Program. This program includes our highly acclaimed Sweat Lodge Program, through which recognized American Indian Traditional Practitioners perform healing ceremonies for American Indian members that impact the physical, mental, emotional, and spiritual well-being of individual participants. This program is funded through our Community Reinvestment program and has delivered over 100 healing ceremonies to our members in the past year.

Interactive Voice Response Changes. Member calls are closely monitored by our Member Services Call Center's leadership team. Calls are reviewed for politeness, accuracy of information, and to identify concerns posed by members. Through this review process, Health Choice identified negative comments from members related to two of our highest volume services: Nonemergency transportation and our OTC vendor for Health Choice Generations members. With these comments in mind, we reviewed the data, and identified potential causes and solutions. We found that members contacting our Call Center frequently were not able to navigate our IVR "phone tree," and ended up having to speak with a member services representative before being transferred over to our transportation vendor. We also found that, to a lesser extent, the same was true with our OTC vendor. In an effort to decrease the number of "touches" a member had to make in order to get their needs met, we completely re-evaluated our IVR system's design to more clearly directly members to our transportation and OTC vendors. Members now have the ability to bypass member services representatives entirely, and move directly to the vendor. This change decreased member complaints related to these vendor services, and increased the availability of member services representatives to assist other members.

Parent Support Now. The Health Choice Integrated Care (HCIC) Member Advisory Council provides adoptive/kinship/foster families of members in out-of-home placement, advocacy groups, and Health Homes with education and outreach materials to increase awareness, identifies and reduces barriers to services, and empower families to participate in the delivery of care and services. The Council engages providers, stakeholders, and families in collaborative communications, resulting in reduction of barriers to services, and encourage a spirit of partnership in improving the quality of life for individuals and their families as a result of better health and better healthcare through their relationship with HCIC.

MIKID successes in 2017:

- 215 children referred to PSN
- 32 children successfully reunified with their families in less than six months
- Average length of out-of-home stay was 7.6 months for 71 reunified families

Through the Council's input, we identified the need to modify and expand our "Parent Support NOW" (PSN) pilot project in Mohave County. PSN is a program that creates a parent-to-parent connection to support, educate, and assist families involved with the Department of Child Safety (DCS). The goal of PSN is to increase the number of successful reunifications of the child with their family, and decrease the amount of time the child is in DCS custody. Based on this feedback, we expanded the PSN program in partnership with MIKID, a family run organization that provides services to families of children with emotional and behavioral challenges in Mohave County. HCIC also partnered with Family Involvement Centers, another family run organization, to expand the program into Yavapai County. These changes addressed the needs expressed by the Council and improved services families.

Provider Feedback and Process Improvement. HCIC has longstanding positive relationships with the Arizona provider community. Our guiding principles for provider relations have been developed through collaboration with a variety of Arizona providers, as well as through evaluation of experience data. Health Choice will build on and expand the current provider partnership model which has been utilized by Northern Arizona Regional Behavioral Health Authority (NARBHA) and HCIC for the past 50 years. Provider satisfaction with this model has been demonstrated via AHCCCS administered provider satisfaction surveys, as well as

feedback from the provider community. To date, HCIC's provider satisfaction results have exceeded all RBHAs and scored at the top in many categories when compared to other AHCCCS contactors with respect to questions related to claims processing, resolution of claims issues, claims customer service, and satisfaction with provider relations staff members.

However, we acknowledge that we can, and must, continue to improve. We will increase provider satisfaction rates through the use of a thoughtful, collaborative, and continuously evaluative approach. We will employ staff who are service-focused, and share our vision of providers as partners. To monitor this effort, Health Choice will utilize a provider dashboard to monitor provider satisfaction. The primary metrics utilized to monitor provider satisfaction will be: Overall claims status inquires, first call resolution, prior authorization status inquiries, complaints and expressions of dissatisfaction, credentialing requests and status inquires, and contract status inquiries. These will be measured through call and email tracking. We will also use post-call surveys.

The provider dashboard will be reviewed with the cross-functional team that participates our twice-weekly "operational huddles," and monthly by the Provider Relations Improvement Committee. This team will identify multiple initiatives for improvement each month. These initiatives will go through a program cycle which will involve planning, development, implementation, and evaluation. Additionally, quarterly internal provider satisfaction surveys will be conducted to monitor satisfaction and identify opportunities for improvement. We will also utilize our provider portal survey functionality to gain ad hoc feedback on specific topics or initiatives.

Provider Feedback Resulting in Improvements. The provider experience is important in retaining and obtaining quality providers that focus on providing health care services in a manner that produces better health outcomes, lower costs and higher member satisfaction. Continuously enhancing the interoperation between Health Choice and its providers is central to our strategy to improve provider satisfaction and member experience. Four examples of provider feedback resulting in improvements are discussed below. These include (1) A decision to change claims systems resulting from provider issues, (2) increased in dental visits for children based on feedback from providers through Joint Operating Committee (JOC) meetings with providers and provider representative visits, (3) the construction and establishment of a much needed 16-bed residential treatment center identified through monthly Provider CMO meetings, and (4) the sharing of data to help link community based providers to value based purchasing, as identified through provider forums and solicitations.

Claims System Change. Through several provider outreach vehicles, including our monthly Provider CEO meetings, we identified that one of the biggest drivers behind provider complaints is related to the use of our legacy claims payment system for processing acute claims. As a result, Health Choice made the decision and investment to move all claims processing to Trizetto's QNXT platform. This product is one of the most highly recognized in the healthcare industry, and is known for its accuracy and adaptability to ever-changing requirements. HCIC has utilized QNXT to process behavioral health claims for over five years. HCIC has been able to configure QNXT to auto-process 85 percent of claims with a 98 percent accuracy rate. QNXT is configured and ready to "go live" in 2018. This will be a key driver to provider satisfaction as we move forward.

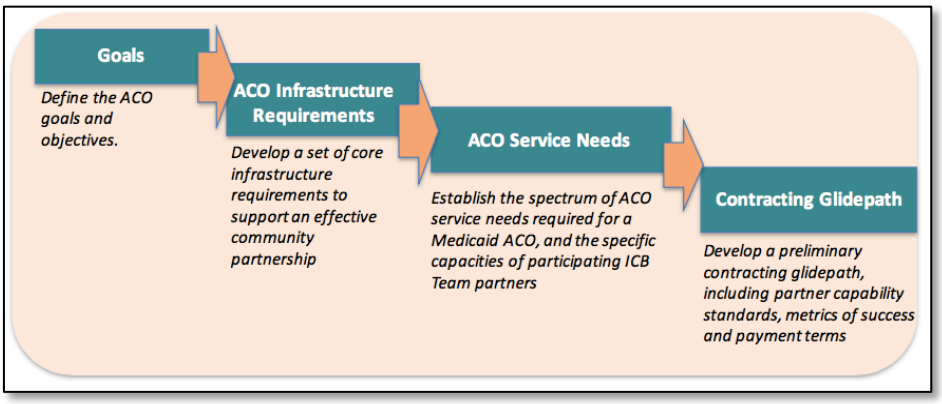
Increased Dental Visits. Through JOCs and network provider visits, Health Choice identified increased concern from the dental community surrounding the low volume of pediatric dental visits and the need for billing education. This was also confirmed through data and analysis conducted by Health Choice's dental team. In an effort to increase the number of dental visits and education for this population and our providers, Health Choice hired a dental coordinator who focuses on scheduling pediatric members for their annual dentist visits, provides education to parents on the importance of dental visits and coordinates provider outreach events. The provider outreach events include education for the providers and staff on proper claims submission, prior authorization education and reporting of members assigned to their offices as "dental homes". The Health Choice dental staff also coordinated with the Community Outreach team to schedule health fairs at provider's offices for our members to increase the number of members being seeing at their offices. Health Choice saw an increase in visits of five percent per month during the first six months of this initiative. The dental coordinator continues to contact members, approximately 300 per month and schedules approximately 150 visits per

month. These initiatives have increased the number of children receiving services and the number of claims submitted and paid.

Albert Long Center. HCIC has held monthly Health Home Medical Director Meetings, chaired by HCIC's Chief Medical Officer, since 1994. On average, 50 medical directors and other behavioral health professionals from providers attend the meeting either in person or via video conferencing. These meetings offer a way for medical directors to provide and receive information, discuss and drive initiatives, develop evidence based practices, and offer training.

We discovered through these meetings that a number of members in Navajo County were repeatedly using the ED and inpatient facilities (with frequent readmissions) due to alcohol intoxication and substance abuse. At almost the same time, this issue was also raised by tribal members to our Tribal Service Team. The medical directors proposed that a nearby underused facility be converted into a chemical dependency residential facility to address the demand. Through collaboration with the Navajo County tribal liaison, HCIC, the NARBHA Institute and Community Bridges, we developed the Albert Long Center, a 16 bed residential treatment center. Individuals receive counseling, living skills training and peer support services. Peer support is provided by those who have lived similar experiences who can share it with others and show they are not alone. The treatment center also provides traditional healing practices, with approximately 30 practitioners from seven different tribes providing the service.

Engaging Community-Based Providers in a Pathway to Value Based Care. In Massachusetts, Steward Health Choice (Steward) learned through local provider forums that several community based providers wanted to take an active role in planning for Massachusetts' transition to Medicaid Accountable Care, while maintaining their autonomy as community-based organizations. In response, Steward brought representatives from 15 organizations together to develop infrastructure and capacity building to link providers across the service continuum. The partners represented community behavioral health providers, long term care services and supports providers, housing and legal services organizations, as well as community health centers, urgent care and emergency medical transportation providers. Facilitated by an independent consultant competitively selected by the group, Steward and the community organizations developed a consensus-based contract model between the ACO and community-based organizations for partnership in a value based, accountable care model. The framework included identifying performance measures, risk arrangements, and operational considerations using language that was tailored specifically for each type of provider. This innovative approach has established Steward as a market leader in integrating community-based providers of behavioral health, long term services and supports, and social determinant of health services.



Conclusion. There are many avenues Health Choice utilizes to obtain member and provider feedback as a means to improve the overall experience. As we see opportunities for improvement, we will continue to act upon them in a planned, thoughtful manner. It is our goal to achieve the best outcomes for members and high satisfaction rates for both members and providers. We will achieve this through stakeholder partnerships in all aspects of system planning and execution, timely and convenient service access, criteria and data-driven service and provider management, coordination throughout internal and external systems, and cost-effectiveness and sound stewardship of public funds.

Narrative Submission 14

Steward Health Choice Arizona (Health Choice) is exceptionally well-positioned to integrate our delivery network in a way that meets the challenges of payment reform. We will employ a provider performance system primarily based on the Health Care Payment Learning & Action Network ("LAN") Category 4B. (Figure 1.) Our largest providers will receive a sub-capitated base payment encompassing the total cost of care for attributed members with a value based, "quality gated" system of shared savings *and* risk. We will target attribution of 75 percent of members to these organizations within five years. We will also use this model to target specific, data-driven quality improvement opportunities, aligning provider incentives with quality and cost targets. Steward has been successful using a value based payment model to achieve specific quality and total medical expense targets in its Massachusetts contracts, and will support Health Choice in adapting best practices for AHCCCS Complete Care. We are also confident in our ability to rapidly effectuate this transition, because Health Choice Arizona (HCA), Health Choice Integrated Care (HCIC), and HCIC's predecessor, the Northern Arizona Regional Behavioral Health Authority (NARBHA), have been working with our physical and behavioral health provider network to prepare providers for this change for more than a decade.

Figure 1. HCP LAN Alternative Payment Models Framework

Health Choice's Foundation for Transitioning Providers to Value Based Payments. Health Choice recognized many years ago the need to transition away from a traditional fee-for-service (LAN "Category 1") provider compensation model, and has been preparing the path for that change. As far back as 2006, NARBHA started this shift incrementally by layering "upside only" provider incentive payments on top of existing payment models. These payments primarily encouraged improved quality, but also aided the development of reporting and care coordination infrastructure (LAN Categories 2A, B, and C). These developments began to refocus providers on improved quality and infrastructure development.

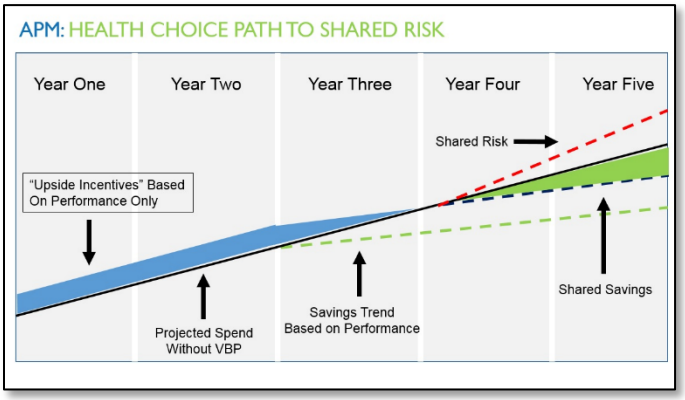


Figure 2. Although using different models, HCA and HCIC have progressed from upside incentive only approaches to shared savings. We are currently in "year four" of our five year strategy.

In 2015, both HCA and HCIC established a five year plan to shift away from "upside only" payments to incentivize quality *and* realign provider incentives, as shown in Figure 2. HCA's model used quality gated, shared saving program using cost reductions below the provider's total cost of care run rate for attributed members to fund a "pool," and then using improved provider performance against standard AHCCCS quality standards to determine how much of the pool would be paid to the provider. HCIC's Value Based Payment program similarly shifted to a system based on AHCCCS quality measures, and balanced these with key service enhancement measures including both physical and behavioral health emergency service utilization, readmissions, post discharge planning, diabetes testing, and increased Naloxone prescribing. These measures were then coupled with total cost of care and member satisfaction measures to form a "balanced scorecard" based on the "triple aim" of improving health outcomes, containing cost, and improving member satisfaction. HCIC also took another step away from the traditional block payment system for behavioral health providers by setting payments based on trended medical costs associated with membership attributed to each specific health home. These changes came about collaboratively and transparently with our provider network, and have done an effective job of setting the stage for "what comes next."

The Result: Value-Based Performance Model for Fully Integrated Providers. We will implement AHCCCS' original vision for the Delivery System Reform Incentive Payment (DSRIP) program, even without the full extent of DSRIP funding. We began this process in 2016 in Northern Arizona in preparation for DSRIP, and with the changes inherent in the transition to AHCCCS Complete Care, we can accelerate the process in Northern Arizona and expand it to the rest of our service region. We will do this by leveraging AHCCCS' Targeted Investment funding, expertise from Steward Health Choice's Massachusetts experience, and our long standing provider relationships, to create what AHCCCS originally called "DSRIP Entities" — a network of regional Integrated Accountable Care Organizations (IACOs) that include integrated ambulatory providers of physical and behavioral health, hospitals and inpatient psychiatric facilities, high volume specialty services, peer and family organizations, and community organizations to support social determinants of health.

The design and composition of these IACOs will take different forms depending on location, partners involved and local economics. The primary care and behavioral health service components will represent an evolution of our existing Integrated Health Home (IHH) network, including new or expanded partnerships throughout Central and Southern Arizona, and our current Accountable Care Organization (ACO) relationships including Phoenix Children's Care Network (PCCN) and Steward Preferred. We also currently work with several physical and behavioral health providers in Central and Southern Arizona who will serve as the "core" of the new IACOs in their respective regions. Social determinant of health services, specialty providers, and inpatient facilities will vary considerably by location, necessitating the formation of unique IACOs by region or community.

Health Choice will compensate our network of IACOs based on the LAN Category 4B performance model. Discussions with our provider network over the course of 2017 have demonstrated that providers are both willing and capable to transition with our active support. For HCIC's current IHH and BHH providers (several of which also have a presence in the Central and Southern regions), this means completing the transition from the "full risk," modified sub-capitation system HCIC currently uses, to a shared risk arrangement based on annually-adjusted population health, risk adjusted, sub-capitation targets. These targets will be derived using the Milliman MedInsight™ system, in a manner that has been developed and employed by HCA's value based program since 2015, and adapted to reflect Steward's best practices developed in its Massachusetts ACOs. The targets will then be used to identify a "per member, per month" rate for providers.

This approach will also provide a transition path for IHH and BHH providers outside of Northern Arizona to transition away from "block purchase" arrangements. We will continue to compensate them on a prospective basis, which will help maintain cash flow stability. However, the actual amount of monthly payments will, at a minimum, change each month based on attributed membership. Health Choice will retain the right and obligation to adjust rates during the year based on substantial changes in the risk profile associated with a provider's attributed member population. Health Choice will also adjust sub-capitation rates at least twice per year, based upon the provider's trended level of encounter experience. Taken together, these adjustments throughout the course of the year will ensure that providers are fully incented to submit encounters on a timely and accurate basis, while the variability of payments from month-to-month will reduce the sense of dependence on "fixed" payments. In addition, Health Choice will retain the ability to manage prior authorization requirements, retain data validation, and concurrent and retrospective review process to ensure that sub-capitated providers' utilization remains appropriate.

As with HCIC's current approach, Health Choice will compensate IHH and IACO providers based on the total cost of care, with *all* member medical costs (i.e., pharmacy, out of state services, and even primary care services which are accessed through providers outside of the IHH or IACO) attributed back to the organization's sub-capitations. Providers will thus have an immediate interest in connecting with attributed members to help better manage their care and encourage the members to use their services. The claims associated with services provided outside of the IHH or IACO will be paid by Health Choice directly in order to ensure timely payment and avoid disputes. These costs will then be internally allocated back to the provider to whom the member is attributed. However, given the increased scale of membership and the relative newness of this system in the physical health context, Health Choice will use the "risk pooling" practice previously used by HCIC to reinsure IHH or IACO providers against certain large medical expenses where utilization is difficult to predict and/or contain. We have used this approach in the past to address costs in categories such as out of state specialty

hospitalizations and adolescent residential stays. The specific categories of medical expenditures included in this arrangement will be determined through discussions with our IHH or IACO providers, and will be adjusted annually based on network-wide performance and experience trends.

For some IACOs outside of Northern Arizona, we recognize that the shift away from a "fee for service" model to this shared risk model may be even more marked. Health Choice will transition risk to these providers on a phased basis, beginning in the second contract year, accompanying the second phase of the member attribution process to these providers, and third year of Targeted Investment. In the interim, Health Choice will maintain its existing level of concurrent and retrospective review intensity, while supporting providers to develop their own internal capacity to manage and deliver care in an integrated manner. Even after the transition to shared risk, Health Choice will maintain an oversight capacity in these areas using a dedicated medical management department to constantly test for under or over-utilization at IACOs. Additionally, Health Choice-employed Integrated Care Managers (discussed more fully in response to Question 4) will provide real time "intelligence" into each IACO's risk management performance by reporting any unexpected utilization patterns to leadership.

We will finalize the specifics of the shared saving arrangement through discussions with our IHHs and IACOs. To date, we have developed consensus with our current integrated providers that our performance arrangement will be substantially similar to the approach AHCCCS is employing in Arizona. Each IACO will bear full risk within a two percentage point corridor on either side of the risk-adjusted, population-based cost target established for each provider. Above and below two percent, risk will be shared equally within a secondary corridor between the provider and Health Choice. The net effect of this methodology is a sharing of risk with providers where providers bear a slightly higher proportion of the risk than the health plan, to emphasize the provider's key role in managing the risk and limited any inherent incentive toward duplicating cost control efforts between the providers and payor.

In order to earn shared savings above the initial population-based cost target, each provider will be required to demonstrate performance against quality gated "stewardship measures." Specific measures will be established in a data-driven manner through discussions with our IHHs and IACOs. They will continue to be based on a balanced scorecard approach, using performance and quality measures issued by AHCCCS with additional incentives for priority initiatives, such as e-prescribing or reductions in opioid use. Health Choice will also reserve the right to reduce payments to providers whose performance falls below the population-based cost target if they have not achieved quality gated targets.

As discussed with our provider network, Health Choice believes this risk share method best aligns incentives to achieve health plan and provider performance metrics, as providers have the most direct and timely ability to influence utilization patterns. This approach will better align the financial incentives, and place Health Choice in the role of partnering with providers to monitor both over and under-utilization (very similar to the manner in which HCIC operates currently), rather than placing us at odds with providers over denied prior authorization or claims. This will also result in both improved provider and member satisfaction scores.

Practice Transformation. Notwithstanding the strides Health Choice has already taken with our provider network, achieving the "End Result" will be a significant change for providers' organizational structure, relationships, and psychology. Health Choice will create a "Practice Transformation Team," including clinical, legal, and organizational development professionals to assist each group of providers in forming IACOs and establishing necessary agreements. Health Choice will also continue to monitor the financial stability of its IACOs on a monthly basis, similar to how HCIC has historically monitored IHH network.

Phased Implementation. Health Choice recognizes that the change must occur in several phases to ensure a smooth transition for both members and providers. The phases that we discuss below have been identified to allow for change in an orderly manner and to lessen potential disruption to members. The phases are also designed to largely coincide with, and leverage, AHCCCS' Targeted Investment funding.

Consistent with Health Choice's overarching strategy of behavioral health-led integration, our first phase is designed to ensure that members with significant behavioral health needs successfully and smoothly navigate the transition to integrated care by making sure that our members have an IHH to meet their needs. Our primary goal in the first phase is to ensure that vulnerable members receive all needed behavioral health

services during the transition to integrated care, thus dramatically reducing the possibility that members will "fall through the cracks in the system." Our secondary goal is to assist members (and again, especially those members with higher acuity behavioral health needs) to develop a relationship with an IHH, thus easing the member's transition to fully integrated services.

We have discussed this approach with both providers and our advocacy groups including the National Alliance on Mental Illness (NAMI), who strongly supports it. Given the required six-month transition period for members to continue using their current providers, we anticipate that full implementation of the above process will take twelve months. Over the course of 2017, Health Choice held an extensive series of discussions with both advocacy groups and our current, and potential new, IHHs that have direct partnerships or affiliations with primary care providers. In Northern Arizona, all of HCIC's members are already attributed to either an IHH or BHH, thus obviating the need for any transition. However, allowing for the six-month required transition period, in all other regions, Health Choice will begin by transitioning pediatric members and members in the General Mental Health/Substance Abuse (GMHSA) group to a contracted IHH for at least behavioral health services. Based on our initial data set, we estimate approximately 90 percent of members who are likely affected already obtain behavioral health services through our contracted or expanded network. In these instances, members would remain with their current provider, although members would always be afforded "choice" and may change IHHs at any time. For members not already utilizing the services of an IHH, Health Choice will provide an extensive member education program around the benefits of the specific IHHs in our network, and offer the opportunity to select one. If members choose not to select an IHH, they will be auto-assigned to an IHH based on their residential zip code, in the same manner as HCIC has done for decades.

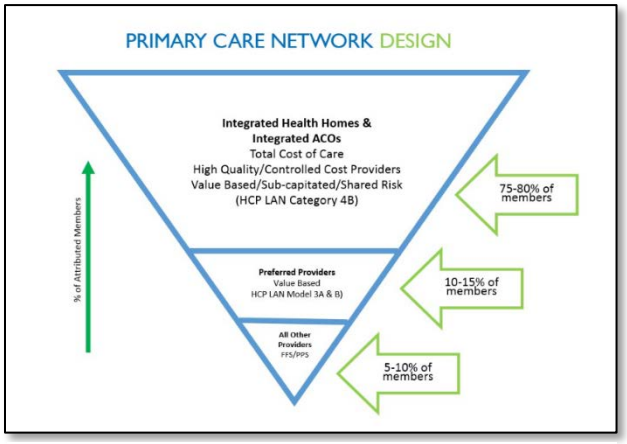


Figure 3. Phase Two Integrated Care Design

The second phase of our transition will assist members to attribute to a fully integrated primary care provider within an IHH or IACO. As noted above, we will use the first phase process to assist in migrating members with high acuity behavioral health needs to appropriate provider resources. This second phase will complete that task by providing marketing and educational materials to members about the benefits of obtaining their primary physical care through the same IHH or IACO as their behavioral health care. Using the SAMHSA Four Quadrant Model, members identified through our MedInsight™ and Johns Hopkins ACG™ population and predictive analytics tools as being in Quadrants 3 (high behavioral health, low physical health needs) and 4 (high behavioral health *and* high physical health needs) will be the focus of this effort.

For members in Quadrants 1 (low behavioral health, low physical health needs) and Quadrants 2 (low behavioral health, high physical health needs), our focus will be to work with members to identify and transition their services to an IHH or IACO. As in the first phase, Health Choice has many members who are already attributed to an IHH or an IACO. Health Choice's own affiliated IACO, Steward Preferred, has initiated an integration strategy through a partnership with Southwest Behavioral & Health Services as part of its Targeted Investment program. Similarly, Health Choice is working with PCCN to integrate pediatric behavioral health services in concert with Health Choice's long-standing relationship with Central Arizona-based behavioral health providers. Approximately 50,000 members are already attributed to these two IACOs, with considerable capability for expansion. In addition, Health Choice will expand additional IACO relationships in Phoenix, Tucson, Prescott and Flagstaff based on the service area awarded and attributed membership patterns.

Health Choice recognizes that the process of working with members to identify and transition services will not be simple. Over the last fifteen months, HCA worked with PCCN on a pilot project to transition pediatric members from local federally qualified health centers to PCCN. This process involved both incentives that compensated PCCN through a valued-based model for members who transitioned to PCCN, as well as an enhanced outreach effort. Although successful, both Health Choice and PCCN learned a great deal from the

process that will allow us to expand and export the effort to the broader member population. A heavy rotation of co-branded outreach and education materials will be delivered using direct mail, email, social media, and web based platforms. These efforts, coupled with member service outreach through our highly-successful "Health Care Buddies" program, will be central to our success. Based on our previous successes and lessons learned, we are confident that the transition of at least 75 percent of attributed members can be effectively and smoothly completed within the first five years of AHCCCS Complete Care.

Value-Based Integration Strategies for Physical Heath-Only and Behavioral Health-Only Providers. Throughout all of the above transition process and even after completion of the process, Health Choice will maintain an adequate provider network which, outside of the IHH and IACO providers, will generally be compensated on a fee-for-service basis (for both physical and behavioral primary care and specialty providers, residential service providers). Where member attribution exceeds 500 members, however, Health Choice will negotiate Advanced Payment Model contracts with non-integrated providers based on LAN Categories 3A, and Category 3B (depending on the provider's capacity to manage risk). The "quality gate" measurements for these contracts will continue to be based on a balanced score card approach, using the performance and quality measures issued by AHCCCS, with additional incentives for important initiatives such as e-prescribing.

Value-Based Integration Strategies for Hospitals. For our larger hospitals providers, Health Choice will similarly employ Advanced Payment Model contracts (LAN Categories 3A and B), although using a diagnosis-related group, rather than fee for service, based approach. With hospitals, our quality measurements will continue to focus primarily on the reduction of readmission rates, health care acquired or other provider preventable conditions, and improvement of patient satisfaction rates.

Value-Based Integration Strategies for Federally Qualified Health Centers. Although federally qualified health centers (FQHCs) will necessarily remain a part of our provider network, our Advance Payment Model plans do not extend to them due to AHCCCS' requirement to follow the federally-mandated Prospect Payment System (PPS). If AHCCCS' PPS requirements change, particularly if the change permits greater negotiated rate flexibility, Health Choice will integrate FQHCs directly into IACOs, similar to how Steward has integrated four FQHCs into its Medicaid ACO in Massachusetts.

Even if the PPS requirements do not change, Health Choice will continue to investigate the potential for creative arrangements which may allow certain federally qualified health centers to be included in a LAN Category 4B model. For example, HCIC's Community Reinvestment Committee has authorized the expenditure of up to $50,000 for North County Health Care – one of our primary rural primary care provider partners in Northern Arizona – to address legal considerations surrounding the formation of a separate legal entity as a joint venture with Little Colorado Behavioral Health in Springerville. This new entity would then contract with Health Choice as an IHH (and eventually an IACO) consistent with the LAN Category 4B model described previously.

Conclusion. Health Choice will use our behavioral health led model, along with our experience in managing within a Health Home context, to facilitate delivery system reform. We will do this both in terms of creating organizational structures that enhance administrative efficiency through the phased implementation of "DSRIP-like entities," and in the interim, by helping members to move to IHHs or IACOs. In both the short and long run, these key providers will be compensated using a LAN Category 4B model, shared risk, quality gated, sub-capitation payment system. For providers who were previously subject to a "block purchase" payment model, this will soften the transition through the use of prospective payments, but will reduce the potential reliance on fixed payments and incentive toward under-reporting of encounters and under-utilization, by allowing us to make adjustments based on attributed membership, risk, and encounter performance.

Conversely, for providers who are accustomed to a "fee-for-service" system, our use of the above approach will better align the financial incentives to encourage appropriate utilization, while encouraging provider financial stability. Lastly, the shared risk corridor model will ensure that both Health Choice, and our provider network, are all pulling in the same direction: Ensuring that members get the care they need in a cost-effective manner, while enhancing member satisfaction.

Given our long history of partnership with major provider groups which have now expanded across Arizona, Health Choice is in the best position to ultimately make the original goal of DSRIP come true — using a balanced system of financial and quality incentives. We look forward to making it happen.

Narrative Submission 15

At Steward Health Choice Arizona (Health Choice), we recognize that improving the health and well-being of our members is directly correlated to our ability to control health care cost trends. It is not the number of services provided, or the volume of services delivered, that matters. What matters are the outcomes related to those services. Put a different way, more care, and more expensive care, is not necessarily better care. And conversely, less care can eventually lead to poor health outcomes and more costly care in the future. This is why outcomes and cost must be balanced within the context of each member's complete cycle of care. The decision making process must involve a clinical team approach, with multiple specialties performing multiple interventions from diagnosis, to treatment, to ongoing management.

Health Choice uses a wide range of demographic, diagnostic, historical, procedural utilization and financial data and information in support of this process. Health Choice also utilizes evidence-based decision support tools to effect care management and optimize member care, while controlling cost.

We recognize that the transition away from a traditional fee for service (FFS) environment for physical health providers (and away from a full-risk environment for behavioral health providers), will significantly change the inherent alignment of financial and quality incentives between Health Choice and our providers. We will use a model similar to the Health Care Payment Learning and Action Network's (HCP/LAN) Model 4B. This model will be "quality gated," using AHCCCS performance measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, and National Quality Forum (NQF) measures. We will use shared risk corridors and other incentives to help drive appropriate utilization and quality outcomes. As a result, Health Choice will also need to evolve our approach to monitoring and controlling health care cost trends.

At the same time, we recognize that we cannot simply abandon our current cost containment efforts for "traditional" risk and utilization management programs. FFS providers will certainly not disappear entirely any time soon. This means that, regardless of what the future may look like, we will need to maintain traditional cost containment tools, such as prior authorization (PA), concurrent review, care management, retrospective medical claims review, and claims-based utilization trending review — even while implementing the "next generation" set of risk and utilization management programs and tools that will be needed to effectively manage and control health care costs using a HCP/LAN Category 4B, "person-centered" Integrated Health Home approach featuring comprehensive population-based payments.

Traditional Utilization Management Programs. Today, Health Choice's utilization management program is based on traditional health plan activities for FFS providers. In this context, our emphasis is necessarily on guarding against over utilization, since the more services provided, the more they potentially will get paid. FFS providers simply do not have the same impetus to use a population health approach, or to follow the long term impact of individual care decisions for an individual member across a continuum of services, when they are being compensated on a per treatment, FFS basis.

Health Choice uses a comprehensive set of analytic and reporting tools, established clinical criteria, and processes for prior, concurrent, and retrospective medical necessity review reports to monitor whether the care being provided is appropriate and medically necessary. We also use established utilization performance standards, automated provider monitoring tools, and data validation reviews. As the examples in this Narrative demonstrate, our current UM program is effective and allows us to identify opportunities for education, changes in payment structures, vendors, service alignment, and new programs. However, we can also see that this structure represents an increasingly costly and burdensome program for providers, and does not align the financial interest of providers and health plans. We are, therefore, developing a next generation set of tools to address the next level of payment reform.

The Future Model: Aligned Provider Incentives for Quality and Cost Performance. As we move toward the future, Health Choice will dramatically change the nature of our provider relationships. We will adopt funding and contract relationships with providers that reduce barriers to specialty and behavioral health services while aligning incentives to achieve quality and cost targets. This transition will rely heavily on provider partners who participate in AHCCCS' Targeted Investment program. We will also accomplish this by using Health Choice's established IHH, and new Integrated Accountable Care Organization (IACO), approach. These models attribute

members to a provider organization, which is then fully accountable for the member's total cost of care. These organizations will contract through a shared risk arrangement, which better aligns financial incentives to promote development of specialty and behavioral health provider services. Through this model, providers will be incentivized to ensure that their members are getting the right care, at the right time, at the right place, and to balance high quality with cost containment. We will also use this model to target specific, data-driven quality improvement opportunities, aligning provider incentives with quality and cost targets.

Health Choice will form a separate, Health Home Medical Management Team (HHM) that will monitor data and collaborate on utilization management programs with providers who share clinical economic risks with us. Due to the improved alignment of financial incentives driven by shared financial risk, IHHs and IACOs that participate in Health Choice's person centered Health Home model. We anticipate that this transition will significantly reduce the need for PA and utilization reviews, as these programs will be developed and carried out at the provider or delivery system level in a manner that best suits the individual needs of the member population they serve. More specifically, many of the traditional medical and utilization risk management functions will be contractually delegated to the IHHs. Delegation will occur only after successful completion of a readiness review and audit exercise to demonstrate provider competency and the presence of sufficient infrastructure. The Health Choice HHM will perform an ongoing oversight function to make sure the IHH and IACO teams are performing adequately, and that health care utilization and costs are trending appropriately. As compared with the traditional FFS utilization management program, the HHM will focus more heavily on discharge planning and transition of care programs – ensuring members assigned to the IHH network are receiving all the medically necessary services identified by the member and their provider-based care team on their treatment plan. The HHM will also be more focused on the potential for under-utilization given that HHs will retain a significant portion of the clinical and financial risk.

As part of the process, Health Choice will work to transition members to providers who can provide the highest quality services to our members, while simultaneously reducing system cost and increasing member satisfaction – thus demonstrating excellence in meeting value and quality objectives. More specifically, Health Choice's IHH and IACO contracts will align financial incentives with quality performance measures to drive performance of measures based on AHCCCS, HEDIS, and NQF performance standards including inpatient utilization, emergency department (ED) utilization, hospital readmissions, post-discharge follow-up, total cost of care and integrated health clinic primary care visits. Health Choice has consistently exceeded AHCCCS' value-based purchasing targets, and will continue to exceed the anticipated AHCCCS Complete Care goals in 2019.

Data, Analytics, and Reporting. The IHH model allows for a team-based approach to improving quality and reduce cost along the full continuum of care. Health Choice will continue to add value to the system through strong partnerships with IHHs and IACOs, particularly through data sharing, analytic and reporting arrangements. Today, IHH and IACO providers receive extensive reporting with complementary analysis of claims and encounter data to evaluate and react to cost trends for both behavioral health and physical health benefit cost and utilization. More specifically, Health Choice's Utilization Management reporting includes length of stay, readmissions, ED utilization, inpatient utilization and behavioral health residential treatment and pharmacy by population and attributed membership. Additionally, IHH and IACO providers receive Value Based Reimbursement Report Cards outlining health care costs by category of service as well as performance against quality measures to detail earned incentives. These reports give providers the necessary tools at the aggregate and member level detail to appropriately and timely observe and react to adverse utilization and cost trends.

Our technology platform combines industry leading products and data management techniques that have enabled Health Choice to develop a centralized data warehouse reporting and analytic environment to drive our health care utilization and cost containment programs. Critical "real time" as well as "lag" data elements are included in the Health Choice data warehouse. These include eligibility, risk group, member demographic, provider demographic, claims and encounters – medical, dental, pharmacy, behavioral health, vision, and lab. The data warehouse also include member level predictive analytics, cost of care, labs, call center call data, provider and member inquiry and response, HEDIS and performance measures, Integrated Care Management Plans, Health Current's Health Information Exchange data (including admit, discharge, transfer, ED and hospital admit alerts), authorizations, care management contacts and financial data.

Leveraging this data services platform, Health Choice has developed an array of daily, weekly, and monthly reports that allow for the early identification of concerning utilization and cost trends. Additionally, Health Choice has invested in Milliman's MedInsight™, an industry-leading health care analytics tool, that enables robust and detailed identification of utilization and cost trend core drivers in the aggregate, as well as at the provider and member detailed level. MedInsight™ enables Health Choice the ability to analyze cost and utilization, physician/hospital efficiency and quality, population health, clinical episodes of care, member risk and acuity modeling as well as the identification of wasteful or unnecessary health care services. The chronic condition view of a population of the Milliman MedInsight™ analytics platform can bolster care and disease management focus at the individual member level. For example, an individual with congestive heart failure and multiple other comorbidities will likely benefit from activities that address the congestive heart failure before any other disease interventions.

Additionally, our Johns Hopkins ACG™ predictive analytics system can integrated data with the Milliman MedInsight™ tool to produce customizable population, provider, and member level predicted risk cost bands and predicted risk ratings for hospitalization and medication adherence, among other reports. It can also identify members that could potentially benefit from Health Choice's "Top Tier" intensive care management and disease management programs.

Monthly, quarterly, or ad-hoc reporting is reviewed by Health Choice's medical economics department, medical management, pharmacy, executive leadership, and other operational areas to ensure proper interpretation of findings, development of solutions, performance improvement and an implementation of utilization and cost management strategies. Furthermore, the information and trends are presented monthly for discussion at the medical management, medical economics, and the pharmacy and therapeutics committees.

Strategically identifying cost and utilization patterns within select populations and specialty care cost categories allows Health Choice to prioritize conditions for disease type and episode management by sorting highest to lowest cost. These reports are evaluated for Top Tier care management and help us analyze per member per month costs to determine the overall average treatment costs for the individuals within the chronic condition category. We also use them to review the condition costs including treatment changes and condition incidence, determine the difference between historic chronic and non-chronic trends, review per member per month costs and incidence over time for one chronic condition to reflect treatment changes and prevalence, compare cost and utilization across chronic conditions to identify trends, and continually update prioritization of disease management resources.

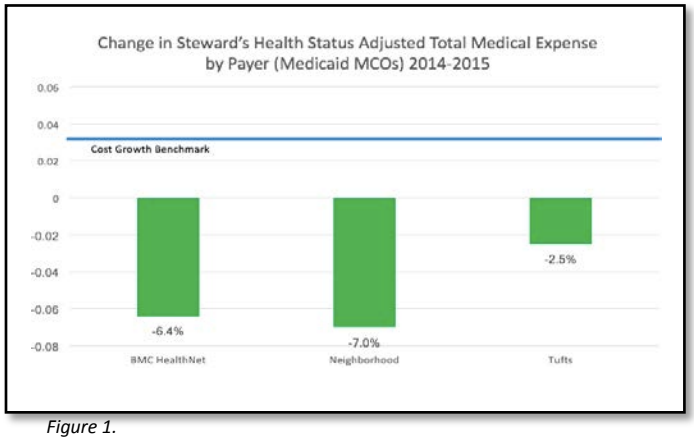


Figure 1.

Additionally, Steward Health Care System's (Steward) acquisition of Health Choice in September 2017 also allows us access to a number of new analytic and performance related tools that will assist us in managing cost. Steward has developed proprietary systems that monitor performance at both the individual practice and provider level. This data coupled with support from Steward's "Practice Transformation Team" helps providers analyze and implement internal process changes to achieve quality improvements and cost savings. Using these tools in conjunction with our provider performance program, Steward has been able to address cost drivers in a collaborative matter with their provider network. In Massachusetts, providers are only eligible to receive performance funds if they achieve all gated "stewardship" measures each year, such as participating in regular trainings and meetings to review cost and quality performance. Once providers meet the "stewardship gate," primary care providers are eligible for value-based payments based on a variety of performance outcomes, including utilization, post-discharge follow-up visits, utilization of population health tools, quality performance, and patient experience scores. As shown in Figure 1 above and reported by the Massachusetts' Center for Health Information Analysis, our performance program has resulted in significant cost saving within

the Massachusetts Medicaid market, with one-year change in health status adjusted total medical expense ranging from 2.5 to 7 percent reductions across three of Steward's Medicaid managed care populations.

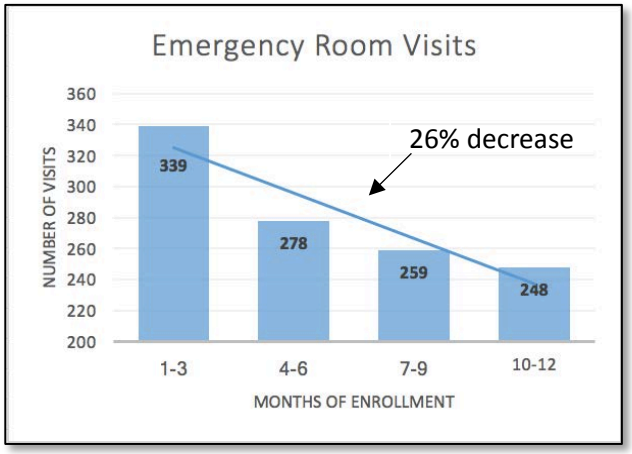
Examples of Unfavorable Cost Trend Identification and Appropriate Action. Health Choice uses a data-driven approach, including the tools described above, to constantly monitor for unfavorable cost and utilizations trends. We then use this data to identify appropriate actions to address the trends. We have identified three examples of instance where Health Choice recently identified an unfavorable cost trend and took appropriate action to address the trend: (1) Increased pharmacy costs, (2) ED utilization in members living with Serious Mental Illness, and (3) Long-acting injectable antipsychotics utilization.

Increased Pharmacy Costs. Like many plans, Health Choice saw pharmacy costs dramatically increase over the course of contract year 2015. Comparing the second quarter pharmacy cost and utilization trend versus the second quarter of contract year 2016 alone, the per member, per month (PMPM) pharmacy cost trend increased by 16.3 percent or $8.33, from $42.17 to $51.05 PMPM. This effectively increased total pharmacy costs by $10.4 million during this time frame — from $26 million to $36.4 million. After further analysis, we determined that this cost trend was primarily driven by increases in manufacturers' drug costs, especially for specialty drugs such as Hepatitis C medications. These drugs represented nearly $3 million of the total increase. We also determined that the generic dispensing rate during this period was flat, due to several new-to-market brand drugs stalling the use of generic equivalents.

Health Choice engaged a leading national pharmacy benefit and expense analytics firm, to perform an industry market pricing study. With their assistance, we determined that our contracted Pharmacy Benefit Manager (PBM) no longer had the size or market share to garner manufacturer drug price discounts at the levels necessary to offset unit cost inflation and utilization increases in specialty medications.

Health Choice subsequently issued a national Request for Proposals to contract with a new PBM. After an extensive review and negotiation process, Health Choice ultimately selected OptumRx. We implemented the new PBM for Health Choice Arizona members on July 1, 2017, followed closely by Health Choice Integrated Care (HCIC) on November 1, 2017, and Health Choice Generations on January 1, 2018. All three transitions were exceptionally smooth, with no member or provider complaints — either internally or to AHCCCS.

Results: Our contract with OptumRx has significantly reduced costs by more than $10 million annually. In addition, OptumRx has also offered us a comprehensive analytics package, which covers compliance, formulary, pharmacy and therapeutics, and many other value added services. It also provides us with calculation and reporting tools regarding morphine equivalent daily dose scores. This allows us to better monitor opioid use, both at a member level and throughout our provider network in order to improve member safety.



ED Utilization Trend for Individuals with Serious Mental Illness. HCIC's medical management team identified an unfavorable trend in ED utilization and hospitalization for individuals with Serious Mental Illness in early 2016. As a result, we developed a protocol and a series of new practices to address the negative trend. The efforts used our data warehouse and Johns Hopkins ACG™ predictive analytics system to identify members with four or more ED visits within the last six months, and those members who were likely to meet that threshold. Our Integrated Care Managers then worked directly with the member's assigned IHH and primary care provider to develop an Individual Care Management Plan that specifically addressed the suspected underlying causes for the member's increased ED use. In many instances, these causes related to substance use and inadequate follow up care. Using the Arizona Health Information Exchange, Health Current, and our data warehouse of demographics, diagnoses, medication fills and services, the Individual Care Management Plan was then used to identify and fill gaps in care, and was distributed to the member's entire

treatment team so that the team could better engage the member, provide necessary services, and help re-enforce the importance of appropriate ED use with the member.

HCIC also provided the member with self-management tools to decrease ED use. We mailed follow up letters to each member. The letter discussed the member's use of the ED, stressed the importance of regular primary care and behavioral health visits, and suggested local alternatives to the ED — such as urgent care options and our nurse hotline. Our "Healthcare Buddies" also directly engaged members by calling them to check on their health status, identify barriers to care and assist with follow up care.

Results: Members with SMI enrolled in our Care Management Program continuously for twelve months demonstrated decreased emergency department utilization by 26.8 percent and inpatient admissions by 64.9 percent. This resulted in overall cost saving of 21.4 percent, with physical health care cost savings of nearly $347,000 per quarter.

Long-Acting Injectable Antipsychotics Utilization. As noted at the outset, we recognize that as our provider network transitions from FFS to a sub-capitated, value based system, Health Choice will need to monitor for both over and under-utilization. This approach is not new to us. HCIC has developed a set of analytic tools to monitor for both over and under-utilization. One recent example of our using these tools was our early identification of a potential under-utilizing of long-acting injectable antipsychotic medications. If left unaddressed, this could potentially have led to higher long term costs and poor health outcomes for members.

In late 2017, our Pharmacy Director noted a significant change in prescribing practices at one of our IHHs. She first identified this change through the prior authorization reports provided by OptumRx. She then validated the trend by comparing the report with ongoing prescribing and utilization data from our data warehouse. These data confirmed that the IHH's utilization of long-acting injectable antipsychotic medications had decreased by approximately 15 percent over a single quarter and as compared to the previous year. Since utilization of these medications had previously been relatively stable, we were concerned that the IHH might be inappropriately restricting use of these medications to reduce pharmacy expenditures. (Long-acting injectable antipsychotics have been one of the most costly pharmaceuticals. However, given the changes in medication pricing associated with Health Choice's transition to OptumRx, the cost to switch to oral antipsychotics medications was now becoming more comparable to the long-acting injectable antipsychotic costs — but with better outcomes.)

Our Chief Medical Officer contacted the IHH's Medical Director and discussed our findings. This conversation indicated a possible concern that medical staff may have been unduly influenced by financial considerations. We then scheduled a meeting with the IHH's Chief Executive Officer, and presented our findings. We discussed the appropriate use of long-acting injectable antipsychotic medications, including evidence-based practices related to member efficacy, quality of life and the impact of improved medication adherence on decreasing inpatient utilization and readmission costs, as well as the recent changes in oral medication costs. Additionally, we presented the data and discussed the topic (while not identifying the specific IHH), during one of our monthly Provider CEO meetings, and at the monthly Provider Medical Director meeting.

Results: The IHH's CEO and Medical Director discussed the prescribing practices and cost implications with their medical staff. The IHH's prescribing patterns and utilization returned to previous levels over subsequent months. While this change did not result in an immediate savings, by using long-acting injectable antipsychotic medications in appropriate situations, the IHH is able to ensure better medication adherence, which should result in improved functioning and quality of life for members, while decreasing inpatient utilization in the long term.

Conclusion. Health Choice uses data analytics and utilization management programs to monitor and control health care cost and utilization trends. We have been thoughtful around the structure and process of these programs as we transition from a FFS based physical health system and a modified sub-capitated behavioral health system to an integrated benefit and payment system that is fundamentally consistent with the HCP/LAN Category 4B, value based, sub-capitated compensation system. We are confident that the improvement in incentive alignment, coupled with our data analytics and provider data sharing arrangements will help to transform healthcare delivery in Arizona, resulting in a positive benefit to the member through optimal utilization, as well as the financial efficiency of the system overall.

Narrative Submission 16

A. Northern Arizona

Introduction. Northern Arizona is one of the most diverse and challenging regions in America when it comes to delivering health care services and managing service delivery. Unique aspects can generally be grouped into four main categories: Geography, Culture, Communications, and Provider Economic challenges. Having health plan employees and providers who understand and respect these differences is the key to ensuring that members and communities obtain services they need in a manner that is comfortable for them.

Geography. The five counties of the Northern Arizona geographic service area cover approximately 63,000 square miles. This alone would present a significant challenge, simply in terms of traveling between population centers to work with members, providers, local governments, and community groups. Compounding matters is the fact that the northwestern portion of the region is bisected by the Grand Canyon, and the southeast and southwest portions by mountain ranges. While these natural barriers make for beautiful landscape, they also create significant challenges for travel and communications throughout the area. Travel, for instance, is frequently compromised by weather: Heavy snow is a common occurrence in Flagstaff and the White Mountains during the winter months, and flooding is common throughout the region during the summer monsoon season.

From a health plan perspective, we recognize the importance of understanding that these physical barriers shape communication and provider use patterns. This often means that members will be more likely to travel to use providers that – on paper – look like they are located further from their homes, but in reality are easier to access because the drive to them involves an easier road.

Above all, however, geography drives the other four unique aspects of delivering medical services in Northern Arizona. The region's unique Culture, Communications, and Provider Economics challenges are greatly influenced (and even caused) in many instances by geography. Communities tend to be separated by great distances, even when not separated by natural barriers. The result is that very different cultural approaches, communication styles, and solutions to provider sustainability have evolved in each of these isolated locales. To assume that two communities separated by less than 100 miles will be similar is to invite significant communication breakdown and organizational ineffectiveness.

The strategy that Health Choice will employ to address geographical considerations is simple and direct: we will continue to have a significant organizational presence located in Northern Arizona, including the primary home base for a significant portion of our executive team. Additionally, Health Choice will continue to deploy its Integrated Care Managers throughout the region, rather than requiring them to be "office based" in either Phoenix or Flagstaff.

Culture. For purposes of this discussion, "culture" is used in its broadest sense, encompassing the region's ethnic, religious, and social attributes. The first of these three considerations is perhaps the most diverse. Northern Arizona is home to twelve Tribal Nations, each of which is unique. In fact, even within a single Nation, there are likely to be dramatic variations in communication style, service expectations, and intra-tribal coalitions that exist between subgroups, such as different clans. Knowing, for instance, that a certain Tribe has two major clan groups, and who the elders and leaders of those groups are, can often make the difference between maintaining a collaborative relationship and having an adversarial one. Furthermore, having a deep rooted sense of respect for Tribal traditions and sovereignty is imperative, although again, even these traditions and attitudes toward principles can vary between groups. Simply put, there is no replacement for having boots on the ground to form personal relationships which are built over years of face to face meetings.

Other ethnic cultural differences in Northern Arizona are more closely intertwined with religious and social distinctions. Several communities boast a strong Hispanic Catholic heritage, and maintain many of the social and religious traditions of both. In some instances, particularly in the Eastern part of the region, these communities are "paired" with a second community with a very different ethnic and religious background even though the two share a common border. (The adjoining towns of Snowflake and Taylor are an example of this.)

Knowing these differences, and respecting them, is again often the key factor in communicating well and working effectively with local members, providers, and the communities themselves.

As with our strategy to address geographical constraints, Health Choice's approach to addressing cultural considerations is fundamentally based on our "being there" and understanding the inherent cultural differences of locations and populations. Health Choice will continue, and expand, our efforts to educate providers around cultural competency and the effects of historical trauma. We will continue to deploy our highly-successful Tribal Services Team to work directly with Tribal Nations and communities. Finally, Health Choice will continue its dedication to treating each community individually and with respect for its interests, belief sets, and histories. This culturally sensitive approach is critical to promoting access to care, utilization of preventative measures and medical care in order to optimize key quality performance measures and the health and well-being of the population we serve.

Related to culture is each area's unique mix of philosophies and belief systems. For example, the Flagstaff micropolitan area tends to be very diverse in its social views, owing no doubt in part to the influence of Northern Arizona University. By contrast, the southern Apache County region and the western and northern Mohave County areas are dramatically different. For example, the social views of eastern Apache County tends to be a complex of social and religious viewpoints, based on the region's rich pioneer and ranching history, and the central place of family and religion in daily life. Mohave County viewpoints are similar, but tend to be more focused on personal rights and liberties with an underlying belief in the need to reduce government's role in individual's lives. Even within these smaller areas, there can be significant variation within short distances. For example, while only 60 miles apart, Show Low and Eagar are dramatically different. The former is heavily influenced by its retirement and tourism-based economy, while the latter is considerably more isolated from outside influences and thus has a stable, family oriented culture. Knowing the difference, and even the nuances between the differences, is absolutely critical to being able to communicate effectively with individuals from each specific region and develop services and programs.

The strategy that Health Choice will employ to address differing viewpoints is again born of our respect for the differences inherent in each region, location, and person. Our physical presence in the region gives us a unique perspective on these differences, and allows us to work effectively in such a diverse environment. More specifically, Health Choice will expand our local government relations team under the leadership of our Justice Administrator, Beya Thayer, to have local staff deployed in the eastern and western portions of Northern Arizona to address the unique needs of those regions.

Communications. As noted above, communicating effectively with members, providers, and community organizations can depend on unique cultural, and social factors. But even outside of these considerations, there are at least two additional considerations that while not unique to Northern Arizona, are nevertheless very important factors.

First among these is the expectation that both health plan staff and providers will engage in a direct, face to face, collaboration. Although admittedly a broad generalization, Northern Arizona providers expect to meet directly. The expectation is that in order to work together collaboratively, you must first develop a relationship. In the absence of this, it is unlikely that a collaborative relationship will exist. A clear understanding of this is one reason why Health Choice Integrated Care (HCIC) has experienced such strong provider satisfaction ratings — the willingness of employees such as HCIC's Network and Advocacy Director, Laura Hartgroves, to log the miles needed to develop relationships with a geographically dispersed provider base.

The second factor is the relative absence of adequate and consistent cellular telephone and internet connectivity. While continuing to improve with each year, the reality remains that large expanses of rural and frontier Northern Arizona have limited cell phone and internet availability. This complicates the ability to rely on web-based resources as a means of communicating with members and providers. As a result, traditional means of providing information to members — such as member handbooks, printed newsletters and other materials, and direct mail — represent a proportionally more important vehicle for transmitting important information. In turn, the inability to keep up with changes in these materials (such as a provider network list included in the member handbook) places a greater reliance on member services resources available via telephone. A

fundamental understanding of this dynamic, and its downstream effects, is imperative to ensure effective communications with members and providers throughout the Northern Arizona region.

The third factor is language. Northern Arizona tribal members use many different languages and dialects. This can create a significant barrier to providing services, since each language or may require a different approach to translation. Additionally, Spanish is still spoken in several rural communities in Northern Arizona.

Health Choice will employ three strategies to address these considerations. First, Health Choice will expand the number of locally based provider service representatives in Northern Arizona. In addition to the provider representatives currently based in Flagstaff and the White Mountains, Health Choice will employ provider relations representatives specifically dedicated to the needs of Mohave and Western Yavapai County providers. These representatives will be physically based in Mohave and Yavapai counties so that they can react quickly to the needs of providers in those locations, and meet with providers — face to face — on short notice. Second, Health Choice will continue to distribute "hard copy" materials to our provider network and community partners. Third, Health Choice will ensure the availability of staff that is fluent in tribal language and Spanish to address both member and provider inquiries. Health Choice will continue to have language translation services available telephonically on demand, and Health Choice will also ensure that member materials are translated into Spanish (per AHCCCS member material translation requirements as set forth in the AHCCCS Contractor Operations Policy, 404).

Provider Economics. Last, but absolutely not least, among the unique aspects of providing services in Northern Arizona are the challenges related to the recruitment and retention of providers in the region. This issue is, at least in part, related to the challenges associated with the limited population of the region. While the region's three micropolitan areas (Kingman/Bullhead City, Prescott/Prescott Valley, and Flagstaff) represent significant population centers, the population density on average of the five county Northern Arizona region is only about 11 people per square mile. This makes it very difficult economically to maintain a sufficient patient base to recruit and retain clinic programs and individual providers. Thus, from a delivery of care standpoint, the ability to support and develop provider and programs becomes a major function of the health plans serving the region. Stated another way, the function of a health plan in Northern Arizona is substantially less about selecting among multiple competing providers for a position within the plan's network, and is instead more about building, developing and preserving scarce provider resources — particularly in the vast, largely unpopulated areas in the Arizona strip north of the Grand Canyon and in the northern and eastern portion of the region.

Health Choice will employ multiple strategies to address the challenges associated with provider development and maintenance in Northern Arizona. First, Health Choice will continue to evolve our Integrated Health Home model through which we continue to work with our network to ensure its financial stability. Even beyond our Health Homes, Health Choice will continue to work with our provider network to encourage and develop provider partnerships that take advantage of efficiencies of scale, while preserving the local heritage and presence of each community. Second, Health Choice will continue its collaborative efforts through our relationships with the NARBHA Institute and Northern Arizona University to develop a "home grown" base of physical and behavioral health providers, support staff, and peer and family resources to support the providers within our communities. For example, Northern Arizona University and the NARBHA Institute have partnered to endow a Chair for Criminal Justice and Behavioral Health. This new Chair will teach undergraduate and graduate students in Criminal Justice about the impact of social determinants of health and behavioral health on people who are involved with the criminal justice system. This will help build a behavioral health and criminal justice workforce that is more culturally competent. Additionally, the NARBHA Institute and North County Health Care (the largest federally qualified health center in Northern Arizona) have been approved to initiate a family practice residency beginning in 2019. This program will graduate physicians with experience in addressing the needs of tribal communities from a population health perspective. These providers will then be more likely to stay in Northern Arizona.

Conclusion. Our fifty year history and physical presence in Northern Arizona gives Health Choice a unique understanding of the social, cultural, and economic complexities of our region. This understanding and physical presence will help us facilitate the transition of our members and provider network to fully integrated care in a smooth and culturally appropriate manner that other organizations cannot.

B. Southern Arizona

Introduction. Much like its Northern counterpart, Southern Arizona represents a rural and frontier landscape with complexities not initially obvious to the outside viewer. Southern Arizona is also incredibly diverse and poses unique challenges and shares many attributes with Northern Arizona including the four main categories of challenges associated with the region: Geography, Culture, Communications, and Provider Economics.

Geography. The seven counties of the Southern Arizona geographic service area cover approximately 33,000 square miles, which again poses significant challenges in terms of traveling between population centers. And while Southern Arizona lacks the major barriers of a Grand Canyon or long mountain ranges, it more than makes up for this with long expanses of open desert bottom land, interspersed with "sky island" mountain peaks. Here, the main travel constraint is pure distance coupled with intense heat nine months of the year. Another regional challenge of this area includes increased substance abuse, rates that exceed the state average, and drug trafficking across the border from neighboring Mexico.

Provider use patterns in Southern Arizona are generally less constrained by natural geologic features, and more often constrained by the simple absence of resources. In general, this means that while primary care and outpatient behavioral health services are available in the rural portions of the region, members are more accustomed to travelling longer distances to Tucson, Phoenix, or Yuma to obtain inpatient and specialty services. This also, however, does present a challenge in terms of access barriers for American Indians living on tribal lands, many of whom are hours away from the nearest provider.

These differences naturally dictate a different strategy for Health Choice. Health Choice already has established relationships with the major primary care and outpatient behavioral health providers in Southern Arizona due to HCIC's work with the same Integrated Health Home providers in Gila County, and Health Choice Arizona's relationships in Pima County. To better serve these providers, Health Choice will expand its office in Tucson to locate Integrated Care Managers and Provider Service Representatives on site, as well as opening an office in Yuma to include the same functions. Health Choice will also locate additional "home based" Integrated Care Managers throughout the region, rather than requiring them to be "office based" in either location.

Culture. Again, for purposes of this discussion, "culture" is used in its broadest sense, encompassing the region's ethnic, religious, and social attributes. Southern Arizona is home to seven Tribal Nations, each of which is again as unique and varied as the Tribal Nations in the North. Health Choice has begun working with several of these Tribal Nations over the last two years, and has included them in activities including our annual Tribal Summit program. Health Choice will expand these activities by locating a Tribal Services Team in Southern Arizona to address the needs of the Tribal Nations located in the region, and to immediately initiate the process of conducting a full resource assessment in collaboration with each Nation. Once completed, Health Choice will use the information gathered through these assessments to work with each Nation to build collaborative protocols, and eventually agreements, to guide communications with the Tribe and the development of services to support it.

Southern Arizona's Hispanic heritage also plays a central role in rural life outside of tribal lands, and even in conjunction with certain Tribal Nations. (For example, the Pasqua Yaqui Tribe's origins in Sonora, Mexico result in certain closer ties to Hispanic culture than is typically seen in Tribal Nations located in Northern Arizona.) An understanding of, and ability to work with community based and religious organizations supported by the Hispanic community has been demonstrated to be an essential part of Health Choice in Southern Arizona to date, and would continue as such. Because of Southern Arizona's proximate "closeness" to the Mexico border, many providers have to be bi-lingual in order to communicate with their clients. Health Choice will continue to support the international program of hiring professionals from universities in Mexico City.

Health Choice's approach to addressing cultural considerations is fundamentally based on our "being there" and understanding the inherent cultural differences of locations and populations. Health Choice will continue (and expand) our efforts to educate providers around cultural competency and the effects of historical trauma. Finally, Health Choice will continue its dedication to treating each community individually and with respect for its interests, belief sets, and histories.

This culturally sensitive approach is critical to promoting access to care and preventative diagnostic testing and medicine in order to optimize key quality performance measures and the health and well-being of the population we serve.

Southern Arizona is every bit the North's equal in terms of the diversity of social viewpoints. The central portion of the region is dominated by the Tucson metropolitan area which tends to be very diverse, again owing in part to the influence of the University of Arizona. The social views of the eastern counties, Graham, Greenlee, and Cochise, tends to be based on the region's rich mining, farming, and ranching history. As is the case in the North, the western portions of the region is also exhibit an ardent focus on individual rights and reducing role of government in individual's lives.

The strategy that Health Choice will employ in Southern Arizona to address the diversity of social views is again born of our respect for the differences inherent in each region, location, and person. Our physical presence in the region will give us a careful and thoughtful perspective on these differences, and will allow us to work effectively in these diverse environments. Health Choice will expand our local government relations team under the leadership of our Justice Administrator, Beya Thayer, to have local staff deployed in the central, eastern and western portions of Southern Arizona to address the unique needs of those regions. The Southern region has multiple prisons and correction facilities, including a federal prison for individuals who are not from the United States. Health Choice will ensure that coordination of care activities include culturally sensitive, bi-lingual approaches to transitions back into the community or country of origin.

Communications. As in Northern Arizona, there are at least three important overarching factors that directly influence the effectiveness of communications in the Southern Arizona region. Again, there is an expectation that both health plan staff and providers will engage in a direct, face to face, collaboration. The expectation is that in order to work together collaboratively, you must first develop a relationship. In the absence of this, it is unlikely that a collaborative relationship will exist. A clear understanding of this is one reason why Health Choice Integrated Care (HCIC) has experienced such strong provider satisfaction ratings — the willingness of employees such as HCIC's Network and Advocacy Director to travel long distances to meet in person. Over the last year, the Network and Advocacy Director and other Health Choice team members have spent countless hours in Southern Arizona meeting with and developing relationships with the region's providers (both physical and behavioral health), as well as community and advocacy groups. Health Choice will continue this process to ensure that provider, community groups, and communities have a face and name that is familiar to them.

The second factor is, again, the relative absence of adequate and consistent cellular telephone and internet connectivity. While continuing to improve with each year, the reality remains that large expanses of rural and frontier Southern Arizona have limited cell phone and internet availability. This complicates the ability to rely on web-based resources as a means of communicating with members and providers. As a result, traditional means of providing information to members — such as member handbooks, printed newsletters and other materials, and direct mail — represent a proportionally more important vehicle for transmitting important information. In turn, the inability to keep up with changes in these materials (such as a provider network list included in the member handbook) places a greater reliance on member services resources available via telephone. A fundamental understanding of this dynamic, and its downstream effects, is imperative to ensure effective communications with members throughout the Southern Arizona region.

Heath Choice will ensure the high level of performance with clinical quality outcomes present in Northern Arizona under HCIC will continue in Southern Arizona though intensive on-site technical assistance and data-driven provider report cards.

Health Choice will employ two strategies to address the two above referenced considerations. First, Health Choice will expand the number of locally based provider service representatives in Southern Arizona. In addition to the provider representatives currently based in Tucson, Health Choice will employ provider relations representatives specifically dedicated to the needs of Yuma County providers. These representatives will be physically based in Pima and Yuma counties so that they can react quickly to the needs of providers in those locations, and meet with providers — face to face — on short notice.

The third factor impacting communications is linked to the Southern Arizona regional geographic and cultural aspects, as the greater Tucson area's diversity is largely representative of Hispanic or Latino descent, which account for more than one-third of the population and approximately 47 percent in the Yuma area. As such, Health Choice will ensure the availability of Spanish-speaking and bilingual staff to address both member and provider inquiries. Health Choice will ensure that telephone language translation services are always available, and that member materials are translated into Spanish (per AHCCCS member material translation requirements as set forth in the AHCCCS Contractor Operations Policy, 404).

Provider Economics. Last, but absolutely not least, among the unique aspects of providing services in Southern Arizona are the challenges related to the recruitment and retention of providers in the region. This issue is, again, at least partly related to the challenges associated with the limited population of the region. While the region's two major cities (Tucson and Yuma), represent significant population centers, the population density on average of the seven county Southern Arizona region is only slightly better than Northern Arizona's – at about 21 people per square mile. This again makes it very difficult economically to maintain a sufficient patient base to recruit and retain clinic programs and individual providers. From a delivery of care standpoint, the ability to support and develop provider and programs becomes a major function of the health plans serving the region, thus again meaning that the function of a health plan in Southern Arizona will involve helping to develop and preserve scarce provider resources.

Health Choice will employ many of the same strategies to address the challenges associated with provider development and maintenance in Southern Arizona. First, Health Choice will continue the evolution of our Integrated Health Home model through which we continue to work with our network to ensure its financial stability. Second, Health Choice will expand its collaborative efforts through our relationships with University of Arizona Medical School (our Chief Medical Officer's daughter is a medical student there now) to develop a "home grown" base of physical and behavioral health providers, support staff, and peer and family resources to support the providers within our communities. Finally, Health Choice will continue to work with our provider network to encourage and develop provider partnerships that take advantage of efficiencies of scale, while preserving the local heritage and presence of each community. Health Choice will award community reinvestment dollars throughout Southern Arizona to further support provider development and access to high quality physical and behavioral healthcare, as well as supportive community-run organizations.

Conclusion. Health Choice's history and experience working in and for members and providers in rural Arizona gives us a strategic advantage in addressing the evolving needs in Southern Arizona. Our fifty year history in rural Arizona gives Health Choice a unique understanding of the social, cultural, and economic complexities of this region. This understanding and physical presence will help us facilitate the transition of our members and provider network to fully integrated care in a smooth and culturally appropriate manner that other organizations cannot.

Narrative Submission 17

Steward Health Choice Arizona (Health Choice) will draw from, and expand upon, our experience, infrastructure, and approach to engaging Tribal Nations and Tribal Leadership, fostering respectful and productive relationships to ensure access to covered services for American Indian members on and off tribal lands. Health Choice will also continue to use multiple communications pathways to identify, escalate, and resolve issues.

Overview. Our primary vehicle for accomplishing these goals will be through our established Health Choice "Tribal Services Team." Health Choice has used this approach for several years to engage and collaborate with each Tribal Nation in our service area through a deep understanding and respect for each Tribal Nation's sovereignty, capacity, and unique goals. Health Choice recognizes there is no "one size fits all" approach to working with Tribal Nations as each is a sovereign and separate nation with its own unique history, leadership, needs, resources, and vision for its future. The Health Choice Tribal Services Team's approach to engagement and collaboration with Tribal Nations is consistent with the AHCCCS Complete Care goals which encourages person and family centered, culturally relevant healthcare services that result in positive outcomes for members, families, and communities. This approach helps us facilitate prompt and appropriate delivery of health services, including the development of a culturally competent provider network (including Tribally-operated agencies), to deliver the full array of covered culturally appropriate behavioral health and physical health services.

Services Provided to Tribal Nations and Members. Providing covered services to the American Indian population presents its own unique challenges as we recognize that American Indians have choice in receiving services through Indian Health Services, a Tribally-Operated 638 Health Program, the American Indian Health Program, or (in the near future) through an AHCCCS Complete Care Health Plan. In order to ensure appropriate care coordination for members who may potentially utilizes services from any combination of these entities, Health Choice continues to foster and maintain our well-established relationships with each of these entities. Additionally, our long history of collaboration with Tribal Nations in identifying needed services, pooling resources, creatively and effectively developing and expanding local and regional access to needed treatment and supports, and building capacity within existing treatment and support programs has helped gain trust with both American Indian members and their respective Tribal Nation. Through our partnerships with Tribal Nations, providers, and other community stakeholders, we continually shape and expand a continuum of service delivery to this population, engaging in an ever evolving array of customized and enhanced delivery system approaches to meet the unique needs of each Tribal Nation.

The services we will provide to and for Tribal Nations and members are coordinated through Memoranda of Understanding (MOU) documents which, if they wish one, are separately negotiated with each Tribal Nation. The services we offer under these MOUs broadly fall into four categories: (1) Tribal consultation services; (2) Nation/Capacity Building supports; (3) Direct services to members, including substance abuse treatment and Traditional Practitioner Program; and (4) Outreach and education.

Memoranda of Understanding. Health Choice uses MOUs with Tribal Nations, which are the primary means of determining what services the Nation wishes us to provide. As sovereign entities, Tribal Nations have the right to tell us what it is they want, not the reverse. In instances where Tribal Nations are interested in having Health Choice provide services, we will continue to work closely with them to negotiate MOUs in accordance with Federal and AHCCCS policy guidelines. The MOUs will identify service expectations and obtain more reliable and accurate data for use in service delivery, addressing initiatives and program development. Currently, we maintain active MOUs with five of the twelve Tribal Nations in Northern Arizona, with seven additional MOUs in progress. Our current MOUs are with: The Havasupai Nation, Yavapai Apache Nation, Hopi Nation, Fort Mojave Indian Tribe, and the Hualapai Tribe (See Table 1.)

One example of a recent success in negotiating and implementing an MOU was with the Havasupai Nation. Health Choice was able to overcome a series of challenges and barriers associated with accessibility, remoteness, and coordination of the various health care delivery systems through our partnership with one of our Flagstaff-based Health Homes, The Guidance Center. This collaborative effort and also expanded in 2016 to include an expanded collaborative effort with the Indian Health Service. This project exceeded all expectations

and enhanced our relationship with the Havasupai Tribal Council by ensuring the delivery of health services to the bottom of the Grand Canyon.

Another example is Health Choice's success in developing a strong and productive relationship between the Yavapai Apache Nation and Spectrum Health Group, another of Health Choice's Integrated Health Home. After many years of work, Health Choice was able to negotiate an MOU which has resulted in greater access to crisis services both on and off tribal lands, and improved collaboration between Tribal Police, Social Services, Behavioral Health providers and Indian Health Services.

However, Tribal resources and approaches differ greatly. For example the San Juan Southern Paiute currently does not have the capacity and infrastructure to enter into an MOU. By contrast, the Tonto Apache and Yavapai Prescott Indian Tribe have the resources, capacity and ability to provide health coverage for their members so rarely need assistance from us. In either instance, we vary our approach to address the Nation's specific needs. Regardless of the resources available to a Tribal Nation, we offer resources and assistance.

Tribal Consultation. The role of the Health Choice Tribal Liaison is instrumental in Tribal Relationship building, serving as the designated interface with Tribal Nations and providers and leading the Tribal Services Team. This participatory approach allows the Tribal Liaison to directly assess the potential needs, barriers to care, and capacities of each Nation. In turn, the Tribal Liaison then works with the Tribal Services Team to provide consultation to the Nation around these issues. Topics which frequently involve consultation include how to navigate AHCCCS or Health Choice resources, how to work with non-tribal health facilities, and interfacing with local governments on matters such as court ordered evaluation processes.

Tribal Relations Memorandum(s) of Understanding (MOUs)		
Tribal MOUs in Place / Active	**Tribal MOUs in Progress**	**Tribal Entity MOUs**
Havasupai Nation (2016) In collaboration with The Guidance Center	• **Kaibab Paiute Indian Tribe** • **Navajo Nation** • **San Juan Southern Paiute** • **White Mountain Apache** • **Tonto Apache** • **Yavapai Prescott Indian Tribe** • **Zuni Pueblo**	Native Americans for Community Action (NACA). Tuba City Regional Health Care Corporation (including Sacred Peaks Health Center in Flagstaff) Tuba City Chapter House. CRIT/Fort Mojave IHS Service Area Office that includes Kaibab Paiute Indian Tribe, Hualapai and Havasupai in this service area.
Yavapai Apache Nation (2017) In collaboration with Spectrum Healthcare Group (SHG), West Yavapai Guidance Clinic and Community Bridges Inc.		
Hopi Tribe/Tewa Tribe (2016) In collaboration with ChangePoint Integrated Health (ChangePoint), The Guidance Center and Community Bridges.		
Fort Mojave Indian Tribe (2016) In collaboration with Mojave Mental Health and Southwest Behavioral Health.		
Hualapai Nation (2016) In collaboration with Mojave Mental Health and Community Bridges.		

Table 1

Recently, this service has been utilized by various Tribal Nations for assistance in areas identified as needing focused attention such as developing and extending crisis protocols for Tribal Nations by providing "step by step" guidance on utilizing the crisis response system in the event of an "emergency" or "crisis" that are geared toward addressing unique or specific situations impacting specific Tribes.

Nation and Capacity Building. Health Choice's Tribal Service Team works directly with Tribal Nations to assist them in developing their own internal resources and programs. In doing so, we recognize that each Nation will have a different approach, which will be dictated by each Nation's MOU. Nation and capacity building involves working with Tribal Nations and entities on topics such: Facilitation of inter-departmental meeting and strategy sessions, consulting on drafting policy, locating and assisting in applying for state and federal funds and

resources, billing support, and collaboratively developing and expanding needed treatment and supports, including telemedicine, both within Tribal communities and in towns that border Tribal lands. An example of this has been assistance in creating policies and protocols for specific Tribal Nations to assist in developing Tribal Court Ordered Treatment programs.

Health Choice has also assisted Tribal Nations in developing their own internal resources through customized training programs. These programs have included providing guidance on specific codes for billing AHCCCS services and Child and Adolescent Services Intensity Instrument Training. Health Choice has also offered training on accessing county court ordered evaluation and treatment process, grief therapy, and suicide prevention in response to Tribal requests following two distinct clusters of suicide. In 2016, our Tribal Services Team rolled-out "SafeTALK" training sessions, which focused on issues that impact each Tribe. The Tribal Services team also introduced the Health Choice Safety, Help, Outreach, Understand, and Track (SHOUT) Protocol to tribes expressing an interest in adopting this protocol for people who have high risk suicide attempts and to provide evidence-based interventions to prevent suicides and suicide attempts. Traditional healing services are also tailored for suicide prevention and services as an additional “choice”.

The Health Choice Tribal Services Team also offers technical assistance in developing tele-health (using “Zoom” technology) programs through which tribal members are connected with internal Health Choice experts to support tele-health development. In addition to expanding access to treatment services, tele-health technology and networks are an effective method of extending training and education and helps strengthen collaboration and partnerships through participation in video meetings. Tele-health technology is embedded in every Health Choice Health Home which allows Tribal Nations with tele-health capacity greater access to services and practitioners, collaboration, and service coordination.

Direct Services. Health Choice also facilitates and provides services directly to tribal members in our service area. We recognize and support the fact that all American Indians have “choice” in accordance with the American Indian Health Care Improvement Act of 1975 and the American Indian Religious Freedoms Act of 1978. Traditional Practitioner Program services include an array of traditional American Indian services, protocols, and training opportunities. American Indian members who select Health Choice have access to all contracted service options and opportunities, and have a choice of Integrated Health Homes and other providers within our network. In addition, however, Health Choice offers services specifically created for Tribal members. One example of this is our Traditional Practitioner Program. The Traditional Practitioner Program was started in 2014, using funding provided through our Community Reinvestment program, and offers healing ceremony services to all American Indian members in our service area. Health Choice’s Sweat Lodge Program supports our Traditional Practitioner Program by supporting and collaborating in the construction and operation of four sweat lodges in Northern Arizona.

Havasupai Community Center at the bottom of the Grand Canyon, where services are provided by The Guidance Center

Another example of collaboration with Tribal Nations in developing direct services is the Albert Long Center, named in honor of the late Navajo Nation Behavioral Health Administrator, in Holbrook, Arizona. In partnership with the Navajo Tribal Regional Behavioral

Health Authority, Community Bridges, and the NARBHA Institute, Health Choice Integrated Care transitioned an under-utilized transitional facility into a 16-bed chemical dependency residential treatment facility for men. The Albert Long Center is available to all members, however treatment and services are specific to American Indian men and include a Sweat Lodge that was built by Tribal members. This initiative allowed Health Choice to collaborate with our Tribal partners in further identifying the need for a Women's Chemical Dependence Residential Treatment Facility. In 2017, Health Choice (again working with Community Bridges) developed a chemical dependency residential treatment facility for women in Payson, Arizona. This facility offers nine beds for women in need of services, and one additional bed which is reserved for individuals who may need psychiatric services and are awaiting services at the Payson Hospital's Emergency Department.

Health Choice also offers direct services in collaboration with Tribal Nations and the Department of Developmental Disabilities. These specialized services for people with developmental disabilities and Autism Spectrum Disorders were identified as a gap in available services by our Tribal Services Team. Health Choice has worked to address this need by expanding our contract with Behavioral Consultation Services of Northern Arizona, a provider of Applied Behavioral Analysis that is closely affiliated with Northern Arizona University. Behavioral Consultation Services hired and trained bi-lingual/bi-cultural American Indian NAU graduates (who are on the path to becoming licensed Behavioral Analysts) and who deliver ABA services throughout northern Arizona, on the Navajo Nation, and in other Tribal communities.

Health Choice also provides care coordination services to assist Tribal members who chose to use health services that are outside of tribal lands. These members often require assistance and collaboration in accessing and coordinating services with Indian Health Service or Tribal 638 programs. Health Choice facilitates communication with tribal staff and our own provider network to promote success in the delivery of services. The Tribal Services Team will also continue to conduct regular meetings with IHS and 638 facilities to discuss questions or concerns, and identify any opportunities for additional trainings or technical assistance.

Identification, Escalation, and Resolution. Health Choice maintains and utilizes a cohesive, inter-disciplinary and a culturally appropriate interactive process for identifying issues and concerns related to our Tribal Services program. Issues and concerns from Tribal Nations and members are received through multiple communication routes, including direct contacts through member services, provider referrals, and referrals from internal care management resources. However, historically, the primary means of issue identification has been through outreach by Health Choice's Tribal Services Team.

The Health Choice Tribal Services team is led by the Health Choice Tribal Liaison with additional support and direction from Health Choice Cultural Competency Administrator. Our Tribal Liaison reports directly to the Health Choice Chief Executive Officer, and meets regularly with the Chief Executive Officer and the entire Health Choice Executive Team. The Health Choice Executive Team further ensures expedited resolution of issues, engagement in the development of programs and initiatives impacting the delivery of care and services to Tribal Communities by referring issues to our Medical Management, Network Development, Quality Management, Care Management and Coordination, Prevention Services, and Communications programs. This interactive process also is used to monitor follow-up on identified issues to ensure a satisfactory resolution.

The Health Choice Tribal Relations team will maintain a detailed and comprehensive work plan, which will be monitored throughout the plan year and evaluated annually for re-assessment of goals and objectives based on outcomes. It will address all review areas as outlined in the AHCCCS Complete Care Contract. We also use this work plan as an effective tool to log and track identified barriers, and address items resulting in escalation during the plan year. At least annually, Health Choice prepares and submits a comprehensive Tribal Services Report, summarizing the activities, services, programs and coordination of care for American Indian members. There are six major categories address in the Tribal Relations Work Plan including: Progress in negotiating and signing MOUs, Tribal Consultation activities, Nation/Capacity Building, Network

Development/Access to Care; the Traditional Practitioner and Sweat Lodge Programs, Coordination of Care and Outreach and Education.

Finally, another Health Choice resource for identifying broader level issue is the development of our Tribal Services Advisory Board, including selected representation from each Tribal Nation within our service area to give input on delivery of service and priorities impacting Tribal Nations.

Outreach and Networking. Health Choice's Tribal Relations Team will also continue its focus on maintaining and enhancing existing relationships with our Integrated Health Homes and provider network, Directors of Tribal behavioral health programs, Tribal leaders, AHCCCS, and other AHCCCS managed care plans. Health Choice's outreach and networking initiatives include sponsorships and active participation in conferences, along with increased outreach to encourage attendance by the Tribes.

Health Choice's most noteworthy networking and outreach event is our Annual Tribal Summit which involves a dedicated day and a half gathering of Tribal leaders, Tribal Behavioral Health and Social Service staff, and Indian Health Service personnel. The Tribal Summit addresses current state-wide topics, opioid resources and trends, traditional medicine, and historical trauma. The annual Tribal Summit is also an excellent vehicle for gathering and disseminating important information. Our 2016 Tribal Summit featured a presentation by AHCCCS related to the development of the American Indian Home program, and in 2017 AHCCCS' Clinical Initiatives Project Manager, Shana Malone, presented on the Opioid State Target Response grant program. We also include workshops that were directly designed to gather feedback from the Tribal representatives in attendance. Over the last four years, the feedback gathered through these workshops has resulted in many significant changes in our approach to provider services — including the development of additional traditional healing services like our Sweat Lodge program.

Participants at our 2015 Tribal Summit engage in wellness exercises

Conclusion. Health Choice has developed and implemented an array of processes and initiatives to engage and collaborate with Tribal Nations for the delivery of services to American Indian members. Our processes are also designed to quickly identify, escalate and resolve any barriers to service delivery for American Indians on and off tribal lands. Health Choice will continue to expand our efforts to actively engage and collaborate with Tribal Nations, including our ongoing efforts to build relationships and secure Memoranda of Understanding (MOU). We will continue to support Tribal Nations through consultation services, nation and capacity building efforts, direct services to member, and outreach programs. Health Choice's Tribal Services Team looks forward to the opportunity to expand its successful program to additional service areas on a fully integrated basis.

Steward Health Care Network

HEALTH CHOICE ARIZONA

Oral Presentation: To follow is a listing of the names and titles (followed by respective resumes) of the participating individuals for Oral Presentations as required in Paragraph 19:

Name of Participant	Participant Title	Employee (Affiliate or Parent Company)
1. Shawn Nau	Chief Executive Officer	Health Choice Integrated Care
2. Dr. Teresa Bertsch	Chief Medical Officer	Health Choice Integrated Care
3. Katrina Cope	Vice President of Operations	Health Choice Arizona
4. Diana Alvarez	Vice President of Marketing	Health Choice Management Co.
5. Angela Sherwin	Vice President of Medicaid	Steward Healthcare System
6. Mark Carroll	Chief Health Officer	The NARBHA Institute

Shawn H. Nau
1300 South Yale Street, Flagstaff, AZ
928.214.2291
Shawn.Nau@iasishealthcare.com

Experience

Chief Executive Officer, Health Choice Integrated Care. 1300 South Yale Street, Flagstaff, Arizona 86001. (February 2013 through present.) Manage business strategy and operations for Northern Arizona behavioral health managed care organization, including community stakeholder collaboration efforts, network service development, cultural competency programs, coordination of tribal services team, communications, public relations, and provider policy development. Initiated and lead team to implement program to manage court ordered evaluations for Coconino County under an intergovernmental agreement with the Arizona Department of Health Services.

City Manager, Eagar, Arizona. 22 W. 2nd Street, Eagar, Arizona 85925. (June 2012 through February 2013.) Turnaround management project for city facing significant financial and operational challenges. Managed all operations including police, fire, public works, planning and zoning, parks and other municipal functions. Completed financial recovery and stabilization plan within fifteen months.

County Manager, La Plata County. Colorado. 1060 East 2nd Avenue, Durango, Colorado 81301. (March 2008 through August 2011.) Managed $68 million county operations including central county administration. Additionally, served on San Juan Basin Health Board; helped create and served as a founding board member of the La Plata County Economic Development Alliance; and helped create and served as a founding board member of the Southwest Colorado Council of Governments.

Director of Heath Care Administration and General Government Services, Maricopa County. Arizona. 301 West Jefferson, Suite 320, Phoenix, Arizona 85003. (January 2000 to March 2008; August 2011 to June 2012.) Managed multi-department agency providing a wide variety of health care, strategic planning, legal, and budget related services with budgetary responsibilities in excess of $325 million. Accomplishments included completion of a public initiative and election process to transition 600-bed County hospital and health plan system to a special health care district; managed $360 million health care litigation portfolio; and Introduced improved prior authorization and

claims payment systems for public and correctional health services. Managed Arnold v. Sarn litigation and coordination with County RHBA; Assisted with reorganization of several key County departments;

Director, Human Resources Department, Maricopa County. Arizona. 301 West Jefferson, Suite 240, Phoenix, Arizona 85003. (September 1996 to January 2000.) Direct personnel system delivering a broad range of human resources services to approximately 14,000 employees, including recruitment, compensation, payroll, employee records, leave and benefit programs, employee relations, and merit systems. Served as the County ethics officer and ADA coordinator. Responsible for operating budget of over $3 million, and benefits trust budget of over $32 million. Served as a lead consultant on Maricopa County's human resources submission to Governing Magazine's "Rating the Counties" project, which resulted in Maricopa County receiving the highest national designation. Served as member of Arizona Joint Legislative Committee on Employee Compensation;

Lead Counsel, Employment Law Section, Maricopa County Attorney's Office, Civil Division. 301 West Jefferson, 8th Floor, Phoenix, Arizona 85003. (October 1993 to September 1996.) Managed practice group of five attorneys representing Maricopa County departments in general counsel and litigation matters. Major accomplishments: Participated in negotiation of Bank One Ballpark (now Chase Field) memorandum of under-standing with Arizona Diamondbacks for construction of Bank One Ballpark; litigated cases precedent setting case under the Fair Labor Standards Act; assisted in restructuring of county as part of stabilization program following fiscal crisis in 1994.

Associate Counsel, Tower Byrne Beaugureau & Shaw, P.C. 2111 East Highland Avenue, Suite 255, Phoenix, Arizona 85016. (October 1991 through October 1993). Represented both private and public sector clients in a variety of legal matters, including Title VII employment discrimination and civil rights litigation, and administrative matters before the Equal Employment Opportunity Commission. Chaired firm's technology committee, and directed implementation of the firm's first computer system.

Assistant Attorney General, Chief Counsel's Staff, Ohio Attorney General. 30 East Broad Street, 17th Floor, Columbus, Ohio 43266-0410 (August 1986 through October 1991). Responsibilities included representation of the state's Department of Administrative Services Division of Personnel, Ohio State University Hospital, Ohio Supreme Court, Governor's Office, Attorney General's Office and Treasurer's Office in financial, employment, and public disclosure matters; served as general counsel to state public employee's deferred compensation fund. Represented other state departments in matters including cases under the Federal Vocational Rehabilitation Act, Americans with Disabilities Act, as well as racial discrimination, gender discrimination and sexual harassment cases. Conducted seminars on various public employment-related issues. Additionally, served as "Open Government Liaison" coordinating public disclosure of media requests for information from the Attorney General's Office and Division of Personnel.

Education

Adjunct Professor, Ohio State University Law School. 1659 North High Street, Columbus, Ohio 43210. (September 1988 through January 1990). Instructed law students in constitutional law, employment law, and legal research and analysis techniques.

Juris Doctorate, University of Toledo School of Law, Toledo, Ohio 43606. Graduated May, 1986, *cum laude*. Ranked in top ten percent of graduating class. Awarded Gelereed Memorial Scholarship. Activities included Moot Court, Mugal Society.

Bachelor of Arts, State University of New York at Buffalo, Department of Philosophy, Buffalo, N.Y. 14226. Graduated *cum laude* (university-wide), *magna cum laude* (department), B.A., Analytical Philosophy. Activities included honors research program on law and ethics, served as judge-advocate in student-wide judiciary alternative dispute resolution program.

International City County Management Association; National Association of Counties; Association of Colorado County Administrators; Society for Human Resources Management; International Personnel Management Association; Admitted to Ohio State Bar and Ohio Federal District Court Bar, November, 1986; Volunteer for United Way, United Cerebral Palsy, Upward Foundation, and Grand Canyon Field Institute.

Teresa Denise Bertsch, MD

Health Choice Integrated Care
Previously Northern Arizona Regional Behavioral Health Authority (NARBHA)
1300 South Yale St., Flagstaff, AZ 86001
928-774-7128 (main) 928-853-1623 (cell)
Teresa.Bertsch@Steward.org

Chief Medical Officer. August 2, 1992 – Current
Chief Clinical Officer. April 1, 2011- January 15, 2013, and December 15, 2000 - January 15, 2003

Oversees all medical, clinical and quality programs for HCIC's Arizona public sector managed care services (physical and behavioral) for adults with serious mental illness, and behavioral health services for Medicaid (AHCCCS) and Arizona state funded managed behavioral health care system, including full continuum of care for children and adults with serious mental illness, and behavioral health and substance use disorders in 65,000 square mile catchment area, including 12 American Indian tribal nations.

- Oversees integration of behavioral health & primary health care, including development of contracts, State Targeted Response to Opioid Crisis Grants, incentive programs, outcomes and strategic direction.
- Develops, reviews and implements medical/clinical/utilization policies, procedures, programs, best practices and performance standards for adult and child medical and behavioral health programs.
- Ensures the quality, consistency, and timeliness of physician case reviews, peer consultations, reconsiderations, and other medical management activities conducted by HCIC medical staff.
- Recruits physician/medical practitioners for network ensuring that HCIC consistently meets its network sufficiency performance goals. Develops physician/medical practitioner practice profiles and makes recommendations regarding credentialing and re-appointment.
- Member of HCIC Executive Team, Leadership Council and Corporate Compliance Committee.
- Chairs Medical Management, Quality Management, Peer Review, HCIC Network Medical Practitioners, Morbidity and Mortality, Pharmacy & Therapeutics Committees.
- Governor appointee for SBIRT Policy Steering Committee for Arizona Governor's Office for Children, Youth and Families SBIRT (Screening, Brief Intervention and Referral to Treatment) SAMHSA grant.
- Has served on numerous state-wide committees developing policies on clinical initiatives, services and treatment priorities for state-funded behavioral health services, including AZ Health Care Cost Containment System (AHCCCS) Health Plan Medical Directors Group (2015- current), Arizona Statewide Regional Behavioral Health Authorities' Medical Directors Group (1992- Current), Arizona Statewide Integration of Care Workgroup (2000-2003), ADHS/DBHS Interagency Committee on Children's Medical Necessity (1993- 2000), Implementation Oversight Committee on Perinatal Substance Abuse (Legislative appointment 1998- 2000) and ADHS/DBHS Best Practices Advisory Committee (2006-2009). **AZ Dept of Health Services/Dept of Behavioral Health (ADHS/DBHS) Workgroups**: Behavioral Health Crisis Response System (2009), Authorization Criteria for Level II/III/HCTC for Adults and Children (2009), Buprenorphine Prescribing Protocols (2009), Pharmacologic Restraint (2008), Birth to Five Psychopharmacology (2008), Treatment of Co-Morbid Behavioral Health and Medical Disorders (2007-2008), AHCCCS/DBHS Coordination of Care (2005), Polypharmacy (2005-2006), Informed Consent (2003-2007), HEDIS Follow-up After Discharge from Inpatient (2004-2006). **ADHS/DBHS Practice Improvement Protocols (PIP)**: Buprenorphine Protocols; Use of Psychotropic Medication in Children and Adolescents; Autistic Spectrum Disorders; Attention Deficit Disorders; Substance Use, Abuse and/or Dependence in Pregnant and Postpartum Women; Special Considerations for Assessment and Treatment of Behavioral Health Disorders in Individuals with DD; Neuropsychological Evaluations from Health Plans and T/RBHAs; Informed Consent for Psychotropic Medication Treatment.

Board-Certified, Community Health Center Psychiatrist. December 1, 2010- current
North Country HealthCare 2920 N. 4th Street, Flagstaff, AZ 86004 928-213-6100
Integrated psychiatric care in support of the primary care and OB/GYN physicians at NCHC, a federally qualified healthcare center. Precepts AT Still School of Osteopathic Medicine medical students and North Arizona University and University of Arizona nurse practitioner students.

Board-Certified, Community Mental Health Center Psychiatrist. August 2, 1992 – July 23, 2010
The Guidance Center, Inc. 2187 North Vickey Street, Flagstaff, AZ 86004 928-527-1899
Inpatient and outpatient psychiatric care of children and adults.

Arizona State Behavioral Health Leadership in Services Award. May 21, 2015
Arizona State University's Center for Applied Behavioral Health Policy award for designing and delivering innovative behavioral health care systems and lifelong dedication to public service. Sedona, AZ

ACADEMIC BACKGROUND

Chief Resident in Psychiatry. June 15, 1991 - June 30, 1992
Residency in Psychiatry. June 15, 1988 - July 30, 1992
University of New Mexico (UNM), Department of Psychiatry. Albuquerque, NM

Medical Degree. August 15, 1984 - May 15, 1988
Case Western Reserve School of Medicine (CWRU). Cleveland, OH

Master of Arts in Linguistics. September 15, 1980- August 15, 1983
Stanford University. Stanford, CA

Bachelor of Arts in Human Languages. September 15, 1976 - June 3, 1980
Stanford University. Stanford, CA

SELECTED RESEARCH AND CONFERENCE PRESENTATIONS

Integrated Behavioral Health and Medical Care

The Future of Psychiatry: Drugs, Bugs, Screens and Greens. Presented at NARBHA Institute 50 Year Anniversary Conference. Flagstaff, AZ. November 2017

Navigating Institutions for Mental Disease (IMD) Compliance and Developing Best Practices. Panel discussion at AZ Hospital and Healthcare Association 2017 Annual Leadership Conference. Marana, AZ. October 2017

Payer's Perspective on the Opioid Crisis in Arizona. Presented at Arizona Public Health Association 2017 Conference. Phoenix, AZ. September 2017

Psychiatric Pearls for PCPs. Presented at North Country HealthCare primary care/ OB-GYN CME. Flagstaff, AZ August 2016; Central Conference in Flagstaff, AZ October 2016; Eastern Conference in Show Low, AZ November 2016; Western Conference in Laughlin, NV February 2017

Be the Bridge: Practical Techniques to Get All Your (or Your Child's) Doctors on the Same Team. Presented at Mental Health America and ASU Center for Applied Behavioral Health Policy SEEDS Conference. Phoenix, AZ. May 2016

Psychiatry's Seat at the Integration Table. The Role of Medical Leadership. Presented at University of New Mexico School of Medicine Integrated Care conference. Albuquerque, New Mexico. April 2015

First Do No Harm: Best Practices in Psychiatric Prescribing for Arizona. Conference organizer and presenter. "Polypharmacy and Mortality Trends in Arizona." Flagstaff, AZ. July 2014

Promising Practices: Advancing Integrated Healthcare through Trauma Informed Care. 2013 Healthcare Integration Conference. Conference organizer and facilitator. Flagstaff, AZ. May 2013

Best in Class: Addressing the Challenges of Bidirectional Integration--You Get What You Pay For: An Arizona Medicaid MCO Incentivizes Behavioral Health Providers to Integrate Care. Presented at National Council for Behavioral Health Annual Conference. Las Vegas, AZ. April 2013

Recognizing Psychiatric Illness and the Effects of Trauma in Primary Care.
Conducting a Psychiatric Evaluation and the Mental Status Examination. Mind Course lectures for AT Still Medical School second-year medical students. Flagstaff, AZ. 2010- Current.

We Are There Now: Perspectives from Four Chief Medical Officers. Presented at Moving Forward: Implementing Integrated Models of Care in Arizona Conference. Phoenix, AZ. August 2012

Self-Serve, Vanilla and Rocky Road: Serving the Mentally Ill from the Provider and Medicaid Managed Care Payer Perspective. Region IX Western Clinicians Network and Association of Community Health Centers 18th annual Leadership Conference. Las Vegas, NV April 2012

The Science of Willpower- It Is Not What You Think. Presented at The Guidance Center Wellness Week. Flagstaff, AZ. March 2012

At Risk in the Emergency Department. An Interactive Training Simulation That Helps ED Staff Learn How to Recognize and Respond to Patients at Risk for Suicide and Substance Abuse. Suicide Prevention Resource Center/ American Foundation for Suicide Prevention Best Practice registry. Arizona Subject Matter Expert. https://az-ared.kognito.com/ December 2011

The Changing Landscape—NARBHA's Program on Integrated Care. Presented at the SAMHSA-funded Addiction Technology Transfer Center Annual Meeting Atlanta, GA. November 2011

Northern Arizona Integrated Healthcare Programs. Presented at the NARBHA Integrated Health Summit. Northern Arizona University, AZ. October 2011

Integration of Behavioral Health and Primary Care Projects. Presented at Arizona Association of Community Health Centers annual conference. Phoenix, AZ. February 2011

Integration of Behavioral Health and Primary Care in Rural Areas. Presented at Arizona Rural and Public Health Policy Forum. Phoenix, AZ. February 2011

NARBHA Integration of Behavioral Health and Primary Care. Presented at Arizona State University Summer Institute. Sedona, AZ. July 2010

Adult & Seriously Mentally Ill

New Research on Bipolar Disorder and How It Affects You. Presented at Flagstaff Medical Center for National Alliance for the Mentally Ill (NAMI). Flagstaff, AZ. May 2013

T36s, Rule 11s and Jail Diversion Systems in Arizona Rural Counties. Presented at Arizona Supreme Court Legal Competency & Restoration Training for Mental Health Professionals Certification. Phoenix, AZ. February 2012

Compassion Fatigue—Antidotes for Behavioral Health Caregivers. Presented at The Guidance Center Wellness Month. Flagstaff, AZ. March 2010

The Incredible Growing and Shrinking Brain—Impact of Trauma and Treatment on Brain Anatomy and Function. Presented at NARBHA Board of Directors and All Staff. Flagstaff, AZ. December 2009

Bipolar Disorder- Treatment and Recovery. Presented at Flagstaff Medical Center for NAMI Awareness Month. Flagstaff, AZ. October 2005

Unmet Healthcare Needs in Women with Serious Mental Illness. Presented at Health Status and Health Care Concerns for Individuals with Serious Mental Illness Conference. Phoenix, AZ 2001

Can I Go to Work Now: Vocational Rehabilitation and the Seriously Mentally Ill. Presented at Rehabilitation Services Administration Conference. Flagstaff, AZ 1999

New Medications: Implications for Arizona. Presented at Arizona Department of Health Services and University of Arizona College of Medicine Conference. Scottsdale, AZ 1997

Evaluating the Quality of Your Psychiatrist. Presented at NAMI National Convention. Nashville, TN 1996 & Albuquerque, NM July 1997

Drugs Are Messy: Recognizing and Managing Side Effects. Presented at The Guidance Center CME lecture series. Flagstaff, AZ 1996

Behind Closed Doors: How Good Is Your Psychiatrist? Presented at Mental Health Association of Arizona's Eighth Annual Seeds Conference. Phoenix, AZ 1995

Hypochondriasis: Treatment and Management in a Primary Care Setting. Presented at Flagstaff Medical Center CME Lecture Series. Flagstaff, AZ 1994

Psychiatry Protocol Cards. Treatment protocols of major psychiatric disorders for resident physicians. UNM 1991

Children & Adolescent Topics

Love is the Best Medicine: Foster Parents Helping Children with Behavioral Health Disorders. Catholic Social Services T19 Therapeutic Foster Parents Training and Videotape Production. Cottonwood, AZ 2002, 2010

ADHS Level of Care Criteria and Service Planning Guidelines in the Public Sector. Presented at MCO Series/ Behavioral Health QM/QI in Public and Commercial Organizations. Phoenix, AZ 1997

Positive Outcomes for Kids and Families in a Managed Care World; NARBHA's Results. Presented at Univ. of Southern Florida's 10th Annual Research Conference for Children's Mental Health. Tampa, FL 1997

On the Firing Line: Practicing Ethically in a Managed Care Environment. Presented at Mental Health Association of Arizona's Ninth Annual Seeds Symposium. Phoenix, AZ 1996

Children's Treatment Guidelines and Outcome Standards. Presented at AZ Association of Behavioral Health Programs Quality Conference. Phoenix, AZ 1996

Labor Support by First-Time Fathers: Direct Observations with a Comparison to Experienced Doulas. Bertsch, et al., *Journal of Psychosomatic Obstetrics Gynecology* (1990) 251-260

First -Time Fathers During Labor Compared to Experienced Doulas: Direct Observations. Presented at American Society for Psychosomatic OB-GYN Conference. New York, NY 1990

Fathers During Labor: Do We Expect Too Much? Presented at Society of Pediatric Research Conference. Anaheim, CA 1987

Persons with Developmental Disabilities Topics

Is That a Side Effect? Assisting Persons with Developmental Disabilities Who Are Taking Psychotropic Medications. Presented at Joint DDD/NARBHA Conference. Flagstaff, AZ 2002, 2009

Psychotropic Medications Use in Persons with Developmental Disabilities. Presented at Joint DDD/NARBHA Conference. Flagstaff, AZ 1998

Evaluating and Serving Persons with Developmental Disabilities and Mental Health Needs. Presented at Joint DDD/NARBHA Conference. Flagstaff, AZ 1997

OTHER PROFESSIONAL POSITIONS

Adjunct Faculty, A.T. Still University School of Osteopathic Medicine in Arizona. 2008- Current. Glendale, AZ

Ironman Global Medical Advisory Board. Kona, HI. 2017- Current.

Member of Coconino County Health Department (CCHD) Disaster Response Incident Management Team and chaired Pandemic Flu Behavioral Health sub-committee

MEDICAL LICENSURE AND CERTIFICATION

ABPN Psychiatry Board Certification. #39147. 1994 (No Expiration)

State of Arizona. #20886. 1992- Current

State of New Mexico. 1990 (Inactive)

Buprenorphine DEA Certification. 2005- Current

KATRINA COPE

Gilbert, Arizona · 480-204-9932 · Katrina.Cope@Steward.org

Healthcare Executive Profile

Dynamic healthcare executive with experience across business operations. Proven ability to lead organizations to achieve desired outcomes. Data and outcomes driven approach to managing business operations. Ability to lead, grow, and direct teams.

Specialized Expertise

- Complex Healthcare Regulations
- Executive Presentation Experience
- Project Management and Execution
- ROI Analysis and Tracking
- State Agency Experience
- Process Improvement and Optimization
- Leadership Development and Mentoring
- RFP Development and Assessment Experience

Professional Experience

Vice President of Operations 2015 - Present
Health Choice Arizona/Health Choice Generations, Phoenix, AZ

Operations leader for Arizona Medicaid and Medicare plans with annual revenues of $800M+. Reports directly to CEO as a member of the Senior Executive team. Responsible for driving operational performance of plans: compliance, operational efficiency, and quality.

Director, Medicare Operations 2013 - 2014
Health Choice Generations, Phoenix, AZ

Responsible for driving initiatives for the Medicare Advantage D-SNP. Specific focus on dual alignment, growth, Star ratings, and operational efficiency.

Program Development Manager
***Arizona Health Care Cost Containment System (AHCCCS),* Phoenix, AZ** 2011 - 2013

In this newly created role at the Arizona State Medicaid agency, was the agency resource for all initiatives Medicare and dual eligible related.

Paralegal – Medicare
***Mercy Care Plan – An Aetna Company*, Phoenix, AZ** 2009 - 2011

In this newly created position at a Medicare/Medicaid health plan, I expanded my paralegal role and was involved in process and policy improvements for the Medicare business.

Legal Secretary – Criminal Defense
***Florence & Bell, Ltd.*, Phoenix, AZ** 2009

Education and Training

Master of Science in Leadership, Grand Canyon University
Paralegal Certificate, The Paralegal Institute
Bachelor of Arts in Sociology, Western Washington University

DIANA ALVAREZ

23632 N. 21 Place
Phoenix, AZ 85024

Phone: 602.478.1628
Email: Diana1324@cox.net

OPERATIONS MANAGEMENT

Healthcare | Insurance | Quality

Confident and knowledgeable Healthcare Management Specialist with over 20 years of experience in operations, development, implementation, research, and training. Outstanding strategist distinguished for saving Maricopa County over $23m in claims cost by coordinating reviews, tracking discrepancies, and identifying invalid claims during settlement and litigation proceedings. Exceptional communicator with strong negotiation, problem resolution and client-needs assessment aptitude.

AREAS OF EXPERTISE

- Budgeting
- Financial & Policy Analysis
- Cost Control
- Healthcare Management
- Risk Management
- Legislation
- Research
- Quality Management
- Problem Resolution

PROFESSIONAL EXPERIENCE

HEALTH CHOICE, Phoenix, AZ 2017-Present
Vice President of Marketing, Community Relations and Training

- Oversight and direction for all member communication and resources.
- Ensure appropriate regulatory requirements are accounted for and implemented as it relates to contract terms.
- Management of community relations programs across the organization.
- Establish internal training processes, curriculum and training programs to ensure consistency across all lines of business and operations centers.
- Ensure that training materials support and stay in pace with contractual requirements and deliverables.
- Supports internal/external brand through systematic communications; accounting for regulation requirements as well as culture and community perception.
- Ensuring communication delivery and direction support the strategic vision in a consistent manner through programs, events, and media relations management.
- Partner and support business development opportunities through branding, communication, outreach and materials.

PHOENIX HEALTH PLAN, Phoenix, AZ 2015-2017
Director of Contract Compliance, Corporate Compliance, Grievance and Appeals, and Business Development

- Senior level executive and point person for oversight, administration, coordination and monitoring of all compliance , grievance and appeals and business development functions.
- Develop and maintain the organization's compliance program structure to reasonably ensure adherence to applicable federal and state rules and regulations.
- Serve as liaison between company and regulatory agencies.
- Conduct internal audits, reviews and monitoring to ensure compliance with regulations including investigations of suspected violations.
- Manage regulatory audits for the Medicaid, Medicare and the Health Insurance Exchange line of business.
- Initiate periodic compliance self-assessments and provide periodic reports to the Board of Directors on the status of compliance efforts.
- Provide advice and serve as a resource for employees, contractors and vendors (as appropriate), agents and any applicable governing Board members on compliance issues.
- Train employees to recognize and identify fraud or abuse and forward report to the appropriate department.
- Develop, distribute, implement, and communicate new and revised compliance policies.
- Implement, conduct, and monitor annual compliance training and education.
- Participate in the development and implementation of internal controls capable of preventing and detecting significant instances or patterns of illegal, unethical, or improper conduct.

- Key point person and project manager for regulatory initiatives such general mental health integration and justice systems initiatives.
- Develop proposals in response to request for proposals (RFPs).
- Strategic marketing and operations planning with top executives, setting objectives and identifying methods to reach goals.
- Develop and participate in organizational growth initiatives related to regional markets and target customer segments.
- Creation of long-term value for the organization from customers, markets, and relationships.
- Oversee the review, research, investigation, negotiation, and processing of CTMs, Appeals and Grievances for the Medicare, Medicaid, and Health Insurance Exchange Product lines of business for three states.

STATE OF ARIZONA, Phoenix, AZ 2012-2015

Operations Manager, Division of Health Care Management

Accomplished professional charged with monitoring the performance of 11 AHCCCS-contracted managed care organizations (MCOs), funded at $5 billion annually to provide acute, long term care, and behavioral health services to over one million Arizona residents. Responsible for the management and oversight of the Operations unit and staff within the division to ensure AHCCCS-contracted MCOs adhere to and perform the duties under contract in a satisfactory manner.

- Monitoring the performance and contract compliance of MCOs delivering acute, long term care, behavioral health and children's rehabilitative services.
- Responsible for evaluating provider network adequacy and availability of services, monitoring claims payment systems for timely and accurate payment, monitoring MCO Member Services function to assure members have timely and accurate access to assistance from the MCO, monitoring the federally required grievance system and monitoring compliance with all other terms of the contract.
- Assure development, completion and publication of a contractor review document in compliance with federal law.
- Coordinate and respond to provider inquiries and complaints regarding MCO performance.
- Lead role in the development of Request for Proposals and the procurement process.
- Annual evaluation for amendments of MCOs delivering acute, long term care, behavioral health and children's rehabilitative services.
- Participate in MCO transition and readiness processes following contract award, including transfer of member data, assessment of MCO readiness (network adequacy, staffing adequacy, policy/procedure development, systems readiness).
- Developing and updating Agency policies in compliance with changing regulatory requirements.
- Monitoring the development of federal and state statutes and regulations impacting the MCOs, and providing feedback to the Agency administration regarding impacts of changes to laws and regulations.

MARICOPA COUNTY, Phoenix, AZ 1997-2012

Administrative and Health Care Litigation Manager, General Government, 2010 – 2012

Administrative and Health Care Litigation Manager charged with managing administrative functions for General Government, Health Care Programs and Pre-AHCCCS litigation. Manage subordinate administrative and operational managerial and supervisory staff, providing the director with considerable input in the development and implementation of department strategic goals and objectives related to the department's mission. Direct the development and implementation of policies and procedures, as well as department plans and programs.

- Identify operational problems and develop solutions.
- Represent the director in high-level meetings with County management, the Board of Supervisors, and outside agencies.
- Direct the overall preparation and administration of the department budget and fiscal matters.
- Research, review and resolve claims and lawsuits for complex litigation and other County responsible healthcare programs.
- Develop training materials, train and coach team members.
- Aid internal and external attorneys with research and interpretation of policies, procedures, and statutory guidelines.
- Act as an expert witness during trial.

Management Analyst/Budget Supervisor, Office of Management and Budget, 2008 – 2010

Management Analyst recruited initially to complete legislative analysis, economic forecasting, policy development and health care litigation. Promoted to Acting Budget Supervisor, with expanded duties including coordinating professional staff on financial and policy analysis in conjunction with developing, analyzing and consolidating the annual County budget. Coordinate and conduct long- and short-range revenue and expenditure analysis of budgetary/fiscal issues.

- Coordinated the work of independent professionals contracted to perform special studies and analyses.

- Provided managerial assistance in the implementation of new programs, procedures, methods and systems for departments.
- Coordinated with technology staff on budget system implementation and administration issues.
- Served as backup for Deputy Budget Director as needed.
- Continued to manage the Pre-AHCCCS litigation, Long-Term Care Residual & Tuberculosis claim functions.

Risk Manager, Department of Correctional Health and Health Care Services, 2008
Risk Manager recruited to plan, organize, and direct the risk management activities of the Correctional Health Services Department, including loss prevention and litigation. Evaluate individual cases and communicate with internal and external customers on specific claims. Obtain evidence for contested and/or litigated claims to assist internal and external attorneys to defend claims and to prepare for trial; prepare and represent the County at court appearances and other administrative bodies.

- Acted as a consultant to other County departments and developed policies and programs designed to limit the County's exposure to risk.
- Was key member of the Correctional Health Service Executive Team and other adjunct teams as needed.
- Managed the CHS Medical Records department, CHS Risk department, Scanning Operations.
- Trained staff and other paraprofessionals.
- Developed and provided periodic statistical, financial, and other performance reports on risk management activities and loss data.
- Compiled and analyzed data on trends to identify high-risk areas and develop action plans accordingly.
- Continued to manage Pre-AHCCCS litigation, Long-Term Care Residual and Tuberculosis claim functions.

Operations Manager, Department of Health Care Programs, 2001 – 2008
Operations Manager promoted to act in the director's absence, manage subordinate administrative and operational managerial and supervisory staff, and provide the director with considerable input on the development and implementation of department strategic goals and objectives related to the department's mission. Direct the development and implementation of policies and procedures, as well as the administrative and operational implementation of department plans and programs.

- Analyzed department results and provided recommendations to the director on how to improve results and service delivery.
- Identified operational problems and developed solutions.
- Lead and directed special operational and organizational studies/project.
- Represented the director in high-level meetings with County management, the Board of Supervisors, and outside agencies.
- Directed the preparation and administration of the department budget and fiscal matters.
- Managed Pre-AHCCCS litigation, AHCCCS Maricopa Managed Care Run-out program, Maricopa County Long Term Residual Program, and the Ryan White Grant Funded Program, as well as the Correctional Health, Juvenile Detention, Long-Term Care and Tuberculosis claim functions.
- Expert witness in three multi-million dollar trials.
- Saved the department millions of dollars in outsourcing costs, while meeting an aggressive six-month timeframe for completion.
- Saved the County over $23m in claims cost by coordinating reviews, tracking discrepancies, and identifying invalid claims during settlement and litigation proceedings.

Account Clerk III & Financial Claims Analyst/Team Leader/Supervisor, 1997 – 2001
Accounting Clerk III recruited initially to research accounts payable issues through specialized computer programs, process third party liability and refund cases, respond to internal and external customer inquiries, and perform data entry assignments.

- Promoted to Financial Claims Analyst to researched/performed claims analysis according to State AHCCCS, Medicare, A.R.S., and Maricopa County rules and regulations.
- Reviewed accounts payable charges for validity and conformance to adopted budgets, fee schedules, or allowable rates.
- Authorized payments of validated charges, researched, prepared for and attended appeal hearings.
- Advanced quickly to Team Leader then Supervisor with expanded supervisory and training duties.
- Computerized and standardized a multi-site file room into a scan shop to consolidate claim and case files, while enabling on-time access to data for better productivity.

EDUCATION & PROFESSIONAL DEVELOPMENT

BACHELOR OF SCIENCE, BUSINESS ADMINISTRATION, UNIVERSITY OF PHOENIX, PHOENIX, AZ (2004)
CERTIFICATION, NURSING ASSISTANT, CITRUS COLLEGE, COVINA, CA (1993 – 1994)
CERTIFICATION, HOME HEALTH AIDE, CITRUS COLLEGE, COVINA, CA (1993 – 1994)
COURSEWORK, TAX ACCOUNTING, CITRUS COLLEGE, COVINA, CA (1993 – 1994)

ANGELA M. SHERWIN, MPH

angela.sherwin@steward.org

LEADERSHIP STYLE

Proven ability to direct multi-stakeholder high profile initiatives in large organizations. Collaborator. Team player. Data-driven decision maker. Consensus builder. Innovator. Goal-oriented, creative problem-solver who thrives in high-pressure, fast-paced environments.

LEADERSHIP EXPERIENCE

Vice President, Medicaid Accountable Care Steward Health Care System April 2016 – Present

Business lead accountable for Steward's Medicaid risk business. Examples of key responsibilities include:

- Formed subsidiary within Steward to manage all Medicaid accountable care programs
- Applied for and selected to participate in both MassHealth's Pilot ACO program & MassHealth's 5 year ACO program; accountable for Steward's performance in these programs
- Established relationships with a network of community providers of behavioral health, long term services and supports, and services that social determinants of health to build a continuum of care for Medicaid risk patients

Vice President, Public Policy & Strategic Analysis Steward Health Care System *2015 – 2016*

Directed Steward's Public Policy and Strategic Analysis units. Examples of key responsibilities include:

- Conducted health care policy research to support Steward Health Care System
- Analyzed and prepare health care policy analysis, briefs and memorandums regarding proposals, reimbursements, regulations, statutory mandates, or administrative bulletins that may impact Steward's goals
- Communicated with state and federal officials to plan for public policy impacts to Steward

Director, Executive Master of Healthcare Leadership Program, Brown University *2013 - 2015*

Leader of Brown University's first Executive Master program, a 16-month intensive degree program designed for innovative clinicians, executives, and senior administrators in the healthcare industry to prepare these leaders to transform healthcare. Examples of key responsibilities include:

- Identified the need for – and subsequently led – a multi-stakeholder strategic planning process for the program, and built consensus for goals and direction among staff, faculty, and leadership
- Institutionalized program beyond its start-up stage: documented policies, streamlined procedures
- Chaired the program's admissions committee: reviewed applications, conducted applicant interviews, and compiled final recommendations for admission to establish a diverse cohort of healthcare leaders in each class
- Refined and implemented evaluation plan for the program to measure success, which includes the design, collection and analysis of survey data
- Recommended and implemented operational adjustments for enhanced student experience of future cohorts based on feedback from students, faculty, and staff (i.e. course order, ratio of on-campus to online modules, and timing of residential sessions), as well as faculty and teaching assistant experience (i.e. refined roles and responsibilities for Chairs and Advisors for the Critical Challenge Project, created new Teaching Associate position to reflect difference in expected roles/responsibilities of TAs)

Assistant Director, HealthSource RI, Rhode Island Health Benefits Exchange, State of Rhode Island *2012 - 2013*
(Promoted from Principal Policy Associate, Office of the Health Insurance Commissioner) *2010 - 2012*

State staff lead for planning and establishment of Rhode Island's Health Benefits Exchange, which included chief responsibility for operations, developing federal funding requests, leading procurements, fostering federal and regional relationships, and representing Rhode Island's Exchange in national meetings and public forums.

Specific examples of key responsibilities include:

- Engaged stakeholders, RI's Exchange Board, and cabinet officials in public dialogue about key decisions related to RI's Exchange planning and establishment

- Led interagency business operations and technical planning team for RI's Exchange, directing the efforts of multiple vendors serving both Medicaid and the Exchange, including financial management services
- Orchestrated Exchange Establishment funding requests that led to RI's successful receipt of five awards: $5.2 million (5/2011) + $58.5 million (11/2011) + $9.8 million (4/2013) + $15 million in supplemental funds, as well as successfully received more than $250,000 in project support from the Robert Wood Johnson Foundation
- Designed and implemented procurement strategies for staff support and expert consulting services required to support RI's Exchange planning and establishment efforts to date, and negotiated all resulting vendor contracts
- Developed and continuously refined RI's strategic plan for its Health Benefits Exchange
- Represented RI's Exchange planning and establishment efforts in regional and national forums, including speaking engagements that highlighted RI's early progress in interagency collaboration and eligibility planning
- Led RI's participation in the Innovator grant-funded New England Consortium to leverage the development of technology components for RI's Exchange

Additional non-Exchange-related responsibilities at the Office of the Health Insurance Commissioner:

- Monitored carrier compliance with OHIC's Affordability Standards (quarterly meetings with each health plan)
- Applied for and successfully received two Rate Review grants for RI ($1 million 2010 + $3.7 million in 2011)

HEALTH POLICY EXPERIENCE

Health Policy Consultant, Independent contractor with entities listed below

Faulkner Consulting Group, Barrington, RI — 2008 – 2010; 2014 – 2015

- Drafted reports and conducted research and data analysis to support Faulkner Consulting Group clients

Arrowhead Health Analytics, LLC, Fall River, MA — *2010*

- Conducted state health policy research and analysis for a broad range of clients, including Fletcher Allen Health Care, Rhode Island Foundation, and Universal Health Care Foundation of Connecticut

Program in Public Health, Brown University, Providence, RI — *2009 – 2010*

- Assessed the implementation of the Health Information Exchange in Rhode Island by co-moderating focus groups, qualitatively analyzing the transcripts, and drafting a report submitted to federal funders

Office of the Health Insurance Commissioner, RI — *2008 – 2010*

- Quantitatively and qualitatively assessed initiatives in health policy and health insurance regulation
- Conducted survey of RI physicians, analyzed data, and produced reports (2008, 2009, 2010)
- Produced white paper, "System Affordability Priorities and Standards for Health Insurers in RI"
- Interviewed small business owners who offered health insurance with wellness incentives (Healthpact)

Care New England, Providence, RI — *2009*

- Moderated focus groups of employees to assess participation rates in wellness-related insurance benefit
- Developed recommendations for improving wellness benefit structure

Rhode Island Area Health Education Center, Providence, RI — *2007*

- Partnered with community organizations to research the health impact of human trafficking in RI
- Created and distributed educational materials to health care providers to improve the identification of victims of sex trafficking and ensure best practices for care and for networking with social services

Department of Community Health Brown University — *2006 – 2007*

- Designed survey of health care decision-making patterns of the uninsured at Rhode Island Free Clinic in collaboration with community stakeholders, including health centers and health plans
- Created study protocol approved by the Brown Institutional Review Board for human research studies

Health Policy Analyst, Massachusetts Health Connector — *2009 – 2010*

Integral team member in the policy division of Massachusetts' health insurance exchange, the entity after which the Affordable Care Act's Health Benefits Exchange provisions are modeled. Examples of key responsibilities include:

- Assessed iterative national health care reform legislative proposals for their potential impact on Massachusetts' existing Exchange policies and operations

- Analyzed benefit designs of products offered inside and outside the Connector to determine how to minimize coverage disruptions when transitioning new small employers into Health Connector products
- Drafted the Health Connector's 2010 Annual Report to the legislature and directed related data analyses
- Led the submission of a $1 million health insurance exchange planning grant (awarded Sept 2010)
- Managed and evaluated Institutional Review Board applications for the use of protected Health Connector data by external researchers
- Coordinated and oversaw survey research of members insured through the subsidized Commonwealth Care program as well as of unsubsidized members who purchased commercial individual or small group coverage
- Maintained and updated monthly premium rate data inside and outside the Connector to track trends

TEACHING EXPERIENCE

Assistant Professor of the Practice in Health Services, Policy & Practice; Brown University 2014-present

Guest Lecturer & Teaching Assistant *2005 – 2013*

- EMHL lectures on "State Experiences Implementing Health Reform" & "Funding Healthcare Innovation"
- Guest lecture on "Consumerism in Healthcare" in US Healthcare System course (Fall 2011, Fall 2013)
- Health Reform in Rhode Island panelist for Brown Medical School with RI public officials (2013)
- Assisted in teaching the graduate seminar "Ethics in Public Health" (Spring 2008, Fall 2009, Fall 2013)

MANAGEMENT EXPERIENCE

Retail Dining Supervisor (Operations Manager), Brown Dining Services, Providence, RI *2007 – 2009*

- Managed the daily operation of four eateries, three coffee shops, and two retail stores in conjunction with the retail management team
- Led the planning and oversight of the staffing, product line, marketing, and operations for the following:
  - Ivy Room (2007 - 2008): vegetarian eatery with annual revenue of approximately $1 million
  - Express Delivery (2008 - 2009): weekday catering service for faculty and staff with annual revenue of approximately $200,000
  - Coffee shops (2008 – 2009): three distinct coffee shops on campus serving the community 18 hours per day with a combined annual revenue of approximately $1.2 million
- Trained and supervised staff across all labor classifications including union, student, and temporary employees
- Identified and acted upon opportunities to improve customer service and enhance operating efficiencies

General Manager, Brown Dining Services, Providence, RI *2006 – 2007*

- Recruited, hired, trained, and retained workforce of ~300 employees (including 8 managers & 55 supervisors)
- Evaluated, designed, implemented, and enforced policies, holding peers accountable for their actions
- Directed design and implementation of "Brownberry" (our web-based interactive shift management portal) and the change management process required to transition staff from a paper-based to an electronic system

COMMUNITY SERVICE

Board Member & Treasurer, Youth Pride, Inc *2013 - 2017*

- Served as Treasurer of the Board of Directors for non-profit youth advocacy organization. Event Chair.

Conservation Commission Member, Town of North Kingstown, RI (three year appointment) *2014 - 2017*

Advocate, Day One—Sexual Assault & Trauma Resource Center, Providence, RI *2006 – 2009*

- Supported survivors of sexual assault and domestic violence through counseling and referrals
- Solicited corporate sponsorship for annual fundraiser; provided additional administrative support as needed

Board President, Jump!, Inc., Providence, RI *2007 – 2009*

- Served one year term as President of the Board of Directors for non-profit youth dance company; prior to presidency, served as a board member and grant writer

Volunteer, Rhode Island Free Clinic, Providence, RI *2007 – 2008*

- Managed volunteer shifts and served as check-out receptionist
- Trained in electronic medical record entry to assist clinic's transition to eClinicalWorks

PROFESSIONAL PRESENTATIONS

Sherwin AM. Understanding Payment Models: How Health Care Systems Can Address Social Determinants of Health. Healthcare Financial Management Association's Annual Thought Leadership Retreat. Washington DC. October 2017.

Sherwin AM. State Experience: Successes and Challenges. Health Insurance Exchange Conference. University of Pennsylvania – Leonard Davis Institute of Health Economics. Philadelphia, PA. April 2013.

Sherwin AM, Florio DF. Health Care Reform in the Ocean State. National Alliance for Medicaid in Education Annual Meeting. Providence, RI. October 2012.

Sherwin AM. Eligibility and enrollment business processes in Rhode Island. State Officials Meeting called by Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. Crystal City, VA. September 2011.

Sherwin AM, Faulkner DT. Rhode Island State Exchange Gate Review. State meeting with Center for Consumer Information and Insurance Oversight, US Dept. of Health and Human Services. Baltimore, MD. September 2011.

Sherwin AM, Florio DF. Rhode Island' Approach to Health Reform Implementation – An Integrated Effort Between Medicaid and the Exchange. State Officials Meeting called by Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. Denver, CO. April 2011.

Sherwin AM, Pearlman DN, Wetle TF, Koller CF. Using Health Insurance Regulation for Medical Cost Containment and Health System Reform: The Rhode Island Experience. [abstract 208533] 2009 American Public Health Association Annual Meeting, Philadelphia, PA. November 2009.

Sherwin AM, Patel C, Pearlman DN. Sex Trafficking: Not in My Backyard. International Women's Day, Brown University Program in Public Health. March 2008.

PUBLICATIONS

Celada MT, Merchant RC, Waxman MJ, and **Sherwin AM**. An ethical evaluation of the 2006 Centers for Disease Control and Prevention recommendations for HIV testing in healthcare settings. *Am J Bioethics*. 2011, 11(4):31-40

Jaklenec, A, Stamp A, Deweerd E, **Sherwin AM**, and Langer R. Progress in the Tissue Engineering and Stem Cell Industry. *Tissue Engineering*. 2012, 18(3):155-166.

Merchant RC, Waxman MJ, Clark MA, Celada MT, and **Sherwin AM**. Are the 2006 CDC HIV testing recommendations ethically justified? It depends! [abstract 131] 2008 National Summit on HIV Diagnosis, Prevention, and Access to Care, Arlington, VA. November 19-21, 2008.

Wetle TF, and **Sherwin AM**. Contemporary Perspectives in Public Health. In T. Prohaska, L. Anderson, and R. Binstock (Eds.), Public Health for An Aging Society. Baltimore, MD: John Hopkins University Press. 2012.

AWARDS

Named one of **Providence Business News 2014 "40 Under Forty"** young professionals based on career success, community involvement, and commitment to making a difference in the community. *2014*

EDUCATION

Master of Public Health, Brown University, Providence, RI
Thesis: "Using Health Insurance Regulation for Medical Cost Containment and Health System Reform: The Rhode Island Experience"

Bachelor of Arts in Biomedical Ethics, Brown University, Providence, RI
Honors Thesis: "Distributive Justice in Health Care: The Role of the Physician"

References available upon request

CURRICULUM VITAE Mark FB Carroll, MD

Personal Information

A mission-driven, margin-adept physician leader with extensive experience in diverse administrative, program development, and clinical roles. Broad skillset across multiple healthcare dimensions, having served in national, regional and local roles within the private sector and public health settings. Strategic innovator, known for ability to bring transformative change through goal-oriented partnerships and collaborations.

Education

Dartmouth Medical School	1981-1985
Dartmouth College	1977-1981

Professional Training

Fellowship: The Robert Wood Johnson Clinical Scholars Program, Stanford University School of Medicine (3rd year funded by staff position at the Lucile Salter Packard Children's Hospital)	1989-1992
Pediatrics Internship and Residency: The Children's Hospital of Philadelphia	1986-1989
General Surgery Internship: The Presbyterian-University of Pennsylvania Medical Center	1985-1986

Employment History and Professional Appointments

(Some positions and roles held concurrently)

Chief Health Officer, The NARBHA Institute	2017-Pres
Physician Program Consultant, Arizona Health Care Cost Containment System (AHCCCS)	2016-2017
Chief Medical Officer, Flagstaff Medical Center (FMC)	2014-2016
Vice-President, Northern Arizona Healthcare	2014-2016
Medical Director, Population Health Innovation, Flagstaff Medical Center & Northern Arizona Healthcare	2012-2014
Medical Officer, Administration, Phoenix Area Indian Health Service (IHS):	
- National Telehealth Program Coordinator and Clinical Consultant	2005-2012
- Director, IHS Native American Cardiology Program	2007-2012
- Director, Telehealth Initiative, IHS Phoenix Area	2008-2010
- Pediatrician (intermittent, including services via telehealth): Hopi Health Care Center and Phoenix Indian Medical Center	2009-2012
Clinical Informatics Consultant, IHS Navajo Area and IHS National Office of Information Technology	2004-2005
Chief Medical Officer, Tuba City Regional Health Care Corporation	2003-2004

Medical Officer, Navajo Area Indian Health Service,
Tuba City Indian Medical Center:
Chief Information Officer, Tuba City Indian Medical Center 2001-2003
Telemedicine Chief Clinical Consultant/Coordinator, Navajo Area IHS 2001-2004
Director, Telehealth Services, Tuba City Indian Medical Center 1999-2003
Physician, Dinnebito Field Clinic, Tuba City Indian Medical Center 1994-2001
Director, Adolescent Health Program, Tuba City Indian Medical Center 1998-2001
Pediatrician, Mountain View Pediatrics 1997-1998
Pediatrician (part-time), Flagstaff Medical Center
Children's Health Center (CRS Clinic) 1998-2000
Preventive Medicine Officer:
Tuba City Indian Medical Center, Navajo Area IHS 1992-1997
Clinical Instructor in Pediatrics, Staff Physician:
Stanford University School of Medicine, Pediatric Critical Care Transport
Service; Lucile Salter Packard Children's Hospital at Stanford (LSPCH) 1991-1992
Additional Part-Time Clinical Experience (during fellowship):
The Santa Clara Kaiser-Permanente Medical Center;
Neonatal ICU Physician 1989-1992
Altos Pediatrics; Los Altos, CA.;
Private Practice Pediatrics 1989-1991
Medical Staff, Department of Emergency Services,
The Children's Hospital of Oakland 1991

Active Professional Licensure and Membership

Fellow, the American Academy of Pediatrics
Certified, American Board of Pediatrics; Oct, 1989; Oct, 1996; Dec, 2003; Dec 2010
Member, American College of Physician Executives/American Association of Physician Leadership
Physician and Surgeon, Arizona Board of Medical Examiners

Special Projects and Activities

AHCCCS Targeted Investments Program & American Indian Medical Home Program:
Physician advisor and collaborator in CMS-approved initiatives for
delivery system transformation to improve care for AZ Medicaid beneficiaries 2016-2017
Regional Transfer Center. Northern Arizona Healthcare:
Executive leadership for development of ED physician-staffed 24/7/365 emergency
transfer center, as a collaboration with FMC's patient placement center staff, to
to serve the entire northern AZ region 2014-2016
Care Management Collaboration - AHCCCS American Indian Health Program Members:
NAH executive lead for collaboration with AZ Medicaid to improve health care quality
And lower costs for Native American members of the American Indian Health Program 2014-2016
Southwest Infectious Disease Council:
Facilitator and co-developer of a multi-organizational council for northern AZ
& the 4 Corners area, focusing on infectious disease prevention & treatment issues 2014-2016
Pathfinder Health Accountable Care Organization:
Collaborator in formative development of physician-led Accountable Care
Organization partnership 2014-2016

"Care Traffic Control":
Collaborative development of a new care management model, to improve clinical outcomes and reduce costs for high need, high cost patients via a comprehensive approach to care across the continuum and with community collaborators 2013-2016

Northern Arizona Collaborative for Native American Health:
Co-facilitator and chair of quarterly collaboration meeting with clinical and administrative leadership of health care organizations across northern Arizona 2005-2016

Northern Arizona Grand Rounds:
Co-founder and program facilitator of continuing education series for clinicians, public health professionals, and researchers across northern AZ 2014-2016

"THRIVE" - The***T****ranslational* ***H****ealth* ***R****esearch* ***I****nitiati****ve***:
Co-developer and steering committee member of population health-focused research collaboration between Northern Arizona Healthcare and Northern Arizona University 2013-2016

"Shi' Hooghan":
Innovative program using GIS home location to connect patients from the Navajo Nation to community resources and post-hospitalization services 2013-2016

"Personalized and Precision Population Health Management":
Co-Principle Investigator in Flinn Foundation grant-funded collaboration between FMC and Northern Arizona University to study and improve care transitions from hospital to home for patients with heart disease 2013-2017

Unconnected Providers Health Information Exchange Grant Program:
Director of grant-funded project to assist participation by Indian health organizations across northern AZ in the AZ state health information exchange 2013-2014

Heart Failure Readmission Reduction Program:
Physician lead for care management collaboration at Flagstaff Medical Center that significantly reduced 30 day readmission rates for adults with heart failure 2012-2014

"Care Beyond Walls and Wires" Program:
Co-developer of innovative public-private collaboration to extend heart failure care to patient homes via relationship-centered remote monitoring program 2010-2012

Telehealth Centers of Excellence:
Project development for multiple regional and national Indian health centers of telehealth consultation for quality service delivery 2004-2012

IHS National Clinical Rounds:
Coordinator of national CE series on innovation and health care quality in Indian health care delivery 2011-2012

Improving Blood Pressure Control for Patients with Diabetes:
an mHealth initiative for home BP monitoring, with the IHS Improving Patient Care Program 2010-2012

National Templated Agreements for Telehealth Credentialing and Privileging:
Developed with the HHS Office of General Counsel 2011

Extending Pediatric Specialty Care to Native American homes:
Grant-funded collaboration, with Flagstaff Medical Center and the Mountain States Genetics Regional Collaborative Center 2011-2102

Northern Arizona Quality Healthcare Collaborative:
Steering Committee member during formative phase of Clinical Integration 2011-2012

The Indian Health *Telehealth Services Network*:
Collaborative development of budget proposal for national network supporting access to quality care for Native American communities using telehealth innovation 2010

Business Case for Medicaid reimbursement:
National ATA workgroup surveying telehealth reimbursement policy & new business models for Medicaid reimbursement of telehealth services 2009-2010

Center for Telehealth Services, IHS Phoenix Area:
Planning and development of regional Center of Telehealth Excellence 2009-2010

Innovation Learning Network:
"Weaver" and representative for the Indian Health Service in Kaiser Permanente-led national workgroup to promote innovation in health care 2008-2012

Southwest Telehealth Access Grid:
Co-Chair, Clinical Services Committee 2008-2009

National coordinator, the IHS VistA Imaging Project:
For planning and implementation of the Veteran's Administration VistA Imaging platform within the Indian health system 2005-2008

The IHS Southwest Telehealth Consortium:
Facilitation for development and support of a regional consortium of IHS Areas collaborating on telehealth service delivery projects 2004-2010

Telehealth Care, Electronic Health Record and VistA Imaging in the IHS:
Assistance with planning and implementation of integrated information technology system platform for the Indian Health Service 2004-2012

Indian Health Telehealth Directory:
Resource listing of current and developing telehealth projects and activities within IHS and Tribal programs/facilities 2004-2005

Telehealth Care to the Community:
Outreach project to local communities on the western Navajo Reservation using emerging telemedicine technologies 2000-2004

The Navajo Area IHS Telehealth Network:
Assisted with design and deployment of broadband, redundant network for teleradiology and other telehealth activities for all Navajo Area IHS 2000-2002

Co-Coordinator; The Tuba City High School "*Teen Wellness Series*":
Experiential-based curriculum for health class, developed in collaboration with health promotion staff and Project Adventure 1999-2001

Co-Founder, Founding Coordinator:
"The Tuba City-Moencopi Family Wellness Center":
A community-based non-profit effort at collaborative project planning and implementation for family wellness 1994-1997

Co-Founder, Founding Director; *M.O.V.E. for Children!*
(*M*obile *O*utreach *V*accinations for *E*ast Palo Alto Children):
Collaborative outreach program integrating university, public health department, and community resources for improved health care delivery underserved children/families in northern California 1990-1992

Director, Co-Founder, "*C.H.O.P. VHS*":
The Children's Hospital of Philadelphia Video Health Service:
Weekly video segments produced for Grand Rounds and other settings 1988-1989

Committees, Appointments, and Consultancy

Advisor, the NARBHA Institute	2016-2017
Member, Arizona Prescription Drug Misuse & Abuse Initiative Health Care Advisory Team	2016-2017
Member, Collaborative Steering Committee with Independent Orthopedic group for Medicare BPCI Orthopedic Bundled Payment Project	2015-2016
Co-Executive Sponsor, NAH ICD 10 Steering Committee	2015-2016
Member, Surgical Services Executive Committee	2015-2016
Invited Member, Virtual Health Strategy workgroup, Indian Health Service	2015-2016
Member, Joint Operating Committee, for newly acquired Orthopedic Surgery Center co-management agreement	2014-2016
Member, Joint Operating Committees, for Inpatient Orthopedic Service and Ambulatory Surgery Center co-management agreements	2014-2016
Northern AZ representative, Arizona Governor's Council on Infectious Disease Preparedness and Response	2014-2016
Member, NAH Board Quality & Safety Committee	2014-2016
Member, *THRIVE* Steering Committee: ***T***ranslational ***H***ealth ***R***esearch Initiati***VE***	2014-2016
Member, One Chart Ambulatory Executive Steering Committee	2014-2016
Chair, NAH Care Management Team	2014
Member, Advisory Group: Partners in Health *Community Outreach & Patient Empowerment* project	2014-2015
Member, Clinical Leadership Workgroup, Pathfinder Health ACO	2014
Member, CI-IT Workgroup, Pathfinder Health ACO	2014
Member, Network Workgroup, Pathfinder Health ACO	2014
Advisory Board Company Leadership Development Academy	2013-2014
Chair, Health Committee, United Way of Northern AZ	2013-2015
Chair, Ethics Committee, Flagstaff Medical Center	2013-2014
Member, Ethics Committee, Flagstaff Medical Center	2013-pres
Member, Institutional Review Board, Northern Arizona Healthcare	2013-2015
Member, CME Committee, Flagstaff Medical Center	2012-2016
Member, Planning Committee, Clinical Integration Entity, Flagstaff Medical Center	2010-2011
Co-Chair, New Technology and Innovation Workgroup; IHS and Veterans Health Administration (VHA) MOU Collaboration	2011-2012
Reviewer, CMS Objective Review Committee, Health Insurance Exchanges	2011
Reviewer, VHA Office of Rural Health Innovation Proposals	2011
Participant, HHS Technical Expert Panel for "Understanding the Impact of Health IT in Underserved Communities and Those with Health Disparities"	2011
Member, HHS Text4Health Taskforce; Co-chair, Health Disparities Workgroup	2010-2011
Chair, Indian Health Service Telehealth & mHealth Workgroup	2010-2012
IHS Representative, VA Rural NativeTelemental Health Advisory Committee	2010-2012
Reviewer, *Telehealth and eHealth* Journal	2010-pres
Member, Federal Telehealth Workgroup; Chair, Access Workgroup	2010-2012
Member, HHS mHealth Collaborative Workgroup	2010-2012
Member, HRSA Text4Baby Advisory Group	2010-2012
IHS Representative, Four Corners Telehealth Consortium	2006-2012
IHS Representative, AZ Telemedicine Council	2004-2012

Project Officer, HRSA-IHS IAA for Telehealth Technology Assessment Center	2009-2012
IHS Representative, AZ Health Care Cost Containment System Telehealth Workgroup	2009-2012
Reviewer, American Telemedicine Association Annual Meeting abstracts	2009-2011
Reviewer, IHS Special Diabetes Program for Indians Community-Directed Grant	2009
Member, Planning Committee, Indian Health Summit	2009
Reviewer, HRSA Telehealth Network Grant Program	2007
Clinical Lecturer, University of Arizona	2005-2010
Member, Indian Health Service Information Systems Advisory Council	2003-2004
Chair, Health Council, United Way of Northern Arizona	2001-2002
Member, Long Range Planning Committee, United Way of Northern Arizona	2000-2001
Member, Allocations Committee, United Way of Northern Arizona	2000-2001
Member, Navajo Area IHS Communicable Disease Committee	1994
Member, Navajo Area IHS Hantavirus Task Force	1993-1995
Member, National Institutes of Health Working Group for the Study of Therapeutic Agents against Hantavirus	1993-1996
Member, CDC Hantavirus Working Group	1993-1995
Instructor, Pediatric Advanced Life Support (PALS)	1993-1998
Collaborator, The Stanford University Center for Biomedical Ethics	1990-1992
Coordinator, Medical Writing Workshop: *The Journal of Pediatrics*	Aug, 1990
Consultant, Walt Disney Imagineering; Disneyland, CA.	Jan, 1990
Instructor, the University of Pennsylvania School of Medicine	1986-1989

Health-Related Awards and Honors

Director's Merit Award: Tucson Area Indian Health Service; To the Native American Cardiology Program	2008
Exceptional Performance Award: Nashville Area Indian Health Service	2006
Director's Award for Excellence: Navajo Area Indian Health Service	2002
Outstanding Medical Director: Arizona Telemedicine Program	2001
Director's Award for Outstanding Health Care Provider: Navajo Area IHS	2001
Medical staff employee of the month: Tuba City Indian Medical Center	Mar, 2001
Excellence in Service Leadership Award: Arizona Hospital Association	1995
Exceptional Performance Award: Navajo Area Indian Health Service	1994
Director's Award for Excellence: Navajo Area Indian Health Service	1994
Santa Clara County Medical Society 1993 Honorable Mention for Outstanding Community Service: Santa Clara, CA.	1993
The Freda M. Ritter Clinician Award, The Children's Hospital of Philadelphia: "For Excellence in the Role of Clinician - Combining Skills of Empathy, Cognitive Knowledge, Judgment, and Interpersonal Skills"	1989
The Jarrett Memorial Prize, Dartmouth Medical School: "In Recognition of Academic Excellence and of Scholarly, Cultural, and Humanitarian Achievement Outside of the Medical Curriculum"	1985
Honors Graduate, Dartmouth Medical School	1985
William Goldman Foundation Scholar, Dartmouth Medical School	1984-1985

Board Membership

Member, Board of Directors, Health Choice Integrated Care	2017-pres
Chair, Board of Directors, United Way of Northern Arizona	2016-2017
Member, Board of Directors, Northern Arizona Health Orthopedic Surgery Center	2015-2016
Member, Board of Directors, Pathfinder Health Accountable Care Organization	2015-2016
Member, Advisory Board, Northern Arizona University Interdisciplinary Health Policy Institute	2015-2016
Vice-Chair, Board of Directors, United Way of Northern Arizona	2014-2015
Member, Board of Directors, Northern Arizona Health Physician group	2014-2015
Member, Board of Directors, United Way of Northern Arizona	2011-2015
School Board Member, BASIS Flagstaff	2012-2013
Health Advisory Board, Native Americans for Community Action	2011-2013
Advisory Board Member, Further Shore, Inc.	2011-2013
Board of Directors, American Telemedicine Association	2007-2011
Member, Coconino County Health Board	1996-1998

Recent Grant Awards and Research

"Personalized and Precision Population Health Management": Flinn Foundation grant #1906. Co-Principal Investigator. Collaboration Between Northern Arizona University and Northern Arizona Healthcare	2013-2017
"Developing a Regional Antibiogram to Improve Population Health and Medication Safety in Northern Arizona": Cardinal Health Foundation Grant. Co-developer.	2014-2015
"*Shi' Hooghan*: Using home GIS location for Navajo patients as a new vital sign for improved service delivery": FMC Foundation Award. Project lead.	2013-2016
"Unconnected Providers Health Information Exchange Grant Program": Arizona Strategic Enterprise Technology for HIE Development. Project director.	2013
"Expanding Specialty Collaboration in Northern Arizona": USDA Rural Utilities Service Distance Learning and Telemedicine Program; Co-developer of proposal and project collaborator.	2013-2014
"Developing a Regional Cardiopulmonary Consultation Network for Northern AZ": USDA Rural Utilities Service Distance Learning and Telemedicine Program; Co-developer of proposal and project collaborator.	2011-2013

Publications and Presentations

12 publications/chapters in peer-reviewed journals and books. Many additional editorial articles in medical journals. Hundreds of presentations within a wide range of health care, academic, and community settings. Additional facilitation of & assistance with planning, moderation, and program facilitation for multiple national meetings.

Full bibliography available upon request.

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

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

As defined by A.R.S. §35-393.01:

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

All Offerors must select one of the following:

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

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

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

Health Choice Arizona, Inc. (Steward Health Choice Arizona)	
Company Name	Signature of Person Authorized to Sign
410 N. 44th Street, Suite #900	Shawn Nau
Address	Printed Name
Phoenix Arizona 85008	Chief Executive Officer
City State Zip	Title

Exhibit E: Affiliated Organization Attestation

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

Offeror Name: **Health Choice Arizona, Inc. (Steward Health Choice Arizona)**

Affiliated Organization Name: **Health Choice Integrated Care, LLC**

All Offerors must select one of the following:

__X__ The Offeror is bidding as an Affiliated Organization and attests to the following:

The Offeror shall come into compliance with the Affiliated Organization requirements of the RFP YH19-0001 no later than October 1, 2018.

- If the Offeror awarded an AHCCCS Complete Care Contract (the AHCCCS Complete Care Contractor) has an Affiliated Organization that holds an AHCCCS RBHA contract serving one or more counties in the same Geographic Service Area (the RBHA affiliate), the Offeror shall make arrangements for a single legal entity to hold both the RBHA and AHCCCS Complete Care Contract effective on or before October 1, 2018. This requirement does not apply to Gila or Pinal County.

- The Offeror shall establish a single brand and market the services provided under both the AHCCCS Complete Care Contract and the RBHA contract as a single product.

____ The Offeror is not bidding as an Affiliated Organization.

Health Choice Arizona, Inc. (Steward Health Choice Arizona)	
Company Name	Signature of Person Authorized to Sign
410 N. 44th Street, Suite #900	Shawn Nau
Address	Printed Name
Phoenix Arizona 85008	Chief Executive Officer
City State Zip	Title

Exhibit F: State Only Pregnancy Termination Agreement

THIS AGREEMENT is entered into by and between the Arizona Health Care Cost Containment System (AHCCCS), located at 701 E. Jefferson, Phoenix, Arizona 85034, and **Health Choice Arizona, Inc. (Steward Health Choice Arizona)** (Offeror).

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

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

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

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

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

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

      1.1.2 Seriously impairing a bodily function of the pregnant member,

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

      1.1.4 Exacerbating a health problem of the pregnant member, or

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

   1.2 Conditions, Limitations and Exclusions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Choice Arizona, Inc. **(Steward Health Choice Arizona)**	
Offeror Name	Signature of Person Authorized to Sign
410 N. 44th Street, Suite #900	**Shawn Nau**
Address	Printed Name
Phoenix, Arizona 85008	**Chief Executive Officer**
City State Zip	Title