Request for Proposal

Solicitation #YH20-0002

Arizona Health Care Cost Containment System Administration (AHCCCS)
Expansion of AHCCCS Complete Care Contract #YH19-0001
Proposal Due Date: October 4, 2021 at 3 P.M. Arizona Time

Submitted by:
Arizona Complete Health for:
Health Net Access, Inc. dba Arizona Complete Health-Complete Care Plan
and Care1st Health Plan Arizona Inc.
1870 W. Rio Salado Parkway
Tempe, Arizona 85281

arizona complete health™

Transforming the health of the community, one person at a time.

Part A

Transforming the health of the community, one person at a time.

A1

Offeror's Checklist

The Offeror shall complete and submit the Offeror's Checklist with its Proposal as the initial pages of the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the CCE notwithstanding the items included in the Offeror's Checklist.

	OFFEROR'S CHECKLIST	
	SUBMISSION REQUIREMENT	OFFEROR'S PROPOSAL PAGE NUMBER(S)
PART A		
A1	Offeror's Checklist	4
A2	Offeror's Completed, Signed Solicitation, and Offer Page	6
A3	Offeror Submission Form	10
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PART B	PROGRAMMATIC - NARRATIVE SUBMISSION	
B1	2-page limit	19
B2	2-page limit	21
B3	3-page limit	23
B4	4-page limit	26
B5.a (North GSA)	2-page limit	30
B5.b. (South GSA)	2-page limit	32
B5.c. (Central GSA)	2-page limit	34
B6	1-page limit for each of a through g	36
B7	5-page limit	43
B8	3-page limit	48
B9	3-page limit	51
B10	2-page limit	54
B11	2-page limit	56
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PART C	CAPITATION AGREEMENT/ADMINISTRATIVE COST BID SUBMISSION	
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C2	Administrative Cost Bid Submission Workbook	62
C3	Actuarial Certification (The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid)	63

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Offeror's Completed, Signed Solicitation and Offer Page

AHCCCS Arizona Health Care Cost Containment System	**NOTICE OF COMPETITIVE CONTRACT EXPANSION**
	SOLICITATION # YH20-0002
	EXPANSION OF AHCCCS COMPLETE CARE CONTRACT YH19-0001

SECTION A: SOLICITATION AND OFFER PAGE

Chief Procurement Officer
Meggan LaPorte, CPPO, MSW
Chief Procurement Officer

Telephone: (602) 417-4538
EMail: CCE-YH20-0002_Questions@azahcccs.gov
Issue Date: October 4, 2021

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

DESCRIPTION: **EXPANSION OF AHCCCS COMPLETE CARE CONTRACT YH19-0001**

PROPOSAL DUE DATE: **OCTOBER 4, 2021** **AT 3:00 P.M. ARIZONA TIME**

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE PROCUREMENT OFFICER NAMED ABOVE, IN WRITING, VIA EMAIL, AS SPECIFIED IN CCE SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE QUESTIONS AND RESPONSE TEMPLATE LOCATED IN THE COMPETITIVE CONTRACT EXPANSION (CCE) LIBRARY. ANSWERS TO QUESTIONS WILL BE POSTED ON THE AHCCCS WEBSITE IN THE FORM OF A SOLICITATION AMENDMENT FOR THE BENEFIT OF ALL POTENTIAL OFFERORS.

Offerors are required to submit Proposals through the AHCCCS Secured File Transfer Protocol (SFTP) as delineated in CCE Section I, Exhibit F, SFTP Instructions.

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

Proposals shall be submitted in accordance with CCE Section H, Instructions to Offerors.

Late Proposals shall not be considered.

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

AHCCCS Arizona Health Care Cost Containment System	NOTICE OF COMPETITIVE CONTRACT EXPANSION
	SOLICITATION # YH20-0002
	EXPANSION OF AHCCCS COMPLETE CARE CONTRACT YH19-0001

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. The undersigned Offeror hereby attests to its understanding that this Solicitation is an amendment to AHCCCS Complete Care Contract #YH19-0001 and the requirements of Contract #YH19-0001 apply in addition to those delineated in this Competitive Contracts Expansion #YH20-0002.

Arizona Transaction (Sales) Privilege Tax License No.:

N/A

Federal Employer Identification No.:
AzCH-CCP: 46-2616037, Care1st: 57-1165217

E-Mail Address: James.V.Stover@azcompletehealth.com
SCummings@care1staz.com

Arizona Complete Health for Health Net Access, Inc. dba Arizona Complete Health-Complete Care Plan for South and Central GSAs and Care1st Health Plan Arizona, Inc. for North GSA

Company Name

1870 W. Rio Salado Parkway, Suite 2A

Address

Tempe	Arizona	85281
City	State	Zip

For clarification of this Offer, contact:

Name: James Stover / Scott Cummings

Title:
Medicaid President / Plan President

Phone: James Stover: 520-343-8004
Scott Cummings: 602-778-1860

JVS / Scott Cummings

Signature of Person Authorized to Sign Offer

James Stover / Scott Cummings

Printed Name

Medicaid President / Plan President

Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

This Contract shall henceforth be referred to as Contract No._____
Award Date: _____

_____

MEGGAN LAPORTE, AHCCCS Chief Procurement Officer

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Offeror Submission Form

CCE EXHIBIT B: OFFEROR SUBMISSION FORM

COMPETITIVE CONTRACT EXPANSION (CCE)
OFFEROR SUBMISSION FORM

1. ACC Contractors owned by the same parent organization shall not submit separate Proposals in response to the CCE Solicitation; only one Proposal is permitted on behalf of all ACC Contractors owned by the same parent organization.

2. The ACC Contractor or its parent organization may only submit one Offeror Submission Form. ACC Contractors or its parent organization may only submit an Offeror Submission Form for the GSAs in which it currently operates as an ACC Contractor. Only those ACC Contractors serving all counties in the South GSA will be eligible to compete for the expanded services in that GSA.

3. The ACC Contractor or its parent organization shall complete the table below to include the Offeror's name, the GSA(s) requested, and priority choice of each GSA. Priority preferences for award shall be indicated by entering (1st choice, 2nd choice, 3rd choice) in the priority choice column below. Additionally, for a parent organization submitting a single Proposal as noted in #1, identify the ACC Contractor by GSA in the table below.

OFFEROR NAME is submitting the CCE Submission Form for the expansion of services in the GSA(s) indicated below:		
GSA		Priority Choice
☒	**North**: Mohave, Coconino, Apache, Navajo, and Yavapai Counties ACC Contractor: Care1st Health Plan Arizona, Inc.	2
☒	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties (Including zip codes 85542, 85192, and 85550) ACC Contractor: Heath Net Access, Inc. dba Arizona Complete Health-Complete Care Plan	1
☒	**Central**: Maricopa, Gila, and Pinal Counties (Excluding zip codes 85542, 85192, and 85550) ACC Contractor: Heath Net Access, Inc. dba Arizona Complete Health-Complete Care Plan	3

/	September 23, 2021
Authorized Signature	Date
James Stover / Scott Cummings	Medicaid President / Plan President
Print Name	Title

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Offeror's Signed Signature Page(s) for each Solicitation Amendment

SOLICITATION AMENDMENT #1

YH20-0002 Competitive Contract Expansion	Solicitation Due Date October 4, 2021 3:00 pm Arizona Time	Chief Procurement Officer Meggan LaPorte CCE-YH20-0002_Questions@azahcccs.gov

A signed copy of this amendment shall be submitted with your solicitation response. This Solicitation Amendment and Answers to Questions will be posted to the CCE Library https://azahcccs.gov/PlansProviders/HealthPlans/YH20-0002.html.

A. The attached Answers to Questions are incorporated as part of this Solicitation amendment.
B. CCE Title XIX XXI Data Supplement for Capitation Rate Setting; Section L. *CCE Amendment #1 Data* is incorporated as part of this Solicitation amendment.
C. This Solicitation is also amended as follows:

SECTION	YH20-0002 AMENDMENT
Title XIX/XXI Contract Section D,36	*Brand Name Drugs*: The Contractor's contract with the PBM shall provide a Guaranteed Brand Name Drug Discount Rate and require the reimbursement of 95 percent of Brand Name Prescription claims, in aggregate, at a minimum, to be the following: […] *Generic Drugs*: The Contractor's contract with the PBM shall require the reimbursement of generic drugs to be guaranteed, in aggregate, at a minimum, at AWP less 84 percent for all Days Supplies dispensed. […] *Specialty and Biosimilar Drugs*: ~~The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate, at a minimum, of AWP less 18.25 percent for all Specialty and Biosimilar Drugs, and 95 percent of Specialty and Biosimilar Prescription claims shall be reimbursed to pharmacies, the lesser of AWP less 18.25 percent, MAC, the Submitted Ingredient Cost, or the Usual & Customary price plus a Dispensing Fee~~. The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate, in aggregate, at a minimum, of AWP less 18.25 percent for all Specialty and Biosimilar Drugs. Ninety-five percent of Specialty and Biosimilar Prescription claims, in aggregate, shall be reimbursed to pharmacies at the lesser of AWP less 18.25 percent, MAC, the Submitted Ingredient Cost, or the Usual & Customary price plus a Dispensing Fee. The Dispensing Fee for non-compounded and compounded prescriptions shall not greater than what is listed in the Arizona State Plan. Limited and exclusive distribution, biosimilars, and specialty drugs are included in the guarantee. […] *Mail Order Prescriptions Services*: The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate for all Mail Order Pharmacy Prescriptions Claims, in aggregate, at a minimum, of AWP less 24 percent and 95 percent of the Mail Order Prescription Claims shall be reimbursed, at a minimum, the lesser of AWP less 24 percent, the Submitted Ingredient Cost, MAC, or the Usual & Customary price. […]
Title XIX/XXI Contract Section D,50	***Reconciliation of Costs to Reimbursement***: AHCCCS will reconcile the Contractor's total medical cost expenses (prospective and PPC) to ~~total~~ net capitation paid (prospective and PPC), excluding COVID-19 Vaccine expenses, to the Contractor. […]

SECTION	YH20-0002 AMENDMENT
Section G: Non-Title XIX/XX Contract Section D,50	Notwithstanding the ~~42~~ 2 CFR Part 200 Subpart F regulations, the Contractor shall include the SABG and MHBG as major programs for the purpose of this Contract." […]
Section I: Exhibit A	**Checklist – Part B Programmatic – Narrative Submission Offeror** **B8** ~~**2-page limit**~~ **3-page limit** **B12** ~~**1-page limit**~~ **2-page limit** **D. EXHIBIT A WILL BE REPOSTED TO THE CCE LIBRARY WITH THESE REVISIONS INCLUDED**
Section I: Exhibit C	**Narrative Submission Requirement B6**. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring. a. Contractor care management, b. Provider case management, c. Outreach and education, d. Stakeholder input, e. Justice system/justice-involved individuals, f. Court Ordered Treatment, and g. ~~Dual alignment of Medicare and Medicaid enrollment.~~ Dually aligned (Medicare and Medicaid) members. [1-page limit for each of B6. a through g] **E. EXHIBIT C WILL BE REPOSTED TO THE CCE LIBRARY WITH THIS REVISION INCLUDED**
Section I: Exhibit C	**Narrative Submission Requirement B8**. Provide the Offeror's assessment of current network adequacy and describe the Offeror's ability to serve members with complex or specialized health care needs to ensure members can be timely and effectively served in the least restrictive setting. Describe how the Offeror will monitor for gaps in the continuum of care, address any identified gaps and implement strategies to resolve network deficiencies. Include any existing relationships and community partnerships the Offeror has, or intends to establish, with providers and stakeholders to enhance collaboration and coordination of care, routinely assess the continuum of care, and strengthen the network to meet the unique needs of individuals served under this Competitive Contract Expansion. ~~[2-page limit]~~ [3-page limit] **F. EXHIBIT C WILL BE REPOSTED TO THE CCE LIBRARY WITH THIS REVISION INCLUDED**
Section I: Exhibit C	**Narrative Submission Requirement B12**. The wellbeing of many Arizona residents has been significantly affected by the COVID-19 public health emergency for the last 18 months, contributing greatly to the need for increased behavioral health services. Describe the Offeror's role and strategies in supporting the State's recovery from the pandemic as it relates to the needs of individuals served under this Competitive Contract Expansion. ~~[1-page limit]~~ [2-page limit] G. **EXHIBIT C WILL BE REPOSTED TO THE CCE LIBRARY WITH THIS REVISION INCLUDED**

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: JS / Scott Cummings	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: James Stover / Scott Cummings	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: Medicaid President / Plan President	TITLE: Chief Procurement Officer
DATE: September 23, 2021	DATE: August 26, 2021

SOLICITATION AMENDMENT #2

YH20-0002 Competitive Contract Expansion	Solicitation Due Date October 4, 2021 3:00 pm Arizona Time	Chief Procurement Officer Meggan LaPorte CCE-YH20-0002_Questions@azahcccs.gov

A signed copy of this amendment shall be submitted with your solicitation response. This Solicitation Amendment and Answers to Questions will be posted to the CCE Library https://azahcccs.gov/PlansProviders/HealthPlans/YH20-0002.html.

A. The attached Answers to Questions are incorporated as part of this Solicitation amendment.
B. This Solicitation is also amended as follows:

SECTION	YH20-0002 AMENDMENT
Section D, Paragraph 15, Staffing Requirements	**Revised as follows:** **Quality Management Manager** who is located in Arizona, and an Arizona-licensed registered nurse, physician or physician's assistant in good standing or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or CHCQM by the American Board of Quality Assurance and Utilization Review Providers. The QM Manager shall have experience in quality management and clinical investigations. Quality Management shall have sufficient local staffing who are licensed clinical or behavioral health professionals to meet the requirements of the quality management program. The Quality Management Manager shall not hold any other position other than the Quality Management Manager position. Staff shall report directly to the Quality Management Manager. The primary functions of the Quality Management Manager position are: a. Ensure individual and systemic quality of care, b. Conduct comprehensive quality-of-care investigations, c. Conduct onsite quality management visits/reviews, d. Conduct Care Needed Today/Immediate Jeopardy investigations, e. Integrate quality throughout the organization, f. Implement quality improvement, and g. Resolve, track, and trend quality of care grievances.
Section D, Paragraph 15, Staffing Requirements	**Revised as follows:** **Performance/Quality Improvement Manager** who is located in Arizona and: a. Is a CPHQ by the National Association for Health Care Quality (NAHQ), b. Is a CHCQM by the American Board of Quality Assurance and Utilization Review Physicians, or c. Has comparable education and experience in health plan data and outcomes measurement. The Performance/Quality Improvement Manager is responsible for quality improvement activities as well as staff conducting quality improvement work as specified in Contract and policy. Staff reporting to this position shall be located in Arizona, have knowledge of both physical and behavioral health service delivery, and appropriately qualified (education/certification/professional experience) to meet the AHCCCS quality improvement contractual and policy requirements. The Performance/Quality Improvement Manager shall not hold any other position other than the Performance/Quality Improvement Manager position. The primary functions of the Performance/Quality Improvement Manager are: a. Focus organizational efforts on improving quality performance measures, b. Develop and implement performance improvement projects, c. Utilize data to develop interventions/strategies to improve quality outcomes and member satisfaction, and d. Report quality improvement/performance outcomes.

SECTION	YH20-0002 AMENDMENT
Section D, Paragraph 36, Subcontracts	**Revised as follows:** ***Pharmacy Benefit Manager Subcontracts Pass-Through Pharmacy Benefit Manager Pricing Model and Discrete Administrative Fee***: The Contractor shall amend the subcontract between the Contractor and its Pharmacy Benefit Manager (PBM) to reflect a pass-through pricing model, defined as a PBM subcontract in which: 1. The Contractor reimburses the PBM the exact amount of the actual payments made to pharmacies inclusive of the ingredient costs and the dispensing fees for prescription claims. 2. ~~The Contractor and PBM shall ensure that no additional direct or indirect remuneration fees, any membership fees or the like may be imposed on a pharmacy as a condition of claims payment or network inclusion. No additional retrospective remuneration or recoupment models including, but not limited to, Generic Effective Rates (GERs) or Brand Effective Rates (BERs) shall be permitted. However, nothing shall preclude the reprocessing of claims due to claims adjudication error of the Contractor or its agent, or claim related pharmacy audit adjustments for incorrectly billed pharmacy claims,~~ Effective January 1, 2022, the Contractor shall ensure that encounters submitted to AHCCCS are payments issued by the MCO's PBM and/or the MCO PBM's contractors or subcontractors and are representative of the amounts allowed under the reimbursement methodology delineated in the contract between the MCO PBM or Pharmacy Services Administrative Organization (PSAO) and the pharmacy, 3. All revenues including direct and indirect payments and credits received by the PBM related to services provided for the Contractor are passed through to the Contractor, including but not limited to: pricing discounts/credited paid to the PBM, inflationary payments, clawbacks, fees, credits, grants, chargebacks, reimbursements, all rebates, administrative fees paid by manufacturers or other related entities, and any other payments received by the PBM on behalf of or related to the Contractor, 4. The Contractor pays the PBM an all-inclusive administrative fee, on a fixed and/or per script basis, for all services provided under the PBM subcontract. The administrative fee shall not be funded directly or indirectly with revenues associated with credits, rebates, or other payments made to the PBM, 5. For all Contractors, including those contracting with a PBM that subcontracts with another PBM, the submitted encounter by the Contractor shall be the actual payment to the pharmacy. The contracts, between the Contractor and the PBM or the PBM and its subcontracted PBM or any other identified subcontracts associated with the delivery or administration of the pharmacy benefit, shall be submitted to AHCCCS upon request, and 6. For Contractors whose PBMs subcontract with a Pharmacy Services Administrative Organization (PSAO), the submitted pharmacy encounter to AHCCCS shall include the actual payment to the pharmacy that provided the service, including the paid ingredient cost and dispensing fee.
Section D, Paragraph 9, Scope of Services, Crisis Services	**Revised to include the following:** There are specific modifier(s) which shall be included on claims to identify that the service is being provided as part of a crisis episode. The Contractor and providers shall work together to ensure the modifier(s) are being included. The Contractor shall educate its providers about the crisis modifier(s) in order to ensure all appropriate costs are included in the capitation rates for the correct risk group.
CCE Library Title XIX/XXI Data Supplement For Capitation Rate Setting, Section F	**Revised and reposted to the CCE Library and SFTP, as applicable, to allow for GSA Combination bids:** Section F. Rate Development Information ○ Administrative Cost Bid Requirements ○ Administrative Cost Bid Submission (SFTP)

SECTION	YH20-0002 AMENDMENT
Section H: Instructions to Offerors	**Revised as follows:** C2 - The Offeror shall bid the administrative cost portion of the capitation rates. The Offeror shall include an administrative rate for each GSA and GSA combination for which the Offeror is submitting a bid. AHCCCS will include an Administrative Cost Bid Submission Workbook and instructions in the Title XIX/XXI Data Supplement For Capitation Rate Setting in the CCE Library. The Offeror shall submit a single Workbook in Excel to AHCCCS via the SFTP server in accordance with Paragraph 19, Contents of Offeror's Proposal in this Section. A separate worksheet shall be included for each GSA and GSA combination in which the Offeror submits a bid.

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: JVS / Scott Cummings	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: James Stover / Scott Cummings	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: Medicaid President / Plan President	TITLE: Chief Procurement Officer
DATE: September 23, 2021	DATE: September 14, 2021

Part B

Programmatic - Narrative Submission

Transforming the health of the community, one person at a time.

B1.Transitioning a contract to a new health plan…

Seamless Transition to Minimize Disruption and Reinforce Program Advancements

Arizona Complete Health (AzCH) is a unification of Arizona Complete Health-Complete Care Plan (AzCH-CCP) and Care1st. Together, we serve all of AZ as an AHCCCS Complete Care plan and as the RBHA in the South GSA for 16 years. AzCH administers integrated physical health (PH) and behavioral health (BH) services for T19/T21/NT19 eligible individuals determined to have a serious mental illness (SMI), as well as crisis services. Given the construct of the new RBHA agreement and the GSAs, we know there will be transitions that impact members, and we are ready to seamlessly transition these members. In the South, we have facilitated multiple major transitions and learned valuable lessons on how to transition *and* minimize disruptions in care. We will leverage our local relationships and history of implementations for AHCCCS' programs, and we are prepared and committed to comply with all transition requirements in Section D, Program Requirements, including D.8 Transition Activities, and Exhibit D, Transition Requirements, the AMPM, and the ACOM. Transition activities will focus on Contract commitments while promoting innovation, integration, continuity of care, and causing no disruption or delays for members or providers. For example, members receiving NT19 services at the time of transition will continue to receive services from any non-network providers for the duration of their treatment, as outlined in our transition of care policy.

Through our Go-Live Rapid Response approach described below, members will have ready access to services with minimal member and provider abrasion. Issues are resolved with urgency while maintaining high standards, program integrity, and transparency. Our informed and continuous feedback loop proactively monitors transition activities, including data and information from all sectors of the integrated delivery system to provide a holistic view of how the transition activities will impact the system of care.

Go-Live Rapid Response Monitoring and Action Plan. AzCH's Go-Live Rapid Response Plan, overseen by our multi-disciplinary Rapid Response Team, minimizes disruption and maximizes the success of any transition through action steps and accountability, vigilant monitoring, and swift issue resolution. The Plan delineates tasks and monitoring activities before, during, and after the transition and is modeled on previous successful AzCH transitions. Our Rapid Response Team will meet daily beginning at contract award through implementation to monitor readiness, implement transition plans for members with high needs, oversee Information Technology systems, outreach to relinquishing RBHAs, update provider lists, and assure alignment with AHCCCS guidelines and goals. This team can be activated within 15 minutes for urgent issues.

Go-Live Daily Dashboard. The Go-Live Dashboard includes a comprehensive data set that identifies service delivery issues and gaps and reports to the QM/PI Committee. Daily, the Go-Live Rapid Response Team will monitor performance measures shown on the Dashboard to assist with the immediate identification of potential access to care issues. The Go-Live Rapid Response Team will review and escalate to QM/PI Committee for systemic issues and trends related to prior authorization volume and timeliness; continuity of care for PH, BH, pharmacy, and transportation services; referrals to specialists; and daily census for all facilities. The Dashboard includes information on timely discharge planning, care plan review and updates, care management and care coordination for active episodes of care, network gaps including access and availability standards, and credentialing timelines. The Dashboard provides data on vulnerable populations as defined by AHCCCS for members with special health care needs. We closely monitor transition-age youth, individuals with SMI, members on court-ordered evaluation/court-ordered treatment, and members with high-risk pregnancies.

Rapid Response Team. Our Chief Operating Officer, Susan Cordier will lead our Go-Live Rapid Response Team. Our Transition Coordinator will generate daily Go-Live Daily Dashboard summaries with key information of the day, issues by type and volume, key resolutions, and issues to monitor for the next day. As needed, we will escalate issues to the Medicaid President for immediate resolution. AzCH uses a vertical and horizontal oversight approach to monitor and act on any issue across the organization or system: vertically through departments who report concerns to leadership; and horizontally through cross-functional committees, including QM/PI. Our QM/PI Committee maintains ultimate oversight of transition activities and proactive monitoring to directly address any issues.

Member Transition. Our multi-channel Member Outreach program includes telephonic, text, email, social media, and mail. We build relationships with members and conduct member welcome and education activities per ACOM. Immediately following go-live, our Care Management team will outreach members to address gaps in care and engage new members to reach 100% of members within 30 days of enrollment. New for this contract, AzCH will assign a Personal Recovery Navigator (PRN) to every new member with SMI designation to orient them to the system of care and

offer navigation. The PRN will talk to members about their family of choice and connect them with family support through a Family-Run Organization as desired. PRNs facilitate warm-hand offs to Care Managers for continuity of care.

Provider Transition. We know receiving and responding to provider input and feedback is critical during the transition and have already engaged our Provider Advisory Group. Our Provider Engagement team will maintain this proactive communication and our stakeholder education plan, featuring monthly provider and community forums starting 60 days pre-go-live and three months post-implementation in each GSA awarded. We have overlaid our existing network in the North and Central GSAs to identify gaps and know that while we meet network adequacy to be fully ready for go-live, additional network contracting efforts will be needed for specialized services such as ACT teams and crisis providers. With new GSAs, we will initiate any needed contracting efforts by January 2022 and complete the first round of provider onboarding by March 2022. We continually monitor network expansion needs.

Community Transition. Our successful approach to community engagement includes integrating into existing community forums to listen and learn and creating collaborative forums to reduce silos amongst stakeholders. We will enhance this across awarded GSAs by participating in or developing, crisis, justice, tribal, and other GSA-specific stakeholder forums to ensure that we are identifying and continuing to advance GSA-specific advances in integration and specialized RBHA services. We will collaborate with MCOs to ensure seamless transitions for stakeholders, for example in Pinal County supporting gains that have been made through partnerships with the justice system.

Staffing for Transformation and Capacity Building. We know that the job market has changed due to COVID, and have put in place a recruitment strategy to ensure we can staff up quickly, including retention and referral bonuses. In 2020 we were identified as the best place to work in AZ by the Phoenix Business Journal. To ensure successful staffing in new GSAs, we would give priority to any qualified, outgoing RBHA staff. We monitor enrollment and staffing ratios to ensure appropriate staffing levels throughout transition, implementation, and operations. We track performance against thresholds (such as call center volume) before and during the go-live period. AzCH's staffing strategy assures all key personnel and departments are appropriately staffed before go-live and enables us to carry out Contract requirements. We understand the importance of ramping up call center staffing, including adding trained temporary employees during implementation, which we will do before and after go-live. We tailor staffing to enrollment levels and GSAs and offer staff training and/or recruit additional qualified staff to maintains strong performance or address enrollment increases.

Strong Local Leadership Backed by Program Experience. AzCH brings more than 16 years of experience providing comprehensive crisis services to more than 450,000 members in urban, rural, and frontier areas, including 19,500 American Indian members. We are a leader in the development of innovative federal grant and state-funded programs to enhance access to care and improve service delivery for all populations, and effective management of services to meet the needs of T19/T21/NT19 adults with SMI. We have trusted and credible relationships with providers, other health plans and programs, stakeholders, and AHCCCS. We have an established Customer Service and Medical Management team trained to assist members in accessing needed services, facilitating a seamless transition. Our Provider Advisory Group helped us design strategies for this new contract and will support us through implementation.

Lessons Learned from Program Transitions. We have experience transitioning all of AHCCCS' Medicaid programs, and we have critical lessons learned to assure minimal disruption to providers and members. As a learning organization, we build from our experience, and we know it is important to minimize administrative burden and acknowledge that a previous transition of payment systems and benefits has highlighted challenges with provider contracting and claims processing. We bring the skills and experience of both AzCH and Care1st that enable us to leverage statewide experience in program transitions. For example, to ensure stakeholders are proactively invited and welcomed to the table before, during, and after the transition, we have developed our Stakeholder Map, which drills down to the neighborhood level. Using our Stakeholder Map, we will continue our best practice of holding 'listening tours' with members and their families, providers, community-based organizations (such as social service agencies and faith-based groups), law enforcement agencies, other government agencies and officials, and tribal representatives and advocates. In considering a transition into a new GSA, we understand that payment models can be different (and confusing) for providers. The payment structure for providers that serve members with SMI in each GSA is significantly different, which can be a source of providers' stress when they are trying to understand reimbursement. To alleviate this stress, AzCH will dedicate staff who are trained on reimbursement models and empowered to resolve provider concerns using a one-call resolution model. We understand that we need to maintain operations for any GSAs that we continue to manage while successfully scaling for any new GSAs that we add.

B2. The delivery of comprehensive and effective integrated service…

AzCH has served individuals with SMI designation as the RBHA for 16 years. Today, we serve over 14,000 Integrated RBHA members with an SMI in the South GSA and cover behavioral health services for over 17,600 members who are NT19/21. Since 2015, members with SMI who have been continuously enrolled in our Integrated RBHA achieved *24% and 23% reductions in BH ED and PH ED visits, respectively*. Members assigned to one of our 19 Integrated Health Home (IHH) experienced *31% and 21% decreases in BH and PH Inpatient admissions, respectively*. Aligned with the AHCCCS Targeted Investment Program (TIP), we worked with our provider network to stand up new programs and achieve integration milestones and member outcomes via the PCP and BH Ambulatory, Criminal Justice Focused, and Hospitals TIP projects. To ensure progress made through TIP is sustainable, AzCH established TIP Collaboratives that convene inter-disciplinary provider teams to discuss technical assistance and best practices. We incorporate TIP milestones into our provider contracts. As an example of related outcomes, the clinic for Justice-Involved Members in Yuma, Pima, and Pinal successfully engaged members in services with *64% of our justice-involved members completing a wellness check within six months of TIP placement*, compared to 11% of their peers.

a. Experience with Service Delivery to Members with SMI Designation

As an embodiment of Adult Guiding Principle Number 3 – *Focus on the individual as a whole person* – AzCH began investing in service delivery integration well before the first integrated RBHA contract. Through our experience in whole person care for individuals with SMI in the South GSA and our deep community relationships built over the years, we are positioned to effectively expand to meet BH, PH, and SDOH needs of communities in the North/Central GSA.

Experience Advancing Integration. Beginning with the 2005 RBHA contract, we established monthly health promotion activities focused on PH co-morbidities and preventive screening mobile events at BH clinics; implemented Whole Health Peer Support Training and invested in peer-delivered Whole Health programs such as Camp Wellness, and executed integrated contracts with all Intake and Care Coordination Agencies in the South GSA. This experience shaped future contracting to articulate IHH development and the evolution of our integrated system of care. Since 2015, we have been hosting monthly provider integrated care meetings to promote continued practice transformation. In 2015 we developed our Integrated Care Management Team (ICMT), expanded networks to include primary care and PH specialty providers, and worked with BH and PH providers to develop bi-directional integration models**.** As an example of our ICMT's outcomes-driven approach, our SUD Co-Occurring Initiative focused on early identification of members with SMI who use IV drugs and develop complex medical infections. Through pro-active care management and provider education, this initiative resulted in a *38.5% reduction in inpatient utilization*.

Investing in a Community Based System of Care that Supports Member Choice. Members can choose to receive PH and BH care within an IHH, including some FQHC's or through separate BH and PH providers via virtual integration. We work with PH providers to enhance their ability to address BH factors and participate in integrated payment methodologies. We invest in building IHH capacity to provide and coordinate PH, BH, and SDOH supports. Our provider network includes 19 IHHs serving RBHA members across multiple locations in the South GSA. We have supported 21 FQHCs in growing effective BH programs, from screening and brief intervention to evidence-based collaborative care, with some becoming IHHs. Recognizing the important role of FQHCs in serving members with SMI, we were the first MCO to work with the AZ Alliance for Community Health Centers to build their clinically integrated network, *VBCare Network*, and implement a corresponding VBP strategy. Recognizing that feedback about member needs and provider outcomes drives network improvement, we created data sharing mechanisms, scorecards, and a progressive payment model. Our collaboration with VBCare Network began in 2017, with a fully executed contract starting on 10/1/2019. Following this approach, we now support three emerging BH ACOs through collaborative data sharing, partnership development, and contracting. AzCH collaborated with stakeholders to develop 13 Centers of Excellence (COEs) with a variety of specialties such as SUD, pain management, and peer and family support services. A Psychiatric and Primary Care Consultation Access Line is available 24/7 to help providers build their knowledge related to integration. We continue to build capacity through integrated VBP arrangements, aligning incentives with AHCCCS goals, with 65% of services delivered by providers participating in VBP models. In 2015, we funded Population Health Administrators within provider practices and built a partnership with the Arizona Telemedicine Project yielding Project ECHO: BH Integration, which offers tele-based trainings. In 2018, we launched our Hospital Engagement and Linkage Peer Program (HELPP) —integrating Peer Support Specialists (PSSs) into hospitals to work with members pre- and post-discharge, achieving a *44% and 46% decrease in readmissions three- and six- months post-discharge respectively* in 2019.

Workforce Development to Advance Integration. We have implemented targeted workforce development efforts focused on advancing integration for providers serving members with SMI. As an example of the myriad efforts, since 2014, we have funded PSSs and Parent/Family Support Providers (P/FSPs) across our provider network to complete the Integrated Health Institute through the University of Arizona (UA). This laid the foundation for Peer and Family Support service delivery within PH settings and prepared the peer and family workforce for bi-directional integration. AzCH's state-approved PSS credentialing curriculum continues this approach - training and credentialing 227 PSSs since 2017. Continuing to develop the peer and family workforce, we invested in the development of a continuing education advanced certificate program for PSS and P/FSPs in partnership with the Peer & Family Career Academy. In partnership with the UA School of Nursing we established an Integrated Care Certificate Program. Our partnerships with Central AZ and Pima Community Colleges enhance BH expertise and recovery orientation of Community Health Workers.

a. Experience with Service Delivery using NT19/21 Funding Sources

Since 2015, AzCH administered over $415M in NT19/21 funding for 100+ providers. During SFY2021 alone, AzCH administered $47.6M in State General Funds for NT19 SMI Services, Housing, NT19 Crisis, and SUD Services; Federal funds including Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), State Opioid Response Grant, AZ COVID-19 ERSP, Emergency COVID-19; County funds, PASRR, and the ADES Cares Act. Collaborations with partners like CODAC, COPE, Sin Puertas/Pima Prevention Partnership, Touchstone, and Community Medical Services allow innovative programs and services targeted toward priority populations. For example, funds from the State Targeted Response Grant and the SOR Grant were used to build seven MAT clinics, including the first 24/7 Integrated MAT Clinic in the country, which served 781 new members from January through May 2021. We used grant funds to increase access to evidence-based First Episode Psychosis (FEP) programming through capacity building and a targeted education and outreach plan for individuals in the prodromal phase who may benefit from FEP services. When compared to a control group, members who participate in FEP programs experienced *10% fewer ED visits after 18 months* in FEP treatment.

b. Administration of NT19/21 Funding Sources

As a RBHA, AzCH has the principal responsibility of ensuring knowledge of and access to NT19/21 funding for all Arizonans. We work with the guidance of AMPM Sections 320-T1/T2 to partner with providers, other ACC plans, TRBHAs, and community stakeholders to effectively leverage these funds. We use a "no wrong door" approach, creating a layered funding structure that guarantees members and families access to high-quality services. Braided funding and intentional provider allocations enable the seamless transition from one funding stream to another without disruption in member services. For example, we partnered with local Public Housing Authorities to use state Housing Trust Funds, HOME, and HUD funding to develop housing solutions for members with SMI, adding 33 housing units over the last two years, with ongoing and sustainable rent subsidy attached. Leveraging NT19/21 funds, we have established 555 housing opportunities for members with SMI since 2015 through a combination of project-based and tenant-based solutions.

Grant Administration. AzCH strengthened our administrative oversight and knowledge by hiring a Grants Analyst to support the required Funding Coordinator and Grants Administrator positions. Our Grants team has 50+ years of collective experience and provides detailed forecasts, budget justifications, and reporting. We engage and cross-train all AzCH departments to prioritize programs and collaborate with providers to serve the targeted priority populations with each designated funding source as outlined in AMPM 320-T1/T2, grant applications, the AHCCCS Allocation Schedule, and AHCCCS allocation letters. AzCH requires providers to account for funds in a way that allows distinct reporting of each state and federal funding source. We participate in SAMHSA audits and consistently demonstrate compliance with requirements. We meet 100% of RBHA financial reporting requirements.

Provider Engagement and Monitoring. Our Grants team meets with providers at least quarterly to confirm compliance with grant and contract requirements. AzCH provides education and technical assistance on policy requirements and the appropriate use of funding sources. We closely monitor provider financial performance and grant expenditures through an innovative financial tracking report that allows us to periodically reallocate funds as necessary to meet member needs and maximize utilization of funds. We establish FFS ceilings and use an NT19 FFS Monitoring Report to monitor ceilings to ensure we are completely and appropriately leveraging NT19 monies. For example, we raised the FFS ceilings for 10 providers totaling $822K in the past 12 months and added $1.4M to providers for expansion programs, including substance use disorder and children's behavioral health. As part of our program development, where applicable, we ensure the sustainability of well-performing programs when funding ends by seamlessly shifting to alternate and ongoing funding sources to promote continuity of care for members.

B3. Describe how the Offeror will use the limited Non-Title XIX/XXI funding to maximize the timely...

AzCH understands the complexities of braiding available funding sources to meet community priorities, maximize access to services and resources for all community members, and ensure Medicaid members receive a full array of services. AzCH recognizes that T19/21 eligibility changes as life situations change and that members and their needs are dynamic. AzCH manages NT19/21 funding to ensure continuity of services regardless of eligibility status. We will continue this effective approach in all awarded GSAs.

a. Sources of Non-Title NT19/21 Funds to Maximize Services to Members

AzCH has effectively administered over $415M from NT19/21 funding sources, managing $47.6M in SFY2021 alone. Our funding allocation has grown consistently – over $7.3M since SFY2016. We leverage NT19/21 funds to build capacity for programming, increase access to services, and positively impact SDOH for both Medicaid and non-Medicaid enrolled community members. AzCH strategically braids funding to develop and implement services that fill identified community gaps with an eye toward sustainability. Sources of NT19 funds that AzCH has administered include:

Fund Source	Types
State	NT19 SMI Services, NT19 SMI Housing, Supported Housing, HIE, Housing Trust Funds, NT19 Crisis, Liquor Services Fees, Substance Use Disorder (SUD) funds, Children's Behavioral Health Services Fund (CBHSF)
County	Pima County Intergovernmental Agreement (IGA) Funds
Federal Block Grant	Mental Health Block Grant (MHBG) SED, MHBG SMI, MHBG FEP, Substance Abuse Block Grant (SABG) – including General, Pregnant/Postpartum Women, SABG Prevention, SABG HIV
Federal Specialty	Medication-Assisted Treatment (MAT)-Prevention Drug and Opioid Addiction (MAT-PDOA), State Youth Treatment, Strategic Prevention Framework-Partnership for Success, Emergency Covid-19, AZ Covid-19 ERSP, AZ Opioid State Targeted Response (STR), AZ State Opioid Response Grant (SOR) I and II, CDC Core State Violence and Injury Prevention, AZ State Pilot Program for Pregnant and Postpartum Women, Federal Cares Act funds through AZ Department of Economic Security
Other	Preadmission Screening and Resident Review, Housing Bridge Subsidy

b. Process for Prioritization and Delivery of Services

AzCH has the infrastructure and experienced staff to effectively manage NT19/21 funds in a manner consistent with AMPM 320-T1/T2. We prioritize service delivery based on each funding source's priority population and those with the highest level of need. Tania Long, AzCH's Grants Administrator, oversees NT19/21 funding, supervising five staff working with providers throughout the South GSA. She has over 20 years of experience in BH, 16 years with grants oversight, and five years with AzCH. Tania leads the Grants Committee, a cross-functional team from across AzCH, which is ultimately overseen by the QM/PI Committee, which includes participation from peers and family. The Grants Committee collaborates across multiple teams: crisis, justice, Tribal, SDOH, supportive employment, OIFA, prevention, finance, claims, pharmacy, encounters, enrollment, UM, and care management. The Grants Committee meets monthly and on an ad hoc basis to cross-train, coordinate, identify service gaps, implement new programs, and address concerns related to NT19/21 funded programs and access to quality services. AzCH develops an annual NT19/21 Spending Plan with budgets for each source of funding, priorities, and mechanisms for monitoring. We update the plan semi-annually – driving provider contracts and requiring that funds are available over 12 months. We update expenditures quarterly and reprioritize semi-annually based on need and expenditures. AzCH also provides education and technical assistance to providers on prohibited expenditures, I-BHS requirements, cost allocation to programs, identifying services with modifiers in the claims, T19/21 screening requirements, and funding limitations. The Grants Committee monitors utilization of funds and alerts providers if funds are being under/over-utilized. We initiate and increase allocations to providers who demonstrate the ability to follow grant guidelines and offer quality services.

Impact of Prioritization and Service Delivery. AzCH works with providers and community partners to ensure timely access to quality services. With NT19/21 funds we develop innovations that would not typically be covered by Medicaid and reach persons who are ineligible for AHCCCS but in need of services. Examples of this successful approach include:

- **Expanding Integrated MAT Services.** AzCH braided SOR, STR, SABG, and Governor's Office SUD funds to partner with CODAC to expand MAT services, ensuring coordination of care for individuals and appropriate use of public and first responder services. In addition to building out the first 24/7 integrated MAT clinic in the country, AzCH used STR funds to pilot a diversion program with Tucson Police Department (TPD) and Pima County to prevent arrests. Based on the pilot's success - diverting 1,092 individuals from jail during the first 20 months post-implementation - TPD secured outside funding to sustain the program. In 2019, we enhanced capacity using STR and SOR funds to create a safety lounge to support members during the withdrawal and/or induction process. We expanded MAT to six additional sites and enhanced MAT programs by including alternative therapies to opioid use, such as an onsite

acupuncturist, with participating members reporting decreased anxiety. With SOR funds, our Justice, BH, and Special Programs Teams collaborated with county detention centers to coordinate MAT for members with OUD. Pima, Pinal, and Yuma County detention centers now allow individuals to receive MAT services while detained. We advanced this innovation with Santa Cruz Detention Center, focusing on pregnant individuals. Our Reach-In Program offers a bridge to MAT and other grant funded services for individuals while incarcerated by contacting eligible members to coordinate re-entry services and identify health care needs. Of members with OUD who chose to participate in Reach-In, 95% continue to engage for six months post-release compared to 39% of non-participants; 77% of Reach-In participants receive MAT services within 15 days versus 19% of non-participants.

> **AzCH Expands MAT Services**
> "AzCH has been a fantastic partner, making it possible to open new clinics and expand treatment throughout rural and underserved areas. AzCH ensures that inability to pay is not a barrier for people in need of SUD treatment, providing rural rate differentials and timely payment for providers along with grant funding for new projects."
> **- Nick Stavros, CEO, CMS**

- **Expanding school-based BH supports.** AzCH used NT19 funds to invest $856,250 directly into school-based service providers, with 118 schools in the South GSA providing the Youth Engagement Specialist (YES) program, an increase of 46 schools over the prior year. Since the inception of YES in 2019, schools have referred 2,084 students for BH services. Referrals contribute to improved overall well-being, leading to a 52% increase in Well Child Visits and a 15% increase in Dental Visits through our partnership with Casa de los Niños, which provides integrated care to children referred from schools for BH services. The power of NT19 supported BH services in schools is exemplified in the following member story.

> **AzCH Member Story: Tony**
> "Tony" attends Buena High School and received a referral for services due to self-harm and suspected depression. We used MHBG funds to enroll Tony in YES. Through weekly visits with his therapist, he opened up about cutting and suicidal ideation. The therapist connected him to Az Children's Association for additional support. Tony currently remains in the classroom setting and his focus has improved. However, in subsequent months if his diagnosis changes to a substance use related indicator, AzCH may change the funding source to SABG. If inpatient hospitalization or residential treatment becomes necessary, AzCH will cover these services utilizing Jake's Law funding. If Tony's family qualifies for AHCCCS, AzCH will change the funding source to Medicaid. AzCH ensures seamless continuity of services even with funding streams changing – sometimes as often as monthly - without the child and family ever knowing and while maintaining continuity of care for the member.

c. Assisting Members to become T19/21 Eligible

As a RBHA, ACC, Medicare, and Marketplace plan, AzCH has line of sight across funding streams– effectively connecting members to care, whether through Medicaid, the Marketplace, or NT19/21 funding sources. Funding providers using both T19/21 and NT19/21 dollars enables a provider to bridge services for a member who is being screened for T19/21. **Education and Accountability for Providers**. We work with providers to utilize funds correctly and educate providers on working with members to screen for eligibility and provide enrollment assistance.

- We contractually require and provide support for all providers to screen members for T19/21 eligibility and document member applications at intake and annually thereafter. MAT Clinic expansion with Community Medical Services (CMS) is an example of the impact of this process. AzCH worked with CMS to screen every individual served by the clinic for T19 eligibility. Through this process, SABG spending dropped as eligible members shifted to T19 status. This affected members across the state, maximizing the use of NT19 funds for NT19 individuals and services, while members that moved to T19 eligibility continued services and received expanded benefits.
- Contracted Integrated Health Homes (IHHs) use Arizona's Health-e-Arizona Plus electronic application to submit applications for enrollment in Medicaid, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families, or to determine if community members are eligible for financial assistance with a qualified health plan offered through the Marketplace. As an example of the volume of screening and eligibility services, one of our largest IHHs conducted 25,742 eligibility screenings and submitted 12,361 applications during 2019. AzCH tracks AHCCCS redetermination dates and sends an alert to the provider to ensure members do not lose eligibility.
- If a member loses T19 eligibility while receiving services, AzCH requires providers to prevent service disruption. AzCH Care Coordinators work with providers to determine whether the member is eligible to continue services through available NT19/21 funding. If the provider does not receive NT19/21 funding, the member's care team identifies a provider that receives NT19/21 funding to serve the member. The original provider facilitates the member's transfer to the new provider, working with AzCH Care Coordinators to ensure continuity and limit service disruption. Our provider contract language stipulates that the provider will be paid while payment details are determined.
- We are monitoring the shift in NT19/21 grant-funded service utilization due to COVID-19 related increases in T19/21 eligibility. Per the Families First Coronavirus Response Act, AHCCCS has not disenrolled members during the public

health emergency. We are working collaboratively with our providers to ensure workforce capacity related to substantial redetermination efforts and the ability to connect individuals to appropriate coverage options.

Reducing Barriers to T19/21 Eligibility and Other Resources. AzCH annually invests in *assisters* – people and programs that help with Medicaid and Marketplace enrollment, providing $120,000 to Helping Families in Need and $10,000 to Keogh Health Connection.

- AzCH contracts with providers such as the Family Involvement Center (FIC) to enhance outreach, eligibility, and enrollment efforts for individuals who are not engaged. FIC participates in a CMS Connecting Kids to Coverage (CKC) Outreach and Enrollment Cooperative Agreement, providing boots-on-the-ground outreach to identify and enroll families eligible for CHIP and Medicaid. Through the Parent Assistance Center, they ensure that individuals are connected to services during the eligibility determination process.
- AzCH implemented SSDI Outreach, Access, and Recovery (SOAR)-specific services with selected providers to increase the success of applications for disability income benefits administered by the Social Security Administration (SSA). Provider case managers complete free training to gain SOAR certification to provide coaching for NT19 members to receive the appropriate benefits. AzCH's Housing Specialist is the state lead for SOAR.
- AzCH promotes the benefits of employment; we educate members and provide assistance to help them use SSA work incentives and AZ Freedom to Work to maintain covered benefits while increasing earned income. The AzCH employment team educates all Supported Employment and IHH providers on the DB101 decision support tool. We set and track quarterly benchmarks for Estimator sessions offered to members for benefits planning. We also focused on DB101 in the Annual Employment Planning Session held with AzCH contracted providers on 9/21/21.

Assisting Members During Times of Transition to Ensure Eligibility. AzCH partners with the AZ Department of Juvenile Corrections to submit AHCCCS applications for youth aging out of DCS, ensuring coverage upon exit. In Pima County, IGA funds support a T-36 team for community response and screenings for members with non-emergent applications. AzCH assisted Pinal and Yuma counties in becoming HEAplus partner organizations to help members who are incarcerated with completing AHCCCS applications pre-release. In Pinal, we contracted for Jail Liaisons as assisters. Our contracted providers assist with eligibility screenings as part of NT19 Court Ordered Treatment. Funding is provided to Observation Units and Urgent Engagement services for eligibility screening. With this experience, we recognize that each county has unique nuances and requires an individualized approach. We are prepared to collaborate with counties in the newly awarded GSAs to implement county IGAs, such as Coconino and Maricopa County IGAs for COE.

d. Coordination of Services

AzCH uses successful processes for the timely coordination of NT19/21 services (Room and Board, Traditional Healing, Acupuncture, Child Care) that have been referred or recommended by all other AHCCCS MCOs.

Provider Initiated Referral Process. Referrals to serve members from other MCOs are initiated by the provider, with different processes established for small versus large providers. AzCH consistently engages providers in education to understand processes and priorities for NT19 funding. The Grants Committee screens funding requests to ensure eligibility and focus on appropriate priority populations for the funding source. Once the eligibility segment is open (within 7 days), the provider begins submitting claims – using braided funding to ensure providers can be nimble.

Crisis System Funding. The crisis system is funded using a capacity-based approach using T19/21, NT19/21, and County IGA funds. This allows a stable staffing pattern to ensure access to services for all Arizonans. All residents are eligible for crisis services regardless of funding source or T19/21 eligibility status.

Demonstrating Coordination. An example of AzCH coordination of services is our collaboration with all MCOs in the region to serve NT19 members for identified housing needs. We ensure the availability of NT19 wrap-around services to assist members in maintaining housing and coordinating with service plan goals. On average, AzCH serves 600 members annually through Housing Services, with more than 50% of the individuals we have housed referred from other MCOs with whom we coordinate care. AzCH worked with the local Continuum of Care, Arizona Department of Housing, and HMIS to create a centralized referral system called AzCH-CCP Coordinated Entry and was the first MCO in AZ to actively ensure that each IHH obtained an HMIS license and training. Being an early adopter of HMIS has shown us how to leverage relationships to encourage buy-in from all stakeholders. Following suit, we are also the only MCO early-adopter of NowPow. While AzCH will no longer be responsible for administering Supported Housing, we will continue collaborating with ABC Housing and AHCCCS to provide input on the new ACOM policy and housing manual. We are preparing the provider network to transition housing resources and supports.

B4. Opportunities for clinical quality improvement for individuals living with Serious Mental Illness.

a. Methods to Assess Disparities/Opportunities for Quality Improvement and Actions Taken

AzCH delivers culturally relevant services to ensure all members with SMI, T19, and NT19, have access to high-quality care regardless of race, ethnicity, sexual orientation, gender identity, language, or zip code. Our system of care approach embodies Adult Guiding Principle 8 – *strengths-based, flexible, responsive services reflective of an individual's cultural preferences*. To identify disparities, we analyze multiple data sources, including HEDIS, CAHPS, assessments, grievances and appeals, Performance Improvement Project data, surveys, and input from members, providers, and stakeholders. We stratify HEDIS data by race, ethnicity, and language using Logistic Regression models. For members where we do not have this data, we use data-driven technologies to reliably attribute race and ethnicity based on local demographics, which has over an 80% validation rate, enabling us to accurately identify disparities experienced by different subpopulations using high validity race/ethnicity data for 100% of our membership. We overlay these analyses with additional data and demographics to observe how variables such as poverty, rural geography, disability, gender, and SDOH contribute to the identification of disparities. Using analytic processes, we have developed our Health Equity Dashboard to identify disparity reduction opportunities and track related performance. The Dashboard displays our performance across 15 HEDIS measures by racial and ethnic groups. The use of geomaps, tables, and bar charts, allows us to easily recognize health disparities by race and ethnicity, tracking change over time. The Dashboard's geomaps overlay SDOH data from our proprietary Neighborhood, Economic, and Social Traits (NEST) Tool, which analyzes over 200 data points to predict the risk of adverse health outcomes. Health equity data is available through our provider portal and shared with providers to drive member engagement and innovative programs. Improving our ability to deliver prospective care gap analytics capabilities to staff and providers, we use Interpreta to create a forward-looking health roadmap for members, enabling staff and providers to identify and address emerging member health issues at the earliest, clinically appropriate time, before they become significant health conditions. Available to Care Managers through TruCare, and to providers through our secure Provider Portal, Interpreta uses near real-time analytics to enable users to see member-specific care gaps, informing timely member outreach, increasing equitable access to services. Used together, these tools allow us to effectively evaluate disparities, target interventions that are impactful in promoting health equity, measure the effectiveness of disparity-reduction initiatives, and continue to deliver high-quality care to all members with SMI.

NCQA Health Equity Distinction
AzCH will pursue NCQA Health Equity Distinction, demonstrating its commitment to facilitating equitable access to care for **ALL** members. CMS recognized Centene with the 2019 Health Equity Award for commitment to providing equal access to quality healthcare and services for people with disabilities in Arizona.

Actions Taken. AzCH incorporates health equity data into our cross-functional QM/PI program to inform system-wide initiatives. Our QM/PI Committee applies a PDSA Rapid Cycle Performance Improvement model to develop interventions that increase health equity for members with SMI. Working closely with providers, we deploy effective solutions to increase access to services for all members as shown in Table B.4.a-1.

Table B.4.a-1. Examples of AzCH's Health Equity Improvement Initiatives

Identified Disparity	Actions Taken	Results
Breast Cancer screening – members with SMI have 6% lower rates of breast cancer screening than other populations.	Promotoras educated members with gaps who were not engaged in care about the importance of screening, assisted with appointment scheduling, and addressed any SDOH barriers. Promotoras offer a culturally relevant approach through Spanish-speaking staff who focus on engaging members in rural areas.	63% of members outreached by the Promotoras completed a mammogram.
Comprehensive Diabetes Care – members with SMI have 2.3% lower rates of Hba1c testing despite having a 79% higher prevalence rate than the general population.	Community Health Workers contacted AzCH members telephonically and conduct home visits to provide education and address barriers to care.	92% of members engaged in preventive care services and 69% of members with diabetes completed an HbA1c test.
Members on COT with diabetes are 1.6 times less likely to complete an HbA1c test, than others and are 1.5 times less likely to engage in preventive screening services.	Through our Connections to Care program for members on COT, AzCH analyzes member data to identify needs and stratify members on COT in real-time, pushing daily insights and care gaps to contracted providers immediately.	We have demonstrated a 100% increase in gaps closed for HbA1c Testing and a 48% closure rate for breast cancer screening.

b. Areas Identified as Greatest Opportunities for Quality Improvement and Actions Taken

AzCH has made great strides in transforming the system of care for members with SMI, integrating operational and clinical practices internally and across the system of care. Based on our experience, data-driven quality processes and stakeholder input, we identified the following as the greatest opportunities for improvement: 1) increase the percentage

of members with a PCP visit, 2) increase follow-up after discharge within 7 days, and 3) decrease all-cause readmissions. Based on a root cause analysis of the factors that contribute to these measures, AzCH takes action to drive improvement with a focus on provider practice transformation support and member engagement strategies, as described below.

Provider Practice Transformation Support. Providers and care teams need actionable, timely data at the point of care to drive decision-making and support members to improve health outcomes as they move through the continuum of care. We collaborate with providers to expand their knowledge and capacity to provide integrated, coordinated high-quality care that meets members' whole health needs. Our interventions, which include data sharing initiatives, clinical practice support, and processes to facilitate care gap closure, are supported by AzCH's value-based payment (VBP) models. Using VBP, we align financial incentives across the system of care to reward providers for delivering high-quality care that improves member outcomes.

Data Sharing Initiatives. To improve access to data, we encourage providers through regular forums and written communications to participate in the state-designated Health Information Exchange, Contexture, which enables bi-directional data feeds between AzCH and our provider network. We will implement Rovicare™, a web-based care coordination and information exchange tool that improves care coordination via efficient and timely information exchange between stakeholders and member care teams. Via a single sign on, providers can view information from participating MCOs provider portals, streamlining information sharing and enhancing providers' ability to use actionable data to inform care. Providers can view and share clinical documents, such as ISPs, assessments, and lab results. Providers without electronic health care systems can upload information to Rovicare via secure email enabling cross-system care coordination and supporting practice transformation.

Clinical Practice Support. AzCH expands provider capacity to deliver integrated care via our BH Integration ECHO, which provides a forum for knowledge sharing on clinical practices for integration such as MAT, opioids and chronic pain, trauma and chronic pain, integrating community and correctional health, and the needs of transgender youth. Provided at no cost, providers have access to an interdisciplinary healthcare team specialized in BH integration. To date, 544 unique provider participants from 28 clinics have engaged in the BH Integration ECHO, increasing their capacity to meet members' whole health needs. Our Psychiatric and Primary Care Consultation Access Line is available 24/7 to help providers build their knowledge related to integration. To support prescribing practices that ensure member safety and empower members to self-manage their health, AzCH offers Medication Therapy Management (MTM). The MTM team, comprised of clinical pharmacists, uses algorithms to identify members with non-adherence, dosage, and safety concerns. The team outreaches providers to inform them of member risk and educate them on alternative medications and minimum recommended monitoring parameters for safe antipsychotic use. Clinical pharmacists in the MTM program address medication participation barriers with members to improve the response rate to antipsychotic monotherapy. Our *Adherence to Antipsychotic Medications for Individuals with Schizophrenia rate improved 7.8% from CYE2019-CYE2020*; our program has contacted providers regarding 281 members at high risk; and for 582 members in MTM, we saw a *17% reduction in Drug-Related Problems*.

Facilitating Care Gap Closure. We have implemented multiple interventions to assist providers in closing member care gaps. We learned that BH providers needed early and actionable data, and PCPs/IHHs needed streamlined reporting with clear data. In response, we developed and distributed a daily BH Inpatient (IP) admissions report to facilitate discharge planning. Since implementation in Q2 of CY2020, *68% of members who appeared on our daily report completed a FUH 7-day appointment*. We partner with Regional Urgent Engagement and Hospital Assessment Team providers to assist in scheduling follow-up visits for members who visited the ED with a primary diagnosis of mental illness or intentional self-harm. From January to May 2021, data indicates a *22% increase in FUM 7-day and a 24% increase in FUH 30-days*. We collaborate with regional Assertive Community Treatment (ACT) teams to provide daily ED discharge data so the ACT team can quickly engage members following ED discharge. From April through June 2021, only *7% of members with an ACT team accessed crisis services, and 100% of them were stabilized in the community.* Through our BHRF Initiative, AzCH Quality staff monitor member care gaps and assist the facility in scheduling services. If the member is not engaged in services, staff participate in Adult Recovery Team meetings to educate on the importance of preventive and dental care. BHRF staff address SDOH barriers to accessing preventive care by coordinating appointments and transportation. With this initiative, we have seen steady improvements *53% of EPSDT-aged members with SMI completed an annual well visit, and 41% completed an annual dental visit while in the BHRF.*

Improving Member Engagement in Services. AzCH has implemented interventions to drive system-wide improvement

through member outreach, new technologies, and closing care gaps to improve member engagement in care.

Assertive Outreach Strategies. AzCH deploys varied, flexible, and individualized strategies to meet members where they are through outreach calls, texts, in-person visits, and collaboration with providers and community organizations. We launched an automated, daily call campaign to contact members recently discharged from the ED to remind them to schedule follow-up appointments with their provider within 7 and 30-days. We have an average *successful outreach rate of 64%,* higher than most Medicaid programs with average reach rates closer to 30%. AzCH aims to improve health outcomes by locating members through outreach and education strategies via our 4Peers program. Provider based 4Peers Specialists are credentialed Peer Support Specialists who conduct field-based outreach to identify members in the community, provide meaningful education on services and supports, and address member's immediate needs. From May 2020 to May 2021, our *4Peers Specialists contacted 15,101 members in the community,* connecting members to resources and providing health education. We partnered with Simon Med to contact any member eligible for a mammogram with an identified breast cancer screening gap to encourage them to complete their annual screening, *educating 1,724 members about the importance of breast cancer screening*. We are expanding outreach efforts through Tucson Medical Center, which will assist with outreach and scheduling for over 5000 members located in Pima County. We are working with two hospitals to expand our Hospital Engagement and Linkage Peer Program (HELPP) to strengthen members' successful transition back into the community by leveraging Peer Support Specialists to work with members pre- and post-discharge. Our 2019 HELPP outcomes data demonstrated a *44% decrease and a 46% decrease in readmissions three- and six months post-discharge,* respectively.

Innovative Technology Solutions. Examples of technologies we use to improve member engagement include Pyx Health and a Medication Participation App from Wellth**.** Through member feedback, we identified the opportunity to address social isolation, which contributes to higher anxiety, depression, and suicide rates. For members involved with our Crisis System, our Disease Management Programs, a suicide attempt, and/or experiencing social isolation, we offer Pyx Health. Pyxir, a chatbot personality, walks alongside members in their health care journey, checking in daily to encourage self-management, identify SDOH needs, and provide companionship. Since June 2020, members who use Pyx Health experience a *78% improvement in loneliness scores; 31% reduction in Hospital IP; 6% increase in Outpatient services* (medical, PCP, specialty); and *79% decrease in suicide attempts*. To improve medication participation for conditions with higher suicide risk and reduce disparities in antidepressant medication adherence for Black and Latinx RBHA members whose rates are 10% lower than others, we refer members to the Wellth App. Wellth encourages self-management through daily check-ins and rewards for participation. *Members using the Wellth App decreased IP use by 53%, ED use by 15%, and urgent care use by 35%,* with an average of 96% medication participation.

Member Incentives. We offer our My Health Pays® reward program to empower members to take personal responsibility by actively engaging in their healthcare and receiving incentives for completing preventive services such as annual PCP visits and comprehensive diabetes management. In 2021, RBHA members reported accessing 3,724 preventive services as part of My Health Pays, collectively earning over $98,000 in incentives.

New Approaches to Service Delivery. AzCH continuously transforms service delivery in response to member preferences for convenience and accessibility, strengthening their engagement in services. Through Lab2u**,** we provide at-home lab kits for HbA1C levels and microalbumin levels so members can engage in preventive care in the comfort of their own homes. Data indicates *80% of RBHA members who received at-home HbA1c test kits closed their HbA1c testing care gap*. Through our collaborative work and meetings with existing First Episode Psychosis (FEP) programs, AzCH knows that many individuals who graduate from FEP programs struggle to maintain their success and recovery in a general outpatient setting. To increase member participation in continued treatment, we have contracted with EPICenter founding director and international FEP leader Dr. Nicholas Brietborde to lead a collaborative effort with stakeholders to design and implement an FEP Step-Down Pilot in Q1 of 2023. We will organize a stakeholder steering committee to closely track implementation and success of the pilot, adjust as necessary, and prepare to scale and replicate strategically based on need throughout the system of care. AzCH will deploy these effective strategies in all GSAs we serve to advance integration, increase care coordination and improve member health outcomes.

c. Experience Achieving Quality Outcomes for Individuals Living with an SMI

AzCH's programs have led to improved health outcomes for members with SMI. For example, members who have been continuously enrolled with us since Day 1 as the RBHA experienced:

- 24% decrease in IP admissions.

- 31% and 21% decreases in BH and PH Inpatient admissions for members receiving services through an IHH.
- 24% decrease in ED visits for BH conditions and 23% decrease in ED visits for PH needs.
- 23% decrease in out-of-home bed days.

For members we assisted in obtaining stable housing, we saw a *45% decrease in ED visits and crisis services, a 52% reduction in IP admissions, and a 56% increase in PCP well visits*. In 2020, providers participating in VBP outperformed other providers on an average 68% of measures such as ED visits, IP utilization, cervical/breast cancer screening, and use of opioids. AzCH has consistently shown year-over-year improvement in performance measures for members with SMI (Table B.4.c-1), demonstrating statistically significant improvement as determined by the Chi-Square Test method.

Table B.4.c-1. CYE2016/2017-CYE2020 Performance/Utilization Measure Improvement

Performance Measure (Baseline Year)	Baseline	CYE2020	Improvement
Ambulatory Care: ED Visits (CYE2016)	122.1	105.1	**16%**
COPD or Asthma in Older Adults Admission Rate (CYE2016)	71.6	52.7	**36%**
Inpatient Utilization - General Hospital/Acute Care (CYE2016)	187.8	77.7	**142%**
Plan All-cause Readmission (CYE2016)	24%	13%	**11%**
Cervical Cancer Screening (CYE2016)	15%	43%	**28%**
Concurrent Use of Opioids and Benzodiazepines (CYE2017)	30%	15%	**15%**
Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (CYE2017)	68%	72%	**4%**
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment -Total - Initiation of AOD Treatment (CYE2017)	41%	46%	**5%**
Use of Opioids from Multiple Pharmacies (CYE2017)	10%	2%	**8%**
Use of Opioids from Multiple Prescribers (CYE2017)	37%	30%	**7%**
Use of Opioids from Multiple Pharmacies & Multiple Prescribers (CYE2017)	6%	1%	**5%**

d. Proposed Clinical Performance Improvement Project for Individuals Living with an SMI

AzCH proposes a PIP to improve outcomes and quality of life for members living with a Schizophrenia Spectrum Disorder (SSD). Members living with SSD experience higher rates of utilization, higher occurrences of co-morbid conditions, increased mortality, higher rates of incarceration, and greater prevalence of experiencing homelessness (unhoused). Our data indicates that members with SSD comprise 38% of the members with SMI we serve and account for nearly 76% of IP stays with double the readmission rates of members without SSD.

PIP Aim. Our PIP goals include to improve access to preventive care and reduce utilization of higher levels of care by:

- Reducing readmissions by 5% in each contract year.
- Exceeding the NCQA 90th percentile for Follow-up after hospitalization for mental illness (7 and 30-day).
- Increasing rates of HbA1c screening by 10% annually.
- Exceeding the statewide average on the Getting Needed Care CAHPS measure.

Proposed Interventions. AzCH will apply the CMS PIP framework to conduct root cause/barrier analysis, identify interventions and inform innovative solutions for each GSA. Our QM/PI Committee will oversee PIP design, implementation, and monitoring with input from our Health Equity Committee and Member and Provider Advisory Groups. We will conduct ongoing monitoring, modify interventions and incorporate effective solutions into the system of care. This PIP will support our mission of improving the health of our community, one person at a time.

Table B.4.d-1. PIP Goals, Interventions, and Measures

Goal	Proposed Interventions	Measures
Improve Access to Preventive Care	• SSD Wellness and Recovery Program • Assertive outreach strategies • Clinical practice support • Provider dashboards • Telehealth expansion	• Members with SSD prescribed antipsychotic medication with an annual diabetes screening • Members with SSD and diabetes with an annual HbA1c test and an LDL-C test • Members with SSD and Cardiovascular disease with an annual LDL-C test • Members with SSD aged 50-74 years who have had a breast cancer screening • Adherence to Antipsychotic Medications for members with SSD • Getting Needed Care (CAHPS measure)
Reduce Utilization of IP, ED, and crisis services	• Expand peer support • Step-down FEP program • Technology tools • VBP programs	• ED Utilization • Plan All-Cause Readmissions • Inpatient Utilization • Follow-up after hospitalization for mental illness (7 and 30-day)

B5. AzCH's experience with the unique aspects of service delivery to members in each GSA…

a. Experience with Unique Aspects of Care among Distinct Communities - North GSA

AzCH draws on our experience as a North GSA ACC health plan through Care1st and our experience as a RBHA to leverage local resources and programming proven successful in other AZ regions. From snow-capped peaks to desert to canyon bottomlands, significant differences can be found here. The North GSA is expansive, filled with geographic interests, and shares borders with rural Nevada, California, Utah, Colorado, and New Mexico. Crossing east to west by car takes 5 hours, but inadequate/unsafe roads and abrupt weather can add hours. Areas like Holbrook, Kingman, Winslow; Tribal communities such as Hopi Nation, Havasupai Indian Community (in the bottom of the Grand Canyon), Hualapai Tribe, Short Creek Community, and Navajo Nation have some of the highest health risks in AZ. *10% of our ACC members are Tribal nation members*. In Navajo, Apache, and Coconino Counties, *AI individuals account for 73%, 43%, and 27% of the population,* respectively; for many, English is not their primary language. Access to care varies; those in Flagstaff have timely access to a full continuum, but the North GSA has fewer specialty providers, limited choice, and FQHCs often act as community anchors. Barriers include poverty, unemployment, inadequate housing, food insecurity, stigma, and poor broadband, while strengths include advocacy and coalitions focused on improving access to care and indigenous cultures who are connected to the land and the local community. Using an applied research approach, our Northern team member's deep expertise, and aligned with Guiding Principle 1: *Respect*, we honor the distinct cultures and characteristics of each community to inform proposed strategies.

Current/Planned Strategies to Ensure Effective Service Delivery.

Care Need: Access to the Full Continuum of Behavioral Health (BH) and Physical Health (PH) Services.

Strategy: Implement Voice & Choice. As AzCH did when it became a RBHA in the South GSA, we will immediately implement our "Voice and Choice" model, which eliminates the need for in-network referrals to BH specialty services, improving member engagement, self-directed care, expansion of peer-driven services and timely and effective access to care. **Strategy: Expand Peer & Family Services.** We will utilize grant and Medicaid funds to expand P/FRO services in communities that lack and can support P/FRO access by: 1) Creating peer support employment training curriculum with Granite Mountain BH in Yavapai County by April 2022. This will increase SUD transition success through peer supports and warm hand-offs between levels of care. 2) Implementing a SUD Peer Navigation Pathway Program by January 2022 that will increase member engagement and decrease utilization of first responders, crisis and EDs by embedding peers in hospital EDs to connect members to appropriate levels of care. This collaboration includes Summit Health Association, eTransX, Navajo County Health Department, and over 40 community partners. We are also partnering with AZ Peer & Family Career Academy to offer co-reflection, mutual support, and education to our statewide peer workforce. 3) Through a SAMHSA grant, we teamed with Northern AZ Peer & Family Coalition to help the Family Involvement Center build a Family Support Network. This will increase family voice, education, mutual support, and system of care knowledge. 4) AzCH is helping the Native American Peer Run Organization (PRO) to establish a community service agency and apply for PRO status with AHCCCS. **Strategy: Expand Crisis Services**. AzCH will assess for expansion of Crisis Mobile Team (CMT) services and determine any needed community co-locations and partnerships to meet members in the community, ensuring a community-based stabilization approach. We will ensure CMT services are available to respond in under 90 minutes, as we have accomplished in all South GSA rural areas. **Strategy: Enhance Network through Grant Funds.** We will implement a Grants Administration Plan to target community needs and underserved populations and equitably distribute funds to maximize benefit to the community. We will make sure OUD treatment, including Methadone treatment, is readily available in rural communities. **Strategy: Expand MAT Services.** Drug use, such as in Mohave County, which has one of the highest Opioid use rates in AZ, can devastate smaller communities with limited services. Working with Tribal leaders, Health Choice, and Community Medical Services, we identified a service need and are adding a MAT site in La Paz County in 2022. We will employ similar tactics to increase access to this evidence-based practice in the North GSA. **Strategy: Increase Network Adequacy.** AzCH has built a statewide network of fully contracted and credentialed providers in more than 20,000 locations. Our network meets Medicaid and Medicare adequacy requirements and is responsive to prevalent chronic conditions, which, according to the 2019 Northern AZ Health Care Community Needs Assessment (CHNA), includes cancer, heart disease, and diabetes. We have expanded needed services, such as when we provided $250,000 in Community Reinvestment funds and partnered with Spectrum Health Care in 2018 to open the first IHH in Prescott. To meet members' needs living near the AZ border, we collaborate with neighboring states, such as the Short Creek Community (which crosses UT/AZ border and encompasses Colorado City, AZ

and Hildale, UT). Previously, residents drove two hours to Page, AZ; now, they can access providers in St. George, Hurricane, and Kanab, UT in 45 minutes. We promote member assignment to IHHs and offer value-based contracts to incent providers who expand access to PCP services and drive greater PCP engagement, while also focusing on the quadruple aim. **Strategy: Improve timely and empathetic transportation.** When Care1st launched our ACC plan, we contracted with MTBA as well as BH providers who wanted to directly transport members. Through AzCH's new contract with MTBA, effective 10/1/21, we incorporated new accountability measures, such as no refusals and safety components; and BH providers are still able to directly transport members through an MTBA subcontract. MTBA's employed drivers are required to complete recovery and resiliency training with an emphasis on stigma reduction (developed in collaboration with HOPE). **Strategy: Closing the Digital Divide.** North GSA broadband rates are some of the lowest in AZ; in Mohave County, one community must drive three miles to access cellular and can only access 911 via cellular service. To develop broadband access strategies, we participate in the AZ Telehealth Broadband Action Team, AZ Broadband Stakeholders Network and Northern AZ Telehealth Alliance; donating $50,000 in community reinvestment dollars to the AZ Broadband Stakeholders Network. We met with Mohave County to develop a cross-state partnership with UZONA Chamber of Commerce and formed a local action team. For members who are not technologically savvy, dis-trust technology, or need assistance, AzCH will offer supports through P/FROs and our mobile health home, MEET; which teaches members how to connect and can accompany them during telehealth visits.

Care Need: Addressing High Rates of Suicide and Expanding Access to Services.

Strategy: Implement ACT Team. AzCH will implement Rural ACT teams to provide intense, wrap services in all major rural communities. Our partnerships with ACT teams in the South GSA resulted in a *35% decrease in BH residential services, a 34% decrease in ED visits, and an 81% decrease in subacute services leading to a 14% decrease in costs*. We expect similar outcomes in the North GSA. **Strategy: Services to reduce suicide.** The CHNA cited high suicide rates, particularly for youth and young adult Tribal members. To address similar issues in the South GSA, AzCH placed Crisis Mobile Teams in Tribal EDs, narrowing response time to just 45 minutes, while also working hand-in-hand with local Tribal crisis/BH teams. We will implement a similar model in the North and work with providers, such as White Mountain Regional Hospital, to expand suicide resources, such as through SAMHSA-recognized Question, Persuade and Refer (QPR) Suicide Prevention Trainings. In conjunction with AHCCCS, we will offer QPR training, building on our success in the Southern Region where we trained nearly 3000 people trained over the last four years. For members with a suicide attempt, we will leverage our Pyx mobile app by 10/1/22, which provides 24/7 connection via a mobile platform. Pyxir, a chatbot personality, checks in and provides companionship. Since March 2021, *members who use Pyx experienced a 79% decrease in suicide attempts*. **Strategy: Launch Mobile Engagement Extension Team (MEET).** AzCH is enhancing the IHH model for members through MEET, a mobile health home model that extends services beyond the traditional clinic to deliver BH and PH services in homes and community settings. Supporting member choice, MEET will be available to any RBHA member. MEET teams will screen, assess, coordinate care, treat and connect members to community resources. We anticipate the MEET model will have *an 8% reduction in ED utilization and increased follow-up after hospitalization*. **Strategy: Expand Access to Benefits and Employment Opportunities.** Some members suffer poor health outcomes due in part to low/no income. We partner with providers to help members access steady disability benefits through SOAR. AZ SOAR services *exceed national disability application approval rates by 9%,* and through AzCH-promoted expansion of SOAR-certified specialists, South GSA members participating in SOAR *increased by 450% from 2019-20.* We will partner to increase SOAR-certified entities from eight to 20 by 2022. We will also partner with a provider to launch a supported employment initiative, such as a Fountain House model, by 10/1/22, which creates transitional employment opportunities and encourages member entrepreneurship in social enterprises created by the provider. **Strategy: Maintain Trusted Partnerships.** Our team was a founding member of the Northern AZ Peer and Family Coalition and also partnered with NAMI Yavapai, NAZCARE, and individual advocates, peers, and family members to establish monthly coalition meetings; both focused to increase peer, family, and stakeholder voice. This collaborative spirit extends to the partnership Care1st established with the Northern AZ Council on Governments (NACOG) in 2018, mirroring work done by AzCH and the COGs in Central and Southern AZ. We now contract with NACOG to provide SDOH support through home assessments and connecting members to resources for housing, food, health care, and education. This allowed us to increase our Care Management reach and reduce barriers that impact member engagement in care. We are contracting with the Western AZ Council of Governments to expand this service to the North GSA.

b. Experience with Unique Aspects of Care among Distinct Communities – South GSA

AzCH has been a RBHA in the South GSA since 2005 and we bring experience, knowledge, and a scaled continuum of BH services unmatched in AZ, such as a nationally recognized crisis system, well-developed IHHs, expansive justice, meaningful SDOH, and grant-funded solutions. Our team members have deep roots here and are dedicated to refining the BH and PH care continuum. The South GSA is a region of modern urban living such as in Tucson, the second-largest city in AZ, to wide-open spaces and significant rural and frontier areas, providing varied access to care. Those in the urban areas may access a full continuum of care in minutes, while a Morenci member may travel 50 minutes for basic services. The South GSA shares borders with California, New Mexico, and Mexico, and members living along the Mexican border, like Nogales, may access services in Mexico--which adds complexity. Southern AZ contains vast mountains, plains, and deserts; crossing by car takes five hours, with rugged terrain adding hours to the drive. US Census data shows the South GSA has the *highest AZ percentage of Hispanic/Latinos (46.2%)* and includes six American Indian tribes; San Carlos Apache, Cocopah, Colorado River, Quechan, Tohono O'odham, and Pascua Yaqui Tribal Nations. Barriers to care include unemployment, poverty, inadequate housing, stigma, and food insecurity, while strengths include a strong sense of community, a rich multi-cultural history, and diversity. Using an applied research approach, and aligned with Guiding Principle 1: *Respect,* we worked with community members to collaboratively develop proposed strategies.

Current/Planned Strategies to Ensure Effective Service Delivery.

Care Need: Ensuring Access to the Full Continuum of Behavioral Health (BH) and Physical Health (PH) Care Services.

Strategy: Expansive Network. AzCH has a fully contracted and credentialed PH and BH network which meets Medicaid and Medicare adequacy and offers more than 20,000 locations. When we entered this GSA, we implemented and will retain our "Voice and Choice" model, which eliminates referrals to in-network BH services; and improves member engagement, self-directed care, expansion of peer-driven services, and timely and effective access to care. We contract with and promote member assignment to 19 IHHs and offer providers value-based purchasing (VBP) incentive models that focus on the quadruple aim. *In 2020, 65.5% of services provided to RBHA members were delivered by IHH providers with VBP contracts*. From 2018-2020, these providers *increased quality performance by 10.9%,* and from 2019-2020 *reduced costs by 4.3%*. On 10/1/22, we will build on this effective approach and launch an innovative BH VBP model that incents BH providers to work together collaboratively to drive greater PCP engagement, especially post-admission. **Strategy: Crisis Services.** AzCH's expansive South GSA crisis system serves all areas. We continue to enhance the system to meet member and community needs, including 911 co-location services and second responder crisis resolution and coordination services. We contract with P/FROs to deliver the second responder services to enhance engagement for members with SMI and SUDs. AzCH has established and continues to build trusting and respected relationships and collaborations with South GSA Tribes. This has led to innovative tribal-focused solutions, including a Tribal Warm Line, Tribal mobile crisis teams, Tribal peer support certification, and unique training for providers on Tribal sovereignty. AzCH delivers crisis services on all Tribal reservations and coordinates through a single point of contact to promote coordination and transition support as members transition between levels of care. **Strategy: ACT teams.** AzCH has two urban and three rural Act teams. Rural ACT teams maintain fidelity to the ACT model while being flexible to tailor to each member's needs. Rural ACT services include mobile BH units, post-ED discharge follow-up, and collaborative meetings with IHHs and PCPs/FQHCs to increase engagement with preventive care. Our urban and rural ACT teams *decreased BH residential services by 35%, ED visits by 34%, and subacute services by 81%*. *Members served by rural ACT saw decreased IP Readmissions*. **Strategy: MAT Services**. Drug trafficking along the border has led to a substance abuse crisis, devastating smaller communities with limited access to treatment. Graham and Pima Counties are among the top five AZ counties for ED visits for drug-dependent hospitalizations. With CODAC Center of Excellence (COE), we used state SUD funds to build the first ever 24/7 integrated MAT clinic in the US. There are now three 24/7 facilities in Pima County and, we offer MAT services in all counties in the South GSA, except Greenlee County, whose residents access MAT at the Graham County clinic (Safford). Many clinics offer extended hours. Working with Tribal leaders, Health Choice, and Community Medical Services, we are adding a MAT site in La Paz in 2022. **Strategy: Trusted Partnerships.** AzCH was instrumental in the launch of the Pima County ED Diversion Collaboration, which provides members in crisis with a single point of contact, from admission to wellness. Care Managers facilitate meetings with IHHs, IP facilities, FQHCs, and providers to address frequent ED and hospital utilization. They facilitate connections to appropriate care to address members' BH and PH needs. AzCH will continue developing partnerships that improves outcomes and quality of life for members on their recovery journey. **Strategy: BH Programs to address top PH diagnoses.** AzCH identified increasing PH

IP length of stays and readmissions for RBHA members. Understanding the connection between BH and PH health, we conducted drill-down analysis and found multiple diagnosis codes trending, such as abscess and cellulitis, which are often related to skin infections for IV drug use. We partnered with stakeholders to implement AzCH's SUD Continuum of Care Program, which connects identified members to MAT therapy, Skilled Nursing Facilities (SNFs) with access to MAT programs, BH navigators, and harm reduction services such as those provided by Sonoran Prevention Works. From 2019 to 2021, members in this program experienced a *39% decrease in IP utilization, a 42% reduction in ED visits, and a 7.4% increase in PCP engagement, leading to a 22% reduction in cost*. **Strategy: Timely and Empathetic Transportation.** Through our Provider Advisory Group, we learned that NEMT services were not reliable, and BH providers want the flexibility to transport their members. Through member feedback, we learned that a lack of reliable transportation creates anxiety. In response, AzCH implemented a new NEMT contract with MTBA, effective 10/1/21, that incorporates accountability measures, such as timeliness and no dropped rides/refusals. BH providers are still able to transport members through an MTBA subcontract, and drivers complete recovery and resiliency training with an emphasis on stigma reduction (developed in collaboration with HOPE). **Strategy: Addressing the Digital Divide.** AzCH bridges the digital divide by connecting members to the Emergency Broadband Benefit program, which provides discounts toward broadband services and devices such as laptops or tablets. We are expanding on this program by investing $50,000 to expand broadband in rural areas. For members who aren't technologically savvy, distrust technology, or need assistance, AzCH will offer supports through P/FROs and our mobile health home, MEET, which teaches members how to connect and can accompany them during telehealth visits. We will equip peer-support specialists with advanced certification in teaching members technology skills/improving health through technology.

Care Need: Addressing High Rates of Suicide and Providing Access to Benefits and Employment.

Strategy: Services to Reduce Suicide Rates. The South GSA has extremely high rates of suicide and self-harm and AzCH has implemented multiple tactics: 1) AzCH is leading a suicide prevention task force for Pima County, and working with Cochise and Yuma County to develop similar task forces by the end of 2021 (Cochise has the 2nd highest suicide rate in the US). 2) We partner with the Southern AZ Veterans Administration Health Care System to support military personnel and veterans, including addressing suicide concerns (Yuma County has the highest veteran suicide rate in AZ). For over six years, AzCH has had an MOU to provide crisis services at Ft. Huachuca. This is a one-of-a-kind innovative MOU in the US Army, and Care Management teams have access to Davis-Monthan Air Force Base to provide crisis services to airmen, veterans, and civilians. 3) According to the CDC, American Indians have the highest rates of suicide of any racial/ethnic group in the US. AzCH placed onsite CMTs in the South GSA's largest and most remote reservations, including the Tohono O'odham Nation ED in Pima County and San Carlos Apache ED in Gila/Graham Counties, *narrowing response times to 45 minutes, well under the 90-minute requirement, with 75% of crisis responses delivered locally*. 4) AzCH offers SAMHSA-recognized Question, Persuade and Refer (QPR) Suicide Prevention Training, and in conjunction with AHCCCS, we will offer QPR, building on our success of training nearly 3000 people on QPR over the last four years**.** 5) For members with a suicide attempt, we leverage our Pyx mobile app, which provides 24/7 companionship via a mobile platform. Pyxir, a chatbot personality, checks in daily to encourage self-management, identify SDOH needs, and provide companionship. Since March 2021, members who use Pyx Health experience a *79% decrease in suicide attempts and a 78% improvement in loneliness scores*. **Strategy: Expanded Access to Benefits and Employment.** Some members lack financial resources due to low/no income, and we help eligible members gain disability benefits by encouraging SOAR certification. AZ's SOAR disability application approval rates *exceeded national levels by 9%,* and through our IHH SOAR partnerships, our data showed a *450% increase in member's SOAR participation* from 2019-20. Four IHHs now have SOAR-certified specialists, and, in partnership with IHHs, we will expand SOAR to at least one site at all South IHHs by 10/1/24. AzCH also works to increase member engagement with RSA/VR, with a goal to increase ISPs with RSA/VR and reduce members dropping out of the program. While AzCH's current engagement rate is 3.4%, all RBHAs experienced a downward trend during the pandemic, and AzCH was one of two RBHAs to trend upward in member referrals since April 2020. AzCH partnered with Old Pueblo Community Services (OPCS) and other community stakeholders, such as the City of Tucson, to launch the Tucson Homeless Work Program (HWP), which gives unhoused individuals access to immediate work. Most participants have a BH, substance use, or other chronic health condition. Begun in 2017, AzCH provided seed funding, and HWP provided *paid work for over 800 homeless persons; 32% secured housing, and 25% enrolled in ongoing employment services*. We continue to support this innovative approach.

c. Aligning Services to Individual Strengths and Needs – Central GSA

In alignment with the Nine Guiding Principles for a Recovery-Oriented Adult System of Care, AzCH builds and manages a system of care that ensures members have the opportunity to develop their own goals and choose services that align with their strengths and needs. We empower members to self-refer, equip them with tools to map their own recovery, and build community capacity to offer high quality, evidence-based services such as peer and family support, supported employment, permanent supportive housing, and assertive community treatment. If awarded the Central GSA, we will utilize this same approach which has led to successful outcomes in the South GSA.

Open Networks to Improve Access to Peer- & Family-Run Organizations.

AzCH will immediately implement our Voice and Choice approach in the Central GSA, supporting member self-referral and eliminating the current referral system in place in the Central GSA, which poses barriers to care.

Understanding the Problem. Over the summer, AzCH held forums with P/FRO leaders in the Central GSA. It was reported that when a member reaches out to the P/FRO first (self-referral), they must contact the assigned clinic for an official referral and put services on hold or risk not getting paid until the referral and updated ISP is received, which can take several months. Oftentimes, the ISP comes back with inaccurate descriptions or codes, which adds lag time.

Strategy: Supporting Self-Referrals. Through AzCH's Voice & Choice approach, a member can self-refer to any P/FRO. As the window of engagement is often very small, we encourage P/FROs to engage members immediately instead of waiting for a referral. We understand that the paperwork timeframe often exceeds the window of engagement. We encourage P/FROs to be licensed to provide their own assessments or to hire independently licensed BHP assessors to complete assessments and begin providing services while coordinating with the IHH, eliminating unnecessary lag time and avoiding the assigned clinic becoming the gatekeeper. To further streamline the referral process, AzCH will work with contracted providers to utilize the Rovicare™ web-based care coordination and information exchange tool.

Strategy: Provider Training and Access to Data to Shift Perceptions and Focus on Outcomes. AzCH will educate BH providers before contract go-live and regularly remind them about Voice & Choice, including a presentation at the first BH Provider CEO meeting. We will establish a Bi-Annual P/FRO Outcomes Report to be shared with P/FROs and presented during BH Provider CEO meetings to build awareness of P/FRO effectiveness. We will use outcome reports to drive targeted P/FRO performance improvement projects and identify areas of excellence and specialization within and across all P/FROs. AzCH will offer education to help providers understand distinct differences between peer and family support.

Targeted Efforts to Increase Utilization of Family Support.

The adult system is lagging in use of family support due to factors such as requirements that family support be added to the member's ISP. If the member does not want family involved, they often reject the idea of adding family support to their ISP. Many outpatient clinics do not regularly consider or discuss family support and its benefits. There is a common misperception the member must sign a Release of Information for the family to access family support which is inaccurate. Finally, there is a lack of workforce accessibility. At onset of the Central GSA contract, we will replicate a Care Management solution that promotes near real-time member engagement. Our process includes proactive Care Manager outreach to discuss member's needs or goals and assist in accessing services in the ISP, emphasizing engagement with Family-Run Organizations. A new Care Management workflow will be implemented to identify individuals who have been petitioned for COE/COT, so the family can be connected to a credentialed Parent/Family Support Provider (P/FSP) who specializes in working with families whose loved ones are going through COE/COT and understands how traumatizing the experience can be for the member and family. Through our partnership with the Peer & Family Career Academy, we will offer advanced certification courses to P/FSPs to specialize in COE/COT-related family support.

Strategy: Family of Choice. AzCH will offer focused education and launch an educational campaign on family of choice. Family is defined by the member. All members should be asked who they want involved in their treatment/treatment planning, and natural supports should be offered family support.

Strategy: Investing in Workforce Capacity. AzCH is invested in bringing a standard of care to family support and raising the bar for continuing education expansion. We invested more than $50,000 in the Peer & Family Career Academy this year, with a commitment for nearly $40,000 more over the life of the contract. The Peer & Family Career Academy will use this funding for new professional development and advanced certification courses and develop a statewide network of Peer and Family Support Specialists to support learning communities, professional networking, and informal coaching.

Additional Interventions and Resources.

Strategy: Meaningful, Member-Driven Goals. AzCH will require providers to use tools such as the Member Recovery Planner and SDOH Screening Tool to identify and address members' self-defined strengths, needs, and goals. We will provide guided tools to P/FROs to assist members to build their own AzCH Peer Related Self-Directed Recovery plan. AzCH will offer a Personal Recovery Navigator (PRN) program by 10/1/22, assigning a provider-based PRN to every member newly determined SMI to ensure the development of meaningful, member-driven goals, support the member during the transition, and enhance provider accountability. The PRN position will be filled by credentialed Peer and Family Support Specialists with advanced certification from the Peer & Family Career Academy. The PRN will enhance member orientation and offer supported navigation. They will discuss the member's family of choice and connect with family support through a FRO as desired, inform the member about peer support, and connect them with a PRO that specializes in areas that best align with the member's interests and goals and ensure the member is connected with a health home. The PRN will support the member through initial ISP planning process and advocate on their behalf when necessary. Once the member has their ISP in place and is connected with services, the PRN will provide check-ins at set intervals to ensure the member is satisfied with their ISP and progressing toward goals. If the PRN identifies issues, they directly alert AzCH's Care Management team and trigger Care Management involvement. **Strategy: Inpatient Peer Supports.** In 2019, we piloted the Hospital Engagement and Linkage Peer Program (HELPP) program to reduce readmissions by improving coordination between the member, hospital staff, PCP, health home, and AzCH. We have seen a *14% reduction in BH inpatient admissions and a 9% reduction in BH readmissions in the past year*. HELPP employs Peer Support Specialists who meet with members before discharge to assist them in understanding their treatment and resource needs. We will expand HELPP into additional Central GSA locations. **Strategy: Incentivize BH Provider Engagement.** AzCH BH VBP agreements align incentives on PCP engagement for Health Homes/FQHCs and piloted P/FRO VBPs, so they collaborate to achieve shared goals. **Strategy: Enhanced Care Coordination.** Rovicare will play a large role in ISP creation and coordinate data collection by enabling providers (including those without an EHR) across provider types to rapidly access and update an ISP to reflect member's preferences and needs. AzCH will ensure providers have access to training, education, and understanding to work with members to customize ISPs. We will provide technical assistance with an emphasis on strategies and interventions to enhance performance through ongoing monitoring. AzCH will contract with newly formed Central GSA BH ACOs, and participate in their QI activities to collaborate on interventions. We will require ACOs to include an ISP improvement project as a core quality focus.

ISP Compliance Oversight.

AzCH will continue to monitor ISPs through medical records audits. During audits, we will give feedback to providers on improving documentation to ensure goals and interventions are member-specific and family supports are offered. For example, we may share feedback on the importance of having a seasoned supervisor to support case managers. AzCH has a robust PDSA-based process improvement protocol model to identify, implement and test strategies to improve overall ISP compliance. AzCH will comply with the finalized AHCCCS Case Management Policy (AMPM 570), which will result in AzCH adding staff, systems, and processes to conduct required oversight.

Compliance with Arnold v. Sarn Requirements. AzCH has gone above and beyond in its approach to monitor fidelity of implementation and educate members and providers on EBPs required by Arnold v Sarn: ACT, Supported Employment, Permanent Supportive Housing, and Peer & Family Support Services. For example, the AzCH fidelity team works with the AHCCCS contracted fidelity auditor (WICHE) to review all 5 ACT and Forensic ACT teams in the South GSA. Our supportive approach includes individualized technical assistance and bringing together EBP providers to build learning collaboratives. We regularly educate hospitals, courts, and others on the value of ACT and how to access services. We have built a flag into our TruCare system that alerts Adult Recovery Team participants that a member receives services from ACT. We will replicate our supportive monitoring and proactive education process in the Central GSA. **Monitoring:** Prospective controls include 1) Updating internal and training for AzCH staff and providers; 2) Refining Provider Manual language to require providers to track Arnold v Sarn metrics; 3) Credentialing contracted providers; 4) Performing monthly sanction screening reviews and excluding prohibited parties; and 5) Modifying tools used in the South GSA to capture the unique needs in Central GSA. Concurrent controls include provider training and technical assistance, as needed. Retrospective controls include 1) Annual Medical Record and Data Validation Audits; 2) Reporting audit results to AzCH's Quality Improvement Committee; and 3) Leveraging AzCH's Special Investigation Unit to mine and analyze data to identify potential fraud, waste and abuse.

B6. For each of the following topics below, describe the single most impactful initiative…

a. Contractor Care Management – Schizophrenia Spectrum Disorder Wellness & Recovery Program

Opportunity. AzCH RBHA members with Schizophrenia Spectrum Disorder (SSD) have higher ED utilization rates related to congestive heart failure (CHF), diabetes, and COPD – nearly twice that of members without SSD, and 53% have a co-occurring substance use disorder (SUD). Although persons with SSD make up 38% of the entire RBHA population, they account for nearly 76% of inpatient stays and are at increased risk of cardiovascular diseases and diabetes as a side effect of taking antipsychotic medications. To improve health outcomes, early screening and monitoring of these conditions is critical. We developed the Schizophrenia Spectrum Disorder Wellness & Recovery Program (SSDWRP) to respond to this need – building on the success of our existing chronic condition management programs, which achieved decreased hospitalizations for RBHA members with COPD by 33% and with diabetes by 43% from Q2 2020 to Q2 2021.

Most Impactful Initiative/Effort: Schizophrenia Spectrum Disorder Wellness & Recovery Program (SSDWRP)	
Purpose	(1) Increase members' ability to self-manage chronic conditions through person-centered wellness and recovery interventions, (2) Improve BH and PH medication participation, and (3) Improve utilization and chronic condition outcomes by addressing barriers to care.
Population	The program serves members with SSD and co-occurring chronic PH conditions based on a risk stratification model that factors in data elements such as ED utilization; inpatient visits; inpatient lengths of stays; justice involvement; court-ordered treatment; and/or SDOH codes for physical or sexual abuse, housing insecurity, food insecurity, educational, or employment needs.
Anticipated Outcomes	• Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia: 4.5% increase (target 77%) • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: 10% increase (target 85%) • Diabetes Monitoring for People with Diabetes and Schizophrenia: 8% increase (target 71%) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia: 5% increase (target 61%)
Status	Existing Program – Launched June 2021

Initiative Description. SSDWRP provides education, health coaching, and practical self-management tools.

Specialized Staff. SSDWRP staff from the AzCH dedicated SMI Care Management team includes RNs and behavioral health medical professionals (BHMPs). Staff complete training on the evidence-based Personal Medicine model (developed by Dr. Pat Deegan and meeting SAMHSA's criteria for Recovery-Based Practice), which promotes self-management and member choice and has been proven to increase activation, supporting Guiding Principle 2**.** Staff also complete training in cognitive remediation therapy to enhance self-management supports, using non-pharmacological methods to improve cognitive function. All SSDWRP staff have completed the University of Arizona's Integrated Care Coordination certificate program and are skilled at engaging members and coordinating care. Staff collaborate with the member's integrated health home (IHH) and specialty providers and make referrals to evidence-based Peer Whole Health programs offered through Peer-Run Organizations, such as Hope. They offer providers technical assistance and coaching on the Personal Medicine model and ensure ongoing services from the member's IHH.

Self-Management Supports. SSDWRP consists of four self-management components, delivered using motivational interviewing and principles of trauma-informed care: (1) psychoeducation and cognitive remediation tips; (2) recognition of early relapse warning signs and development of a relapse prevention plan; (3) coping skills; and (4) setting recovery goals. Members graduate from SSDWRP when the member and their Adult Recovery Team determine the member can self-manage conditions and has decreased ED and inpatient use and increased medication participation.

Health Education. We educate members on risk reduction, self-management skills, simple activities to improve cognition, and accessing services and community resources. We provide education on SSD symptom management such as identifying triggers, the importance of exercise and self-care, Wellness Recovery Action Planning, and medications. We coordinate with pharmacies for medication optimization and education on long-acting injectables. We use the American Diabetes Association's Diabetes Action Path and the American Lung Association's guide to managing COPD.

Technology Supports. Digital tools to reinforce self-management and education include: 1) a Medication Participation App from Wellth that reinforces healthy choices via daily check-ins and incentives, 2) Digital Health Connect, allowing members to securely communicate with their Care Managers and monitor goals, and 3) Pyx Health, which reduces social isolation through daily engagement, identifies SDOH needs and links members to AzCH for follow up.

Monitoring and Evaluation. We monitor progress towards anticipated outcomes via monthly utilization management reports, screening and assessment results, member and provider reports, pharmacy utilization, and predictive modeling and risk stratification results. Our QM/PI tracks preventable ED and hospital admissions and medication participation.

b. Provider Case Management – Mobile Engagement Extension Team (MEET)

Opportunity. While all our Integrated Health Homes (IHHs) offer community-based services, our Provider Advisory Group identified the opportunity to restructure case management teams and workflows to best support the delivery of services where people live, learn, work, and socialize. MEET is an evolution of the IHH based on lessons learned during the COVID-19 pandemic, shifts in the way people prefer to engage in care, the profound increase in people experiencing isolation, and the need to improve accessibility in rural communities.

Most Impactful Initiative/Effort: Mobile Engagement Extension Team (MEET)	
Purpose	To improve engagement by decentralizing care and extending services beyond the walls of the clinic with a mobile model.
Population	MEET will be available to RBHA members who choose this care model. We anticipate serving approx. 6,000 members in Year 1.
Anticipated Outcomes[1]	• ED utilization – 8% reduction • 90% 7-day follow up after hospitalization; 95% 30-day follow up after hospitalization • Member satisfaction scores – 5 Stars
Status	New Program – Provider Collaboration for Program Development Began May 2021, Launch Date of October 2022

Initiative Description. MEET offers clinical and non-clinical services through an integrated model in community settings while revolutionizing our approach to provider-based case management. Provider case management here is part of a comprehensive program. MEET is an embodiment of Adult Guiding Principle 1 – *we use respect as the cornerstone and meet the person where they are without judgement, with great patience and compassion.* In partnership with Spectrum Healthcare, the MEET pilot will include a full Mobile Health Home Model and an Extender Model.

Full Mobile Health Home. Leveraging the success of Spectrum's *Anywhere Care Teams*, the Full Mobile Health Home will include a partnership between Spectrum, Escalera Health (an IHH), Hope (a peer-run organization (PRO)), and a family-run organization (FRO). Staff will include a multidisciplinary team of BH and PH professionals and case managers, 95% of whom will be completely community-based. Case managers will include BH specialists, peer support specialists, parent/family support providers, RNs, community health workers, social workers, SUD specialists, and SDOH specialists. Escalera PCPs and psychiatrists may connect with members virtually, while a MEET case manager is with the member to support them during virtual connections. MEET case managers provide in-person technology skills training, access to a device when needed, and assist with internet connectivity. Inclusion of P/FROs as part of the team will improve access to peer and family support and a broad array of psychosocial rehabilitation services. All partners will work through a single electronic health record, participate in daily team huddles, and function as a single integrated team.

Extender Model. As a supplement of our Full Mobile Health Home model, our MEET Extender Model will be deployed in partnership with an FQHC, such as Chiricahua Community Health Center, who is looking to enhance their ability to provide whole-person care to the SMI population. The MEET Extender Team will be an extension of the FQHC – enabling the provider to supplement their current staff to increase field-based service delivery while maintaining PCP assignment.

Service Provision. MEET teams will screen, assess, coordinate care, treat, and connect members to local community resources as needed. MEET can serve as the primary PCP for members or coordinate with a member's established PCP. MEET targets barriers to care that are keeping members from receiving needed services, with a strong emphasis on addressing SDOH needs. This can include things like assisting with job searches, transportation assistance, coordinating with food banks and shelters, and more. MEET offers *Just In Time* scheduling to avoid the long wait times that typically result from traditional scheduling; rapid response to hospitals to coordinate discharge needs and close gaps in post-discharge follow-up; and community outreach to places where people gather, such as food banks and homeless shelters. Case managers bring a mobile kit to all field visits, including things such as diagnostic testing and vital sign equipment.

Training. MEET staff will participate in Pat Deegan's evidence-based *Medication Empowerment* training, promoting a collaborative approach for decision-making and medication management with tools to support people on their journey.

Scalability. Before April 2023, we will implement two more MEET Health Homes—one in a rural setting and the other in an urban setting—chosen based on health equity data. MEET providers will participate in our VBP model which includes a combination of fee-for-service, shared savings, shared risk, and shared incentive payments with participating P/FROs.

Monitoring and Evaluation. AzCH will convene a MEET Steering Committee prior to 10/1/2022. The Committee will be comprised of peers, family, participating providers from awarded regions, and AzCH program leaders. The Committee will receive pilot program utilization, member/family satisfaction, and outcome data monthly from our QM Department. Meeting quarterly or as needed, the Committee will drive program adjustments and enhancements using a PDSA cycle.

[1] Anticipated outcomes are based on early and promising outcomes data from current Spectrum *Anywhere Care* teams.

c. Outreach & Education – 4Peers Outreach & Education Program

Opportunity. The national average 11-year delay between BH symptom onset and treatment indicates a need for proactive community-based outreach and education. Through provider feedback, AzCH recognized that providers experience barriers in outreaching those who are disconnected or hard to find, especially those who are unhoused, due to taking time away from clinical service delivery and inability to bill for time spent searching for people. Through our 12-month longitudinal study of the impact of peer support (published in 2018), we confirmed what national research already tells us – peer workers generate better outcomes in terms of outreach – with members participating in peer-delivered services demonstrating as much as a 55% decrease in crisis utilization. Leveraging our investment in the peer workforce, we established and continue to support and fund the 4Peers Outreach and Education Program.

Most Impactful Initiative/Effort: 4Peers *(formally known as Outreach Specialist Program)*	
Purpose	4Peers is a peer-delivered program with four key components: 1) find individuals who need support, 2) build trust by addressing immediate needs – such as providing water or access to a shower, 3) provide health education, and 4) link to resources.
Population	At-risk individuals with SMI (including those with co-occurring SUD) who are disconnected from services, including unhoused individuals, veterans, individuals who are pregnant and/or parenting, and members at risk for SUD/overdose.
Outcomes	• From May 2020 – May 2021, 4Peers Outreach Specialists contacted 15,101 individuals in the community – connecting to resources and providing health education; similar reach expected in future years within all GSAs awarded • Members connected to housing through 4Peers have consistently shown improvement in engagement with preventative care and decrease in preventable use of higher levels of care. For example, for members who entered housing in 2019, we saw a 45% decrease in ED utilization, a 46% decrease in utilization of crisis services, and a 56% increase in PCP well visits.
Status	Existing Program – Launched in 2015 as Outreach Specialist Program with expansion in 2017 and further enhancements in 2021

Initiative Description. 4Peers Specialists start from *a foundation of trust* to build *compassion-based alliances* - Adult Guiding Principle 6. They work alongside police, first responders, the Department of Child Safety, and others to connect with people in the community and provide system navigation supports and health education. Using their in-depth knowledge of local resources, 4Peers specialists educate members on needed services using health promotion with a focus on increasing health literacy. 4Peers specialists go to parks, churches, food banks, and street corners, where they are likely to find individuals in need of support. Targeted outreach efforts are driven by community-identified needs. For example, when Pima County Health Department reported an increase in overdoses in a specific zip code, AzCH rapidly responded to this community health need by working with the 4Peers program to increase outreach efforts in the identified zip code. A partnership was forged with the Tucson Police Department (TPD), with 4Peers Specialists accompanying police to homeless encampments. Due to the success of this partnership, TPD requested expanded collaboration through 4Peers participation in the TPD Drug Marketing Intervention program.

Member Education. Once a 4Peers specialist engages a member, they provide education on available resources, healthcare services, SUD, impacts of COVID-19 and vaccine hesitancy, benefit eligibility and AHCCCS applications, self-care, housing, employment, personal hygiene, food resources, and medical care. They educate members on recovery, how to access care, and making informed choices regarding services.

Partnerships. We deliver 4Peers through a partnership with CBOs, opioid treatment providers, and 24/7 MAT providers. Our contracted 4Peers providers include HOPE, TLC Recovery, Sonoran Prevention Works, Community Bridges, Inc., CODAC, PPEP, Community Health Associates, COPE, and Community Medical Services.

Training. AzCH contracts with the Peer & Family Career Academy to offer advanced certification to 4Peers Specialists, supporting a career ladder for skilled integrated care workers. Trained in evidence-based practices, 4Peers specialists are skilled at Motivational Interviewing, SDOH screening, use of VISPDT to prioritize housing needs, and assessing risk through tools such as the Columbia Suicide Severity Rating Scale.

Monitoring and Evaluation. AzCH obtains monthly and ad hoc deliverables from 4Peers providers such as: number of contacts, referral tracking, and AHCCCS's required OUD/SUD co-occurring outreach deliverables. We initiate technical assistance meetings when needed. We hold a 4Peers provider meeting and thought exchange quarterly to discuss successes, barriers, and new innovations and/or partnerships. The following member story reflects the impact of 4Peers:

AzCH Member Story: Donna
A 4Peers Specialist located a member, Donna, who was unhoused and disconnected from services. Using motivational interviewing to uncover Donna's immediate needs, the 4Peers Specialist took her to Grace St. Paul's, in Tucson, for food and a shower. Donna reported having an SMI and being off medication for about a year. She said she used opiates and stimulants and expressed fearing for her life. The 4Peers Specialist utilized de-escalation strategies and provided education on BH services, self-care, and medication participation. The 4Peers Specialist then linked Donna to Cornerstone BH for detox services and has continued meeting with her for continued rapport building while at Cornerstone.

d. Stakeholder Input – AzCH Community Consensus Collaborative (C3)

Opportunity. Stakeholders tell us they often feel MCOs across the state are *listening*, but that their feedback is not always being *acted upon*. AzCH has a track record of bridging feedback to immediate action. Going above and beyond AHCCCS required regularly occurring meetings with key stakeholders, we currently receive, process, and respond to stakeholder feedback from nearly 90 different formal and informal mechanisms – including sources such as member and family focus groups and advocacy councils, regularly occurring stakeholder meetings such as quarterly county-specific crisis meetings, one-on-one system partner outreach, subject matter specific advisory boards such as the COE/COT Advisory Board, community forums and surveys, provider advisory groups, and monthly integrated provider calls. We recognize the need to bring these varied sources of information together to identify common trends and to de-silo efforts and solutions. For example, an issue that the crisis providers are experiencing may be impacted by something the Member Advocacy Council is working on and may also benefit from collaboration with faith-based groups. When problems and solutions are only worked through the lens of stakeholders in a single sector, the opportunity for cross-departmental efforts and collective impact to improve the system can be missed. AzCH's Community Consensus Collaborative (C3) builds consensus around the feedback loop by bringing together disparate groups who may have different perspectives, with no single group having a bigger seat at the table than the others. We have already activated our stakeholders and seek their feedback regularly, and now we are going to build the culture of consensus-based action focused on reducing PH, BH, and SDOH disparities.

Most Impactful Initiative/Effort: AzCH's Community Consensus Collaborative (C3)	
Purpose	To eliminate silos found in traditional input strategies, bring diverse perspectives together from across stakeholder groups and subject areas, and implement concrete, system-wide action based on stakeholder feedback received throughout the year.
Population	The C3 will include key representatives from various stakeholder groups identified through Stakeholder Mapping, including but not limited to members, families, business leaders, providers, tribal representatives, advocates, the justice system, first responders, government agencies and officials, and community-based organizations – such as non-profits and faith-based groups.
Outcomes	The C3 will result in a C3 Action Plan to address key community needs impacting people with SMI – with various stakeholder groups working together to achieve measurable goals and complete clear action steps.
Status	New Initiative – Will Launch October 1, 2022; built from the nearly 90 existing mechanisms for gathering stakeholder input today

Initiative Description. The C3 uses a proven consensus-based planning approach to gather feedback, evaluate and organize feedback, work with community representatives to build solutions based on feedback trends, and monitor the implementation of the solutions. Building upon the lessons learned from *AZ Dialogues*, which brings people together from differing perspectives to engage in reflection and dialogue, we now bring our activated stakeholders together from across subject matter areas to engage in thought exchange and join forces for action. Feedback is tracked and trended across stakeholder groups and from various sources throughout the year. We capture and feed this information into an organization wide C3 Dashboard. Two to three stakeholder feedback trends pointing towards system wide issues will be identified each year to become the area of focus and action planning during the C3. The C3 will take place two times per year, with rotating accessible locations in each contracted GSA. The first C3 of each year will focus on developing a C3 Action Plan based on the top two to three system issues identified via the prior year's feedback mechanisms and dashboard. The second C3 of the year will focus on assessing progress towards C3 Action Plan goals, addressing barriers, and refining objectives as needed. The C3 will not replace existing stakeholder feedback mechanisms, but instead is designed to offer a culmination of feedback and opportunity for community members to collaborate so that 'all ships can rise to the same level.' Our inaugural C3 will focus on stigma reduction and value-based purchasing, as identified by our most recent stakeholder input trends.

> "AzCH is an asset to the communities they serve as they are collaborative, meaningful, and offer leadership to community providers, so that members get the services that they're seeking."
> **- Dan Haley, CEO, HOPE**

Supporting Members & Family. AzCH will offer training to members with SMI and family to help them feel confident in participating in this type of broad-based collaborative. We will sponsor NAMI Smarts for Advocacy for C3 participants, helping to bring this hands-on training program to AZ for the first time.

Monitoring and Evaluation. When a solution is identified at the C3, we will collaborate with C3 participants to define key metrics measured at an agreed-upon frequency and length of time. We will incorporate action items from the resulting C3 Action Plan into our AzCH Strategic Plan and QMPI plan. If metrics are not improving, we will refine the solution or mitigate risks to implementation. We will publish progress and updates to the C3 Action Plan to ensure full transparency. AzCH will review solutions and tracking plans with the Member/Family Advocacy Council and feed them into other standing committees and subject matter workgroups to ensure accountability to all stakeholders.

e. Justice System/Justice Involved Individuals – Reciprocal Collaborative Data Sharing (CDS)

Opportunity. Through the AzCH justice team's work with the community, we recognized a need for refined and efficient data sharing beyond member demographics. Through years of relationship building with justice system partners, we identified data elements that, if shared, could support reentry programming, compliance with court mandates, and improvement in overall health outcomes. AzCH took a collaborative approach, working together with justice system partners to design and adapt a reciprocal CDS system and process that works for each partner. CDS helps connect people to preventive services, reduces recidivism, and creates a *foundation of hope for the journey towards recovery and community reintegration post release* - Adult Guiding Principle 9.

Most Impactful Initiative/Effort: Reciprocal Collaborative Data Sharing (CDS) with Justice Partners	
Purpose	To effectively and proactively help our justice partners and providers better engage and serve members as they enter and move through the justice system while reducing administrative burden by facilitating reciprocal data sharing.
Population	The CDS initiative pertains to members with SMI who are justice involved, impacting 621 members from July 2020 to June 2021.
Outcomes	• Increase in members with SMI engaged in preventive services upon release and while in probation • As of May 2021, our CDS agreement with the probation departments has resulted in the following percentages of members with SMI engaged in preventive services: Pima County 90%; Pinal County 97.8%; La Paz County 100%; Yuma 100%. In Pima county, we have increased our engagement ratio by 50% through CDS. We anticipate similar outcomes in awarded GSAs.
Status	Existing Program – Began in 2018, with expansion and near system-wide participation by Q4 2019

Initiative Description. AzCH's CDS approach exceeds AHCCCS requirements and what other MCOs are doing today. Based on SAMHSA GAINS Center's Sequential Intercept Model (SIM), CDS enables us to identify resources and gaps in services at each member touchpoint with the justice system in order to link to services as appropriate. AzCH has established CDS agreements with partners across the justice system. For example, we have fully executed agreements with Pima, Pinal, Yuma, La Paz, and Santa Cruz, allowing appropriate access to the AzCH Community Partner Portal (CPP) for the jail medical providers and giving us line of sight on 90% of all persons detained in county facilities in the South GSA. We are working with Cochise and Maricopa Counties to enact similar agreements by Spring 2022. As a trailblazer, AzCH's CDS agreements have led to justice-involved stakeholders increasing work with other MCOs (e.g., another MCO scaled our CDS agreement with the probation department in Yuma).

CDS at Initial Detention/Court Hearings: Pima, Pinal, Yuma, and La Paz Counties share daily booking files, which we match to our member roster. We then share SMI determination, COT status, and provider information with jail medical staff. We share prescription data and additional provider information via our CPP, supporting care coordination and medication continuity. Prior to Initial Appearance hearings in Pima County, AzCH contracted jail liaisons provide member eligibility for mental health specialty courts to the court clerk, encouraging diversion to treatment.

CDS with Jail and Courts: AzCH uses direct jail data for early identification of members, to locate scheduled release dates, and initiate contact for reentry planning with our Reach-In Program. This enables early coordination to support the member's transition back to the community, increasing the likelihood of successful reentry and reducing recidivism.

CDS at Reentry: We receive scheduled release files from participating jails daily and match to our membership, strengthening reentry coordination with providers before release. Along with scheduled release dates, we communicate specialty referrals for SUD needs and forensic peer support services to Reach-In staff.

CDS with Probation: We receive monthly probation rosters from La Paz, Pima, Pinal, and Yuma Counties and are the only plan to receive a roster from the Maricopa County Adult Probation's Community Reintegration. We match probation rosters with the AzCH membership roster and provide health risk, care gap, and service engagement data to the respective probation department as approved through county Administrative Orders. We are currently the only plan analyzing member services and engagement relative to criminogenic risk to create tailored supports.

Monitoring and Evaluation. We hold monthly meetings with each CDS partner to review trends, member enrollment, and opportunities. Internally, we review pre- and post-detention reports, service tracking reports, and claims data. We collaborate with partners to identify opportunities to improve and expand data elements reported and the CDS process.

AzCH Community Partner

"Our data sharing agreement with AzCH allows us a window we have never had before. We are now able to see when a negative pattern develops in a probationer's service history and assist the provider in re-engaging the person quickly. CDS helps us to address a probationer's criminogenic needs while allowing us to see the dosage of key BH services. In my 30 years of experience in adult community corrections, this is the first time this crucial information has been made available. This shared approach could be a model for both community corrections agencies and the BH system to more effectively collaborate to improve mission critical outcomes. We look forward to continuing and growing our partnership with AzCH."

- R. Brian Colgan, Division Director, Pinal County Adult Probation

f. Court Ordered Treatment – Connections to Care Program

Opportunity. Approximately 90% of AzCH members on COT have an SMI designation. As of July 2021, 1,256 AzCH members are receiving COT. Through data analytics, we identified most of these members have outstanding gaps in care including screenings, A1C testing, well-checks, and BH appointments. AzCH launched Connections to Care to close gaps in care with the greatest impact on member health. For example, SMI is associated with increased risk for type 2 diabetes, resulting in elevated cardiovascular risk and limited life expectancy. People with long-term schizophrenia are three times more likely than the general population to have diabetes, and schizophrenia is associated with a significantly increased risk of breast cancer incidence in women. In response, Connections to Care focuses on improving outcomes for two specific measures:

- **A1C testing:** 64.12% of COT members who have diabetes had an open care gap for A1C testing
- **Breast Cancer Screening:** 81.25% of COT members who are eligible for breast cancer screening had an open care gap

As an embodiment of Adult Guiding Principle 3 – we recognize that COT presents an opportunity to *focus on the individual as a whole person*, and we utilize this time to address care and support needs that go beyond the original presenting reason for COT. AzCH has been conducting annual COT reviews, Behavioral Health Medical Professional (BHMP) visit compliance reviews, and continued COT reviews for 10 years. *We achieved a 97% compliance rate with reviews across our COT provider network.* We developed Connections to Care to continue positively impacting whole person health outcomes based on identified gaps in care.

Most Impactful Initiative/Effort: Connections to Care Program for Members on Court Ordered Treatment (COT)	
Purpose	*Connections to Care* aims to close care gaps for individuals on COT. It supports providers in connecting members to preventive services, avoiding escalation of chronic condition symptoms.
Population	Members on COT, with targeted focus on those with SMI who have increased risk for care gaps
Outcomes	• We expect to achieve statistically significant increase in closure rates for A1C Testing and Breast Cancer Screening care gaps. • Although the program recently launched in April 2021, we are already showing positive results. In just this short time we have demonstrated a 100% closure rate increase for A1C Testing and a 48% closure rate for breast cancer screening. We expect to see consistent outcomes in all awarded GSAs.
Status	Existing Program – Launched April 2021

Initiative Description. As a proactive system, we do not wait for events to spark action; we work to predict and prevent negative health outcomes for members on COT. Connections to Care closes care gaps and increases access to preventive care services for members with acute needs who are reluctant to engage in care. The project holds providers accountable for engaging members on COT in care in all 10 counties we serve. Connections to Care leverages the experience of our COT Team and Quality staff. We analyze time-sensitive data with member history to identify needs and stratify members on COT in real-time, pushing daily insights and care gaps to the attention of our contracted providers immediately.

> **Connections to Care Impact**
> We have demonstrated a **100.4% increase** in gaps closed for A1C Testing and **a 48% closure rate** for breast cancer screening.

Collaborative Design. In March 2020, AzCH identified the care gap measures in partnership with our QI Team. We then met with every outpatient provider in the southern GSA which serves members on COT to collaboratively design the Connections to Care program, get buy-in, and minimize administrative burden.

Gap Identification & Closure. The AzCH COT team receives a monthly list of members on COT generated through partnerships with outpatient providers, the courts, and inpatient facilities. The QI Team then pulls utilization and care gap data from claims monthly for those members currently on COT. The COT team sorts and sends the information to the respective outpatient providers for review and highlights the care gaps. To close the loop, providers report the date of care gap closure back to us, which means we do not have to wait for claims data to act. The member's AzCH Care Manager works with outpatient providers to ensure care coordination and care gap closures.

Scalability. Based on promising early outcomes data and positive provider feedback, we are planning to scale this program across all awarded GSAs. We are working with outpatient service providers such as La Frontera to generate scalable COT care gap closure best practices to help ensure continuity of care for all members regardless of outpatient provider assignment.

Monitoring and Evaluation. AzCH's COT team, the Director of Justice and Crisis, and the QI Manager jointly evaluate the effectiveness of our processes with the QI Team through auditing and reviewing our COT care gap data and case files monthly. We continue to conduct our monthly COT audits to ensure members meet with their BHMP's each month, which further supports care gap closure and care engagement.

g. Dually Aligned (Medicare and Medicaid) Members – Rural Intensive Case Management Program

Opportunity. Compared to the general Medicare population, members who are dually eligible have more significant health and functional support needs. Rural areas often lack specialty services and have SDOH gaps like food deserts and inadequate/non-existent public transportation. Our Rural Intensive Case Management Program was designed specifically to support members with high needs in rural areas.

Most Impactful Initiative/Effort: Rural Intensive Case Management Program	
Purpose	Through the AzCH Rural Intensive Case Management Program, we use high-touch supports and home-based care to close health and SDOH care gaps, decrease avoidable ED and inpatient utilization, and maintain Medicare and Medicaid alignment.
Population	Medicaid and Medicare dually eligible members with an SMI designation who live in rural communities
Outcomes	• We expect to continue to achieve statistically significant decreases in hospitalization, readmission, and ED visits. • AzCH RBHA members served through the Rural Intensive Case Management Program benefited from a 60% decrease in 30-day readmission rates, a 10.2% reduction in hospitalizations and a 3% reduction in ED visits from CYE2020 to August 2021. • We anticipate similar results in all awarded GSAs.
Status	Existing Program – Launched October 2016

Initiative Description. The AzCH Rural Intensive Case Management Program is delivered through a provider contract with Adobe, an integrated provider offering in-home PH, BH, and SDOH care and support. In alignment with Adult Guiding Principle 2, dually eligible members with SMI can choose to work with Adobe with the flexibility of continuing care with other providers. Given access challenges in rural areas, Adobe comes to the member's home and helps them connect with other providers via telehealth when necessary. Adobe also offers extra support to providers – enhancing their engagement strategies, working collaboratively with primary care providers, coordinating specialty care, and offering insights related to proactive treatment. Our Rural Intensive Case Management Program currently serves 40% of AzCH's dually aligned members with SMI – providing field-based, integrated case management and close care coordination with AzCH Care Management staff. We have a *92% retention rate in our Medicare plan* for members who receive Adobe services, indicating member satisfaction and supporting continuity of care.

Monthly, we send Adobe a member eligibility file and initial risk stratification to identify members who would most benefit from our Rural Intensive Case Management Program, which offers individualized services including:

- **Integrated Case Management:** In-home case management services delivered by trained staff (e.g., LCSW, RN, LPN, NP, dieticians, care navigators); support with medication participation; member and family education.
- **SDOH Supports:** Linkages to community-based resources for employment/vocational training/education, interpersonal safety, housing, food, clothing, home repairs, transportation, and financial supports.
- **Transitional Care:** Relationships with inpatient facilities to allow for face-to-face visits from Adobe staff while the member is inpatient, discharge planning in collaboration with providers and AzCH, follow-up visits post-discharge.
- **Preventive Care:** In-home wellness assessments, immunizations, screenings (e.g., vision, colorectal, A1C, bone density), and medication reconciliation.
- **In-home Primary Care:** Management of chronic illnesses, palliative care, and acute episodes in-home.
- **Safety:** Home safety checks for working heat and air-conditioning, wheelchair accessibility, safety bars and ramps, mold, broken windows, the need for assistive technology, and creative supports for activities of daily living.
- **Outreach and Member Communication:** Wellness calls, health risk screenings, SDOH screenings, in-home assistance connecting with telehealth, member surveys, and health education, including chronic condition management.
- **Technology Supports:** Data analysis, predictive modeling, reporting, and a member dashboard to support the member's whole-health goals and proactive coordination with the care team.

Scalability. AzCH is positioned to expand this program within newly awarded GSAs. Our contracted provider, Adobe, is already established within rural communities across all three GSAs.

Monitoring and Evaluation. AzCH monitors the Rural Intensive Case Management Program through weekly utilization and health outcomes data and joint meetings with Adobe and our QI Team to review HEDIS tools and STARS ratings.

The following member story illustrates the impact of the Rural Intensive Case Management Program:

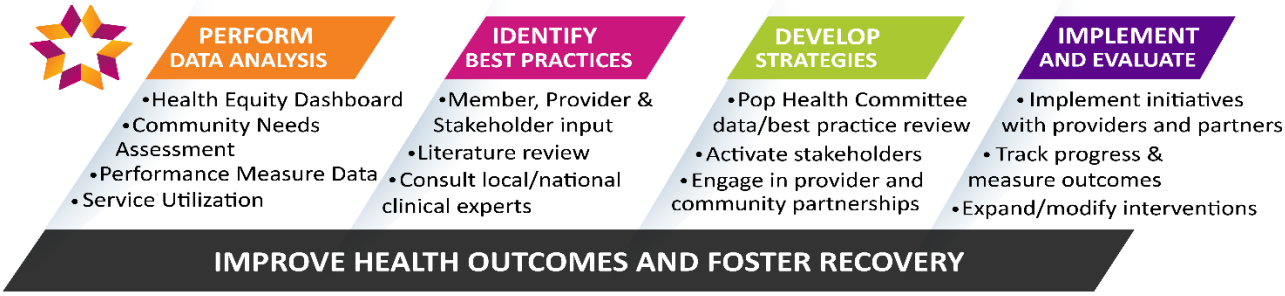
AzCH Member Story: David

Adobe integrated care staff began engaging with David, a dually enrolled member in Cochise County, while inpatient at Canyon Vista hospital with various presenting needs, including hypertension, diabetes, and depression. Adobe staff met with David face-to-face while inpatient to build rapport and support a comprehensive discharge plan. The Adobe case manager coordinated care and helped David transfer to the Haven - a more appropriate setting. The case manager continued to work with David and his family to develop person-centered goals and provide family support and education. Upon discharge, the case manager coordinated David's move to Louisiana to live with his daughter who actively participates in his care.

B7. Improving the system of care for individuals with SMI through innovation and best practices…

Since 2015, AzCH has applied a data-driven, continuous quality improvement process to advance the system of care for individuals with SMI. With input from members, providers, system partners, and oversight from our multidisciplinary Population Health Management Committee, we deploy best practices and innovative solutions to advance integration, serve members with co-occurring SMI/ SUD, increase access to evidence-based services, ensure equitable care, and increase member engagement. **Figure B.7-1** shows AzCH's systematic approach for improving the System of Care for individuals with SMI.

B.7-1. AzCH Systematically Improves the System of Care for Individuals with SMI.



a. Advancing an Enhanced Integrated Care Model to Improve Member Health Outcomes

AzCH has a goal to exceed the 90th percentile for the Follow Up After ED for a Mental Health/SUD condition measure for each contract year for members with SMI. We will achieve these goals by providing integrated support for members with chronic conditions, building provider capacity, and breaking down silos through innovative service delivery models.

Supporting Members with Complex Needs. We advance integration through our partnership with Catalytic Health Partners (CHP), which provides high-touch outreach for members in all GSAs with co-occurring BH and medical needs, SUD, and SDOH factors. CHP's field-based team of bilingual, multidisciplinary staff including nurse practitioners, medical liaisons, care coordinators, BH counselors, licensed clinical social workers, and case managers serving members in the community. The team meets members where they are (e.g., libraries, shelters) to deliver in-person, community-based services. *AzCH members receiving integrated care through CHP experience an average of 44% decrease in ED utilization, a 7% increase in PCP visits, and an 18% increase in medication participation*.

Integrating Care for Members with Co-Morbid Conditions. Using advanced analytics tools, AzCH identifies opportunities to improve care for members with SMI and chronic PH conditions. For example, our data showed that members with SMI often take medications that interact with their physical health medications, placing them at higher risk for sudden cardiac death. AzCH proactively mines data to identify members at risk for sudden cardiac death, informs their provider of the risk, and educates the provider on alternative medications. We coordinated with providers and disseminated BH, PH, and pharmacy data to reduce risks for 281 members with SMI in 2021. Through in-depth data analysis and committee monitoring, AzCH identified increasing IP length of stays and readmissions for RBHA members with PH conditions. Drill-down analysis revealed that multiple diagnoses codes related to skin infections, such as abscess and cellulitis, for members with IV drug use were the primary reason for this trend. Further analysis showed that these members were not receiving MAT after discharge, increasing readmissions and continued risk for infections. In response, AzCH implemented a fully integrated approach focused on treating the member's infection and facilitating early initiation of MAT services during the IP stay with continued services post-discharge. *Members experienced a 55% decrease in IP utilization with a corresponding 32% increase in primary care services and 52% increase in specialty utilization, leading to 22% PMPM cost savings.* Using advanced data analytics tools and feedback from members, providers, and stakeholders, AzCH will deploy these fully integrated initiatives based on member needs in each GSA.

Building Provider Capacity to Serve Member Whole Health Needs. AzCH enhances provider capacity to deliver integrated care via our unique partnership with Project ECHO. The BH Integration ECHO trains providers on BH integration topics such as MAT, opioids and chronic pain, intersection of trauma and chronic pain, and neonatal abstinence syndrome; integrating community and correctional health care; and needs of transgender youth. Provided at no cost, providers have access to an interdisciplinary healthcare team specialized in BH integration. To date, 544 unique provider participants from 28 clinics have engaged in the BH Integration ECHO, increasing their capacity to meet members' whole health needs. Our Psychiatric and Primary Care Consultation Access Line, which offers providers the opportunity to consult with peers to build their capacity to serve members with complex needs, is available 24/7 to help

providers build their knowledge related to integration. It enables consults between PCPs and specialists to increase provider capacity to meet member needs. In response to feedback from our Provider Advisory Group, which expressed the need for access to neurologists, AzCH will include a panel of subspecialists to include neurologists to consult with providers. AzCH will build on this process to develop GSA-specific learning collaboratives to give providers the opportunity to share best practices and effective strategies, expanding system capacity to serve members with SMI.

Overcoming Silos Through Integrated Network Innovations. AzCH listened and is acting on feedback from BH providers who voiced a desire to build provider-governed, clinically integrated organizations through an Accountable Care Organization (ACO) framework. By organizing as a BH ACO, providers work closely to increase timely access to care, deliver effective care coordination, provide transition support, and deploy population health management strategies at the practice level. AzCH will use our tailored approach to support provider partners, sharing needed data, tools, processes, and expertise. We have a letter of intent with our BH ACO partners, InterMountain Centers for Human Development and Connections AZ, who are launching an integrated ACO in 2022. We will collaborate with other forming BH ACOs, including ONEcare and Integral Health Network of Southern AZ, who have expressed interest in an AzCH relationship. Through ACOs, members will have access to a collaborative network of doctors and providers who work together to deliver integrated services. The ONEcare ACO has reported positive outcomes that AzCH expects to replicate in all GSAs we serve – *Members with BH and chronic medical conditions experienced a 70% reduction in avoidable bed days and hospitalizations, a 50% decrease in the average length of stay, and a 20% decrease in BH readmissions leading to a total cost of care savings of $30-35M.*

b. Co-occurring SMI/SUD Service Delivery

Members with co-occurring SMI and SUD are at greater risk for developing chronic PH conditions that may be life-threatening. Our analysis shows that 40% of members with SMI have a co-occurring SUD and account for over 80% of BH admissions and 90% of 30- and 90-day readmissions. AzCH has a goal of reducing readmissions by 5% in each contract year for members with co-occurring SMI/SUD needs. To achieve this goal, we will leverage T19 and NT19 funds to offer the following programs for all members with SMI/SUD, as overseen by the Population Health Management Committee.

SUD-Focused Integrated Care Model. AzCH is launching an SUD-focused integrated care model in the South GSA. It will integrate treatment and high-touch care coordination aligned with the Recovery Management model through a full-risk VBP contract with axialHealthcare. It will provide access to a full array of in-person and telehealth services addressing a member's PH, BH, SUD, and SDOH needs through a team of addiction specialists, physicians, peers, social workers, and BH professionals. The team will coordinate closely with PCPs, BH providers, EDs, and system partners to develop person-centered care plans that support the member's recovery journey.

Wellness and Recovery Program. AzCH's Wellness and Recovery Program for members with co-occurring SMI/SUD is a strategic approach driven by our Population Health Committee that includes care management support from AzCH in concert with services for members struggling with co-occurring disorders. It offers a support system that helps them navigate the early stages of recovery and minimize the risk of relapse. The program engages members in services based on their Stage of Change to reduce risks for ED visits and IP admissions, involvement with law enforcement, and drug overdose. AzCH's specialized, multidisciplinary care management team includes a BH medical director with 40-years' experience as an addiction specialist who is responsible for overseeing AzCH's programs for serving members with SUD. Our field-based intervention team includes an Addictionologist, psychiatrist (or extender), BH professionals with expertise in SUD, and peer supports that work to understand where members are in their recovery journeys and connect them to services and resources to meet their whole-health needs. The program is based on evidence-based practices such as MAT, behavioral therapies, lifestyle coaching, alternative pain management, and interventions that empower members to manage their chronic pain without using opioids. We incorporate peer support into our care management and wellness programs to increase member engagement in preventive services and ongoing BH services. This person-centered model is guided by the member's self-defined goals, needs, and preferences and offers flexible services based on their readiness to change and stage of recovery. For example, members receive transition support through our SMI/SUD Readmission Prevention Program. Studies show that IP hospitalization is an effective time for reaching members who need SUD services, as they realize that substance use has negatively affected their health. During interactions with IP and outpatient (OP) BH providers, AzCH learned that members with SUD are often treated for their primary diagnoses, but hospitals are not equipped to deliver MAT services. Members with co-occurring SMI are often discharged without receiving evidence-based services, such as MAT, and are not connected to ongoing community-

based treatment. To facilitate early intervention, AzCH is contracting with Novum Behavioral Health Systems to offer members the opportunity to start MAT while in the hospital. In collaboration with hospital staff, the Novum team connects the member to a MAT provider, as appropriate, ensures member needs are addressed during the IP hospital stay, and assists with developing a discharge plan that includes coordinating with OP providers to secure ongoing, community-based SUD services at discharge. By engaging with members when they are ready to participate in care, we reduce risk for readmission, aid them in achieving recovery goals, and improve transitions between IP and OP services.

c. Improving Access to Evidence-Based Outpatient BH Services

Based on our experience and input from members and providers, we identified the opportunity to bring OP BH services directly to members. AzCH has a goal to exceed the NCQA 90th percentile for rates of Follow Up After ED Visits for Mental Health in Year 1, demonstrating the effectiveness of our access improvement strategies described below.

Mobile Engagement Extension Teams (MEET). Our Provider Advisory Group, comprised of BH and PH providers from all three GSAs, determined that community services can be restructured to best support the delivery of services where people live, learn, work, and socialize. In response to this feedback, AzCH developed MEET, a health home best practice initiative that extends services beyond the walls of a traditional clinic to deliver BH and PH services and supports in members' homes and community settings. This builds on Spectrum Health's success delivering services through the Anywhere Care Teams. By 10/1/2022, we will pilot a scalable, agile mobile health home model paired with a VBP model while simultaneously building the capacity of existing community providers. Aligned with Adult Guiding Principle 1 - this model *meets the person where they are without judgment, with great patience and compassion.* Supporting member choice, MEET will be available to any interested member with SMI. MEET will receive referrals from any source, and teams will screen, assess, coordinate care, treat, and connect members to local community resources as needed. Teams consist of a team lead, family nurse practitioner, case managers, an intake/eligibility specialist, and a service team that provides or connects members to the full spectrum of health home services. Case managers bring a mobile kit to field visits, which includes supplies for blood draws and injections, diagnostic testing, a mobile EKG machine, and a stethoscope with virtual connection if the visit is via telehealth.

Assertive Community Treatment (ACT). In conversations with providers in all GSAs, AzCH learned of a statewide demand to support members with high levels of need. Building on the success of our rural ACT teams, we will work with providers in each GSA to deploy full fidelity ACT teams. AzCH worked with our ACT provider (Telecare) to develop ACT teams to match the needs of rural areas. For example, Yuma had higher demands than Casa Grande and Sierra Vista, so we adjusted ACT teams accordingly. In response to provider feedback on staff recruitment and retention challenges, we asked local Mobile Crisis Teams to assist in responding to less intensive crisis calls, enabling ACT staff to focus on vulnerable members. In response to input from justice system partners, we developed a Forensic ACT (FACT) team and educated the system on FACT services. *ACT/FACT teams show a 35% decrease in Behavioral Health Residential Facility (BHRF) utilization, 34% decrease in ED visits, and 81% decrease in subacute services.*

First Episode Psychosis (FEP) Program. Through our work with existing FEP programs, AzCH knows that FEP programs struggle to identify and connect individuals in the prodromal phases of psychosis and that many FEP program graduates struggle to maintain their success and recovery in a general OP setting. By 10/1/2022, AzCH will implement a targeted outreach and education program that includes: 1) roll-out and provider training in use of evidence-based pre-screening tools; 2) targeted education for key community touchpoints such as schools; and 3) funding for positions within existing FEP programs to focus on outreach and liaise with community touchpoints. To increase member participation in continued treatment post FEP graduation, we have contracted with EPICenter founding director and international FEP leader Dr. Nicholas Brietborde to lead a collaborative effort with stakeholders to design and implement an FEP Step-Down Pilot. We will organize a stakeholder steering committee to closely track the implementation and success of the pilot, adjust as necessary, and prepare to scale and replicate strategically based on use patterns and need throughout the system of care. We will launch the pilot in Q1 of 2023. AzCH will deploy this approach in all GSAs we serve.

Solving for Transportation Barriers. Through our Provider Advisor Group and member outreach via our OIFA, we heard that transportation providers are not reliable, creating anxiety for members and disrupting progress on their recovery journey. To address these concerns and remove transportation as a barrier to accessing care, AzCH contracted with a new transportation vendor – MTBA – through a contract that includes accountability measures and a revised payment model. Developed in collaboration with HOPE, we will deliver recovery and resiliency training to MTBA staff with an emphasis on stigma reduction, creating a safe and comfortable transportation experience for members with SMI.

d. Ensuring Health Equity and Eliminating Disparities

AzCH uses advanced data analytics to identify health disparities by race, ethnicity, sexual orientation, gender identity, and zip code. Based on data trends and stakeholder input, we implement innovative strategies to ensure equitable access to care for all members by connecting members to providers who understand their cultural needs through the following strategies. AzCH has a goal to achieve NCQA Health Equity distinction by 2024**.** We have already started developing the tools, processes, and systems to achieve this distinction. For example, we are creating a Health Equity Plan that includes a Health Equity Committee to oversee our strategies for eliminating disparities and using data from our Health Equity Dashboard to identify opportunities for improvement.

Ensuring Equitable Care. AzCH delivers culturally relevant services to ensure all T19 and NT19 members with SMI have access to high-quality care and services regardless of race, ethnicity, sexual orientation, gender identity, language, or zip code in alignment with Adult Guiding Principle 8 – *strengths-based, flexible, responsive services reflective of an individual's cultural preferences*. We collate data from multiple sources as inputs into our Health Equity Improvement Model and Dashboard**,** an advanced data analytics tool that provides a holistic population health view allowing us to identify potential gaps in care, health inequities, and SDOH needs for intervention. For example, our Dashboard data shows higher rates of gaps in preventive services for Latinx members. AzCH has partnered with Promotoras to build member connections, reduce language barriers, and drive awareness about programs and services while encouraging appropriate utilization. Their unique knowledge and experience on community needs allow them to better engage members to close care gaps. *In 2020, Promotoras closed 46% of care gaps for Latinx members served by AzCH*.

Culturally-Relevant Centers of Excellence. In alignment with SAMHSA's priority populations for BH Health Equity, AzCH is developing two new COEs, which we will launch in Year 1 of the ACC-RBHA contract in all GSAs, specific to populations with identified health disparities:

- American Indian/Alaskan Native (AI) – AI members in AZ have double the rates of chronic conditions, 20% higher suicide rates and three times higher mortality rates.
- LGTBQIA+ individuals – AZ is home to over 203,000 LGBTQIA+ adults who face 26 times higher rates of suicide and a high prevalence of depression (over 44%).

Using evidence-based practices and providers with demonstrated expertise, each COE will focus on the specific disparities experienced by the population served. Each COE will incorporate best practices for serving members with SMI, including supported employment, supportive housing, P/FROs and ACT.

AI COE. In partnership with Tribal leaders, we will select providers with proven success in working with Tribal nations to participate in our AI COE**,** which will deliver culturally competent care such as traditional healing services and enhance care coordination with Tribal providers. The AI COE will allow us to identify network providers that: have AI-specific, culturally appropriate, evidence-based programs like White Bison, Fatherhood is Leadership, and Motherhood is Sacred; complete an AI cultural competency curriculum; provide crisis services; offer non-Medicaid reimbursable services such as acupuncture and traditional healing services; and hire or designate a Tribal Liaison as the single point of contact for care coordination with Tribal providers.

Our **COE for LGBTQIA+ individuals** will incorporate advocates to help the member feel safe and welcome when seeking care, increasing access to care by providers with expertise to serve transgender members. AzCH will leverage resources available through organizations such as the Trevor Project to assist members in defining their family of choice, educate the member's identified family on how to best support them, and connect the member and family to tools and resources for suicide prevention. For over six years, AzCH has trained providers and system partners on best practices for supporting LGBTQIA+ individuals. We will train a core group of staff on transgender disparities and community-based resources to advocate for transgender members and address their PH and BH needs.

Best Practices for Members with Traumatic Brain Injury (TBI). National data indicates that 60% of members in the justice system have a TBI. Our data reveals that the rate of TBI jumps to 95% among those with SMI in the justice system. With this data and the CDC identifying TBI as a disparity, AzCH implemented a TBI program for members involved in the justice system with TBI. Building on this initiative, we are piloting a wellness and recovery program to support all members with TBI through early screening, referrals to community resources, peer support, and psychoeducation. In collaboration with community partners such as HOPE, the program will incorporate curriculum such as Achieving Healing through Education, Accountability, and Determination for TBI from the University of Denver and Mindsource Brain Injury Network. Peers will be trained to apply this approach when assisting members with TBI to cope

with and address their symptoms, such as short-term memory loss, and difficulty with emotional regulation.

Best Practices for Refugees. As a resettlement region, AZ expects to accept a significant number of refugees with high rates of posttraumatic stress (30%-80%) and depression (over 94%). To address their unique needs and facilitate early identification of individuals with BH needs who may have SMI, AzCH will offer culturally relevant services delivered through a trauma-informed lens. In collaboration with providers such as Valleywise, which operates a clinic for refugees, we will customize programs to the refugee's culture of origin and preferred language. Members will receive BH and PH services, case management and care coordination from trained team members, assistance with integrating into American culture (e.g., employment, SDOH supports), connections to relocation services such as the Arizona Refugee Resettlement Program, and assistance with navigating the healthcare delivery system.

e. Utilizing Technology to Maximize Member Engagement

Through ongoing Member Advisory Council feedback, members with SMI shared that they preferred to engage with us through mobile devices and social media. In response to this feedback, AzCH makes technology tools readily available to help members self-manage their care and promote the understanding that members have a voice and choice in their healthcare decisions. Our data shows that 25% of members actively use the technology tools we offer. We have a goal to increase utilization of web/mobile-based applications and devices to engage members with SMI in their healthcare by 10% each year. To achieve this goal, we are removing barriers to adoption which disproportionately affects Tribal communities, lower-income households, the elderly, and people with disabilities due to cost, digital literacy, and readiness. AzCH bridges the digital divide by connecting members to the Emergency Broadband Benefit program, which provides discounts toward broadband services and devices such as laptops or tablets. We are expanding on this program by investing $50,000 to expand broadband in rural areas. We assist members in using technology by deploying Peer Support Specialists and community health workers to provide individualized hands-on support and connect members to free smartphones via SafeLink and WIFI-enabled tablets. Members can use these tools to access services via telehealth, participate in mobile apps, and communicate with providers, Care Managers, AzCH and system partners. Examples of current technologies we use to improve member engagement include Pyx Health and a Medication Participation App from Wellth. Pyx Health provides 24/7 companionship via a mobile platform and compassionate support center that conducts member outreach. While all members have access to Pyx, AzCH focuses on connecting members in our anxiety and COPD disease management programs, involved in the crisis system, with a suicide attempt, and experiencing social isolation. Since June 2020, *members who used Pyx Health realized a 78% improvement in loneliness scores, 31% reduction in hospital IP, 20% increase in medications, 6% increase in OP services (medical, PCP, specialty), and 79% decrease in suicide attempts***.** To improve medication participation for members with suicide risk, we refer them to the Wellth App to encourage self-management through daily check-ins and rewards for participation. Data indicates that members using the app over a 6-month period experienced a *53% decrease in IP use, 15% reduction in ED visits, and 35% decrease in urgent care*.

Engaging Members Through Remote Patient Monitoring (RPM) Tools. Providers in all GSAs AzCH serves will be able to connect members to RPMs that enable members to take charge of their health via tools that actively track their vital measurements. Using WiFi connected devices, members receive information that enables them to track progress toward treatment goals and increases communication with their healthcare team, improving health literacy. Members have access to tools (e.g., Bluetooth-enabled glucose monitors, blood pressure monitors, weight scales) to track chronic conditions such as diabetes, cardiac and respiratory conditions, and kidney disease. RPMs provide on-time feedback that promotes early intervention, increases member engagement, and reduces avoidable ED visits and IP admissions. Providers use the data available through RPMs to target health coaching and support member self-management.

Telehealth. Telehealth enables members to access providers with the right expertise to provide care appropriate for their culture, race, gender, sexual orientation, and lived experience. AzCH provides services via telehealth in alignment with the AHCCCS Medical Policy 320-I, which identifies telemedicine as a strategy for improving quality of care. AzCH partners with Teladoc® to provide a broad-based telehealth platform that enables members to schedule visits seven days a week. This flexible and HIPPA-compliant solution allows members to video-chat, upload images, or call a doctor from wherever they are via a smartphone, tablet, or desktop computer. Services are provided in numerous languages, including Spanish and American Sign Language, through 3-way visits with an interpreter. AzCH will collaborate with stakeholders in each GSA to customize solutions to improve the system of care for members with SMI.

B8. Provide the Offeror's assessment of current network adequacy and describe ability to serve…

AzCH has built numerous strategic partnerships with providers and community stakeholders who share our mission to improve the health of our communities one person at a time. To support members achieve recovery goals, our comprehensive network provides the full continuum of PH, BH, and SDOH services and supports, and we work with our partners to meet members' complex and/or specialized health care needs in the least restrictive setting. We have served individuals with SMI for 16 years, and our approach has matured through lessons learned and implemented best practices. At go-live, AzCH will leverage our fully contracted and credentialed statewide provider network with more than 20,000 locations; and our SDOH network of more than 6,300 organizations with more than 20,000 social services and support across all GSAs. Informed by the *Nine Guiding Principles for Recovery-Oriented Adult System of Care*, our integrated network of community- and facility-based services provides timely and effective access to care. In compliance with Section D26 of this CCE, AzCH does not subcontract for or delegate to another entity for the delivery of BH services.

AzCH's Network Development Strategy Monitors Gaps in the Continuum of Care.

AzCH's Network Development and Management Plan outlines our network strategy. We continually monitor for gaps in care, which we identify through feedback, assessment, and oversight.

Feedback. Feedback is a vital monitoring source to routinely assess the care continuum. We regularly receive formal and informal feedback from nearly 90 different mechanisms, including members, families, providers, and stakeholders in all settings and formats. We held more than 30 recent stakeholder sessions to get input and convened a Provider Advisory Group (PAG) to build collaborative solutions to system challenges. We use compiled feedback to identify trends and implement solutions to strengthen the network to meet unique needs, such as feedback we received from parents at Family Support Meetings who identified a lack of parent support services when children return from DCS. We are collaborating with three P/FROs to develop a post-reunification support program.

Routine Assessment. AzCH combines feedback with a quarterly multi-tiered network assessment, which includes: a) geo-mapping and time/distance software to analyze member/provider travel distances for each GSA's provider types; b) combining in- and out-of-network utilization, member trends, and geographic data to identify hot spots, health disparities, health equity issues, and disease prevalence, especially for complex/specialized health needs; c) conducting quarterly appointment availability and wait time calls (*current appointment availability compliance averages 99.1% across PCP, specialist, dental, maternity and BH appointments*); and d) reviewing provider panel size. Through feedback and analysis, and aligned to Guiding Principle 2, AzCH implemented our Voice & Choice approach, which eliminates the need for in-network referrals to BH specialty services, such as P/FROs, improving timely and effective access to care.

Oversight. AzCH uses a vertical and horizontal oversight approach to monitor and act on care gaps: vertically through departments who report concerns to leadership; and horizontally through cross-functional committees, including QM/PI, Grievance & Appeals, Compliance, and Network Oversight-which is dedicated to resolving identified gaps.

AzCH's Network Development (ND) Strategy Resolves Gaps in the Continuum of Care.

AzCH has developed long-term partnerships with providers and stakeholders and, together, we jointly identify network enhancement opportunities and flex to develop and implement effective strategies, including the following.

Offering a Crisis Service Continuum Optimizes Least Restrictive Settings for Complex/Specialized Need Members.

Opportunity. Based on reviews of Crisis Response Center law enforcement drop-off data, crisis line call center data, and first responder and Pima County Quarterly Crisis Meeting feedback, we identified a need to coordinate crisis calls.

Strategy. In partnership with the City of Tucson, AzCH co-located crisis professionals within Tucson's Public Safety Communications Center to answer 911 calls with a BH crisis nexus. Implemented in April 2019, the co-located crisis call center is the only program in AZ (and one of few nationally) that has full 911 Computer Aided Dispatch access, allowing co-located professionals to clear calls from first responders and document closure in the 911 system. For calls not resolved telephonically, AzCH contracts with trained Crisis Mobile Team (CMT) providers to resolve BH crisis situations in person. The Crisis Line uses GPS-enabled phones to locate the closest CMT team to quickly respond to the member. AzCH co-locates CMTs in rural and Tribal communities, such as the Tohono O'odham ED and San Carlos Apache Nation ED, improving response time. Through partnerships with CMTs, we achieved a 2020 *community stabilization rate of 68% with an average response time of 41 minutes, much quicker than the required 90-minutes*. Since 2015, AzCH doubled CMT capacity, with a 2020 monthly average of 1,094 activations. *85% of CMT-served members remained stable*, having no IP admission 45 days post service. We will scale these programs if awarded other GSAs. **Opportunity.** Based on feedback from stakeholders, we developed a variety of solutions to address crisis situations in the least restrictive

setting. **Strategy.** AzCH crisis services includes our nationally-recognized 23-Hour Obs. Units that provide assessment and stabilization in lieu of ED or inpatient settings with LOS consistent at 24-hours or less. Through flexible design, we replicated this model in Yuma, Benson, Casa Grande, Globe and Payson and can scale in other awarded areas. AzCH offers Brief Intervention Programs (BIP) providing continued crisis stabilization in a BH setting for up to 10 days, shortening and preventing inpatient admissions and readmissions. AzCH implemented Urgent Engagement (UE) in which OP providers respond within one hour of a request at a 23-hour Obs Unit or BH facility. For members receiving OP services, UE facilitates real-time care coordination and assists with discharge planning. *1-hour UEs are completed 96% on time, and 24-hour UEs are completed 84% on time*. **Opportunity.** Based on feedback from providers and member trends, we know immediate, short-term services can help connect members to needed care to stay well post-crisis. **Strategy.** In partnership with providers such as Old Pueblo Community Services, HOPE, and TLC-R, we developed the Second Responder Program (SRP) to deliver immediate needs post-crisis, including housing stabilization and peer support/navigation**.** Through the Crisis Line, crisis providers make SRP referrals to an SRP provider, who contacts the referred member within 24 hours and provides immediate services; then collaborates with the ongoing BH providers to coordinate care transition. This Southern AZ-unique program has a *98% timely contact rate* and is scalable statewide.

Engaging with Partners to Enhance Collaboration and Care Coordination. **Opportunity.** AzCH identified increasing PH length of stays (LOS) and readmissions for RBHA members. Through in-depth analysis and committee monitoring, we determined multiple diagnoses codes, such as abscess and cellulitis, were for skin infections related to IV drug use. **Strategy.** To address this issue, we partnered with community and provider stakeholders to implement our SUD Continuum of Care Program. The program quickly connects members to appropriate services and levels of care, such as MAT therapy, SNFs with access to MAT programs, BH navigators, and harm reduction services. From December 2019-August 2021, AzCH engaged 112 members; *increased PCP engagement 7.4%; and reduced IP utilization (38.5%), specialist utilization (35%), and ED utilization (42%).* **Opportunity.** Based on stakeholder feedback, we identified the need for greater mobile care options, especially for complex members. **Strategy.** To enhance the IHH model, AzCH is piloting the Mobile Engagement Extension Team (MEET), an agile, mobile health home featuring provider-based, multidisciplinary case management teams structured to support service delivery where members live. MEET includes a partnership between Spectrum and other IHHs such as Escalera and a peer-run organization such as HOPE. To launch by 10/1/22, MEET's 'no wrong door' approach allows referrals from any source. The team will screen, assess, coordinate care, treat and connect members to SDOH resources. We anticipate MEET will *decrease ED utilization 8%*. **Opportunity.** Through review of UM and QM data, we identified an opportunity to help members transition from IP settings**. Strategy.** In 2018, in partnership with HOPE and CHEEERS (PROs), AzCH launched the Hospital Engagement and Linkages Peer Program (HELPP) to leverage peer support pre-and post-IP admissions. HELPP peers work with members to address barriers, with members remaining involved for up to 45 days post-discharge. HELPP interacts face-to-face with members at Aurora Hospitals in Maricopa County, and we will expand this program to other BH and PH hospitals by 6/1/22. Outcome data showed a *46% decrease in readmissions six-month's post-discharge*.

Collaborating with Partners to Routinely Assess the Continuum and Strengthen the Network for Unique Needs. **Opportunity.** Compliant with *AHCCCS Contractor Operations Manual Policies 417 and 436*, AzCH's network is *100% compliant* with AHCCCS adequacy requirements in all three GSAs, except for Pediatric Dentists (PD) in Gila County. We identified a time and distance gap for members aged 18-20 in three zip codes where no PD exists. For zips 85542 and 85550, a member travels 40 miles to the nearest PD in Globe; for zip 85192, 20 miles to Kearney. **Strategy.** Given the area's remoteness, recruiting specialty dentists is difficult. To address this, we timely transport members to the nearest PD, offer general dentistry, partner with our dental vendor on alternative approaches, and collaborate with providers, stakeholders, and communities to recruit more PDs. **Opportunity.** Based on stakeholder feedback, membership trends, and utilization data, AzCH identified continuing SUD and opioid use disorder (OUD) crisis concerns. **Strategy.** In collaboration with the CODAC Center of Excellence (COE), we used state SUD funds to expand MAT services, ensuring coordination of care. Together, we built the first ever 24/7 integrated MAT clinic in the country. Opened in 2018, the clinic operates 24/7 and, in the past six months, has had *1,169 intakes*. Expanding MAT capacity enabled AzCH and CODAC to partner with Tucson Police and Pima County to implement a diversion program and prevent arrests – *successfully deflecting 1,092 individuals* during the first 20 months. In collaboration with Health Choice, Community Medical Services, and Tribal leaders, we are expanding MAT capacity in La Paz County, as members (including Tribal members) had to travel to Yuma for MAT services. We will continue this service assessment approach to identify any

needed expansion in all GSAs. **Opportunity.** Through feedback from ACT teams and review of preventable service utilization, we identified a greater need for ACT services in Yuma than in Casa Grande or Sierra Vista. **Strategy.** AzCH collaborated with two urban and three rural ACT teams to shift staffing to Yuma and facilitated agreements between impacted rural ACT teams and local CMTs. This allows CMTs to manage lower-level crises and ACT to focus on high-need members. This collaboration resulted in *utilization decreases in BH residential facility (35%), ED visits (34%), and subacute services (81%)*. **Opportunity.** Based on feedback and analyses, rural areas may under-utilize peer and parent/family supports due to workforce shortages. **Strategy.** In 2021, we partnered with the Peer & Family Career Academy (PFCA) to invest in workforce development focused on credentialed peer support specialists and parent/family support providers. This builds on our network of approximately 600 credentialed peer support specialists and 55 certified family support providers. PFCA brings advanced certification opportunities, continuing education, and a career ladder for peer specialists to progress into new roles. AzCH will identify and partner with COE peer support agencies, including Hope, and MIKID, leveraging our PFCA partnership to expand credentialed peer support specialists and raising the bar for continuing education of parent/family support providers. PFCA estimates 480 peer/family professionals will obtain advanced certification in the next three years, with the *first 280 trained by 10/1/22*.

Evolving Payment Models and New Provider Organizations Help Strengthen the Network. Opportunity. Through thousands of statewide conversations over multiple years, we know providers want effective and fair payment models. Through PAG sessions, we learned IHH providers want VBP models with focused goals; and BH specialty providers, such as P/FROs, want to participate in VBP contracts. **Strategy.** AzCH will continue fee-for-service contracting and evolve our VBP strategy to promote greater PH/BH integration and move providers up the CMS Learning Action Network (LAN) continuum by 1) Our current VBP model will be updated to incorporate an innovative approach to improve PCP engagement by 10/1/22. To achieve initial shared savings, BH providers must meet *7-day follow-up after hospitalization (FUH)* and *% of members with PCP visit* targets. Once initial targets are met; VBP providers will be eligible to earn more by achieving additional quality performance goals. 2) By 1/1/23, we will also launch an innovative VBP shared savings arrangement with select BH specialty providers (such as P/FROs) chosen for VBP readiness and ability to partner with IHH colleagues to drive FUH and all-cause readmission improvements. 3) AzCH (through Care1st) is the only MCO early adopter of the new NowPow Closed Loop Referral System, which coordinates services between providers and Community-Based Organizations (CBOs) to address member's SDOH needs. By go-live, AzCH will incentivize providers to begin use of NowPow and integrate NowPow into their EHRs. High-level LAN VBP agreements will also allocate a portion of savings to CBOs with the top five highest volume of referrals to encourage alignment and SDOH coordination. 4) VBP providers need access to actionable data, which is an AzCH strength. Our VBP providers confirmed they have ready access to adequate and timely historic and real-time data via our Provider Analytics and Patient Analytics platforms and the Interpreta daily care and risk gap tool. 5) In 2020, *65.5% of services provided to RBHA members were delivered by providers with VBP contracts, exceeding requirements by more than 40%*. A 2018-2020 comparative analysis found VBP providers *averaged a 10.9% quality performance increase, exceeding non-VBP peers by 4.6%*. A 2019-2020 Health Benefit Ratio (HBR) analysis also found that VBP providers *reduced HBR by 2.6% and claims costs by 4.3%*. We anticipate the new models will achieve similar positive outcomes and improve SDOH coordination, and can be replicated in new GSAs**. Opportunity.** Providers are building new transformative organizations focused on improving care coordination, PH and BH integration, and access to care. **Strategy.** As providers form new entities, such as new BH Accountable Care Organizations (ACOs), we will use our tailored partnership approach, such as through data, tools, and expertise. In 2018, we partnered with the AZ Alliance for Community Health Centers (VBCare Inc.) on their VBP strategy. Through collaboration we fulfilled VBCare's data-sharing needs, executing a progressive payment model with meaningful performance criteria. AzCH will partner in a similar manner with InterMountain Centers for Human Development (ICHD) and Connections AZ as they launch a new integrated BH ACO in 2022. AzCH has received a Partnership Letter of Intent from this new ACO, which will develop innovative value-based partnerships with AZ providers and community stakeholders, aimed at providing coordinated and integrated psychiatric and PCP services, wraparound supports and services to positively impact SDOH; all supported by a population health technology platform, in order to improve healthcare access, quality, cost, and outcomes, particularly for AZ's most vulnerable. We are collaboratively developing an agreement to incent ACO provider participants for improved care and quality outcomes. We will collaborate with other BH ACOs, including ONEcare and Integral Health Network of Southern AZ, who also expressed interest in an AzCH relationship. AzCH will monitor all ACOs for compliance with AHCCCS requirements and non-redundant operations.

B9. Describe the best practices of Arizona's crisis system.

Arizona Crisis System Best Practices and AzCH Innovations

The Arizona Crisis System in the South GSA deploys national best practices via a highly coordinated system to achieve a common goal—stabilization in the most clinically appropriate and least restrictive level of care**.** Built on the premise of *respect – meeting each person where they are with patience and compassion and without judgement* - Guiding Principle 1, our crisis system exceeds SAMHSA guidelines and is emulated as a national model. With 16 years of RBHA experience, AzCH has worked with system partners to implement innovative solutions that are unique to the South GSA. We will work with system partners in each awarded GSA to enhance the local crisis system, serving individuals, regardless of health plan or Medicaid enrollment.

Integrated Crisis Line. In April 2019, AzCH co-located crisis line professionals with the City of Tucson's Public Safety Communications Center to answer 911 calls related to a BH crisis. The co-located crisis call center in the South GSA is the only program in the state and one of a handful of its kind in the nation with full 911 Computer Aided Dispatch (CAD) access. CAD allows co-located professionals to clear calls from first responders and document closure in the 911 system. Through smart call triage, we identify and intercept BH crisis calls to the City of Tucson 911 system for immediate de-escalation and crisis stabilization. Integration of the Crisis Line allows our call center to effectively connect callers to a clinician as early as possible and facilitate appropriate crisis interventions. We will expand Virtual Co-Location to Cochise, Santa Cruz, and Pima County to divert calls from an overtaxed and often understaffed first responder workforce to the crisis system where trauma-informed care is readily available.

Rapid Deployment of Crisis Mobile Teams (CMTs). For calls not resolved telephonically, AzCH contracts with trained CMT providers to resolve BH crises in person. Our system functions as a Traffic Control Center, electronically dispatching and tracking CMTs to rapidly respond to member crises, optimizing crisis resources. The Crisis Line uses GPS-enabled phones to locate the closest CMT team to quickly respond to the member. AzCH co-locates CMTs in rural and Tribal communities, such as Tohono O'odham ED/Jail and San Carlos Apache Nation ED, to improve response time and support members in EDs, Tribal communities, and detention facilities. Since 2015, AzCH doubled CMT capacity, with a monthly average of 1,094 activations in 2020, with *68% of members remaining in the community, avoiding a higher level of care. 85% of these members remained stable in the community without inpatient admission 45 days post-service provision***.** The average response time for CMTs is 41 minutes, much quicker than the 90-minute requirement. During the COVID-19 pandemic, we continued to provide in-person CMTs while ensuring social distancing and safety and continued to provide timely response to members in crisis situations.

Coordination of Services. AzCH coordinates pre-and post-crisis outreach to connect members to the care they need to stay well in the community. Unique to the South GSA, AzCH developed Second Responder Programs (SRP) for the immediate provision of services post-crisis, including peer and family support/navigation for adults and in-home supports for youth and families. SRPs are a short-term intervention available to anyone receiving crisis services, regardless of ACC plan. Providers must have telephonic or face-to-face contact within 24 hours of receiving the referral from the Crisis Line. Currently, providers connect with 98% of identified members. We are the only RBHA to provide 24/7 outpatient scheduling for anyone calling the Crisis Line. We use Online Appointment Scheduling Software to facilitate timely appointment scheduling and track follow-up. The YTD stabilization rate for members using online scheduling is 71.5%, as defined by not having a CMT response, crisis referral to a higher level of care, or notification of observation unit (OBS) admission 30 days post appointment schedule date. AzCH offers a full continuum of services to resolve crisis situations according to the member's needs, including 23-HourOBS that provide assessment and stabilization in lieu of ED or inpatient settings. Brief Intervention Programs (BIP) provide continued crisis stabilization in a BH setting for up to 10 days, shortening and preventing inpatient admissions and readmissions. AzCH implemented Urgent Engagement in which outpatient providers respond within one hour of a request at a 23-hour OBS or BH facility. For members receiving outpatient services, Urgent Engagement facilitates real-time care coordination and discharge planning. Unassigned members receive the same coordination with an abbreviated intake and follow-up appointments. Key to inpatient and ED diversion, OBS accept walk-in referrals, ED transfers, and crisis drop-offs from first responders. OBS provide rapid assessment, early intervention, and proactive discharge planning, with most members returning to community-based care. An example of this successful model is the Crisis Response Center (CRC), the centerpiece of the nationally recognized Tucson crisis system and the only crisis center in the state serving both adults and youth. Law enforcement uses the CRC as their central BH receiving facility, dropping off members on voluntary and involuntary

status with a turnaround time of 10 minutes or less. AzCH replicated this model in rural communities including Yuma, Benson, Casa Grande, Globe, and Payson, leveraging licensed BH facilities. Length of stay at the CRC remains consistently around 24-hours, demonstrating its ability to stabilize members and quickly find the right level of care. Based on our success, *the Department of Justice selected Tucson as one of 10 original (14 total now) law enforcement Mental Health Learning Sites.* AzCH enhanced the crisis continuum in the South GSA by collaborating to develop a real-time crisis bed registry – Crisis Bed Connect (CBC). CBC is a web-based bed availability tracker for inpatient, BIP, and BH residential facilities with 108 contracted sites throughout AZ. Open to the public, providers and system partners (such as the probation department) can access the CBC 24/7 to identify available beds for the level of care appropriate to the member's needs, facilitating timely admission and streamlining care coordination.

Strategies for Driving Continued Improvement

AzCH has the experience, expertise, and infrastructure with rural, urban, and frontier populations to drive continued crisis system improvement statewide while ensuring resources are designed with and for AZ's diverse communities. In 2018, AzCH stepped in to lead the transition from a 72-hour model of payment to a 24-hour service model, providing key infrastructure and processes to help ACC MCOs seamlessly integrate with the crisis system (e.g., crisis line appointment scheduling, Urgent Engagements, and data exchange). Our innovative approach uses real-time crisis data to identify and focus improvements on gaps in the system of care. We will continue to drive improvement and innovation through:

- AzCH Crisis System Dashboarding, which produces reports from the Crisis Line's EHR to provide insight into CMT use, call times/volume, presenting symptoms, acuity scales (danger to self or others, psychosis, and substance use), health plan, OBS admission, and Urgent Engagement data. AzCH shares data with counties, Tribes, and ACC plans to discuss trends and changes. We are responsive to the needs of our system partners; for example, AzCH created special utilization reports for Banner to provide insights on crisis utilization for members they serve.
- Participation in the Law Enforcement-Mental Health learning site allows AzCH to learn from and contribute to the development of national best practices for crisis care. We share data with our partners, ensuring a detailed review of 911 call transfers and police calls for services, including response time and 911 co-location outcomes.

The following examples demonstrate AzCH's commitment to continuous quality improvement:

- AzCH identified an opportunity to reduce administrative costs and improve care delivery through the CRC. We issued a competitive RFI and created a cross-functional review committee that chose to contract directly with Connections Az. Together, we developed new services, directed more dollars to care, reduced wait time from OBS to inpatient, and created innovative payment models and shared savings.
- When outpatient service providers and hospital staff communicated a need for increased care coordination at EDs, we expanded the one-hour Urgent Engagement process to include Pima County EDs for members with a BH need.
- In 2018, AzCH found that 40% of youth crisis calls were generated in schools for students aged 7-17 years old. AzCH worked with law enforcement to provide school-based BH services and the Pima County Sheriff's Department to develop the School Resource Officer Therapy Canine Program. In 2019, when elementary students witnessed a shooting, AzCH first responder liaisons arranged for CMTs and the Canine Program to provide onsite support.

Primary Objectives. We will continue to drive innovation through initiatives that achieve the following objectives:

- **Leverage existing infrastructure, experience, and expertise to expand and replicate best practices** – Using standard protocols, we collaborate with communities to operationalize crisis systems for their unique needs and resources.
- **Divert first responder calls to the crisis system** to increase community stabilization and ensure members receive appropriate care in the least restrictive environment, reducing avoidable ED, urgent care and hospital visits.
- **Build upon existing relationships to enhance Tribal collaboration** - AzCH was the first MCO to have a full Tribal Team, hire a dedicated Tribal Services Coordinator, have on-reservation co-located CMTs, and offer a Tribal Warm Line. *We are the only MCO with a designated Tribal Care Management team.*
- **Reduce unnecessary law enforcement encounters** for members in crisis through engagement and training.

Action steps. AzCH will fulfill our objectives through the following action steps:

Enhance and Expand Infrastructure. With SAMHSA citing crisis texting/chatting as a best practice, we developed the capacity for our crisis line to receive and respond to texts from members in crisis. We are working with AHCCCS to roll out the national 988 system for suicide prevention and mental health emergencies.

Timeline. AzCH has the infrastructure for crisis texting and will align with AHCCCS approval and/or 988 implementation. We will continue to create opportunities for service improvement through Master Crisis Reporting, which centrally

houses individual and provider information related to crisis episodes for comparison and reporting. We will automate real-time data sharing for all MCOs, American Indian Health Plan, and providers through Daily Crisis Notifications. **Timeline.** We are enhancing our capabilities and developing data-sharing agreements for implementation by Q4 2022. We will expand our peer-driven Crisis Living Room program (in Yuma and La Paz), which functions as a 24/7 stabilization location. All members receive a Crisis Risk Assessment and are connected to Outpatient services. **Timeline.** Expansion of the Crisis Living Room program will occur in Q4 of 2022.

Implement ED Diversion Strategies. Through our long-standing collaboration with fire, EMS, and AHCCCS, we will implement Emergency Triage, Treat & Transport (ET3), a CMS reimbursement model pilot. ET3 takes best practices from the Treat & Refer, Mobile Integrated Healthcare, and community paramedicine models to create a sustainable model. **Timeline.** AzCH will fully implement ET3 by Q4 of 2022.

We will expand the use of Urgent Engagement while members are in 23-hour Obs or inpatient settings to engage them in care within 24 hours of arrival at a crisis facility and offer credentialed family support through MIKID, Family Involvement Center, and Hope. **Timeline.** AzCH is finalizing guidelines with hospitals for implementation in Q2 2022.

We will pilot a Family Support program staffed by credentialed family support providers to increase family stability during or post-crisis situations to improve safety, reduce overall crisis episodes, and increase connection to and utilization of natural and community supports. **Timeline.** AzCH will implement the Family Support program in Q4 2022.

Reduce Unnecessary Law Enforcement Encounters. We are in ongoing discussions with the University of Arizona, Pima Community College, Cochise County, and Pinal County Law Enforcement Departments to expand the 911 program with CAD access. During the pandemic, we successfully moved our 911 staff from the 911 call center per safety protocols while continuing to respond to crisis calls diverted from the 911 system. As a result, we learned that, through virtual co-location, this effective program can be scaled to rural/smaller 911 communication centers. **Timeline.** AzCH will seek CAD training/access approval for implementation Q1 of 2022.

Enhance Tribal Partnerships. AzCH leads AZ in Tribal collaboration to ensure crisis services are available on reservations in our GSA. We will continue to ensure access to crisis services on and off the reservation through crisis team co-location and dedicated Tribal crisis and warm lines. **Timeline.** We are identifying Tribal agency partners for the expansion of Tribal crisis services in Q4 of 2022.

Effective Stakeholder Involvement. The National Association of State Mental Health Program Directors highlighted AzCH's role in the ACS for providing governance and accountability that ensures crisis services operate as an organized and coordinated system. Because the Crisis System impacts multiple stakeholders (i.e., members and families, criminal justice, county government, schools, DCS, first responders, providers, Tribal entities), we proactively engage with partners to identify emerging trends, collect data/feedback, and drive system improvement.

Infrastructure for Feedback & Accountability. AzCH assigns a First Responder Liaison (Liaison) as the single point of contact for all stakeholders in each of the South GSA's eight counties. Liaisons convene Crisis System quarterly meetings to foster connectivity among partners, promote awareness of crisis services and how to access them, and discuss system-related issues. AzCH uses the Crisis Meeting to identify strengths and barriers and resolve issues. Each year, we collaborate with system partners to develop and implement crisis protocols that drive the crisis system in each County and Tribe, serving as a framework for a robust crisis system with community-wide ownership. Liaisons contact stakeholders through standing meetings, informal touch bases, surveys, and data reviews.

Stakeholder Engagement Informs System Enhancements. AzCH continually adapts the crisis system based on input from stakeholders. For example, during the COVID-19 pandemic, it was critical to keep members in crisis from the ED to keep members safe and reduce the strain on the health system. AzCH worked with Obs and inpatient facilities to establish a testing protocol in Pima County for involuntary members, conducted PPE audits for Obs and CMT providers, audited safety and cleaning precautions at Obs, updated crisis/dispatch triages to screen for COVID-19, and worked with Pima County Health Department to establish a CMT response process for hotels hosting individuals positive for COVID-19. The crisis system never reduced capacity and functioned smoothly throughout the pandemic. During the peak of the pandemic, AzCH responded to feedback from ADHS, AHCCCS, counties, and hospitals that noted increasing stress and strain placed on county health departments, intensive care units, COVID-19 units, and EDs. This led to one of the largest Critical Incident Stress Management (CISM) responses conducted by AzCH. Used for prior AZ crises and natural disasters, CISM is a highly structured process to aid people exposed to a critical incident to share their experiences. We provided 146 hours of CISM to Tucson Medical Center, Pima County Health Dept. and Yuma Regional Medical Center.

B10. American Indian/Alaska Native members have a unique status within the Medicaid system…

Unique Aspects of Tribal Delivery System

We have deep relationships with Tribal communities, built over the years – we listen to each Tribe to gain insight into their unique goals, build trust, prioritize health disparities, and tailor our programs to meet each Tribe's strengths and needs. We honor Tribal sovereignty, working in partnership with Tribal governments, providers, and communities to ensure access to comprehensive services. We recognize each Tribal Nation has its own jurisdiction and unique language, customs, and community characteristics. We serve each community through Tribal collaboration activities, crisis services, and Medicaid and grant-funded programs focusing on Tribal identified health disparities and needs. We proactively coordinate with the American Indian Health Program (AIHP). Today, we have 19,500 American Indian/Alaska Native (AI) members enrolled in AzCH plans across Arizona. We embody Adult Guiding Principle 1 – *Respect* – as the cornerstone for all collaborative Tribal activities.

Understanding Tribal Culture. Emphasizing the uniqueness of each Tribe, we developed trainings such as Tribal Sovereignty 101 for staff and providers, narrated by indigenous elders, which explains tribal sovereignty, the Tribal healthcare delivery system, and real-life implications for how we deliver care. Other trainings include Effective Engagement of AI in Integrated Care, AI Service Choices, AzCH Tribal Programs Overview, Tohono O'odham Nation (TON) History and Culture, Tribal Meet Me Where I Am (customized for Southern Tribes), and Working with Tribes 101.

Understanding Tribal Healthcare Delivery Systems and Supporting AI Choice. With a dedicated Tribal Team, AzCH collaborates with and supports the various delivery systems that an AI member may interact with, such as Indian Health Services (IHS), Tribal 638 facilities, urban Indian organizations, Tribal RBHAs, and our contracted provider network.

Spotlight: Tribal Programs Supervisor
Our Tribal Programs Supervisor (AHCCCS required Tribal Coordinator position), **Sheina Yellowhair**, has 13+ years of experience working with the Tribal healthcare delivery system and supervises a team of three individuals exclusively dedicated to working with Tribal communities. Ms. Yellowhair acts as the Tribal single point of contact and participates in monthly Extended Leadership meetings to ensure Tribal issues and needs are elevated. Our Tribal Programs Specialist is a liaison for tribes and urban Indian organizations, our Tribal Services Coordinator focuses on member service-related matters, and our Tribal Relations Program Manager offers boots-on-the-ground in the North GSA.

Understanding AI Transitions. We recognize AI members can choose their health plan/program daily and support member choice by coordinating the transition (per AMPM 520). We anticipate upcoming AHCCCS policy change shifting default enrollment of Tribal members to AIHP may result in increased transitions, and we are prepared to provide support. For AIHP members transitioning to AzCH, we conduct outreach to identify the individual's Tribe, cultural needs, preferences, and reservation location, if applicable. This creates a personalized relationship that enables us to connect the member to the right care. From 2020-2021, our Tribal Services Coordinator coordinated an average of 22 transitions from AIHP per month using a cross-departmental approach. Our Care Management department includes an AI Care Management Team and Designated SMI Tribal Care Coordinator who support AI members - creating individualized care plans. Demonstrating the benefits of this approach, according to a 2019 pre/post-study, AI members in contact with our Tribal Services Coordinator and AI Care Management Team for clinical services experienced a *55% decrease in crisis episodes, 32% decrease in ED visits, 54% decrease in inpatient admissions, and 2% increase in physical health visits*.

Understanding of Tribal Health Disparities and Social Risk Factors. AzCH's Health Equity Dashboard provides a complete view of health disparities, looking across our network through utilization data and demographics, further informed by community needs assessments and national trends. According to the CDC, AI individuals have the highest rates of suicide of any racial/ethnic group in the nation. AzCH's Health Equity Dashboard highlights disparities in HEDIS rates for AI members such as Antidepressant Medication Management, Comprehensive Diabetes, and Cancer Screenings. We collaborate with each Tribal Nation and Tribal members to prioritize initiatives based on what is important to each Tribe**.** We meet each Tribe where they are to focus on the disparities they identify. We strengthen this understanding through forums and events such as Tribal Collaboration Meetings with Tribal providers, IHS, network providers, and AHCCCS; Tribal Crisis and Crisis Protocol Planning meetings; and AzCH's annual Tribal Community Wellness & Awareness Conference, which brings together youth, parents, elders, and Tribal staff from across the State.

Examples of Working in Partnership with Tribal Communities to Address Health Disparities

We aim to achieve a faster rate of improvement in identified disparities by allocating resources in proportion to need. AzCH works in partnership with Tribal partners to close gaps through efforts such as those outlined below:

Crisis. In working with Southern Tribes, we determined a peer support line staffed by people of like culture familiar with Tribal communities would increase AI members' engagement levels. Today, AzCH's Tribal Warm Line provides ongoing

daily support, including immediate crisis and follow-up support for AI members. Through our history working with TON and San Carlos Apache Nation (San Carlos) community leaders, suicide risk was identified as community concern. In response, AzCH placed onsite Crisis Mobile Teams in the Tribal ED and Jail, narrowing the response times to just 45 minutes, well under the 90-minute required time. Additionally, we: 1) provide daily crisis reports and notifications to AIHP and the Tribal BH providers; 2) built a strong partnership with San Carlos' Tribal Wellness Center's Life is Precious Crisis Response Team; 3) provided suicide prevention training to over 500 agency partners and Tribal staff, including tribal first responders; 4) deployed Critical Incident Stress Management teams to reservation high schools; and 5) assisted with Tribal involuntary commitment process and code development.

Peer Support. Through AI member feedback, we identified a gap in access to culturally responsive Peer Support services in Tribal communities. In response, and in alignment with Adult Guiding Principle 6, *Partnership between individuals, staff, and family members/natural supports for shared decision making*, AzCH established a Tribal Peer Support Certification Training and works with Tribes to improve leadership skills and mentoring programs. This program cultivated nearly 50 local trainers and Tribal peer support specialists (PSSs) within the Tribal health system to help address disparities like Antidepressant Medication compliance and substance use. Pascua Yaqui Tribe and Colorado River Indian Tribe (CRIT) have implemented their own curriculum, allowing the Tribes to train and certify their own PSSs. AzCH offers equitable access to peer support – with 0.25 Tribal PSSs per AI member and 0.25 general PSSs per all RBHA members.

> **AzCH Inspires Tribal Peer Support Business Opportunities**
> "Peer Support has empowered me and other tribal members to bring together recovery concepts, connect traditional culture and healing with recovery and fight the stigma that we encounter here in our community."
> **– Founder, Tribal PRO**

Diabetes & Food Security. The Navajo Nation's Special Diabetes Project focuses on increasing access to traditional foods as key to fighting diabetes. In line with this approach, AzCH provides community investments, including a $15,000 grant to Native American Advancement Foundation for a food insecurity project on the TON. In partnership with Native Health, we are funding the replication of their evidence-based literacy and nutrition education program, Read It & Eat, on the Cocopah reservation in 4Q 2021.

SUD. We use SABG block grant dollars to target disparities related to engagement in SUD treatment for AI members. For example, we used grant dollars to offer Naloxone trainings and distribution in coordination with CRIT. When Cocopah Tribal staff expressed a need for more transitional living homes in Yuma, we responded by leveraging grant dollars to expand Oxford Houses in the area – offering an evidence-based model where people with SUD find a safe and supportive home. Based on claims data for *AzCH AI members, HEDIS rates for Initiation and Engagement of Alcohol and Other Drug Abuse/Dependence Treatment is 6% above the national benchmark average, exceeding the 75th percentile.*

> **AzCH Member Story: Tribal Team Success**
> A 54-year-old AI man was reportedly using methamphetamine and refused to leave his evicted apartment while experiencing paranoia, hallucinations, and reported SI statements. This member was referred to our Tribal Services Coordinator who worked with our AI Care Management Team to ensure collaboration with the Tribal 638 case management team, crisis mobile team, and local law enforcement to have the member safely placed in an inpatient facility. During his stay, the member was designated to have an SMI and discharged to a BH Residential Facility to learn living and coping skills. Through our Team's ongoing oversight and regular communication with the family, the member successfully transitioned to his sister's home and has not had an inpatient admission in more than two years.

Innovations to Further Support the AI Population

Due to the multiple systems serving AI members and long claims lag for Blind Spot Data, incomplete data brings challenges to having a complete picture of AI health disparities. We are working with Tribal leaders and provider partners such as Intermountain, CPIH, and The Haven to establish AI Centers of Excellence (COE). AI COEs will be launched in Year 1 of the new ACC-RBHA contract within each awarded GSA to improve access to culturally competent care and traditional healing services and enhanced coordination of care with Tribal providers. The AI COE will enable us to identify network providers that have AI-specific, culturally appropriate evidence-based programs like White Bison, Fatherhood is Leadership, and Motherhood is Sacred; complete an AI cultural competency curriculum; offer traditional healing services; and hire or designate a Tribal Liaison as the single point of contact for coordination with Tribal providers. To further enhance communication across the AI COEs and non-network Tribal providers, we will pilot Rovicare™ with interested Tribal partners by 10/1/2022. Rovicare is a web-based care coordination and information exchange tool that provides real-time views of members' transition and care planning across various settings to all stakeholders involved. Through this enhanced care coordination and data exchange, we will have a broader purview of AI members' needs and care patterns while further supporting transitions and honoring Tribal sovereignty.

B11. Describe how the Offeror will address social risk factors…

AzCH improves member health through person-centered, integrated solutions that address members' PH and BH needs and social risk factors. We meet each member where they are to facilitate equitable access to care by removing barriers such as lack of housing, reliable transportation, or food insecurity. We apply our award-winning Health Equity Improvement Model to identify, perform root cause analysis on, and understand regional social determinants of health (SDOH). This ongoing assessment informs innovative programs and community-based solutions that impact social risk factors like homelessness, food insecurity, social isolation, and employment.

Addressing Social Risk Factors through Compensable and Non-Compensable Services and Supports

We focus on identifying and addressing members' immediate social risk factors and linking members to compensable and non-compensable community services and supports at every point of contact. Our Care Management stratification includes prioritizing Care Management outreach for members with SDOH needs that are identified through data capture and predictive modeling, self-report, or provider report. SDOH risk prioritization will be shared with our providers and their case managers through our Provider Portal. Our Care Managers and provider case managers screen for SDOH needs. Care/case managers complete referrals to community-based organizations (CBOs) and providers to address unmet social risk factors (as well as PH/BH needs); incorporate resources to address SDOH into care plans; document and monitor member progress. For members with targeted support needs, AzCH offers Care Grants as enhanced non-compensable support. Care Grant funds are accessed through our Care Management staff and address SDOH barriers to health care or care plan goal attainment, such as purchasing a bike for a member as a means of transportation.

AzCH Member Story: Jackie
Jackie was involved with child welfare for many years and lived in a foster and group home before aging out of that system. After being arrested for shoplifting and drug paraphernalia, she lost her housing. AzCH assisted Jackie in obtaining PSH through Achieve Enterprise Services housing program. At 23, Jackie was drug-free and gained employment at Achieve. Soon after, Jackie completed her Peer Support Specialist training with TLC Recovery, where she continues to grow and help others. One month later, Jackie moved into an independent setting.

Working with the Community. In support of Guiding Principle 3 - *focus on the individual as a whole person…and developing natural supports,* we connect members to community resources that support their recovery goals by addressing SDOH needs. Care/case Managers leverage our SDOH network of more than 6,300 organizations across all GSAs to help members access more than 20,000 social services and non-compensable supports. Our CBO partnerships include local Public Housing Authorities, Community Food Bank of Southern Arizona, Circle the City, and Avondale Resource Center. We will work with AHCCCS' new Housing partner to promote PSH, to maximize member access to state-funded affordable housing, and we are the first plan in AZ to manage referrals through Homeless Management Information Systems (HMIS), annually connecting an average of 555 HUD vouchers to RBHA members in Southern AZ. We offer system-wide SDOH trainings to improve whole-person care. In 2019 we delivered 50 training sessions to strengthen collaboration between treatment providers and justice system partners to remove SDOH barriers. We will invite community leaders from CBOs, justice and crisis systems, NowPow to participate in targeted discussions led by a panel of Arizona community leaders to discuss social risks and strategies to eliminate them. Insights gained will feed into both operational process improvement efforts, as well as guide topics for our annual Community Consensus Collaborative. We celebrate providers and organizations that demonstrate excellence in addressing SDOH needs through our quarterly SDOH Champion Awards. We select champions, such as Crossroads Mission and CPIH based on use of ICD-10 Z-codes, completion of SDOH screens, improved outcomes, provision of SDOH supports, and innovative programs.

Closed-Loop Referral System (CLRS). AzCH works with CBOs to coordinate non-compensable services and close gaps in SDOH needs for individuals with SMI. We are excited to be a leader in advancing the statewide CLRS. Through Care1st, AzCH is the only MCO early adopter of the new NowPow CLRS. We will partner with Arizona's 2-1-1 and Contexture (formerly known as Health Current) to support CBO participation in the CLRS. AzCH will incentive providers to begin use of NowPow by go-live, and for provider integration of the NowPow into their EHRs. We will require providers in cost savings agreements to allocate a portion of their savings to CBOs with the top five highest volumes of referrals to encourage alignment and coordination for timely connection to services and supports that address SDOH needs.

AzCH's Community Engagement Team (CET). Our CET are member advocates and specialists in transitions of care, housing, employment supports, and other social risk factors that connect members to local community resources to address their social needs. The CET provides community resource information to our Care Managers and provider-based case managers to expedite connections to supports. Our CET builds our partnerships with CBOs, establishes community contracts, mobilizes resources to fill service gaps, and identifies opportunities to pilot new SDOH solutions, including

NowPow. Our CET Housing Specialist ensures members have access to non-compensable wrap-around services including HUD-funded PSH and home-based services to help maintain housing and achieve their self-defined goals, and our CET Employment & Vocational Specialist works with providers to encourage the use of decision support tools such as DB101; participate in Freedom to Work Medicaid buy-in as appropriate; maximize resources through Ticket to Work, VR and One-Stop and Workforce Investment Act programs; and set up plans for financial wellness through Social Security Work Incentives such as PASS. Our CET are leaders locally, recruiting six Targeted Investment Healthcare Providers and nine CBOs in Central and North GSAs as early adopters of the CLRS to facilitate referral tracking and data collection. In response to input from our CET, Contexture hosted two CBO-specific virtual sessions to promote participation in the HIE. Our CET are leaders nationally, participating in Centene's National SDOH Center for SDOH best practice idea exchange.

Identifying and Capturing SDOH Data Supports Timely Linkages to Social Services

AzCH uses our enterprise data warehouse (EDW) to capture SDOH data from multiple sources, including SDOH mini screenings, AHCCCS approved screenings (such as PRAPARE), and through the mining of internal and external data sources. Data from our EDW feeds our Centelligence reporting and analytics platform to perform predictive modeling using our proprietary Neighborhood, Environmental, Economic, and Social Traits (NEST); this translates into prioritization for Care Management outreach to support timely member linkage to social services. NEST determines the social risk factors affecting healthcare utilization, and it further aggregates scores based on geography to create heat maps to identify and address social indicators correlated with poor health outcomes at the community and member level. This information rolls into our SDOH KPI Dashboard and Health Equity Dashboard, which provides a comprehensive view of metrics related to social risk factors that leadership reviews daily to monitor leading risk indicators and key performance metrics. The Dashboard aggregates Z-code, health risk assessments, financial, and utilization data to analyze trends, costs, and prevalence to drive interventions and gathers key data documenting inequities and the factors driving them. As NowPow develops, AzCH will integrate data from assessments conducted in or integrated into NowPow from EHRs into our dashboards for analyses. We will continually validate our findings by making the aggregated data-view available to providers through our Provider Portal, and to stakeholders through feedback meetings, for alignment on issues impacting member and community health. This will enable us to target programmatic solutions or provider/CBO innovation to address community needs or health disparities. For example, our data shows the following prevalent SDOH needs for RBHA members: homelessness - approximately 1,511 members are experiencing homelessness; food insecurity – 1 in 6 Arizonans experiences food insecurity; and social isolation - 16% of members with SMI have no primary support group, and employment instability – which can positively impact mental health. Based on these data and information, AzCH offers innovative strategies and evidence-based approaches such as a Housing First Model and Supported Employment to address SDOH needs, shown in Table B.11-1.

Table B.11-1. Examples of AzCH Initiatives to Address SDOH Needs.

Social Risk Factor	Innovation/Initiative
Homelessness	• AzCH invests in housing for individuals with SMI, adding 33 housing units over the last 2 years, with ongoing and sustainable rent subsidies. Leveraging NT19/21 funds, we established 555 housing opportunities for members with SMI since 2015 through a combination of project-based and tenant-based solutions. • In 2019, we saw significant health improvements for members after securing housing, including a *45% reduction in ED visits, a 46% decrease in crisis services, a 52% reduction in IP admissions, and cost savings of $564,704.89*.
Food Insecurity	• AzCH partners with local CBOs to meet members where they are to increase access to healthy food. For example, together with the Community Food Bank of Southern Arizona we are increasing rural members' access to healthy food through Food for a Healthy Future, distributing healthy food boxes to members at outpatient clinics.
Social Isolation	• Pyx Health, a smartphone app used to combat loneliness for members experiencing social isolation, with certain conditions, crisis system engagement, or who are at high risk for adverse clinical outcomes. • Since June 2020, members using Pyx Health experienced a *78% improvement in loneliness scores, a 31% reduction in Hospital IP, and 6% increase in Outpatient services, and a 79% decrease in suicide attempts* since March 2021.
Employment Instability	• We partner with the Peer & Family Career Academy to prepare Peer Support Specialists to teach members about financial literacy, micro-loans for self-employment, and Individual Development Accounts. • In job placement reporting from providers, *over 1200 positions were filled by AzCH members in FY19*; activities are now focused on increasing referrals to Voc. Rehab. Member surveys show that AzCH members who became employed reported improved quality of life, better physical and mental health, and increased regularity of PCP visits.

B12. The wellbeing of many Arizona residents has been significantly affected by the COVID-19…

Role and Strategies during Arizona's Recovery from the COVID-19 Public Health Emergency (PHE)

AzCH's role as a RBHA is to serve AHCCCS and the community as a lead collaborator with other RBHAs and MCOs, a communicator to streamline access to critical information and reduce confusion, and a convener focused on removing barriers through funding and coordination of both short- and long-term solutions that anticipate, identify and address the health care services and secondary issues of the PHE (e.g., suicide and provider burden**).** We understood early on, that the PHE necessitated activation of our Business Continuity Plan for plan and delivery system operations**.** We support the whole system of care for individuals with SMI to sustain and increase providers for ongoing access to care.

Supporting Arizona Communities
In partnership with our Care1st Health Plan, **AzCH obtained and distributed more than 58,000 masks, gowns, and face shields to local governments, community partners, and social service organizations**; and more than $52,500 in gift cards with which members and/or Community Based Organizations could purchase food and other necessities immediately.

Collaborator Supporting the State's Recovery. A key strategy to support recovery efforts is to leverage our relationships and effective use of community resources to meet member needs in all GSAs and continue to fund community-specific programming to improve RBHA member health in alignment with the State's HCBS strategies and the American Rescue Plan (ARP) Act of 2021. Should the HCBS proposal be approved, we will identify our RBHA members who would benefit from personal care and attendant care services and be prepared to extend those benefits accordingly. SDOH needs increased during the PHE, and our Community Engagement team (CET) mobilized to minimize the impact for RBHA members. We have funded and distributed resources throughout the community and will continue to be a leader in supporting the recovery efforts, including *$88,350 to combat food insecurity supporting 40+ community organizations, $10,000 in Amazon gift cards for individuals and families (essential supplies), traveled to 118 schools in the South GSA and received 1,000+ referrals for those affected by COVID-related trauma, and provided $350,000 in grants to alleviate food and housing insecurity in 2021 to date.* As the economy recovers, members return to work and may lose eligibility; we will provide outreach, support, and education for redeterminations and other coverage options.

AzCH has been a leader in the successful administration of N19 grants, and have partnered with AHCCCS to secure additional federal grant funding to support the COVID relief and recovery efforts, such as the Federal Suicide Prevention Emergency Grant (in partnership with CODAC Health, Recovery & Wellness, Inc.; Community Bridges Inc.; and Emerge Center Against Domestic Abuse). Through our MHBG COVID Supplemental Funding proposal, we plan to expand our efforts; we will support ARP priorities by leveraging our expertise with the BHRF Crisis Bed Connect in the South GSA; expanding comprehensive TIP-funded clinics to youth based on our expertise with the adult model in Yuma. We monitor and promote fidelity to ACT, supportive housing, and supportive employment - strategies that align with ARP initiatives.

Communicator. AzCH was a leader in supporting clear, consistent messaging and guidance during the PHE, and our strategies to continue to build on our success around centralized communication and vaccination messaging. We took the lead with Contexture to develop a central communication repository as regulations and information were changing rapidly to address the PHE. We partner with AHCCCS RBHAs and MCOs to step to work together to ensure a consistent response, reducing confusion during a PHE to ensure continuity for RBHA members.

Communication and Collaboration for Vaccination Efforts. Our COVID-19 Task Force is leading ongoing initiatives to promote vaccinations for individuals with SMI. To date, *63% of AzCH RBHA members are vaccinated*, and we aim to drive this number even higher by partnering with CBOs. *Our goal is to have 75% of our RBHA members will be fully vaccinated by the end of the year, and we model this commitment by mandating all employees get vaccinated.* Our Care Management team performs targeted outreach to RBHA members to provide vaccine information and address any questions or hesitancy. Once members' vaccination status is verified, through our COVID-19 Vaccine dashboard on our secure, Provider Portal providers can see their members that still need their vaccine, facilitating member-facing conversations around vaccines. We provide materials for PCP-member conversations and share strategies. Our Community Affairs team maintains constant contact with local health officials and FQHCs to stay up to date on COVID-19 vaccination sites in real-time and communicate this through member and provider-facing staff for timely information. We have seen that Tribal communities have higher vaccination rates, due in part to Tribal messaging on vaccinations that focuses on the protection of community and culture. We will collaborate on similar messaging to decrease health disparities in vaccination rates among Latinx populations, whose rates are only at 29% (Kaiser Family Foundation). We partner with CBOs that provide culturally relevant messaging and that members will trust to reduce vaccine disparities. This includes promotion of the Yuma vaccination site, partnering with CBOs to get vaccinations to Spanish-speaking and

farmworker communities, and as a volunteer coordinator working with ADHS, ASU, and DEMA at the Phoenix Municipal Stadium site where we hosted a Communities of Color event. *We have coordinated 50 pop-up vaccination events,* offering health screenings with partners such as Chicanos Por La Causa. We are hosting vaccine events focused on Peer and Family members in coordination with Hope, Inc. to increase access for individuals with SMI.

Convener. Our strategies to provide ongoing support for recovery as a convener focus on bringing together diverse stakeholders for collaborative problem solving and providing the funding or resources to implement solutions.

Convening Diverse Groups to Address Broadband Access. We ensure connectivity across resources, benefits, programs, and stakeholders following members' needs and wants (with voice and choice). COVID-19 has highlighted the needs of vulnerable individuals and how system strengths and trusting relationships can be leveraged to harness member and community innate resilience to move towards recovery. With the system's fast pivot to expand telehealth services, broadband availability in under-resourced, rural, and Tribal communities became critical to enabling access to services. To address the challenges of limited broadband availability and the technology required to employ broadband connectivity, our CET participates in key stakeholder groups focused on improving broadband and internet access for underserved/rural/tribal communities. We launched (through Care1st) the AZ Broadband Initiative, which remains part of AzCH's long-term strategy for enhancing the broadband infrastructure in all GSAs we serve and have invested $50,000 to the AZ Broadband Stakeholders Network, and will support/fund initiatives in all GSAs we are awarded. Working with community members from Short Creek Community (encompasses Colorado City, AZ, and Hildale, UT), we convened stakeholders including the AZ State Broadband Director, elected officials, and sheriffs from both states in 2021 to facilitate discussion on broadband access and infrastructure, including opportunities, barriers, and next steps. Recently, we facilitated a partnership with Local First Arizona and the State Broadband Director to support communities with grant writers at no cost to pursue federal and state grants, and we will continue to convene these types of supports for all GSAs awarded. We recognize that members may need support in utilizing telehealth technology, and we will support this both through the Personal Recovery Navigator program and with P/FROs to support technical assistance.

Increasing the Capacity of the Service Delivery System. The PHE increased the demand for BH services and postponed critical physical health services for members including those with SMI and individuals in crisis. AzCH continues to build our capacity to respond to a pandemic or other event requiring sudden demand for high acuity care.

Ensuring BH Crisis Services. During the pandemic, we carefully monitored crisis episodes and access to care. Our Crisis Team worked with the Crisis Response Center (CRC) to ensure testing, placement escalation, and review process for voluntary and involuntary members with COVID-19. This proactive approach to outreach to EDs and IP facilities helped alleviate facilities from being overwhelmed with BH admissions. AzCH collected COVID-19 response and health and safety protocols for all Obs. units in the South GSA. In Pima, we held staffings with IP hospitals, the CRC, and CBI Obs. unit to establish transition points, testing protocols, and make sure throughput was not impacted by members testing positive. We will also convert our Quarterly Crisis System Meetings to be an open forum to discuss issues, successes, and barriers, increasing these meetings to a monthly cadence and including public health officials to make sure we are addressing each counties' unique needs related to PHE recovery. We will lead efforts to support each county in implementing initiatives and continue to work with stakeholders to strengthen the delivery system and/or processes.

Provider Collaboration and Support. We have prioritized strategies that help keep providers financially stable through pausing repayments of advances that stabilized cash flow for providers, and we will continue to support providers through value-based arrangements that offer opportunities for financial incentives with continued expansion of services and quality. We work with providers to increase services through telehealth/virtual care as a strategy to bring services directly to RBHA members. We hosted a webinar and technical assistance for all AZ providers on applying for PHE grants. Our Crisis Team provided Critical Incident Stress Management (CISM) BH support for providers on the frontlines. We will offer 24/7 CISM and have expanded our scope to include health departments and EDs. *We provided 100+ hours of CISM and related supports* to the Pima County Health Department, Yuma Regional Medical Center, and Tucson Medical Center. We invest in support for providers and increasing access to providers; *distributing 1440+ meals from local restaurants to frontline hospital and FQHC staff, awarding $250,000 in COVID-19 grants to providers and community organizations including $20,000 for childcare for first responders and health care workers, and investing $856,000 to add three providers to deliver school-based BH services, and are adding another in the coming year.* We will continue to strengthen AZ's health and BH system capabilities throughout recovery and ensure preparedness for any future PHE.

Part C

Capitation Agreement/Administrative Cost Bid Submission

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C1

Agreement Accepting Capitation Rates

(In accordance with Section H - Instructions to Offerors, Part C1 has been uploaded as a PDF to the SFTP)

C2

Administrative Cost Bid Submission Workbook

(In accordance with Section H - Instructions to Offerors, Part C2 has been uploaded as an Excel Workbook to the SFTP)

C3

Actuarial Certification

(In accordance with Section H - Instructions to Offerors, Part C3 has been uploaded as a PDF to the SFTP)