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	1
A2	Offeror's Completed, Signed Solicitation, and Offer Page	2
A3	Offeror Submission Form	4
A4	Offeror's Signed Signature Page(s) for **each** Solicitation Amendment, if applicable	5-9
PART B	PROGRAMMATIC - NARRATIVE SUBMISSION	
B1	2-page limit	12-13
B2	2-page limit	15-16
B3	3-page limit	18-20
B4	4-page limit	22-25
B5.a (North GSA)	2-page limit	27-28
B5.b. (South GSA)	2-page limit	NA
B5.c. (Central GSA)	2-page limit	29-30
B6	1-page limit for each of a through g	32-38
B7	5-page limit	40-44
B8	3-page limit	46-48
B9	3-page limit	50-52
B10	2-page limit	54-55
B11	2-page limit	57-58
B12	2-page limit	60-61
PART C	CAPITATION AGREEMENT/ADMINISTRATIVE COST BID SUBMISSION	
C1	Agreement accepting capitation rates	63
C2	Administrative Cost Bid Submission Workbook	64-66
C3	Actuarial Certification (The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid)	67-72

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
701 E. Jefferson, MD5700
Phoenix, AZ 85034

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

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (AHCCCS)**

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

Late Proposals shall not be considered.

Persons 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.: 62-1796494

E-Mail Address: Shawn.Nau@healthchoiceaz.com

Health Choice Arizona
Company Name

410 N. 44th Street, #900
Address

Phoenix | AZ | 85008
City | State | Zip

For clarification of this Offer, contact:

Name: Shawn Nau

Title: Chief Executive Officer

Phone: (928) 214-2291

Signature of Person Authorized to Sign Offer

Shawn Nau
Printed Name

Chief Executive Officer
Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

This Contract shall henceforth be referred to as Contract No._____

Award Date: _____

_____

MEGGAN LAPORTE, AHCCCS Chief Procurement Officer

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: Health Choice Arizona	1
☐	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties (Including zip codes 85542, 85192, and 85550) ACC Contractor:	
☒	**Central**: Maricopa, Gila, and Pinal Counties (Excluding zip codes 85542, 85192, and 85550) ACC Contractor: Health Choice Arizona	2

Authorized Signature — 10/1/21 Date

Shawn Nau — Chief Executive Officer

Print Name — Title

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Jami Snyder, Director

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. [...]

COMPETITIVE CONTRACT EXPANSION SOLICITATION #YH20-0002
AMENDMENT #1 – QUESTIONS AND RESPONSES

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:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: September 27, 2021	DATE: August 26, 2021

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Jami Snyder, Director

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:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: September 27, 2021	DATE: September 14, 2021

NARRATIVE SUBMISSION REQUIREMENTS

Health CHOICE

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

B1.

NARRATIVE SUBMISSION REQUIREMENTS

B1: Transitioning a contract to a new health plan has the potential to slow the critical processes of the delivery system while the new Contractor broadens its understanding for providing services to the population. Describe the efforts the Offeror will undertake to minimize delays and disruption to both members and providers, and to ensure advances that have been made in recent years continue in the transfer of responsibility. This submission will not be scored.

Response B1: Health Choice Arizona (HCA) recognizes that health plan transitions represent a critical event which, if not handled properly, can cause considerable harm to members, providers, and communities. As the current RBHA in the North GSA and Gila County in the Central GSA, HCA is in the unique position of being the incumbent health plan. Thus, if awarded, no member or provider transitions would need to occur in the North GSA or Gila County in the Central GSA.

If awarded the Central GSA, HCA's strategy will be based on our experience and expertise in managing complex member and provider transition processes, and will be informed by *three guiding principles*: (1) Put the member first, in *every* respect; (2) Exceed each of AHCCCS' stated transition expectations (including those outlined in Exhibit D); and (3) Initially adjust our business practices and policies to mirror those of the exiting plan, rather than making members, providers, and other organizations adjust to us. (Results of the ACC transition suggests this last principle is unique to HCA.) HCA will use these three principles to guide all implementation strategies and execution of our detailed and tested Comprehensive Transition Plan (CTP) and "go live" process.

Consistent with the first and third principles above, the first strategy in our CTP is initially to make changes to our own business practices to mirror the exiting health plan's network and service delivery models for up to 18 months following the transition date. We recognize that modifications to business practices and delivery models will be needed over time. However our experience indicates that changes must be made incrementally, and in coordination with AHCCCS and stakeholders, to prevent gaps in care or losses in advancements that have been made in recent years. In our case, continuity with the exiting RBHA's processes is made easier by the fact that we modified our RBHA provider manual in 2015 to align with Mercy Care, and similarly changed our behavioral health provider contract rate structure and most practices prior to the ACC transition in an effort to ease the on the large number of providers in Maricopa County. We also use the same PBM, claims system, and claims clearinghouse. In addition, we are already contracted with all major behavioral health providers in the Central GSA, and work closely with all Tribal communities. Where other modifications are needed, we will mirror the exiting RBHA's practices. Finally, we are committed to exceeding AHCCCS required time periods for honoring prior authorizations and non-contracted provider claims as defined in Exhibit D and the draft contract. **Flexibility *on our part* is the key to a smooth transition**.

The second strategy in our CTP is to maintain a permanent transition team presence within our organization. HCA's transition team never "stood down" following the ACC transition. We followed up the ACC transition (including a close collaboration with Care1st) with DD and CMDP transitions involving collaborations with Mercy Care and United. We also manage member transition on a daily basis as American Indian members move between HCA, AIHP, TRBHAs, and other AHCCCS plans. Our efforts will continue to be managed by our Transition Management Team (TMT), chaired by our CEO, Shawn Nau. The TMT includes membership from each department, including Chief Operating Officer, Diana Policky; Chief Medical Officer, Dr. Mark Carroll; VP/Clinical Operations, Ellen Lewis; and Chief Compliance Officer, Nicole Larson. The TMT is staffed with a full-time Transition Program Manager. Each TMT team member is required to be available 24/7 during the first 90 days, and emergency contact information for each TMT member will be provided to AHCCCS so issues can be resolved immediately. The TMT will meet regularly leading up to, and following, the transition date. The TMT will meet twice daily starting two weeks prior to the transition date and will continue doing so, at a minimum, for the first quarter following "go live." We will be happy to also include AHCCCS and exiting RBHA staff in these meetings in order to foster collaborative problem solving, as well as offer transparency to AHCCCS.

Each TMT meeting is used to review updates to our self-monitoring Transition Dashboard, designed to identify emerging issues, and to assign interventional tasks, which at a minimum, will include:

- Member clinical status, including proactive, high touch outreach by internal staff and provider-based resources to high-risk members identified using DEF, ETF, blind spot, and member data from the outgoing contractor through our Johns Hopkins ACG predictive analytics, CareRadius care management system, and QlikSense self-service analytics tools (an approach we used during the COVID pandemic and the recent CMDP transition)
- Feedback received through member, provider, peer and family organizations (PFROs), advocacy groups, government, and other stakeholder outreach, education, and other communications efforts

- Member inpatient, housing, and residential facility data monitoring (including collaborative meetings with other plans to support these transitions) to ensure appropriate transitions between levels of care and address member transportation issues
- Member and provider call center service metrics and identified issue trends, monitored five times per day
- Member individual service plan status and updates
- Member and provider complaints, grievances, and appeals
- Collaborative outreach and education efforts through PFROs, connector agencies, and community resources
- Provider and pharmacy claims pending, denials, *and* clearing house rejection status (an undetected issue in 2018)
- Prior authorization performance and issues
- Credentialing timeliness performance and issues
- Provider network adequacy and performance (including quality and vendor performance, such as DME)

*The strategies we have developed based on our **three guiding principles** have been highly successful. As one of the largest peer and family providers in Maricopa County summed up the general consensus during a post-ACC transition meeting at the Arizona Council: "Health Choice had the smoothest transition … by far."*

The third CTP strategy is to provide extensive education, communications, and outreach to members, providers, and stakeholders. The TMT will oversee a schedule of pre- and post-transition efforts which will be submitted to AHCCCS in advance for approval. These efforts will include a series of member, family, provider, and community forums in conjunction with our many partner organizations such as NAMI, Arizona Coalition for Military Families, Be Connected, and the AZ Peer & Family Coalition. We will offer extensive on-demand educational resources through webinars, social media, podcasts, and "how to" guides. Similar to the ACC transition, the TMT will hold daily provider bridge line calls for at least a month, and the TMT will oversee our team's strategies to meet directly with all providers. The TMT will oversee the development and distribution of member and provider educational materials, as well as an update to our Member Handbook – using Peer and Family representatives, and our Member Advisory Council, Provider CEO Council, and Governance Committee – to ensure readability and the inclusion of "voice and choice." The TMT will also oversee the creation and distribution of new member cards and introductory materials which will identify both the PCP and behavioral health provider assigned to each member and the process to change them if the member wishes to do so. Lastly, the TMT will oversee the development and implementation of training for all HCA staff members.

And although our detailed and tested CTP strategy is essential to a smooth transition process, it must be supported by experienced staff with the resources to execute it. With the active support of Blue Cross Blue Shield of Arizona (BCBSAZ), HCA's core leadership team from the ACC transition has remained in place – but with important additions. These include our CMO, Dr. Mark Carroll (formerly with AHCCCS, Indian Health Service, and Northern Arizona Healthcare), and recently, our VP/Network Services, Charlotte Whitmore (previously with Mercy Care) and Network Operations Director, Kijuana Wright (previously with AHCCCS and HSAG). We will again commit to expanding our provider and peer/outreach staff during readiness, and increasing our call center, claims processing, and prior authorization staff by at least 200% of normal staffing levels starting the month before go-live and continuing as long as needed, with back up support from BCBSAZ's member and provider call center, clinical, and other operational teams.

HCA has also greatly expanded our support, technology, and analytic resources. Since our acquisition by BCBSAZ, we have solidified our core services structures, as evidenced by a recent AHCCCS report showing that HCA ranked best of the AHCCCS health plans in call center and prior authorization metrics. Our prior authorization, claims, and call center operations have exceeded all AHCCCS, NCQA, and CMS compliance requirements for two years straight. We have expanded our use of QlikSense's self-service analytics so we can identify and fix transition issues in real time. We have implemented new resources designed to improve member engagement and identify emerging quality, health equity, social isolation, and prescription adherence challenges – including app-based services from Wellth and Pyx Health – so we can quickly address special needs and populations during the transition period.

Health Choice Arizona is committed to making certain that members, providers, and stakeholders experience a smooth and transparent transition process. **But as challenges occur, the burden to solve them will be on us – *and no one else*.**

B2.

NARRATIVE SUBMISSION REQUIREMENTS

B2: The delivery of comprehensive and effective integrated services (physical health, behavioral health, social service referrals, and support) to individuals with an SMI designation and efficient administration of Non-Title XIX/XXI funding, including federal grants, require significant expertise and experience. Describe the Offeror's experience with:

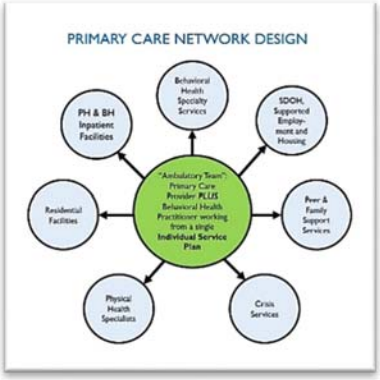
a. Service delivery to individuals with an SMI designation (Title XIX/XXI and Non-Title XIX/XXI), and

b. Service delivery using Non-Title XIX/XXI funding sources including federal grants.

c. Administration of Non-Title XIX/XXI funding sources including federal grants.

The description shall include, but is not limited to, geographic coverage, population served, enrollment, efforts to advance health care integration, years serving individuals with an SMI designation, and years administering Non-Title XIX/XXI funding, including federal grants.

Response B2. Service Delivery to Individuals Living With SMI. Health Choice Arizona (HCA) has continuously served as the RBHA for the North GSA for 29 years, and has managed federal mental health funds for 54 years. HCA's experience has provided us with a comprehensive understanding of the history and unique challenges associated with providing integrated services for individuals living with Serious Mental Illness (SMI) in the region, including challenges involving physical and behavioral health delivery, social service referrals, and member supports. HCA's role in administrating NT19/21 funding dates even further – to the origins of the federal Community Mental Health Act's grant programs in 1967, when our predecessor organization, NARBHA, served as the convener of Arizona's first rural community mental health system. Fast forward to today, HCA's system of care is informed by the *Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems*, and built on a whole-health foundation of respect, autonomy, member voice, and peer/family support participation in shared decision-making. Strong partnerships have been established with AHCCCS, ADHS, Tribal Nations, health care providers, counties and municipalities, law enforcement agencies, schools, and the judicial system. Our system of care is centered on a version of the SAMHSA Four Quadrant Model that has been modified to include Substance Use Disorders, and the Institute for Healthcare Improvement's Quadruple Aim of improved population health outcomes, provider and member satisfaction, at a lower cost. Our model has been developed over our long history and is scalable and adaptable to any region in Arizona. Based on this experience, our model has produced exceptional results:



- **HCA has expanded access to integrated care.** Since October 2015, 12,296 unique HCA members with an SMI designation have been enrolled and served across the North GSA. Currently, HCA serves 7,493 unique members living with SMI, of which 22% are NT19/21 members with SMI, and 13% are aligned members with our DSNP. All members are assigned to both a Health Home (HH) and a PCP. A member may change either provider at any time by calling HCA's toll-free member service line. Assignment to both a PCP and HH ensures that a care team is responsible for integration of PCP and behavioral health services. In four locations, members currently have the choice to receive onsite, fully integrated health care with a single integrated medical record and Adult Recovery Team (ART). In all other locations, HHs partner with FQHCs or PCPs to provide integrated care. This model, has enhanced integration of services for all members. *Results: At present, 60% of HCA members with an SMI designation receive fully integrated behavioral health and primary care services at an HCA integrated provider – an increase from 23% in 2015.*
- **HCA has implemented innovative programming, based on member needs assessments.** HCA's *Recover Wellness* (RW) Integrated Care Management Program advances risk-stratified integrated care management, targeted disease management, and facilitated provider care coordination for members with SMI. The RW care model is informed by national, evidence-based, best practices and supervised by a team of dedicated physicians, nurses, and health care professionals. *Results: 91% of provider survey respondents report high satisfaction with the RW model, and agree HCA's integrated care management aids them in delivering quality integrated care for members with SMI. Members enrolled in our RW Diabetes Disease Management Program (DDMP) have 40% fewer diabetes emergency visits after enrolling in DDMP. Well Visits (EPSDT) for 18-20 year old members with SMI have increased 27% in the past 2 years.*
- **HCA's service improvements are customized to address special needs.** HCA's population health approach is based on a thorough understanding of our region and populations, enabling system-wide approaches as well as targeted interventions for members living with SMI who have unique needs or require special assistance. HCA's RW program offers enhanced support for members including those who are pregnant, between the ages of 18-20 years, on high-risk medications, or in need of housing or other SDOH assistance. Our Integrated Care Managers also assist members who have had high risk suicide attempts, involvement with the justice system, or have cultural and language support needs. They work with other AHCCCS MCO plans and the American Indian Health Program to ensure smooth member transitions. *Results: Members in HCA housing show a 16% reduction in healthcare costs, 33% reduction in inpatient care, 19% reduction in crisis services, and a 60% reduction in chemical dependency residential services. Since 2015, members in HCA's Supported Employment programs experienced an average of 127% improvement in their employment goals – the only RBHA with this level of achievement.*

- **Quality care has improved, while avoidable utilization has decreased.** HCA's individualized care management approach facilitates secure data-sharing across the integrated care team on a range of vital demographic, health care utilization, preventive care, and prescription information. It also improves outcomes. *Results: Members enrolled in HCA's RW Integrated Care Management program experience 27% average decrease in emergency department (ED) visits, 23% decrease in inpatient admissions, and 15% decrease in total cost of care. We also have improved rates of preventive/ambulatory care (current HEDIS AAP measure: 93.4%) and achieved significant reduction in ED visits (presently under 54 ED visits per 1,000 member months) for members living with SMI.*

Service Delivery Using NT19/21 Funding and Grants. Using funds from T19/21, NT19/21, and grant funding, HCA annually serves about 3,300 prioritized adults with or without a SMI designation**,** children with serious emotional disturbance (SED), individuals with substance use disorders (SUD), and anyone in crisis in the North GSA. HCA's experience with NT19/21 funding dates back to origins of its legacy programs in 1967, and includes whole person support and services for vulnerable populations. HCA has administered over $86M in services and programs since 2018 in the form of state funds (e.g., NT19/21 SMI, Crisis, Prevention, and Housing), federal block grants (e.g., MHBG, SABG), competitively funded discretionary grants (e.g., SBIRT, STR, SOR, eCOVID), state-funded grants (e.g., GO-SUD) and county court ordered evaluation funds from Coconino and Mohave counties. Additionally, over $23M has been distributed in community reinvestment and related grants since 2018 through The NARBHA Institute and Blue Cross Blue Shield Arizona, including the behavioral health-focused MobilizeAZ program. Highlights of these programs include:

- Evolution of a comprehensive rural/frontier crisis system, administered since 1984. In the past three years, HCA has provided over $8.4M in crisis services based on a SAMHSA best practice model that includes four crisis stabilization units, inpatient psychiatric facilities, locally-based mobile crisis providers, and enhanced post-crisis services. HCA also developed protocols for use with Tribal communities. In response to the COVID pandemic, HCA expanded telehealth crisis care to local EDs and worked with counties to implement 9-1-1 diversion processes.
- Children with SED who might not otherwise be eligible for services receive services through NT19 funding.
- HCA developed and implemented a First Episode Psychosis (FEP) program for youth experiencing their first psychosis through provider training in best practices, and clinical care pathways to improve self-management.
- Since 2015, HCA and The NARBHA Institute funded delivery of over 5,000 Mental Health First Aid Trainings to help prevent suicide, as part of a multi-county effort to significantly expand community suicide prevention training.
- HCA expanded Tribal-focused and gender-specific services in five rural SUD Behavioral Health Residential Facilities.
- HCA managed jail re-entry service coordination and street outreach programs. In 2020, over 7,200 inmates were screened for BH, SUD, and SDOH needs, and over 900 inmates with SUD engaged in services post-release.
- Through the SOR Program, HCA expanded funding to 24 providers, law enforcement agencies, schools, hospital EDs, and other community coalitions. Rural Medication Assisted Treatment (MAT) providers increased services by 133% and Buprenorphine-waivered prescribers increased services by 72% since 2018 – with 12,505 naloxone kits distributed. As of May 2021, 66% of all members with a diagnosed Opioid Use Disorder are engaged in MAT.
- Since 2018, HCA and Oxford House, a peer-led transitional housing program, have opened 15 houses serving 148 members; Catholic Charities has housed 28 families; and Opioid Patient Assistance Funds have housed 27 families**.**

Administration of NT19/21 Funding Sources. To maintain the highest standards, HCA has a dedicated grant administration team, which ensures adherence to: (1) AHCCCS AMPM 320-T1/320-T2 and ACOM 323 policies for fiscal management and administration of grant funding; (2) SAMHSA and other federal guidelines for block grants; and (3) the State of Arizona Accounting Manual for reimbursement-based grants. NT19/21 funds are managed using a model developed in collaboration with our providers and community partners that employs streamlined enrollment and claims or encounter processes. Funds are distributed to providers based on an analytics model that identifies population needs and contractual program requirements, while taking into account each provider's demonstrated abilities to effectively use the funding for grant-specific services. HCA's approach minimizes regional gaps in NT19/21 services and preserves member choice. Funding is administered to ensure federal and local resources are used first, thus preserving limited state funds. Since 2018, HCA has successfully and efficiently administered over $86M in federal and discretionary grants, and has receive unqualified single audits in each year.

B3.

NARRATIVE SUBMISSION REQUIREMENTS

B3: Describe how the Offeror will use the limited Non-Title XIX/XXI funding to maximize the timely provision of quality services to members. At minimum, the Offeror's response shall address each of the following:

a. All sources of Non-Title XIX/XXI funding that the Offeror will be allocated (e.g., Grant, Federal, General Fund, County, Local),

b. The Offeror's process for the prioritization and delivery of services,

c. How the Offeror will encourage and further enable and assist Non-Title XIX/XXI members to become Title XIX/XXI eligible, and

d. How the Offeror will timely coordinate provision of Non-Title XIX/XXI services that have been referred or recommended by all other AHCCCS Managed Care Organizations (MCOs).

Response B3. Health Choice Arizona's (HCA) experience administering NT19/21 funding dates back 54 years to the inception of the federal Community Mental Health Act programs in 1967. Over the subsequent five decades, we have successfully managed a broad portfolio of NT19/21 funds to develop a comprehensive system of care that maximizes use of limited resources through targeted behavioral health, SUD, employment, housing services, crisis, case management, and rehabilitative services and interventions. HCA's approach is built on:

- An allocation methodology guided by funding source requirements, historical utilization trends, and focused population-based initiatives (as prioritized with stakeholders).
- A reliance on strong partnerships with social/community service organizations and network providers to create a coordinated delivery system connecting eligible populations to timely high-quality services.
- The use of industry-leading data analytics, communication, and educational tools, complementing an experienced network of providers and community service resources, to identify persons who meet T19/21 or NT19/21 service eligibility criteria and assist them through the application process.
- The implementation of collaborative innovation to achieve coordinated, reliable, and quality service delivery.

Allocation of NT19/21 Funding. HCA's allocation methodology for NT19/21 (including federal, state, and local) funding is designed to optimize impact through a thoughtful and thorough understanding of: (1) the funding entity's requirements and programmatic goals; (2) regional service gaps, needs, and expectations; and (3) the unique needs of targeted populations and regions. The process begins with a comprehensive review of the requirements, limitations, and programmatic goals for each funding source, with close attention paid to the permitted uses of each resource. Once this analysis is complete, HCA reviews historical utilization patterns for each funding resource by location and provider, leveraging input from local community and stakeholders. When existing providers have not demonstrated success in providing high quality services or have not optimally utilized previous allocations, HCA recruits additional local providers to deploy funding. If existing local providers are not available or able to meet funding program requirements, HCA recruits and incentivizes new providers to offer innovative services to the area. We also use – and often actively develop – health assessment data from ADHS, county and city public health departments, foundations, and educational institutions. Data drives allocation decision-making so that available NT19/21 resources are targeted for priority needs.

In the North GSA, HCA utilizes its established integrated Health Home (HH) and crisis provider network as the primary vehicle for delivering services using NT19/21 SMI, Mental Health Block Grant (MHBG), Substance Abuse Block Grant (SABG), Crisis, and other grant funds. Funding allocation based on historical utilization preserves member choice, helps maintain a strong local provider presence in rural locations that may not otherwise be able to economically support a provider, and allows members to receive behavioral health services in their own communities. HCA has also allocated funding to an additional 200 providers in the region, to ensure that specific programs and specialized services are delivered where they are most needed. These supplemental allocations are based on competitive proposals, targeted initiative specifications, and community-specific needs. Of note, HCA has made extensive use of the recently updated Northern Arizona Regional Health Equity Assessment, commissioned by HCA and The NARBHA Institute, to help identify disparity trends and prioritize population health interventions.

There are differences in provider availability, member living circumstances, and community conditions in the Central GSA; HCA acknowledges the importance of customizing its allocation methodology for the region. In addition to the successful data-driven approach used in the North GSA, a critical evaluation of existing funding allocations, program successes, and community specific barriers for effective service delivery will be conducted for the Central GSA. To ensure stability, providers already receiving NT19/21 dollars will initially continue to receive that funding. Upon completion of HCA's assessment, we will work closely with AHCCCS, community stakeholders, and currently funded providers to make appropriate programmatic changes or funding reallocations.

Our allocation methodology in the North GSA has achieved important results. Program examples and results include:

a. ***Treatment for FEP:*** Using MHBG funds awarded in 2017, HCA created the *Fast Forward* program, to expand provider capacity for psychosis-focused services for youth and young adults experiencing a first episode of psychosis (FEP). ***Results***: Since program inception, the inpatient admission rate for members in the program has decreased by five

percent. From 2019 to 2021, 23% of members saw improvements in social functioning, 20% reported improvement in family relationships, 36% have experienced improvement in school/work performance, and 41% were in recovery.

b. Expanded OUD treatment*:* Using State Targeted/Opioid Response (STR/SOR) grants awarded since 2017, HCA has targeted expansion of Opioid Use Disorder (OUD) treatment, coordinated care, recovery support services, and prevention services. Twenty-four organizations have received support for jail re-entry coordination, the addition of four new Opioid Treatment Programs, and housing assistance for members with OUD through rapid re-entry, peer-run sober living housing, and wrap-around services. ***Results***: In 2020, over 25% of 7,200 voluntary post-release inmates screened for behavioral health, SUD, and SDOH needs received coordinated services post-incarceration for opioid and/or stimulants use. Since 2018, there has been a 42% increase in members engaged in OUD treatment and a 50% increase in NT19 members engaged in treatment.

Process for the Prioritization and Delivery of Services. NT19/21 services are initially prioritized based upon the funding entity's stated requirements. Services qualifying for multiple funding streams are tiered, with decisions guided by an established hierarchy of funding. In general, services are first funded using T19/21 resources, when allowable. When T19/21 funding is not available for an individual or service, but *is* available under other federal grant programs, these federal grant resources are used next. If more than one federal grant program is available, HCA follows each grant's respective eligibility criteria (e.g., MHBG funds are used before SABG). If neither T19/21 nor federal grant funds are available, HCA uses local or state funding next, again depending on the requirements and limitations of the funding source. Optimal use of limited state dollars is accomplished through tiered utilization of other funding. For example, HCA would typically use NT19 crisis funds to address the needs of a non-AHCCCS member in crisis. However, if the individual requires Court Ordered Evaluations (COE) services, screening is directed to county-funded resources or HCA uses the county funds available to us under HCA's IGA or COE contracts (in Coconino and Mohave counties).

Priority Populations: HCA prioritizes populations for NT19/21 resources in compliance with federal/state funding guidelines and in strict adherence to AMPM 320-T1 and 320-T2. For example, SABG funding supports services for pregnant woman/teens who use drugs by injection, and women/teens who use substances, other persons using drugs by injection, women/teens with dependent children and their families. All other individuals with SUD receive funding based on availability. MHBG service allocations prioritize adults determined as SMI, children determined as Serious Emotional Disturbance (SED), and FEP populations. As permitted by grant requirements and available resources, HCA prioritizes services for individuals with SMI, SED, SUD, and health care workers impacted by COVID through timely crisis intervention services, mental health and substance use disorder treatment, and recovery supports. Discretionary grants are vital to our funding support for high priority populations. Since 2018, HCA has administered over $86M in federal and state grants and distributed $8M in Community Reinvestment funds. During that same time period, Blue Cross Blue Shield Arizona's MobilizeAZ initiative has invested over $15.4M in initiatives, grant programs, and community partnerships to address SUD, mental health, diabetes, and SDOH needs for all Arizonans. Special support for American Indian populations has included diabetes care, food assistance, and resources for Tribal communities seriously affected by the COVID pandemic. Extensive community outreach and provider education is conducted across the region and with Tribes, to assure awareness of and participation in expanded service offerings.

Crisis Services: HCA's crisis services network serves all individuals regardless of eligibility or insurance, in accordance with AMPM Policy 590. As part of a full-service continuum that supports local needs, HCA contracts with dedicated mobile crisis teams across the North GSA to provide community-based services in individual's homes, emergency departments and other community settings. All crisis encounters result in an eligibility determination for any individual who may need or want ongoing services. All eligible members are assigned to a HH or contracted behavioral health provider, to quickly engage with the individual and initiate necessary services. From October 2018 through August 2021, 57% (26,338 claims) of all crisis services were for NT19/21 individuals.

Substance Use Services: HCA uses ASAM level of care assessments to prioritize service delivery for members with substance use and co-occurring disorders through our HH and extended NT19/21 provider network. This approach ensures that those individuals with the highest level of need receive services. Because HCA has developed a geographically distributed network of SUD Residential Facilities (including gender-specific facilities that accept NT19/21

members), individuals eligible for services can receive care close to their homes. HCA also receives funding through multiple competitive state and federal grants targeted at under and uninsured individuals with SUD. We utilize these grants to fund innovative community-based treatment programs, developed in response to the opioid crisis. Because several grants have similar themes, HCA ensures that each funding resource addresses different gaps within the system. For example, SABG supports NT19/21 covered services provided through our HH network, while the SOR supports program development and non-covered services, with GO-SUD funds supporting NT19/21 covered services when SABG funding is exhausted. Sonoran Prevention Works' (SPW) street outreach program has delivered 4,783 outreach encounters for HCA members with SUD, including support services such as overdose education, and has distributed 4,772 naloxone kits.

Workforce Competency: HCA uses NT19/21 grant funding to improve the competency of clinical and support staff in rural/frontier communities in the care of specialized populations. Project ECHO, an evidence-based tele-education model, connects subject matter experts with community providers to treat complex conditions. At the onset of the opioid crisis, HCA and The NARBHA Institute successfully implemented the first Arizona Project ECHO for Pain Management. Our partnership has subsequently funded and hosted Mountain ECHO EPI-FEP, the third such implementation in the world and the only ECHO program focused on early FEP in the West. Participants in HCA ECHO programs report an increase in knowledge and skill by 80%, and 20% report positive changes in prescribing practices and services. In 2022, HCA will utilize NT19/21 funding to implement a Project ECHO hub focused on the Maternal Health for members living with SMI – a key priority population from a health disparity perspective.

Encourage, Enable, and Assist NT19/21 Members To Become T19/21 Eligible. HCA conducts continuous outreach to potential members through distribution of educational materials, advertisements, and outreach events. In the past three years, we have supported hundreds of health-related events and reached over 40,000 participants. HCA NT19/21 providers are also required to identify or refer for eligibility determination all individuals who receive crisis services or may qualify as SMI, SED, or FEP. HCA monitors provider performance through review of diagnostic and pharmacy data to ensure that potential members are being assessed. HCA's providers are routinely trained to conduct an assessment, and contractually required to assist all individuals in completing the screening and verification process through use of the AHCCCS Health-e-Arizona PLUS application and our dedicated provider portal. The same quick, one-stop process is used when an individual has a change in qualifying circumstances or requires a renewal. All individuals are assessed and referred for SMI determination if they potentially qualify. Additionally, HCA distributes a registry of NT19/21-only members monthly to our provider network so that providers can follow up with members regarding T19/21 eligibility, and our team of eligibility experts actively help members and providers determine eligibility and navigate enrollment. HCA also assists with referral for SMI determinations for American Indian members.

Incarcerated populations are also prioritized for support. Grant dollars support jail coordinators for county jail systems, sheriffs' offices, and each HH network provider. Jail coordinators ensure that members are either reinstated or apply for T19/21 or NT19/21 upon release from incarceration and get immediately connected to services. Jail referrals comprise 45% of all referrals received by SOR-supported Opioid Care Management team – a 27% increase in referrals in 2021.

Timely Coordination of NT19/21 Services Referred By Other MCOs. Collaboration, not competition, is the key to ensuring members obtain timely NT19/21 services regardless of health plan enrollment. HCA conducts monthly Adult and Child System of Care meetings. These meetings include discussions related to processes, identified barriers, successes, or needed supports. The HCA team collaborates with other MCOs, AIHP, providers, and social service organizations through Adult and Child Services Committee meetings, and actively works with all MCOs and the AHCCCS AIHP program, to assist with referral processes and coordination. HCA's policy and workflow on RBHA referral for NT19/21 services is published on the HCA website and directly distributed to all MCOs, AIHP, and TRBHAs. If an MCO identifies a person for NT19/21 covered service, the MCO notifies HCA's eligibility department/call center or works directly with an HCA contracted NT19/21 service provider, who submits a state-only enrollment using HCA's dedicated NT19/21 service portal. This process permits our contracted NT19/21 providers to serve members *immediately.* In the past two years, over 50% of HCAs NT19/21 housing funds have been expended on members enrolled with other MCOs.

B4.

NARRATIVE SUBMISSION REQUIREMENTS

B4: There are many opportunities for clinical quality improvement for care of individuals living with Serious Mental Illness (SMI). The Offeror shall:

a. Describe methods the Offeror uses to assess disparities or improvement opportunities for broad-based (system-wide) quality improvement and the related actions taken,

b. Describe areas the Offeror has identified as presenting the greatest opportunities for broad-based (system-wide) quality improvement and the related actions taken,

c. Describe the Offeror's experience in achieving quality outcomes for individuals living with an SMI or similar Medicaid populations. When applicable, provide statistically relevant results of previous interventions implemented by the Offeror, and

d. Describe the Offeror's proposed approach to a clinical Performance Improvement Project (PIP) designed to improve outcomes for individuals living with an SMI. [Note: AHCCCS will review the Awarded Offeror's PIP and may require the Offeror to implement the proposal as an AHCCCS-mandated PIP (subject to AHCCCS-required adjustments) for the Geographic Service Areas (GSAs) served].

Response B4. Health Choice Arizona (HCA), through our legacy organizations, has managed behavioral health services since 1967. This history has allowed us to develop an extensive, customized infrastructure to improve clinical quality and successfully integrate care for members living with Serious Mental Illness (SMI), including members aligned with our Health Choice Pathway D-SNP. HCA's commitment to an equity-based culture of continuous quality improvement is evidenced by the strength of our strategic partnerships, our engagement with providers and members, and implementation of best practice improvements that measurably improve health outcomes.

Methods used to assess health disparities, improvement opportunities, and related actions taken. The HCA Quality Management Performance Improvement (QM/PI) Program advances innovative practices that address disparities through a robust quality improvement methodology. Guided by the Institute for Healthcare Improvement's "Quadruple Aim" – improving health outcomes, enhancing member experience, reducing costs, and increasing provider satisfaction – HCA's QM/PI program applies evidence-based quality improvement techniques and tools (i.e., *Lean*, *Six Sigma*, and the *Plan, Do, Study, Act* models) to assess, measure, and improve individual member care.

Arizona counties and communities vary greatly in demographics, social determinant trends, and barriers to care. This diversity requires that health issues, community assets, and barriers to wellbeing are evaluated in a locally-specific context. Members living with SMI face unique geographic, transportation, weather, and service access challenges in communities across the North and Central GSAs. To optimally assess these challenges and target solution development that is responsive to specific circumstances, HCA's Health Equity Committee analyzes differences in healthcare access and delivery, and monitors multiple information sources segmented by subpopulation, geographic area, condition risk and cost, race and ethnicity, Tribal affiliation, and language. Through data-driven analytics, provider performance monitoring, and use of Northern Arizona University's Regional Health Equity Assessment, our integrated improvement methodology is designed to achieve high quality outcomes. Key components of our approach, and interventions taken in response to identified improvement opportunities, include:

- *Disparity analyses available from our Arcadia Quality Analytics and the Johns Hopkins ACG system.* These analytics engines perform risk stratification of members living with SMI by many factors, including morbidity risk scores, inpatient/emergency department utilization risk, social risk factors, geography, and demographics. **Action:** Throughout the pandemic, the Hopkins ACG system has enabled risk-stratified member outreach, with focus on those members at highest risk of COVID infection, including American Indian members. **Results:** The COVID mortality rate for HCA's RBHA members is less than 50% the rate reported for the Arizona general population.
- *Zip code heat maps to identify geographic areas for targeted interventions to close gaps in care*. Maps are constructed for regions based on HEDIS and preventive outcome priorities. **Action:** In response to rural community variations in breast cancer screening for women with SMI, HCA and The NARBHA Institute worked with providers to implement a preventive "test and treat" women's health program, and deployed mobile lab testing, mammography, and other community screening events to high need areas. **Results:** Breast cancer screenings have increased by 16% in Kingman, Lake Havasu, Seligman, Round Valley, Flagstaff, and Show Low. North Country Health Care recently performed over 150 mammograms and pap smears at a single event in Flagstaff.
- *A proprietary Tableau dashboard* overlaying publicly available data in an interactive format that includes a "resource desert" analysis, an analysis of social and environmental determinants of health factors, and risk stratification by educational attainment, economic conditions, and the built environment. **Action:** In response to the food desert location information, the Blue Cross Blue Shield Arizona/HCA Community Health and Advancement team developed and funded a multi-phase strategy to address food insecurity. **Results:** Over $2.5M in Blue Cross Blue Shield Arizona's MobilizeAZ funding has supported food access for Tribal members and other underserved Arizonans.
- *The Regional Health Equity Assessment* (RHEA) has been a vital resource to identify health disparities. HCA commissioned the RHEA with financial support from The NARBHA Institute. Northern Arizona University's Center for Health Equity Research conducted the assessment in 2017, and continues to update it. **Action**: Through the RHEA, we identified a need to strengthen LGBTQ+ care and support services. We have since partnered with several organizations including the Trevor Project, PFLAG, and Trans Lifeline to improve LGBTQ+ population health.

Leveraging decades of collaborative relationship building with community providers, HCA conducts respectful provider-specific improvement interventions in response to data trends, community needs, and individual member circumstances. Collaborative Technical Assistance meetings with provider clinical leadership exemplify the strategic inclusion of patient safety recommendations, medical records standards, and system of care best practices. This approach, coupled with ongoing medical record monitoring, has resulted in 95% compliance with AHCCCS Quality Management medical record standards. Provider quality improvement information, including performance metrics, dashboard indicators, and member outcomes, are routinely disseminated to key stakeholders through the Behavioral Health Quality Improvement Collaborative, Quarterly Provider Forums and Newsletters, monthly Provider CEO, Medical Director, and CFO Meetings, and HCA QM/PI Committee meetings.

Greatest opportunities for improvement and actions taken. The HCA QM/PI Committee holds organizational accountability for quality assessment and system-wide performance improvement, prioritizing action plans for enhanced provider services, clinical programs, and performance improvement processes. Statistical analyses, such as variation analysis, value stream mapping, and root cause analysis help identify improvement opportunities with the greatest system-wide impact. This information is regularly reviewed with the HCA Executive Leadership Team via a real-time Quality Dashboard, monitoring progress on priority outcome measures and internal quality initiatives. A dedicated Quality Improvement Medical Director leads system-wide performance improvement projects with providers, ensuring collaborative relationships and action interventions that are based on provider-specific performance data. Interdisciplinary quality improvement projects are conducted by an experienced QM unit led by HCA's Quality Director, an in-house Lean Six Sigma Black Belt, who trains Quality Improvement staff on the *Define Measure Analyze Improve Control* (DMAIC) improvement model and how to apply analytic and statistical tools to healthcare quality improvement. Performance Improvement Coordinators (PIC) partner closely with provider practices and our PI Medical Director to support closure of gaps in care. The approach received important validation: HCA achieved **100% compliance** on the Quality Improvement domain during the 2020 NCQA Health Plan Accreditation Survey.

Our process has produced continued quality improvements since 2015 for a targeted set of seven system-wide integrated measures identified by data analytics as needing broad-based improvement:

- Electronic provider prescribing
- Hospital readmission
- Inpatient utilization
- BH post-discharge follow-up
- Acute care post-discharge follow-up
- ED utilization
- PCP integrated health home visits
- Total cost of care

For 7 APM/ICI Measures Monitored Between FY2016 and FY2019:

- 17% of APM provider groups improved in 5 or more measures
- 50% of APM provider groups improved in 4 or more measures
- 67% of APM provider groups improved in 3 or more measures
- 100% of APM provider groups improved in 2 or more measures

Average number of measures improved per APM provider group was 3.3 measures per group

In partnership with its provider network, HCA established the Alternative Payment Methodology Integrated Care Improvement (APM/ICI) program. Developed specifically to improve care for members living with SMI, the APM/ICI program engaged five structurally integrated health homes and two specialty provider organizations serving members with SMI in a Value-Based Purchasing/APM improvement initiative. Because HCA had already established shared risk sub-capitated agreements with participating Health Homes (HH), HCA was able to use APM/ICI incentives to improve integrated measures on top of sub-capitation – thus moving participating providers into Category 4 of the Health Care Learning and Action Network's APM Framework (the highest level of population-based payment APM methodologies). Regular monitoring of performance was reviewed with APM/ICI participating organizations, informing collaborative development of system-wide improvement best practices.

As summarized in the table above, the results were significant: Of the seven APM measures tracked for average change between 2016 and 2019, 50% of APM/ICI provider groups improved in four or more measures, with 100% of participating providers improving in two or more measures. The improvement in provider e-prescribing is especially noteworthy. Consistent with the significant gains in e-prescribing performance seen across the entire HCA network as

part of an AHCCCS Performance Improvement Program (PIP) for all RBHA contractors, providers participating in the APM/ICI program exceeded 80% in e-prescribing by the conclusion of the initiative.

Quality results. Through the use of best practices, targeted interventions, and collaborative partnerships, HCA has consistently demonstrated improved integrated quality outcomes since the 2015 SMI Integration:

- All-Cause Readmission rates have decreased 38%.
- Emergency Department Use has decreased 48%.
- Use of Opioids in Persons without Cancer has decreased 91% and concurrent Use of Opioids and Benzodiazepines has decreased 52% (since measurement began in 2017).

HCA's 2020 Case File Review audit of Behavioral Health Provider records for members with SMI found clinical assessments included all requirements per AHCCCS AMPM 320-O for 98% of records. Over 93% of participants received a substance use assessment when indicated. Cultural/Special Needs/Language were assessed appropriately in 100% of medical records, and demonstrated that staff actively and appropriately engaged the member, family and natural supports, and other agencies 100% of the time. The Child and Family Team (CFT) Process scored over 93%, and Crisis Plans demonstrated 99% compliance. Timely outreach and engagement was completed 100% of the time. Review of the Arizona Controlled Substances Prescription Monitoring Program, when indicated, yielded a 93% compliance rate.

Our *Recover Wellness* (RW) Integrated Care Management Program ensures high quality integrated care and improves outcomes of members living with a SMI and high-risk conditions. Members enrolled in RW for at least 12 months show a ***27% decrease in ED visits, a 23% decrease in all-cause inpatient admissions, and a 15% decrease in total cost of care.***

In response to a pattern of suicide deaths, the HCA Mortality and Morbidity Committee developed a comprehensive suicide prevention protocol, *SHOUT.* Using evidence-based interventions, such as PCP coordination to reduce access to lethal means and increased use of outpatient services, HCA's care management staff ensures protocol adherence and mentors provider case managers in evidence-based suicide prevention. SHOUT has demonstrated positive results – the rate of suicide death within a year following enrollment is ***22% better than published rates in peer-reviewed literature***.

The *Benzodiazepine and Opioid Warning Signs (BOWS) Prevention Protocol* is another HCA quality initiative developed in 2016 to respond to member overdose deaths in which Mortality and Morbidity reviews identified warning signs present in the medical record but not addressed with a change in provider prescribing, supervision, or services. BOWS uses evidence-based interventions, including immediate risk assessment at the time of suspected overdose, care team alerts, and naloxone prescribing. Since 2016, for 254 members enrolled followed a BOWS qualifying event, only 6% have experienced a repeat event, with ***no overdose deaths*** for participating BOWS members. BOWS Prevention Protocol interventions consistently result in changes in prescribing patterns, including a 38% average decrease in Morphine Equivalent Daily Dose and a 51% decrease in Diazepam Equivalent Daily Dose over 6 months.

HCA also participated in the Electronic Prescribing (E-Rx) AHCCCS PIP, to increase the number of prescribers electronically prescribing and the percentage of prescriptions submitted electronically. E-Rx has been shown to decrease medication errors across ambulatory settings as well as in hospitals and emergency departments. HCA interventions included value-based contracting, enhanced data sharing, and one-on-one provider technical assistance. It resulted in statistically significant increases from the baseline measurement year to the final project year: ***39% more prescribers were using electronic prescribing and 26% more prescriptions were filled electronically***.

In response to the opioid epidemic, HCA conducted an additional PIP for Opioid Targeted Response, with significant increases in the number of T19 and NT19 members receiving Opioid Use Disorder (OUD) Treatment and Medication Assisted Treatment (MAT). From October of 2017 to July of 2018, HCA noted a 20% increase in the number of T19 members receiving OUD Treatment and a 22% increase in the number of those members receiving MAT. The NT19 population experienced a ***56% increase in OUD treatment and over 330% increase in MAT services.***

HCA is dedicated to improving individual and systemic quality of care through comprehensive QOC investigations to address health and safety issues. Timely investigation is important, and timely resolution was achieved for ***100% of our 1,178 cases investigated since January 1, 2019***. Corrective Action Plans have been initiated for all substantiated quality

of care concerns, and each followed to successful completion. Partnerships with Health Homes have produced sustained improvements. For example, one Health Home improved missed appointment reengagement by 23% in two years.

Highly specific and accurate clinical documentation is vital to the provision of high quality care and preventing unnecessary medical errors, while also ensuring coordinated care and the data necessary to document and track outcomes. HCA catalyzed positive results in clinical documentation through an initiative to address tracking, monitoring, and provision of SMI Special Assistance for members living with SMI. Corrective actions with all Health Homes resulted in an improvement with Special Assistance requirements from ***59% in CY2018 to 97% in CY2019***.

A Proposed Clinical Performance Improvement Project. In addition to the collaborative PIPs currently underway to address AHCCCS primary and secondary measures, HCA proposes a multifaceted PIP for maternal health: *Bright from the Start.* Each year, HCA's *Recover Wellness* (RW) Integrated Care Management program manages more than 100 pregnant members with SMI. Despite a number of improvement efforts for this population, trends in prenatal and, most notably, postpartum care remain a concern. In addition, 2020 rates of C-sections (39%) and pre-term delivery (11%) are higher than best practice. And approximately 10% of babies born to women with SMI need neonatal intensive care unit (NICU) treatment, and 15% are either low birth weight or very low birth weight. In short, although some improvements have been made in maternal and newborn health measures, such as neonatal abstinence syndrome, the overall impact of our efforts in recent years has not produced anticipated results.

Bright from the Start is being designed to bring positive change. Evolving from previous person-centered efforts for pregnant women conducted in our RW program, this PIP proposes a comprehensive improvement approach that will: (1) Include peer supports in HCA women's pregnancy and postpartum care teams; (2) Offer enrollment in Pyx Health, a 24/7 mobile technology platform that assists with SDOH needs and reduces loneliness and post-partum isolation through companionship and timely interventions. (Pyx will be available to fathers too, as they have also been shown to experience an under-recognized, high incidence of post-partum depression); (3) Offer a new Project ECHO Maternal Health hub; (4) Weekly interdisciplinary Maternal Rounds with providers and community service organizations, led by HCA physicians with specialty OB and SMI/SUD expertise; and (5) Enhance coordinated service delivery for pregnant women with co-occurring SMI and substance use disorder (SUD) through: (a) Dedicated provider case management, in collaboration with a newly-hired HCA maternal health care manager, to ensure active member engagement in behavioral health and SUD services during, and after, pregnancy; (b) Ongoing collaboration with the Hushabye Nursery, a specialized nursery providing compassionate, evidence-based care for opioid-exposed newborns to improve bonding, reduce neonatal abstinence syndrome and neonatal ICU stays, promote breastfeeding, and connect the members and families with SDOH and other ongoing care. Coordination will also continue with other services funded by HCA, such as: Sonoran Prevention Works (SPW), for direct outreach to individuals who use drugs and are experiencing homelessness; jail re-entry coordinators located in county jails across North GSA; and (c) An axialHealth Risk Mitigation and Recovery Solutions programs, delivering provider education and peer and SDOH supports for members in the recovery process.
Anticipated Results: The following results are proposed for all pregnant women with SMI within two years:

- The rate of C-sections in women living with SMI will be reduced by 10%.
- The rate of low and very low birth weight babies will be reduced by 5%.
- 100% of pregnant women living with SMI will be offered peer support for at least one year post-delivery.
- At least 80% of women with SMI will receive behavioral health care during their pregnancies and postpartum.
- At least 80% of women with SMI will receive recommended prenatal and postpartum visits.

Continuous Quality Improvement. HCA's culture of quality is evident in its year-over-year improvement in health outcomes for the members we serve. Through an evidence-based, structured approach to population health improvement, we advance the health of our members by identifying and addressing disparities, increasing health literacy and self-management, offering member specific interventions, and doing so through collaborative relationships with providers. It is a proven model for our members with SMI, and for our entire plan. We look forward to continuing its implementation, refinement, and achieving improvements across the North and Central GSAs.

B5.

NARRATIVE SUBMISSION REQUIREMENTS

B5: GSA Specific Submission Requirement:

a. If submitting a Proposal for North GSA

Describe the Offeror's experience with the unique aspects of service delivery to members in the North GSA. What current or planned strategies will the Offeror employ to ensure the effective delivery of services? Provide evidence supporting and/or expected outcome of the approach.

b. If submitting a Proposal for South GSA

Describe the Offeror's experience with the unique aspects of service delivery to members in the South GSA. What current or planned strategies will the Offeror employ to ensure the effective delivery of services? Provide evidence supporting and/or expected outcome of the approach.

c. If submitting a Proposal for Central GSA

Contractors are required to develop and incorporate member-specific goals and needs in the individual service plan. Recent Quality Service Reviews reveal that family support may be limited and/or goals may be generically individualized and not member-specific.

Describe how the Offeror will ensure members' services are aligned with their individual strengths and needs, and how the Offeror intends to ensure that Peer and Family Supports are offered and available to assist in meeting the members' needs. Additionally, describe how the Offeror will incorporate additional Arnold vs. Sarn requirements into service planning for members, and how the Offeror intends to achieve and measure compliance with the settlement requirements.

Response B5a. Northern Arizona is one of the most geopolitically, culturally diverse, and challenging regions in America, particularly as it relates to the delivery of health services. Health Choice Arizona's (HCA) 54-year history in Northern Arizona gives us the ability to identify strategies that address the region's unique social, cultural, geographical, technological, and economic needs. HCA and its providers are committed to supporting members and communities in obtaining services in a culturally sensitive manner that best meets their individual needs and expectations.

Geographic Challenges: One of the most unique aspects of serving members in the North GSA is its expanse, covering over 60,000 square miles. Because of this, communities tend to be separated by great distances and significant natural barriers, such as the Grand Canyon. Weather challenges can further complicate access to care due to heavy rain and snow. HCA utilizes a variety of strategies to meet the geographic needs of its members. Since 1996, HCA has used a custom-designed telehealth system to support members' behavioral and physical health needs. This system was further expanded during the COVID pandemic, resulting in a 400% increase in utilization. We provide free Zoom accounts to help "brick and mortar" providers continue delivering telehealth services during the pandemic. Where telehealth has been hampered by limited broadband connectivity, we fund cell-based wireless tablet devices for providers and members. In even more remote communities (such as Havasupai Village in the Grand Canyon) where reliable broadband or cellular service is not available, we arranged and supported WiMax-based internet connectivity. HCA will continue to expand our telehealth network through a collaborative effort with local behavioral health providers to build on the foundation we have collectively established during the pandemic.

Reliable transportation is a significant challenge to effective service delivery. Through our non-emergent transportation vendors, members have access to a variety of vehicle types to meet their needs. This includes vehicles with 4-wheel drive to mitigate issues through tough terrain and snow, minivans, stretcher vans that carry up to 600 pounds, and large group transportation. Our transportation vendor has agreements with all Tribal nations to allow dedicated drivers to travel on and off of Tribal lands. Priority travel arrangements are available for members in need of specialty services, such as those with chemical sensitivities, children with ASD, and those requiring dialysis services. We also contract with our Health Home network, located across the North GSA, to provide transportation to members, giving them access to drivers within their communities that they know and trust, and case manager support when needed.

Network Strategies: HCA relies on a regionally based system of Health Homes, coupled with over 2,000 specialty providers, to serve the BH needs of our members living with SMI. However, consistent with ACOM 415 and 436, HCA continuously analyzes utilization data and conducts regular assessments to identify gaps in our network. To increase access to care, we regularly deploy mobile clinical care as well as in-home services. Recently, when the Navajo Nation lost a mobile dental provider, we worked with a dentist in Flagstaff to offer mobile services to meet the needs of affected members. Mammography screening has proven to significantly decrease breast cancer mortality, with a greater than 40% reduction expected when annual screening starts at age 40 for women of average risk. However, less than half of all eligible women have a mammogram annually. Because we identified that this number was significantly worse in Kingman, Lake Havasu, Seligman, Round Valley, and Show Low, HCA used a targeted outreach campaign and mobile mammography providers to offer breast cancer screening services in these rural locations. Early in the COVID pandemic, we identified that members needed lab work to adjust psychotropic medications (such as clozapine which requires weekly blood draws), but were anxious about leaving home. As a result, we made in-home phlebotomy services available to members who may not feel comfortable going to a lab draw site or have transportation challenges.

Provider Support & Development: Provider shortages and economic issues represent very real challenges in the North GSA. Given low member densities, it is financially difficult to maintain a sufficient patient base to recruit and retain clinic programs and individual providers. This means that, unlike the Central GSA, an important function of a health plan in the North GSA is provider development and maintenance. HCA has long supported local providers through a system of stable funding structures, and the identification and funding of new provider capacities when inadequacies are identified. In collaboration with The NARBHA Institute, we will continue to fund Family Medicine and dental residency (and add psychiatry) programs at North Country Health Care (supported through an affiliation with the University of Arizona), and support placement of at least 60 additional master's level counseling students through Northern Arizona University. HCA has also continued to develop and evolve our innovative Integrated Health Home model, which was

designed to address the unique needs of provider economics in rural locations, while advancing whole person care. Our primary approach to integrating behavioral health and physical health services is to contract with fully integrated providers where members living with Serious Mental Illness (SMI) may choose to receive fully integrated care at one location, supported by an integrated clinical team and a single integrated medical record. Over 40% of HCA's Health Homes currently rank themselves at Level 4 or above using SAMHSA's integration model. HCA will work with our network to increase this to 80% within three years. Integration efforts are further supported by HCA's Recover Wellness program, which provides integrated care management for individuals living with SMI. Over the last five years, the program showed a 27% decrease in emergency room visits, a 23% decrease in inpatient admissions, and 15% decrease in the total cost of care. HCA will expand this program with technology and telehealth services to further decrease the use of avoidable emergency and inpatient resources and reduce costs. Finally, as noted previously, telehealth, mobile clinical care, and in-home services have provided a way to make services available in location where having resident professional staff is not otherwise feasible. Together, when used effectively, these programs and services make integrated care available in locations where it would not otherwise exist.

Substance Use: Outside of COVID, the fastest developing and most significant challenges over the last five years have related to substance use disorders. The specific substances in use differ dramatically, however, depending on region. Opioid use has been most prevalent in Mohave and Yavapai counties, with over 60% of substance use cases involving opioids since 2017. HCA will continue to focus the use of available OUD resources to further develop our T19 and NT19 provider resources in those counties. In Coconino, Navajo, and Apache counties, use of methamphetamines and prescription medications remains prevalent. HCA will emphasize the use of financial resources that are not dedicated to OUD to these geographic areas. We have expanded the MAT provider network to provide treatment including naloxone prescribing. Without HCA's collaborative relationships and comprehensive regional knowledge, the need for these efforts would not have been readily apparent and funding would not have been used to maximum effect.

Crisis Services: Providing crisis services is another challenging aspect of serving the North GSA. HCA has continued to develop and expand our system since 1992. HCA's system implements SAMHSA's "anyone, anywhere, and anytime" approach, and ensures communities have access to timely crisis care. The full continuum of crisis services are available 24/7, and are free to anyone, irrespective of eligibility. Despite a 38% increase in the number of requests since 2018, our average mobile team response time is under 28 minutes – 60% better than required. During the COVID pandemic, HCA supported mobile crisis services by deploying telehealth crisis services for hospitals, including some of the most hard-hit Tribal facilities. HCA will evolve our crisis strategies through the transition of mobile crisis services to one or more dedicated regional providers and development of an adolescent crisis stabilization unit and emergency respite program.

Tribal Services: Tribal communications is exceptionally important in the North GSA, including consultation with the largest US Tribe in terms of both population and geography – the Navajo Nation. Our relationships are based on respect for the fact that each Tribal Nation is organizationally and culturally unique. HCA's strategy involves the use of a Tribal Services Team approach, led by our Tribal Coordinator, and supported by staff from clinical and operational departments. Our Tribal Services Team maintains communications through at least quarterly meetings with each Tribal Government and Tribal Providers, and holds an annual Tribal Summit. HCA has established working agreements, whether written or informal, with 13 of the 17 Tribal communities in the North and Central GSAs. With Tribal consent, we will complete the remaining four within the next two years. We will continue to use Community Reinvestment funds to provide Traditional Practitioner and Sweat Lodge ceremonies. During the height of the COVID pandemic, HCA and Blue Cross Blue Shield Arizona, provided funding, protective equipment, and organized collaborations among Tribal providers and bordering health facilities to address ICU and ED bed constraints, staffing shortages, and protective equipment limitations. HCA will continue to facilitate this collaboration to ensure that logistic and staffing challenges do not hamper Tribal efforts to recover from COVID.

COVID Response: HCA has played a supportive role to the region's public health system by leading several provider, Tribal, health plan, and local government collaborative efforts to address the ever-changing needs of the region. These efforts have included facilitation of the Northern Arizona Health Leaders Coalition. The need for our unique role will continue to evolve as the pandemic subsides, and HCA will be there to support evolving community needs.

Response B5c. Health Choice Arizona (HCA) has a comprehensive understanding of the history and requirements of the *Arnold v. Sarn* lawsuit, originally filed in 1981 and settled in 2014 based on an agreement to provide certain community services and adhere to quality and network standards as well as SAMHSA fidelity tools. HCA is also uniquely qualified because we employ two of the five individuals who served as Maricopa County's *Arnold v. Sarn* Administrator over the class action's 25-year history. We embrace the requirements of the settlement agreement, which provide a solid framework to ensure members have access to community-based services, supportive housing, and supported employment based on their personal needs. HCA's population health model in the North GSA is grounded on these requirements, in that it provides member centric assessment, service planning, family and peer support, is evidence-based, and is culturally and linguistically focused. It also provides a comprehensive array of services including the agreement's focus areas: **Assertive Community Treatment, Supported Employment, Supportive Housing, and Peer and Family Services**. We understand and support the use of the tools required by the settlement to evaluate services in Maricopa County, including quality service review, network capacity analysis, and SAMHSA fidelity tools. We acknowledge and support the requirements of the *Arnold v. Sarn* settlement agreement as a *baseline* framework to ensure members have access to community-based services, supportive housing, and supported employment aligned with their assessed needs – and we are dedicated to *exceeding* that baseline.

Alignment with Strengths and Needs. Every member with a SMI designation has an Adult Recovery Team (ART) that works in collaboration with the member, and is actively engaged in the member's assessment, developing the individual service plan (ISP), and providing services. In the North GSA, including Gila County, HCA works with Health Homes to develop and facilitate ARTs. In the Central GSA, HCA is either already contracted with, or will contract with, Health Homes to facilitate ARTs. HCA makes certain these providers are responsible and responsive to member needs through the timely initiation and continual monitoring of member's ISPs, which serve as the roadmap for supports, activities, and resources necessary for members to achieve personal recovery goals. The ISP is developed in coordination with the member, desired supports, and their care team. The ISP documents decisions and agreements made during a person-centered process of planning and information gathering. Whole person health and the member's personal preferences are the key considerations in the development of all plans. To measure compliance with ISP requirements, HCA conducts ongoing Quality Review Audits through proportional random sampling. These reviews include an in-depth examination of the ISP and progress notes to confirm member's services are aligned with individualized strengths and needs. Providers who do not meet minimum performance standards receive technical assistance in real time and a corrective action plan (CAP) is initiated, including a root cause analysis, targeted monitoring, and process improvement activities until CAP closure requirements are met. HCA will also conduct member outreach activities to confirm ISPs are being individualized to the unique needs of each member. HCA will expand its *Recover Wellness* (RW) Program to the Central GSA, an integrated care management model that supports members and providers. RW Integrated Care Managers are key partners in the ISP process providing education, care coordination and oversight. Throughout the year, HCA also conducts trainings to support providers and to share best practices across the continuum. Service capacity assessments will be conducted to determine if services need to be expanded.

Peer and Family Supports. Peer, family, and natural supports are critical to whole person care. A key aspect of the assessment and treatment planning process is to document in the ISP who the member identifies as their support. HCA will require that contracted providers include peer and family participation in all aspects of care including assessment and treatment planning. Clinical teams will be required to have sufficient numbers of peer and family specialists available for members. HCA will offer and require training on person and family-centered care and peer support approaches to care. Monthly Advisory Council meetings with be held with clinic Directors, Provider CEOs, and other stakeholders to inquire about ongoing member and family participation in decision making, quality improvement, and enhancement of customer service. Peer support specialists require ongoing education. HCA makes them aware of training resources on a continual basis. HCA created a Behavioral Health Referral Training based on recommendations from members and family members, and members and families will be invited to participate in focus groups to identify what is working and what can be improved to drive training content and the overall process improvement. HCA contracts with Peer Run Organizations in the Central GSA who provide a number of employment services including, Recovery Empowerment Network (REN), CHEEERS, and STAR Centers. We also contract with Transitional

Living Center which provides housing and employment services. HCA contracts with axialHealthcare which provides peer and family support through their OUD Recovery Solutions program in the Central GSA. We have expanded family resources through FIC and MiKid to further support youths as they transition into adult SMI status. Peers with axialHealthcare engage with members in person, by telephone, via messaging, and by video to support OUD recovery. HCA also has a long history of developing new resources (such as NAZCARE), and will work with family resource partners to expand services in the Central GSA.

Assertive Community Treatment (ACT) teams. HCA employs the SAMHSA program model of ACT in the North GSA, a proven method of delivering a full array of individualized, flexible services to assist members with their basic needs, such as housing, employment, medication adherence, transportation, PCP appointments, and outpatient BH care. We will work with the 24 existing providers in the Central GSA to maintain current ACT teams and add additional providers.

Supported Employment services assist individuals living with SMI to prepare, identify, attain, and sustain competitive employment. Factors that influence a person's employment service and support needs include age, education, culture, language, employment experiences, socioeconomic background, co-occurring conditions, and employment goals. Services will include job coaching, transportation, assistive technology, specialized job training, and individually tailored supervision. HCA will ensure employment specialists and case managers are trained and continue to remain in regular contact with the member and, as appropriate, the employer.

Supportive Housing is permanent housing with tenancy rights and services that support individuals living with SMI to attain and keep affordable housing. Establishing stable supportive housing is of great importance to our members. HCA was among the first health plans to adopt SAMHSA's "Housing First" Model, which uses housing as a tool for recovery. We work closely with our network of housing providers and clinics to present housing options for members. HCA will adopt use of the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as a method for prioritizing the most vulnerable individuals for whom to spend community reinvestment housing dollars. HCA is a partner with the Closing the Gap (CTG) program operated by Catholic Charities Community Services, bringing housing stability to the chronic substance abuse population who are high users of emergency and law enforcement resources. CTG has shown a significant reduction in encounters and cost by providing stable housing to this extremely vulnerable member population, with the main focus on providing housing stability while meeting recovery needs. As we are already doing in the North GSA, HCA will work closely with Arizona Behavioral Health Corporation to ensure members receive housing support.

Compliance with the *Arnold v. Sarn* Settlement Agreement. HCA's initial strategy will be to maintain what is working in the Central GSA, while forming collaborative partnerships with AHCCCS, providers, members and families, and advocacy groups to evaluate future improvements. HCA is a recognized leader in developing collaborative relationships across the state, counties, health systems, other AHCCCS health plans, and governmental agencies – as evidenced by its work throughout the COVID pandemic. We will ensure compliance is measured using the SAMHSA Fidelity Model. Ultimately, provider staff training will be critical to compliance with *Sarn's* requirements. The HCA Workforce Development Administrator will play a key role delivering the required training to ensure the workforce has the capacity, capability, and competence needed to provide services, including training on Comprehensive Assessment, ISP development and management, person-and family centered care approach, peer support, and the SAMHSA Fidelity model. HCA quality management processes will include extensive medical record audits to validate the required components of service provision. We use a PDSA model to consider, audit, and address Functional Assessments, ISP Goals, Member Input, Evidence of Services, and Rationale for Barriers to Service Delivery for each component of the model. HCA will also provide technical assistance to providers for each component. Tracking, trending, and analysis of outcome data including utilization data, such as inpatient and emergency visits, are also current HCA processes. Routine assessment of outcomes, along with training and innovative problem solving, will ensure success.

HCA is currently the only NCQA accredited AHCCCS health plan, and our integrated care management programs were highly rated by NCQA. NCQA's care management standards describe 17 mandatory requirements which align with the *Arnold v. Sarn* for individualized member assessment and development of ISPs, and goals which include evaluation of SDOH, caregiver resources, community resources, and health literacy. HCA scored 100% in this NCQA domain.

B6.

NARRATIVE SUBMISSION REQUIREMENTS

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.

Response B6a. Health Choice Arizona's *Recover Wellness* Integrated Care Management program (RW) is a specialized care management program for individuals living with Serious Mental Illness (SMI) and who are members of either Health Choice Arizona (HCA) or our aligned Health Choice Pathway DSNP. This innovative program was created in 2015 and was built upon the existing strengths of, and tailored to, HCA's unique service delivery model, which we have developed over five decades. The RW program is anchored by a team of Integrated Care Managers (ICMs) who are Arizona-licensed RNs and social workers, assigned to specific geographic areas. This allows the ICMs to develop collaborative relationships with local Health Homes, PCPs, and specialists, and to develop in-depth knowledge of the social service and support resources available in their communities. The ICMs are seen by providers as a value-added layer of support for members living with SMI.

Success Story: *One of our members (a 59-year-old man with bipolar disorder, type 2 diabetes, COPD, HTN, and chronic back pain) had 31 ED visits in six months, and frequently called the HCA nurse line with anxiety. Our ICM coordinated BH & PCP outreach to the member after every ED visit and nurse call. Frequent BH and PCP appointments were scheduled, and pain management services were initiated. After 15 months, the member has had no ED visits or nurse calls and reports significantly decreased anxiety.*

Results: RW has been exceptionally successful: Members enrolled in RW have shown a 27% decrease in ED visits, a 23% decrease in inpatient admitssions, and a 15% decrease in overall total cost of care. Members enrolled in the RW Diabetes Disease Management Program show a 40% decrease in ED visits related to diabetes, and, for members involved in the RW SHOUT suicide prevention protocol, the rate of suicide death in the year immediately following a high-risk suicide attempt was 22% lower than the predicted rate published in a 2016 study.

Program Design: Members are identified for enrollment on a "no wrong door" basis – with referrals coming from providers, family members, and internal data sources. Once a member is enrolled, the ICM conducts a comprehensive assessment of the member's needs, strengths, and resources based on a Health Risk Assessment, input from the member's natural supports, care team, predictive analytics from the Johns Hopkins ACG system, and Arizona Controlled Substance Prescription Monitoring Program, and all available claims, HIE, pharmacy, and authorization data.

The ICM works with the member and care team to develop a whole person, recovery-oriented Integrated Care Management Plan document (ICMP) which includes all of the above information, and incorporates the preferences of the member, family, and/or guardian. Care strategies and special health care needs (such as COVID inpatient care, Arizona State Hospital, or Psychiatric Security Review Board involvement, co-occurring SMI/SUD, tribal affiliation, or CRS diagnosis) are all identified in the ICMP. Contact information for all providers and team members is listed on the face sheet to encourage collaboration and care coordination. The ICM distributes the member's ICMP to all providers on the member's care team for supporting data-informed treatment decisions, coordinating care with treating providers, identifying gaps in preventative care, and calling attention to risks or alerts that may only be visible at the health plan level. A December 2020 provider survey showed that 91% of respondents reported that the ICMP provided valuable information regarding their patient. According to the survey's comments, ICMPs are "a helpful tool for provider teams that work with the SMI population" and "offer a wealth of information." ICMs also manage additional functions, including facilitating member transitions between treatment settings, coordinating care between providers, and supporting development of member self-management skills.

Population Care Leads (PCLs) support the ICMs by identifying and implementing population level interventions that improve integrated care across not only our network, but the entire Arizona system by working collaboratively with other health plans. PCLs proactively identify members (including high risk/high need members) who will benefit from intensive care management or specialized disease management processes for members with chronic conditions. They also create integrated care trainings and provider toolkits for behavioral health providers and PCPs serving members living with SMI. Of note, the HCA Integrated Care Training Series, is available to all Arizona behavioral health providers through the Relias platform, and has delivered 1,539 trainings since 2017.

HCA's RW Program improves member health outcomes and satisfaction, decreases cost, and improves provider satisfaction. And we are not done: HCA has added an axialHealthcare Recovery peer program in Maricopa County and will expand perinatal programs for pregnant members living with SMI in 2022.

Response B6b. Provider case managers are trained to handle a myriad of important functions, but they rarely have the training or resources to focus on specialized key areas of member support. HCA recognizes, however, that properly trained provider case managers play an essential role in helping members obtain and maintain employment as an important step in the recovery process. As a result, HCA developed a Supported Employment Initiative (SEI), designed to develop a cohort of provider case managers to improve employment-related outcomes for individuals living with SMI.

Program Design: HCA's SEI Program consolidated several vocational service-related programs under one "roof." These programs included job coaching skills training, and collaborative skills building courses offered in concert with the DES' Rehabilitation Services Administration (RSA) and community employment providers. The SEI Program also emphasizes the use of an evidenced-based, best practice training series, called Disability Benefits 101 (DB101). This training helps members understand how their employment may affect health coverage and other benefit programs, and how to maintain important benefits to ensure their continued health and well-being. The SEI Program has been financially supported through resources made available to providers by AHCCCS' Targeted Investment Program, HCA's value based programs, and direct HCA staff support.

The SEI Program has developed a team of Vocational Coordinators (VCs), who have proven to be a passionate group of professionals dedicated to helping people living with SMI build confidence and overcome stigma. Trained VCs are now in place at all 25 of our Health Home locations throughout Northern Arizona. VCs work with the Adult Recovery Team (ART) to help members gain access to behavioral health services and find other resources necessary to attain their goals. As key members of the ART, VCs provide direct supportive services to the member to advocate for their employment goals and increase their likelihood of positive treatment outcomes. The VCs provide case management and support employment services like pre-employment and job coaching. Pre-employment services provide soft skills, such as interviewing techniques and positive engagement. VCs are now an extension of HCA's approach to deploying specialized provider case managers in every community to serve high need individuals and other special populations.

> *"[Having a job makes] me feel like I really accomplished something for the first time in five years. I feel I have a purpose in life and can hold my head up again."*
> *-- Janice, age 35*

Results: The SEI Program sounds deceptively simple, but has demonstrated extraordinary results. One of the most critical provider case management tasks performed by VCs is coordination of care with Vocational Counselors at RSA. VCs conduct over 70 coordination sessions with their RSA counterparts every month. As a result of this collaboration, members in HCA's Supportive Employment Programs have improved rates of employment by 97% since 2015, resulting in 1,254 members with SMI (or 20% of the average SMI population in the North GSA) becoming newly employed. According to 2021 data from RSA, HCA is the only RBHA with an increasing quarterly rate of employment, with an average 9% increase each quarter since 2015. Additionally, since 2018, HCA members with SMI have experienced a 90% increase in community activity, including full-time and part-time employment, volunteering, and Work Adjustment Training, and a 10% increase in involvement with pre-employment activities. SEI has also resulted in educational/vocational goals being incorporated in all adult treatment plans (HCA 2020 Case File Review score was 100%, as compared to the 2017 score of 81%).

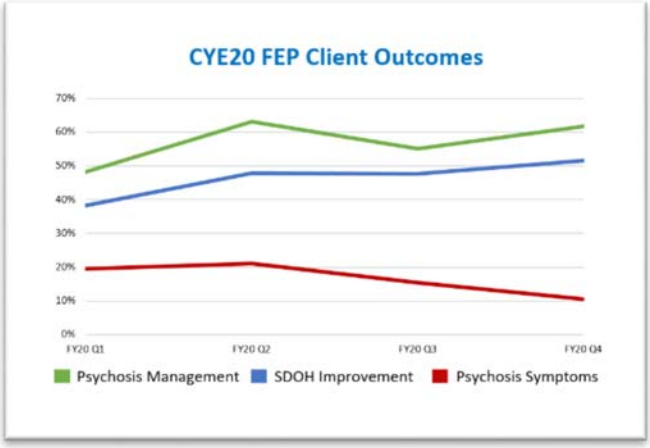
HCA members in our Supported Employment Program now work 25 hours or more per week on average, and consistently earn above the Arizona minimum wage. The SEI specialized case management program is an excellent example of how integrated health care, coupled with social support programs, can work to address historical health care equity issues and improve the lives of members.

Response B6c. The use of innovative outreach and education efforts have been a core component of HCA's strategy to address member needs across our largely rural region. HCA's First Episode Psychosis (FEP) program is an example of these efforts, and has improved member's lives through member outreach and education, early identification, and treatment for early SMI (ESMI) or SMI. Early accurate diagnosis, intervention, and appropriate treatment are imperative to improving outcomes for members with ESMI, and, more importantly, help members early in their recovery process.

Program Design, Education, Training, and Outreach: HCA initially contracted with NAVIGATE, the leading expert in FEP research and treatment, to provide multiple trainings on FEP treatment modalities, including psychopharmacology. FEP providers were also trained in Cognitive Behavioral Therapy for Psychosis (CBTp). Provider surveys indicate 100% of CBTp training participants felt that the training enhanced their skills. In addition, HCA offered a series on Special Topics in Early Psychosis led by FEP expert, Dr. Eric Arzubi. This educational opportunity produced similar results, with participants reporting they learned new skills to transform service delivery and achieve better member outcomes. HCA also developed a Relias training on FEP, which has been completed by over 90 professionals across the State.

HCA's FEP program uses our Mountain ECHO Early Psychosis Intervention approach (EPI ECHO), a telementoring strategy designed to assist rural practitioners to care for individuals with complex conditions. EPI ECHO is one of four ECHO hubs in the world on early psychosis intervention, and the only psychosis-related ECHO hub in the Southwest. Since launching in 2020, 25 practitioners across Arizona have been mentored by HCA. EPI ECHO effectively increases providers' capacity and confidence to treat patients with FEP. Over 50% of provider survey participants indicate they will make positive changes to their practice as a result of EPI ECHO. The 2020 survey indicated provider participants increased their understanding of the impact of substance use on psychosis, the intersection of trauma and psychosis, and how culture affects psychosis. This effort ensures that providers have the tools they need to provide care in rural and frontier communities where specialists are not available.

For these tools to produce results, however, members need to be engaged in services. HCA provided community and member outreach and education on identify the signs of FEP, and worked with community partners to identify and refer individuals experiencing early psychosis to treatment. In 2020, HCA provided over 20 trainings on early psychosis to coalitions, homeless shelters, advocacy groups, and other community partners. This included training for law enforcement agencies on how to interact with someone experiencing psychosis. HCA also supported FEP provider's effort to engage in community and member-level outreach. HCA and FEP providers collaborated with local schools and law enforcement through tailored education opportunities, participation in community coalition meetings to promote FEP services, and collaboration on infrastructure-building partnerships. As a result, the FEP program has fostered a sense of community by giving providers and stakeholders a common language to communicate about early psychosis.



Results: HCA's FEP program serves an average of 71 members per quarter and has experienced a 30% increase in member retention since 2019. A key component to FEP is starting and adhering to antipsychotic medications so that social, educational, and vocational gains are not lost. 90% of FEP members fill their prescriptions, including long acting injectables, which are the preferred formulation for members with FEP to improve adherence. Only 8% of enrolled members have utilized crisis services during the past year — a reduction of over 20%. These improvements are a direct result of our education and training efforts, and our continuing commitment to collaboration with specialized providers, other AHCCCS health plans, health insurers, Tribal Nations, and communities throughout the region, which we will continue to expand over the next five years.

Response B6d. Health challenges for individuals living with SMI are complex and are influenced by factors related to access to care, co-occurring physical health conditions, stigma, and social service and other SDOH needs. To better understand these needs, and to promote an ecosystem of support optimally suited for the treatment and prevention of SMI and other behavioral health conditions, HCA has collaborated with The NARBHA Institute in the continued development of a comprehensive *Regional Health Equity Assessment* (RHEA) for Northern Arizona, initiated by the Northern Arizona University's Center for Health Equity Research (NAU) in 2017, and recently updated in 2021.

Assessing Challenges: Assessing regional needs can be challenging. The natural temptation is to react to a few influential voices, which potentially risks missing the needs of the greater population. To avoid this, the RHEA collected and analyzed an extensive array of qualitative and quantitative data through a first of its kind process for Northern Arizona. The project had three goals to: (1) Engage a broad cross section of local stakeholders in an interactive process to help identify communities and organizations as potential partners that can build collaborations to improve health outcomes; (2) Synthesize existing data and conduct deeper data-dives to understand regional patterns in health outcomes and access resources; and (3) Identify local and institutional strengths, needs, barriers, and resources for addressing health disparities.

> *"The comprehensive nature of the analysis is unique; the report authors are not aware of any previous studies occurring in the region with similar breadth and scope"*
>
> *-- RHEA Executive Summary*

Stakeholder Input: The Assessment has, and continues to, gather input from a diverse group of stakeholders. To date, NAU has facilitated 18 stakeholder meetings, 13 conferences and community forums, 62 interviews with community leaders and service providers, and seven focus groups. A detailed analysis was also performed of 57 existing community health needs assessments previously conducted across the six-county region – each of which involved valuable stakeholder input from individuals with SMI and lived experience. Stakeholder input continues to be received from all communities in the region, including Tribal communities and vulnerable populations at higher risk for behavioral health challenges (e.g., the LGBTQ+ community). This qualitative data informed RHEA's rich quantitative data set, with multiple federal and state primary sources and secondary, tiered data analyses of county-level information.

Results: The RHEA has, and continues to, provide useful data on social, economic, cultural, and systems level influences on behavioral and physical health of diverse populations, and continues to inform our decision making. While the assessment includes the needs of all regions and sub-populations, special focus is given to the needs and resources of individuals with SMI and other behavioral health conditions. Several findings have highlighted variations in access to care, fatalities, suicide, and injury rates, and, importantly, the impact of substance use and poor behavioral health on other causes of morbidity and mortality, education, self-sufficiency, and social engagement. Workforce development needs for PCPs, law enforcement, and behavioral health workers were also identified as important factors for community resiliency, along with potential solutions to address these challenges.

The RHEA continues to produce results through the development of collaborative approaches to service expansions addressing challenging health conditions and the SDOH needs of the region. The RHEA has already resulted in ongoing development grants to support the following areas of service expansion, outreach, and education:

- The ongoing development of Caregiver Employment and Wellness programs in Coconino and Yavapai counties, and development of a new Behavioral Health Residential Facility focused on gero-psychiatric populations in Mohave County. Both efforts were designed to address the growing population of members living with SMI over 65.
- The expansion of Suicide Awareness Education programming in the two North GSA counties with the highest suicide rates per capita: Navajo and Apache counties. The programs provided training to over 400 participants.
- School-based integrated health improvement education, which has trained over 1,200 children and teachers.
- Establishment of an ongoing, endowed Chair of Behavioral Health & Criminal Justice at Northern Arizona University.
- Establishment of a Family and Community Medicine Residency with North Country Health Care that prepares PCPs for integrated physical and behavioral health care in a population health framework. The first group of Physician Residents began in 2020.

Response B6e. HCA established a Justice Diversion Initiative (JDI) in 2018, to address the growing need and increased numbers of individuals with behavioral health and substance use presenting in the justice system. Wherever possible, this initiative transitions individuals with Serious Mental Illness (SMI) and substance use toward appropriate and culturally competent community-based behavioral health care, while diverting or releasing them from jails, prisons, the Arizona State Hospital, or in-custody restoration programs. As a result, the JDI reduces the criminalization of behaviors resulting from psychiatric disorders by obtaining psychiatric treatment for high risk/high need individuals.

Results: Approximately 79% of members with SMI identified through the JDI program successfully engaged in behavioral health services, and the initiative has increased voluntary engagement in behavioral health services by almost 60%. This means individuals living with SMI are successfully finding alternatives to incarceration. In addition, at least 14% of the beneficiaries of this initiative self-identified as Tribal members, providing another example of HCA's efforts to combat health and social service disparities in Arizona.

"I've been watching the revolving door … for months and years, chasing him around town … not able to catch him in jail long enough to get a provider over there to evaluate him. It was heartbreaking and I had pretty much resigned myself to believe that he would not be alive much longer. HCA stepped in, the public defender stepped in, and the Court had finally had enough all at the same time."

– Member's Guardian

Program Design: HCA's role under our JDI design is to be the "care traffic controller" and neutral third party to direct and connect justice involved individuals to appropriate behavioral health services prior to incarceration or restoration to competency services. Our JDI team facilitates jail furloughs for psychiatric hospitalization, court-ordered evaluations, and medications not available on the jail formulary, such as Medication Assisted Treatment for Opioid Use, and costly long-acting antipsychotic injectables. The JDI also funds pre-release, in-custody behavioral health assessments through HCA Community Reinvestment and The NARBHA Institute. These services would otherwise not be available to inmates, given that Medicaid benefits are suspended upon incarceration. The JDI also increases collaboration with public fiduciaries to establish T14+ guardianships to consent to involuntary behavioral health treatment and reconnects individuals with the Division of Developmental Disabilities and Veteran's Affairs. HCA and our providers work directly with other AHCCCS MCOs and other health insurers in the state to ensure a seamless transition for people regardless of health plan. (Approximately 31% of the people served by this initiative belonged to a different health plan or insurer.) When a Tribal member intersects with the JDI, we work to connect the person with the appropriate Tribal programs. JDI also connects individuals with out-of-area behavioral health services and assists with coordinating transportation to their community of origin.

Future Expansion: HCA's initial JDI involved a collaboration with the Coconino County Detention Facility, the City of Flagstaff's Prosecutor and Public Defender, The NARBHA Institute, The Guidance Center, Southwest Behavioral Health, and multiple crisis service providers. The success of JDI in Coconino County led HCA to prioritize further development and expansion. JDI will complete implementation in Mohave and Navajo counties by July 2022, and with the involvement and consent of local governments, to all counties served by HCA by the end of 2025. If awarded the Central GSA, HCA will collaborate with AHCCCS and Maricopa County partners and stakeholders to adapt the program in Maricopa County, to meet the obligations identified in the *Arnold v. Sarn* litigation settlement agreement to develop programs to review appropriateness and necessity for admission to jail. HCA is also expanding the existing partnerships involved in JDI to include a broader set of local social service agencies, such as Hope Lives Viva La Esperanza, a peer run provider of forensic peer support, and housing resources through Catholic Charities' "Closing the Gap" program. JDI will also leverage resources from Blue Cross Blue Shield Arizona's MobilizeAZ mental health improvement initiative.

The HCA JDI initiative has been highly successful in diverting people with SMI from incarceration, and into appropriate care settings. Ongoing collaboration efforts between HCA, our behavioral health providers, and our justice partners are key to ensuring that our highest needs members receive the care they deserve.

Response B6f. Through our direct involvement in managing Coconino and Mohave County's Court Ordered Evaluation (COE) programs, HCA identified the need to develop a Court Ordered Treatment Oversight Program (COTOP). Nationally, 20% of COE-related re-hospitalizations are due to non-adherence in outpatient services. COTOP combines our role as the contracted administrator for two county COE programs with the oversight of COT members through a specialized initiative to monitor, screen, and evaluate results spanning both processes. HCA began this initiative in 2014 with Coconino County, and expanded it to Mohave County in 2019. COTOP's goal is to reduce re-hospitalizations and re-engagements with the COE process, increase treatment adherence, and to transition members to the least restrictive interventions. COTOP is directed by our Justice and Court Administrator, a Masters-level counselor and a former law enforcement officer, who has successfully and positively impacted the lives of individuals by ensuring they are participating in ongoing treatment and assisting counties by reducing readmissions to the COE process.

Program Design: The focus of COTOP is to monitor all patients who progress through both COE and COT processes in those counties where we have direct access to patient and provider data. Our Justice and Court Administrator is the single point of contact for COTOP, managing and validating transactions between the county, HCA's contracted provider network, forensic peer support services and other local SDOH and community programs. Additionally, the Administrator facilitates collaboration and education for stakeholders, including the Arizona State Hospital, behavioral health providers, other MCOs, state and local law enforcement, county attorneys, defense counsel, courts, Tribal Nations, and community partners. HCA hosts quarterly meetings with the counties and COE providers to process and provide technical assistance. HCA's contracted providers are trained in all aspects of the COE/COT process. HCA has also provided Crisis Intervention Training for over 450 community partners, including law enforcement, attorneys, probation, and court staff. Recently, HCA and The NARBHA Institute provided Mental Health First Aid training for over 400 justice system partners, first responders, and law enforcement officers in the North GSA. We promote Tribal sovereignty by educating providers on the process of ARS § 12-136 and the Supreme Court Rules of Procedure for Recognition of Tribal Court Commitment Orders.

Results & Fiscal Responsibility: HCA closely monitors the volume and cost of COE and COT-related services. This serves to create a consistent and fiscally responsible system where member rights are upheld and respected. As a result, Court processing times have decreased by nine percent, and unduplicated re-hospitalizations and re-engagements with the COE/COT process have decreased by 18% in Coconino County between 2016 and 2020. HCA has also demonstrated fiscal responsibility, saving Coconino and Mohave County over $2.2M as compared to prior run rates, since the program's inception. COTOP has also reduced costs to counties through the coordination of benefits and monitoring of third-party payor liabilities, which alone has saved Coconino County $1.4M since 2015.

Eligibility and Treatment: The COTOP program goes beyond the requirements of the COE process and COT petition. Assisted Court Ordered Outpatient Treatment is made available through the comprehensive Health Home network HCA has facilitated over the last 50 years. COTOP oversees an average of 208 members annually. In addition to providing all covered services, our Health Homes assist individuals on COT to secure their SMI status. Through a well-developed partnership with Solari, HCA ensures Health Homes are trained in the SMI evaluation/determination. Our Health Homes are financially accountable under a shared risk and Alternative Payment Model, ensuring integration of all aspects of individual care. COTOP also extends HCA's resources to other AHCCCS health plans and insurers to assist them in coordinating patient care. HCA has custom-designed predictive analytics that it will begin using in January 2022. This new capability will enable the COTOP program to synthesize data from HCA with incarceration data from jails to further enhance our ability to identify, treat, and track individuals who may encounter COE/COT.

COTOP works to help members gain insight and choose the help they need without resorting to limitations on civil liberties, while helping to manage the fiscal responsibilities of the counties we serve.

Response B6g. HCA's single most impactful initiative to improve outcomes for Medicare and Medicaid eligible members living with Serious Mental Illness (SMI) is called *Incentivizing Better Care* (IBC), and involves a targeted use of a mobile device-based application to improve disease and self-management through medication adherence. The application is offered by Wellth as an extension of HCA's quality improvement and pharmacy programs. HCA currently manages care for 6,268 AHCCCS members who are living with SMI, 983 of whom are currently enrolled in our Health Choice Pathway (HCP) Medicare Advantage Dual Eligible Special Needs Plan (DSNP). The SMI DSNP population is especially vulnerable because of multiple challenges impacting their ability to manage their health – notably including challenges with medication adherence and the development of routines that support whole person health.

Program Design: Based on both pharmacy encounter data and CMS Star performance, HCA identified that medication adherence was one of the main challenges facing our dually eligible members living with SMI. We recognized that members with SMI who struggled with medication adherence demonstrated proportionally higher adverse outcomes and increased cost of care. To address this challenge, HCA developed IBC as a health and quality improvement adherence initiative. The centerpiece of this initiative was a collaboration with Wellth, a technology company which offers an easy-to-use, mobile application that applies behavioral economics to motivate healthy habit formation using daily reminders, behavior reinforcements and monthly financial incentives. The stated goals of the initiative were to improve treatment plan adherence, reduce inpatient and emergency utilization, while improving member engagement and satisfaction.

It's helped me remember to take my medications on time, especially my blood pressure medications that I would always forget. I was also able to use the rewards I earned to pay my phone bill, which was really great because I didn't have any money.
-- Suzanne

Using the mobile app, members earn member financial incentives by snapping a photo daily of their medications as they take them, which then is processed through Wellth's AI-based image recognition system. Adherence is then verified by HCA over time using comparative pharmacy and clinical data. Data obtained through the Wellth app is also being used to inform additional care and quality improvement strategies related to medication utilization. The member can use the monthly incentives they have earned via a dedicated debit card which tracks and limits the types of items being purchased. To date, over 90% of purchases have been used for food, groceries, transportation, or household items.

Results: The IBC initiative has delivered results on all of it goals, and more. Overall, average adherence has improved by 31%. Inpatient utilization in the target population has decreased by 80%, resulting in an estimated cost reduction of over $540,576 per year for eligible members living with SMI. At the same time, member engagement using the app is over 80%, and member satisfaction as measured by net promoter score has increased by over 66 points.

Avg Adherence (PDC) Improvement	31%
Inpatient Utilization Reduction	80%
ED Utilization Reduction	15%

Along with other strategies, these improvements to medication adherence contributed to HCP's dramatic improvement in CMS Stars scores. Specifically, HCP's performance improved in each key medication adherence measure despite the negative effects of the COVID pandemic on overall Stars performance in 2020. As recently announced by CMS, this initiative has helped HCP achieve a Five Star rating in Part D (Pharmacy) and an overall **CMS Four-Star** health plan rating for 2020. (There were no Four-Star Arizona DSNP health plans in 2019.)

HCP looks forward to continuing the development of this initiative as we move beyond the COVID pandemic. We also anticipate additional performance improvement from the Wellth portion of the initiative in light of the increased amount allowed for member incentive from $150 to $300 annually, as recently authorized in ACOM 404. Most importantly, however, we anticipate that the initiative will help members live more complete and healthy lives.

B7.

NARRATIVE SUBMISSION REQUIREMENTS

B7: AHCCCS expects Contractors to continually strive to improve the system of care for individuals with an SMI designation through the pursuit of innovation and advancing best practices. Describe opportunities for improvement the Offeror considers to be important and proposed strategies for each of the following:

a. Advancing an enhanced integrated care model to improve member health outcomes,

b. Co-occurring SMI/SUD service delivery,

c. Improving access to evidence-based outpatient behavioral health services and the delivery system framework to access meaningful services,

d. Ensuring equitable health care and eliminating existing disparities, and

e. Utilizing technology to maximize member engagement.

Response B7. Advancing an Integrated Care Model. Health Choice Arizona's (HCA) integrated care model for members living with Serious Mental Illness (SMI) incorporates numerous member engagement practices with providers whose care is coordinated, co-located, and integrated via transformative practice change – the three key components of SAMHSA's best practice framework for integrated care. Our highly integrated system of care is advanced by HCA's *Recover Wellness* program, an intensive care management initiative serving SMI members with complex co-occurring physical and behavioral health conditions. Results of this health plan-provider collaborative care model have been impressive: At present, 60% of HCA RBHA members receive fully integrated behavioral health and primary care services across the North GSA, an increase from 23% in 2015. High risk members enrolled in RW have also shown a 27% decrease in ED visits, a 23% decrease in inpatient admissions, and a 15% decrease in total cost of care.

Opportunity for Improvement: While the *Recover Wellness* intensive integrated care management program is highly effective, it is a high touch, population health-informed model designed to care for members with the highest need – the "top tier" of members living with SMI. Extending the benefits of the program to the next tier of members with lower risk health profiles – a set of conditions often identified in evidence-based practice as "rising risk" – presents unique challenges. Members in the rising risk tier tend to engage less frequently with providers, making them often difficult to identify and engage. Additionally, members of the cohort are usually younger, and benefit from a different set of mobile-enabled, prevention-oriented, health promotion, and disease self-management tools that encourage engagement. These tools help lower risk members avoid development of chronic health conditions and maintain optimal personal health. Although all members living with SMI receive care coordination and individualized care planning, a customized approach for those in the rising risk tier will enhance the benefits of integrated care.

Innovation: HCA will implement a member-centered initiative, known as *Care 4 Me*, designed to enhance whole person health through a suite of four technology-based, member-centered digital care tools proven to improve timely community-based care, member engagement, and health literacy, and, most importantly, health outcomes. Key components of the *Care 4 Me* member toolkit will include: (1) Coordinated and layered use of home-based telehealth and mobile health capability, such as the Blue Cross Blue Shield Arizona's (BCBSAZ) 24/7 Amwell Telehealth Solution and HCA's Philips Remote Patient Monitoring platform; (2) Expanded access to Pyx Health, a 24/7 technology solution that decreases isolation and loneliness through companionship and timely interventions that support unmet health and SDOH needs; (3) Targeted member engagement in HCA's partnership with Wellth, a behavioral economics solution that improves quality and member satisfaction by using the right incentive at the right time, to motivate members to engage with health services and form life-changing healthy habits; (4) full access to the HCA *Let's Be Well Together* online education integrated health library, a set of digital videos built in partnership with BCBSAZ and developed in collaboration with members. *Care 4 Me* will be implemented as an extension of our *Recover Wellness* program, in collaboration with our integrated provider network. Like *Recover* Wellness, it will include extensive and ongoing member, provider, and community stakeholder input. Members will be identified for participation in the program through self-referral, provider referrals, use of our Johns Hopkins ACG predictive analytics system, HCA's QlikSense platform, and data gathered through Amwell, Pyx Health, and Wellth member interactions. Member-specific information received from *Care 4 Me* will be imported into our CareRadius care management system and integrated into indvidual service plans. HCA's value-based contracts with our integrated Health Homes and high performing ACO network will offer additional provider support for member engagement in *Care 4 Me.*

Anticipated Results: The following results are expected, based on RW's success and our early experience with select *Care 4 Me* components:

- Members enrolled in *Care 4 Me* will experience an annual average 10% reduction in avoidable emergency visits.
- Provider satisfaction ratings for both *Recover Wellness*/*Care 4 Me* will exceed 75% annually.
- An annual 10% average improvement in the *Care 4 Me* core HEDIS measure set will be achieved.
- Member isolation/loneliness as measured by the UCLA Loneliness Scale will decrease by 10%, for members using the Pyx Health solution.
- 40% of members engaged with Wellth will earn the maximum annual financial incentive ($300/year).
- By CYE 2024, 40% of members with an SMI designation in all GSAs will be enrolled in either RW or *Care 4 Me*.

Co-occurring SMI/SUD Service Delivery. Each year more than 100 HCA pregnant members living with SMI receive care management through our *Recover Wellness* (RW) integrated care management program. In 2020, 26% of these pregnant members with SMI also had co-occurring SUD, and three percent of their newborns showed multiple substances (opioids, benzodiazepines, and stimulants) present at birth. Data also reveals that rates of prenatal and postnatal physical and behavioral health care among pregnant members with SMI/SUD were static or decreasing – even before the COVID pandemic.

Opportunities for Improvement: A comprehensive review of challenges has identified the following opportunities:

- Many practitioners for high-risk pregnant members with SMI/SUD are not experts in this form of specialized care. For example, the ADHS Maternal Mental Health Taskforce has identified that many OB and BH providers frequently refuse to serve pregnant members with SMI/SUD, citing a lack of confidence and liability concerns.
- Low engagement of pregnant women in OB, behavioral health, and SUD services can negatively affect maternal and child health. In 2020, only 44% of HCA pregnant/postpartum members with SMI/SUD consistently engaged in behavioral health care. While 71% of members completed prenatal care, only 30% completed postpartum care. Low rate of postpartum care reduce identification of postpartum depression, psychosis, and SUD relapse.
- Medication assisted treatment (MAT) is not optimally utilized for opioid use disorder (OUD) during pregnancy. In 2020, 6% of HCA pregnant members with SMI/SUD received MAT, while 41% had an OUD diagnosis. This discrepancy suggests that women are not being referred for MAT services during pregnancy.

Innovations: As a subset of HCA's *Bright from the Start* best practice program, HCA proposes the following:

Enhanced practitioner expertise and confidence. (1) HCA is instituting a tele-mentoring weekly interdisciplinary Maternal Rounds for HCA Integrated Care Managers (ICMs), OB providers, behavioral health providers, provider case managers, and social service agencies. Led by HCA physicians with specialty OB and SMI/SUD expertise, Maternal Rounds will focus on the needs of each pregnant member with SMI/SUD through best practice anticipatory guidance, clinical protocols with improved integrated care and coordinated service delivery, expanded use of motivational interviewing and CBT, and member self-management. (2) Experts from the ADHS Maternal Mental Health Taskforce will be invited to collaborate on training material and resource guide development.

Strengthened member engagement. (1) Each perinatal member will have a dedicated Health Home case manager and an HCA ICM throughout pregnancy and for one year post-delivery, to ensure an expanded focus on the postpartum period. (2) Each perinatal member will be referred for specialized intensive perinatal peer support. This will be a collaboration among HCA, PFROs such as Family Involvement Center (FIC) and Mentally Ill Kinds in Distress (MIKID), our Health Homes, and obstetric providers, and will maximize appropriate use of telehealth for peer support. Such perinatal community peer support is a best practice for improving maternal outcomes, per the ADHS Maternal Mortalities and Severe Maternal Morbidity in 2020. (3) HCA will offer HCA's Wellth mobile application for pregnant women with an SMI designation, with specific incentives for medication adherence (e.g. MAT), and prenatal and postpartum care.

Expanded Medication Assisted Treatment. (1) HCA will establish a single point of contact at each Health Home and Opioid Treatment Program for perinatal care referrals, to ensure timely outreach, engagement and urgent referrals to qualified specialists. Care will be closely monitored by HCA ICMs using the *SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants*, ASAM criteria, and perinatal depression screening. (2) In partnership with The NARBHA Institute and BCBSAZ's MobilizeAZ initiative, HCA will continue our support for Hushabye Nursery, a specialized nursery providing evidence-based care for parents and opioid-exposed newborns with NAS to improve bonding, reduce neonatal ICU stays, promote breastfeeding, establish appropriate connections to SDOH resources, and ensure continued MAT services for mothers following delivery.

Anticipated Results: The following results are expected for perinatal members with SMI and SUD:

- 80% will consistently engage in BH care pregnancy and 90% will receive recommended prenatal care.
- 100% will be offered peer support and MAT (if experiencing OUD during pregnancy).
- Postpartum follow-up will increase to 90% by 2025, resulting in best practice postpartum depression screening.

Improving Access to Evidence-based Outpatient Behavioral Health Services and the Delivery System Framework to Access Meaningful Services. HCA's model for delivering outpatient behavioral health care is based on the *9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems* and modified version of SAMHSA's *Four Quadrant Model*. HCA recognizes that there are many opportunities to improve access to evidence-based outpatient BH case and the delivery system that supports it. HCA is already engaged in a number of education and support related initiatives to expand access, such as our collaboration with the Arizona Department of Veteran Services to provide education on PTSD and our development of a program to create specialized vocational counselor provider case managers. However, HCA's data clearly demonstrates that one of the most influential factors in assisting members living with SMI to engage, and stay engaged, with outpatient behavioral health care is the use of peer and family supports.

Opportunities for Improvement: HCA has continuously refined our strategies to ensure access to evidence-based behavioral health (BH) care through a whole person, member-centered approach that promotes recovery, is respectful, honors member "voice and choice," and incorporates each individual's cultural preferences, autonomy, and natural support systems. One of the most effective evidence-based strategies is to integrate peer and family services as part of the outpatient continuum. In 2019, HCA members who received at least one peer support service had a 14% higher utilization rate of other behavioral health services. HCA's Case File Review results show a steady increase in the use of peer and family services starting in 2013, with a high of 80% in 2018. Unfortunately, that rate declined to 67% by 2020. While this is likely due in part to the COVID pandemic, it represents a cause for concern. All outpatient BH services for members living with SMI have their care coordinated using the Adult Recovery Team (ART) model through HCA's behavioral health providers, including our Health Home network, in accordance with the Adult System of Care Guiding Principles. Through this process, peer and family supports services are required to be included as a listed service in the member's Individual Service Plan (ISP).

Innovations: HCA will catalyze expansion of peer and family services for members living with SMI, to improve adherence with outpatient BH services and support post-pandemic recovery.

1. In consultation with AHCCCS, HCA proposes to implement a revised policy that allows members living with SMI to present for peer support services at any PFRO for up to 90 days after receiving the first service, without the requirement that services must first be included in the Individual Service Plan. If this approach is approved, HCA will modify our peer and family service data validation and claims/encounter policies to remove any limitation on PFRO claims that are not documented in a member's ISP during the first 90 days.
2. During *every* ISP meeting, the behavioral health provider facilitating the meeting will be required to provide each member with a "peer and family supports package," prepared by HCA's Office of Individual and Family Affairs (OIFA) in collaboration with peer and family members, and peer and family service providers, and approved through technical assistance from AHCCCS. This package of materials will include an overview of the benefits of peer and family services, a listing of all available peer and family services (including those offered through telehealth), and brochures and related materials from each peer and family service provider.
3. If the member is receiving services through a PFRO, a representative from that organization will be invited to participate in the member's ISP meetings (unless the member requests otherwise). The ISP will specifically document the member's choice of peer and family supports.
4. HCA will expand our existing specialized provider case management training program and create an analogous specialty provider peer and family work force, with enhanced expertise in Tribal services, employment, pregnancy and postpartum care ("doulas"), and access to SDOH services through the NowPow closed loop referral system. Use of these specialized peer and family services will be incentivized through enhanced provider reimbursement rates.

Anticipated Results: The following results are expected:

- Within 2 years, the Annual Case File Review will demonstrate that 100% of members living with SMI are provided a peer and family support packet during ISP meetings, and that the member's PFRO was invited to the ISP meeting, unless the member requested otherwise.
- The percentage of members living with SMI who are engaged with peer and family services will return to the pre-

pandemic level of 80% within one year, and increase to 90% in the second year.

- HCA BH providers and PFROs will employ at least 25 new specialized peer and family specialists within two years.

Ensuring Equitable Health Care and Eliminating Existing Disparities. As defined by *Healthy People 2030,* health equity is the "attainment of the highest level of health for all people." A framework that achieves equity includes components that value people equally, addresses societal injustices and inequalities, and eliminates disparities in health and health care for the most vulnerable populations and groups of community members. One of the primary goals of AHCCCS' drive to fully integrate care was to improve the life expectancy for members living with SMI. One measure of success of this model is that members living with SMI are now living longer. But this has effectively created a new, emerging, vulnerable population from a health equity perspective – a Senior SMI population. Between 2015 and 2020, HCA membership over the age of 65 increased an average of one percent per year. As members with SMI live longer, they are experiencing increased levels of isolation and homelessness, physical health deterioration including dementia, and nutritional deficits due to food insecurity. The AHCCCS Administration's Spending Plan for Implementation of the American Rescue Plan Act of 2021 identifies four key populations as the focus of delivering equitable health care. Two of the designated populations involve the intersection of Arizona's senior population and individuals living with SMI.

Opportunity for improvement: HCA is working to address disparities for our seniors with SMI, and we have identified some key challenges: (1) Providers are not uniformly equipped to treat physical health comorbidities and behavioral health symptomology in an aging population. In addition, seniors can have multiple prescribers that inadvertently create polypharmacy overmedication, resulting in poor adherence and adverse side effects, like falls and confusion; (2) There are an insufficient number of facilities available to provide gero-psychiatric treatment; and (3) Seniors with SMI may not be able to adequately manage their self-care needs, yet not meet institutional level criteria to qualify for ALTCS.

Innovations: HCA and our Health Choice Preferred DSNP, recently developed a strategic plan for senior members with SMI to address these diverse challenges. This plan is informed by our participation in state and national health equity workgroups (AHCCCS' Health Equity Committee, the ADHS Equity Task Force, and the national BCBSAZ's Equity workgroup). Analyses from internal and external sources shaped the plan's development, including specific population assessment from HCA's QlikSense platform and critical trends in equity from the Northern Arizona University's *Regional Health Equity Assessment*, which was commissioned by The NARBHA Institute in collaboration with HCA.

Key components include: (1) HCA's *Recover Wellness* (RW) team will develop a High Risk Registry of members 65 years and older who have problematic polypharmacy identified by RW care management. Medications will be reviewed with prescribers to promote the benefits of deprescribing, as identified in the Bruyere Deprescribing Research Guidelines, including use of their "deprescribing app" to inform decision-making about changes. (2) HCA will expand its network of neuropsychologists for patient testing, both in person and by telehealth, to improve accuracy of dementia diagnoses and members' functional levels to inform care planning. (3) In conjunction with BCBSAZ's Health Equity and Inclusion initiative, HCA will offer provider and member education for support services designed to increase access to senior health services. (4) HCA will continue our financial support for development of residential facilities designed for seniors with SMI, including personal care and attendant care services. (5) HCA will advocate for AHCCCS' proposed extension of HCBS to aging members living with SMI. (6) HCA will partner with The NARBHA Institute to develop palliative care resources for members with SMI, including connections to faith-based organizations and completion of meaningful Advance Directives. An Arizona Community Grand Rounds on this topic is scheduled this autumn.

Anticipated Results: The following results are expected:

- 25% of aging members identified as eligible for deprescribing will see a reduction in their medication burden.
- A provider survey will demonstrate that 90% of providers indicate HCA education and support materials improved their ability to recognize and address polypharmacy and dementia.
- Availability and utilization of neuropsychologic testing services will increase by 25%.
- At least two new residential facilities will be identified for aging members with SMI with physical comorbidities.
- HCA will collaborate with AHCCCS to provide Home and Community Based and related services, if authorized, for eligible members who do not qualify for ALTCS, in order to allow them to live in the least restrictive setting.

Utilizing Technology to Maximize Member Engagement. Engaging with members who are living with SMI through innovative technologies is not new to HCA. Our history of telehealth advancement includes implementation of Arizona's first tele-behavioral health network in 1996 ("NARBHAnet") and early adoption of the SafeNet phone system. HCA is also a founding member in the Northern Arizona Telehealth Alliance, the Arizona Telehealth Broadband Action Team, the Arizona Telemedicine Council, and the national American Telemedicine Association. This diverse expertise with member-facing technology enabled HCA to respond rapidly during the COVID pandemic with a variety of innovations that maximized SMI member engagement when physical presence at a physician's office was no longer an option, such as HIPAA-compliant Zoom accounts for secure telehealth and mobile mental health and peer services via cell phone-enabled tablets for members in Apache and Coconino counties.

Opportunity for improvement: The digital divide is real. At a time when a growing number of Americans have 24/7 access to care through app-based urgent care services, many members living with SMI do not have access to or under-utilize digital tools and available telehealth services. This disparity prevents members from receiving optimal care. From 2015 to 2021, HCA's performance for members with SMI qualifying for inclusion in the HEDIS measure "follow-up after hospitalization for mental illness within 30 days" (FUH) has improved 14%. Despite this increase, more can be done to ensure every member hospitalized for mental illness receives timely care following hospital discharge.

Innovation: In partnership with the Collaborative Care Coalition (CCC), HCA will implement an evidence-informed, technology-enabled *Care 2 the Point of Need* (C2PN) initiative for all members transitioning home following hospitalization for mental illness. Formerly called the Behavioral Health Medical Director group, CCC is a longstanding HCA-led collaboration with clinical leaders from inpatient psychiatric and community behavioral health providers in the North GSA. In response to the ongoing challenge of member transitions following psychiatric hospitalization, and the rapid emergence of digital technology capabilities, HCA will develop and implement C2PN as a best practice, structured care process (i.e., a care pathway) that leverages emerging digital tools to ensure timely services and follow-up for members who are discharged from adult psychiatric hospitals. C2PN will emphasize "service to the point of need," a member-centered framework of care delivery that deploys technology to ensure members receive HCA's Five Member Rights of Technology Innovation: *Right care, Right time, Right place, Right relationship, and Right innovation.* The fourth and fifth rights – *right relationship* and *right innovation* – are often under-emphasized in health care. They will be key pillars of the C2PN so that each member's individual needs and telecommunication access capability are considered in hospital discharge planning. In partnership with health home case managers, HCA's medical management and integrated care management staff will coordinate with hospital clinical staff to enroll members in the CCC-developed care pathway. Whenever possible, members will receive needed equipment, such as cell phones and home patient monitoring tools, *before discharge*. C2PN will be piloted in 2022 with The Guidance Center in the North GSA and with CPR's Transition of Care program in the Central GSA; following evaluation using the PDSA improvement process, the pathway will be refined and implemented across both GSAs. The set of technology tools incorporated into the structured care pathway will include smart phone-based apps, appropriate use of remote home monitoring tools from Philips Healthcare, and secure texting facilitated through the Arcadia Population Health Platform.

As part of the C2PN initiative, HCA will also deploy several evidence based mobile applications that we have added to our member engagement portfolio over the last two years. These applications will include the use of Pyx Health's mobile applications that engages members to reduce social isolation and connect them to SDOH resources, Wellth's mobile application which supports prescription adherence, and an improved member portal application being developed through BCBSAZ.

Anticipated Results: We expect the following results from C2PN:

- HCA system-wide performance for the HEDIS FUH in 7 and 30 day measures will exceed 85% by 2025.
- The all cause 30 day readmission rate for members enrolled in the FUH clinical pathway will decrease by 5%.
- After successful implementation of the collaborative care pathway for FUH, a second care pathway for Follow-Up after Emergency visit for mental illness (FUE) will be developed and implemented.

B8.

NARRATIVE SUBMISSION REQUIREMENTS

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.

Response B8. Health Choice Arizona (HCA) has over 50 years' experience developing and strengthening provider network resources throughout Arizona. Currently, HCA's statewide network consists of approximately 23,000 providers, with over 5,800 providers (25%) speaking more than one language. It is based on our network of Health Home and primary care relationships that we helped create and support over our 54-year history. We also offer interpreter services 24/7 through a vendor who provides coverage in over 200 different languages. Telehealth has long been a key strategy for ensuring the delivery of services in rural areas, and we have expanded its use during the COVID pandemic.

Current Network Adequacy. HCA conducts a quarterly and full annual network adequacy analysis which includes geo-mapping; time and distance calculations, review of utilization data, and review of other administrative data elements received by the plan. HCA assesses whether network capacity can be enhanced through other mechanisms such as telehealth, mobile access, and transportation, and uses monthly secret shopper calls to confirm that providers are delivering the care as expected. During the past year, over 99.5% of HCA's providers have met appointment standards.

HCA currently meets all RBHA AHCCCS time and distance standards. Recently, we identified issues with our ACC network of pediatric dentists (Coconino/Apache) and pediatric PCPs (Coconino), both of which were caused by recent changes in member residence and provider office locations. In response, we worked in coordination with a pediatric dental office in Northern Arizona to provide mobile dentistry, added tele-dentistry and provided transportation to neighboring counties. Even beyond AHCCCS' network standards, HCA has developed its own network for Certified Professional Counselors, Psychologists, Certified Independent Social Workers, and Licensed Marriage and Family Therapists. Using these standards, we identified challenges in Mohave County with limited existing availability of psychologists. In response, we have increased availability of tele-psychiatry and tele-behavioral health resources, and provide transportation to neighboring counties. We are actively working to increase capacity in all identified areas by recruiting new providers through contract incentives, collaborative residency and intern programs, mobile health clinics, and by identifying new technologies to support members in rural areas.

We have also partnered with AHCCCS to develop new providers, including a new women's residential facility in Bullhead City. We have added four other chemical dependency providers in the North GSA within the last two years. We have addressed Arizona's long-term shortages in Residential Treatment Centers for children with complex needs through: (1) Expansion of in-home, intensive, wrap-around services; (2) Collaborations with in-state providers to identify and expand other forms of appropriate placement or level of care; (3) Increased provider capacity through funding and other supports, and (4) Utilization of appropriate out-of-state placement after all other in-state resources have been exhausted and following coordination of all placements with AHCCCS. In short, HCA uses a continuous, consistent, and multi-threaded approach to successfully maintain network adequacy.

Serving Members with Complex or Special Health Care Needs. HCA's approach to serve members with complex or special health needs always starts with the member. HCA and our providers do not use pre-filled templates to develop care plans. An HCA member care plan is, truly, an *individualized* service plan. Multidisciplinary, collaborative teams are actively involved in assessing a member's needs (including social supports), service planning, and service delivery. The teams include, at minimum, the member, member's guardian/designated representative, natural supports, advocates (if assigned), and qualified physical and behavioral health provider representatives, including specialists. Every member designated as SMI has an individualized service plan, which is maintained by the member's behavioral health provider and covers all appropriate health services based on member voice and choice. When a transition to a less restrictive setting or less intrusive form or level of treatment is identified as feasible, it is included as an objective in the member's Individual Service Plan (ISP), along with the specific strategies necessary to achieve it. To ensure ISPs are timely and comprehensive, HCA conducts annual case file review audits. Based on the most recent annual audit conducted in 2020:

- 100% of staff actively engage the member, supports and other agencies in treatment planning
- 100% of ISP requiring specialty providers are referred to and receive specialty services
- 100% of cultural preferences, primary language and special needs are assessed, discussed, and documented
- 100% of ISP contain a recovery goal/person-family vision

HCA's specialized *Recover Wellness* (RW) Integrated Care Management program is designed to improve outcomes for members with specialized healthcare needs and is used to further support members with complex or special health needs. Members are identified for enrollment in RW through HRAs, ETIs, pharmacy reporting, predictive analytics, and self, family, or provider referral. RW promotes seamless care coordination across the entire delivery system by establishing the Integrated Care Manager (ICM) as the central point-of-contact assigned to specific providers within geographic areas. ICMs conduct comprehensive assessments of program participant's needs, strengths, and resources, and develop a recovery-oriented Integrated Care Management Plan (ICMP) based on the preferences of the member/family/guardian. Collaborative relationships are foundational for effective change: RW ICMs develop productive partnerships with their assigned integrated providers, PCPs, OBs, and specialists, and develop an in-depth knowledge of the resources available in communities served by these providers. ICMs also often identify providers to add to our network. This approach produces results: High risk members enrolled in RW experience a 27% decrease in ED visits, a 23% decrease in inpatient admissions, and a 15% decrease in total cost of care. In a recent provider satisfaction survey, 91% of respondents reported that the RW program helped them deliver high quality integrated care.

HCA's approach to serving members with complex or specialized health care needs in the least restrictive manner is likewise built on decades of developing an experienced local provider network. This has not been a matter of simply contracting with existing providers. HCA's predecessor organization partnered with local community groups (such as religious organizations and chambers of commerce) in the late 60s to create community-based behavioral providers, from the ground up. Over succeeding years, these efforts produced the sustainable network of Health Homes that exist today. Many of the frontier Health Homes are the only provider in their area. While these providers may not "specialize" in a specific type of service as would typically be the case in urban areas, they work together to provide specialized services for all members with complex or special needs – such as peer and family services, vocational programs, housing, residential, crisis, SDOH referral, and inpatient services – that would not otherwise be available. All HCA members are assigned to both a BH provider and PCP to coordinate their care, and members may change providers at any time by calling our member services toll free number. We work with our Health Homes to assess member needs and deliver care in the least restrictive setting. When a Health Home is not able to provide a service to meet a member's needs, or a member wishes to use a different provider, HCA assists by providing referrals and coordinating care.

To assure network adequacy, HCA contracts with over 2,000 specialty BH providers located across Arizona. We also develop and guide the selection of centers of excellence through needs assessment, coordinated efforts with providers, ACOs, and social service agencies, as well as through enhanced rates, grant funding, data sharing and evaluation. These providers support members with complex and special needs of members across a wide variety of specialties, including ASD spectrum services (such as Southwest Behavioral Health's ASD Center of Excellence), specialized peer and support services (such as MiKid and FIC), SDOH, and adolescent and gero-psychiatric residential services. We also use data from these programs to guide the selection of centers of excellence (with enhanced rates), and use APM and other value-driven payment strategies to support quality performance improvement. Lastly, if a member needs additional services, we routinely enter into single case agreements to do so — usually within 24 hours of request.

Monitoring Gaps and Addressing Network Deficiencies. HCA continuously monitors for gaps in the full continuum of care using a variety of techniques, including: (1) Tracking multiple data points identified in HCA's Annual Network Development and Management Plan; (2) Monitoring utilization data to identify potential provider shortages; (3) Deploying analytic tools such as Quest geo-mapping and time-and-distance reporting; (4) Panel analysis to monitor attribution and identify providers with excessively high enrollments; and (5) Assessing accessibility through complaint reporting, member and BH advisory committee feedback, other provider/stakeholder input, and trending of grievance and appeals data. HCA views network adequacy as a critical plan function requiring confirmation. We regularly conduct on-site and virtual visits with *every* contracted provider to assess capacity and identify needed support.

HCA's organizational infrastructure is vital to this work. The Network Services Committee meets monthly and is composed of 25 HCA staff members from every operational area responsible for implementing strategies to resolve identified or potential network deficiencies, including efforts to expand NT19/21 services. Such strategies are diverse and include supporting providers to expand their scope, increasing capacity through workforce development, enhancing

provider recruitment and contracting efforts, providing grant funding to support providers in building capacity, and offering technological support and financial incentives for quality and cost performance. For example: a) HCA's partnership with Northern Arizona University has successfully placed over 60 master's level counseling students in internships with network providers, with a LMSW/LCSW examination preparation training resulting in 15 clinicians successfully acquiring their licenses and remaining in Arizona to practice; b) through a collaboration with The NARBHA Institute, HCA is helping address physician shortages in the North GSA through $6M funding and development of the North Country Health Care Family Medicine Residency. The goal for these strategies is to support community-specific solutions that improve access to care through innovative improvements, complemented by customized payment strategies developed to ensure provider network stability and accessibility.

Additional and Future Collaborative Relationships to Improve Care. Continued enhancements to HCA's existing service delivery and provider network are supported through the ongoing development of community partnerships, including HCA's Tribal partners and health systems. Over many years, HCA has built relationships with Tribal governments and Indian Health Service/Tribal 638/Urban Indian health organization behavioral and social case managers to ensure optimal care coordination for Tribal members regardless of where they seek care. Grounded in respect for Tribal sovereignty, trusted collaborations in culturally integrated care helped develop HCA's traditional practitioner program, offering traditional healing practices and sweat lodge ceremonies for member treatment, expanded access to culturally appropriate covered services, and awareness training for local providers. HCA proactively consults with Tribal partners to identify additional specialty needs that create a culturally competent Tribal services strategic plan. Stakeholder input is solicited throughout of community service area. In response to recent feedback, HCA is proposing to revise our provider payment methodology in 2022 to facilitate and pay for peer and family services without the need for a referral for the first 90 days. Our approach will continue to encourage inclusion of peer and family services in every member's Individual Service Plan while offering greater choice to members.

We continue to expand relationships with community-based organizations and providers across Arizona to support the needs of members. For example, in partnership with our parent organization, Blue Cross Blue Shield Arizona, a $5M grant was recently awarded in 2020 to Chicanos Por La Causa, in support of expanded employment opportunities through small business development. Over the past two years, HCA and The NARBHA Institute have issued $2M in grants to support service expansion, including funding for Mohave Mental Health Clinic's development of a specialized gero-psychiatric unit to address the growing population of members over the age of 65 living with SMI.

Lastly, the wellbeing and professional fulfillment of Arizona's health professional workforce is essential to maintaining the strength and capacity of our network, as well as supporting the state's pandemic recovery effort. HCA actively collaborates with many health professional support efforts, including the Arizona System CMO group, ADHS Health Improvement Plan, the Northern Arizona Health Leaders Coalition, and the Stronger as One coalition. Our collective efforts include:

- Promotion of provider participation in the Resilient AZ CCP, the AzNA Connect4Nurses program, ArMA's Virtual Doctors' Lounge, the ADHS Social Connectedness Campaign, and Mental Health First Aid trainings.
- Dissemination of inpatient behavioral health care protocols during the pandemic, such as the work plan developed by The Guidance Center on inpatient psychiatric care for members testing positive for COVID.
- Facilitation of the Arizona Monoclonal Antibody workgroup, a learning collaborative which shares information on trends, challenges, and best practices related the use of monoclonal antibody therapies.
- Formation of the Arizona Wellbeing Collaborative for Health Professionals**,** with active participation from major health systems, public health, and professional associations across Arizona.

HCA is engaged in many other efforts to strengthen and deepen our provider network. These include: (1) Expanding employment services through partnerships with DES and NACOG's Economic Development Council; (2) Collaboration with Hopi Health Care Center to support crisis interventions; and (3) extending Hazel Health's in-school crisis, physical, and behavioral health services to connect school staff, families, and their students with timely crisis and wrap-around services to the North GSA. HCA is dedicated to ensuring every member has ready access to quality care.

B9.

NARRATIVE SUBMISSION REQUIREMENTS

B9: Describe the best practices of Arizona's crisis system. Describe how the Offeror will maintain and drive continued improvement for Arizona's crisis continuum by building on the foundation that is already in place. Provide a detailed strategy including primary objectives, actionable steps, timelines, and stakeholder involvement that will be used to drive improvements.

Response B9. Health Choice Arizona (HCA) has administered behavioral health (BH) crisis services in Northern Arizona since the RBHA system began in 1992. In 2015, HCA made substantial changes to create a crisis system to meet the unique needs of Northern Arizona communities, integrate with county court ordered evaluation and treatment processes, and support our Zero Suicide model. HCA's crisis system is grounded in best practices, including SAMHSA's "anyone, anywhere and anytime" approach, which ensures crisis services are available 24/7, at no cost to any individual, regardless of insurance or eligibility. In recent years, the North GSA crisis system has evolved into a well-established continuum that currently serves six counties, all regional Tribal communities, and over 30 law enforcement agencies – while still being responsive to the evolving needs of our communities and partners during the COVID pandemic.

The HCA crisis system follows the ***SAMHSA National Guidelines for Behavioral Health Crisis Care Toolkit***. This toolkit incorporates a comprehensive system that reduces barriers to care by incorporating technology, targeted prevention and response, and collaborative partnerships. These practices, along with SAMHSA's core elements, are the foundation of the HCA crisis system. HCA is equipped to deliver enhanced crisis services in the North GSA, and if selected, bring improved crisis services to the Central GSA.

SAMHSA's Core Elements of a Crisis System:

- Crisis call center
- 24/7 mobile crisis teams
- Crisis stabilization facilities
- Essential crisis care practices

24/7 Telephonic Crisis Services: The first tier of our best practice crisis system is the 24/7 crisis hotline and call center, which is operated by Solari Crisis Response Network. There has been an 80% increase in call volume, and on average 85% of calls were resolved over the phone with an average speed to answer of seven seconds since 2015. Solari triages calls, conducts safety/risk assessments, and attempts to resolve crises telephonically. The hotline actively engages with individuals in crisis, and offers real-time care coordination, and, when needed, dispatches a local mobile crisis resource. Solari has helped HCA resolve the longstanding "medical clearance" issue that has plagued the crisis system for many years. The crisis call center ensures follow up by notifying all HCA providers and AHCCCS health plans of their member's engagement with the crisis system within 24 hours. Our Health Homes follow up directly with their members, and assist them with AHCCCS applications for ongoing services. Pyx Health also contacts members to provide follow-up support and SDOH referral. If a member is admitted to an inpatient facility, the member's Health Home is alerted to ensure safety/discharge planning and follow care. Our Tribal Coordinator offers assistance connecting individuals with Tribal resources. HCA has also increased crisis system awareness by providing recurring education to stakeholders (e.g., law enforcement, emergency departments [EDs], health departments, and schools). If the assigned crisis call provider changes in the future, HCA will work with the selected provider to achieve similar high quality results.

HCA's collaboration with providers and justice partners has established 911 diversion programs in four 911 communications centers. These programs enable a 911 dispatchers to transfer calls to the crisis hotline for support, eliminating unnecessary interactions with law enforcement, reducing burden on the 911 system and ED holds, and providing more rapid and appropriate responses for individuals in crisis. Collaborators meet regularly to identify and address challenges such as educating 911 staff on the types of calls appropriate for transfer. As a result, the number of successfully diverted calls at one 911 center (Flagstaff) more than doubled between October 2020 and July 2021.

24/7 Mobile Crisis Services: HCA contracts with providers to ensure mobile crisis team coverage for all six counties currently in the North GSA through value based agreements with Terros and our Health Home network. Using established best practices, mobile crisis teams meet the individual where they are to provide crisis de-escalation and resolution, thus reducing use of law enforcement and EDs. Since 2018, HCA's network has resolved 48% of responses in the community – despite a 38% increase in the average number of mobile team dispatches. In 2021, mobile teams were dispatched an average of 748 times per month, with nearly half of crisis calls stabilized on site. Since 2018, the average mobile response time for all mobile providers was 27 minutes, which is significantly below the AHCCCS contract standard of 90 minutes for rural areas and 60 minutes for the Central GSA. The demographic distribution for mobile response remains steady, with Caucasians comprising 58%, Native Americans nine percent, African Americans two percent, Hispanics one percent, Asian/Pacific Islanders less than one percent, and others at thirty percent.

The HCA crisis system offers a priority response for law enforcement, Tribes, and EDs, which triggers automatic dispatch of a mobile crisis team and escalates the call to a crisis call center supervisor for real-time coordination. This process provides faster care, avoids escalation, and provides real-time support to first responders and health care workers. Demand for mobile services by hospitals and justice partners increased significantly during the COVID pandemic, with monthly requests increasing by 36% over the last 18 months. Despite this, a recent law enforcement survey indicates 85% of agencies reported quick and easy access to crisis resources and 100% report crisis services are helpful.

During the pandemic, HCA has also eliminated disruptions to mobile crisis services by quickly developing and activating telehealth crisis services for EDs. Telehealth crisis services allowed HCA to meet the needs of partners and continue delivering crisis services while mitigating risk of infection. For example, over a 15-month period in 2020-2021, HCA managed more than 730 telehealth crisis interactions with Flagstaff Medical Center. The average response time for these telehealth responses was 17 minutes. HCA also expanded telehealth crisis services for emergencies and disasters, such as wildfire and snowstorms, where in-person interaction may be difficult due to closures and severe conditions. We continue to use Crisis Preparation and Response's ED intervention program to avoid avoidable delays in crisis care.

24/7 Facility-Based Crisis Stabilization Services: HCA's existing network includes four crisis stabilization units (CSUs), which were developed by HCA after exploring feasibility, developing cost projections, and providing startup funding. The four North GSA CSUs (The Guidance Center CSU, Southwest Behavioral and Health Services Observation Unit, Polara Health CSU, and Change Point CSU) respond to an average of 2,870 crisis situations each year. CSUs provide 24/7/365 continuous psychiatric nursing assessments and crisis stabilization services, helps avoid a medical crisis, and offer a "no-wrong door" approach to crisis care. Law enforcement drop off times at CSUs average under five minutes. CSUs are co-located with a psychiatric inpatient facility to support seamless transitions of care. If an inpatient admission occurs, the member's Health Home will begin member-centered safety/discharge planning. HCA also partners with Community Bridges' Brief Intervention Program, which facilitates emergency admissions to a Behavioral Health Residential Facility for up to five days, reducing ED holds and inpatient utilization. HCA supports two Substance Abuse Transitional ("Detox") facilities in the North GSA, offering less intensive recovery options. HCA also manages a Project ECHO SUD hub and First Episode Psychosis program, and partners with a full range of community based services, like Alcoholics/Narcotics Anonymous, MAT, and sober living homes. Collectively, HCA's CSU, detox facilities, and embedded peer support programs provide individuals with the most appropriate level of care, in the least restrictive environment.

24/7 Emergency Preparedness and Response: HCA's emergency preparedness and incident management system has expanded considerably over the last few years, resulting in improved inter-RBHA and Tribal collaboration and introduction of Critical Incident Stress Management/Debriefing (CISM/D) and Psychological First Aid (PFA) services. HCA has created a Community Disaster Response Guide (CDRG) and increased collaboration with other RBHAs and partners to prepare for statewide emergencies. There have been 54 incident responses in the last two years, including wildfires, snowstorms, and the COVID pandemic. Due to our preparedness efforts, no community should experience interruptions to services due to an emergency. HCA will deliver a similar model of integrated crisis services in the Central GSA.

Future Development: Leveraging our experience, HCA will continue to drive improvements across the North and Central GSA crisis systems. Our primary goals include: Enhancing the core system, expanding services, increasing community access, introducing innovations to create a more efficient crisis response system, and above all, zero suicides. Primary improvements will be completed within the next two years as described in the following six objectives:

1. **Enhanced Core Crisis Services.** HCA will further develop our crisis service system through the following:

❖ HCA will enhance mobile crisis services by issuing a competitive bid in the first year after contract award to select one or more providers for each county in the North GSA. HCA will directly involve stakeholders, including law enforcement, EDs, and government agencies, in the selection process to ensure that the best provider for each location receives a contract, develops strong collaborations, and introduces desired innovations to reduce community response times. The bid process will result in an improved crisis system that addresses each county's unique needs. A similar process will be used in the Central GSA, although one year later to ensure stability during the transition process.

❖ HCA will increase the number of crises appropriately resolved by a mobile team in the field by 10%. On average, five percent of mobile responses result in the initiation of an involuntary petition, and 33% result in voluntary admission to a

higher level of care, such as detox facilities, CSUs, and psychiatric inpatient facilities. In support of this goal, HCA will also offer GSA-wide, crisis trauma-informed care training, specialized I/DD training, Mental Health First Aid, suicide prevention, situational awareness, and approaches for special populations, such as individuals with I/DD. (HCA has already co-sponsored Mental Health First Aid training of over 5,000 individuals in the last five years.)

- HCA will launch a new performance improvement project (PIP) to evaluate CSU utilization, assess community needs, evaluate law enforcement engagement, and identify future enhancements, including increasing capacity and additional locations. The PIP will be launched in 2022, in partnership with staff at each of the CSUs and local law enforcement.
- HCA will expand follow-up crisis care within each GSA by increasing collaboration and improving the crisis follow up processes to integrate SDOH referrals through the NowPow closed loop system. This will be finalized within two years, in partnership with providers and health plans in all-awarded GSAs.
- HCA will transition its crisis system and providers towards the single statewide crisis line aligned with the 988 National Suicide Prevention Lifeline (NSPL). We will work with AHCCCS and the other RBHA contractors to extend our current crisis text services and real time bed tracking capabilities. Throughout the service transition, HCA will provide education and outreach to partners, including law enforcement, EDs, schools, Tribes, and community organizations.

2. Expanded Children's Crisis Services: Due to limited bed capacity, children's facility-based crisis services have been a long-standing challenge for Arizona. Within two years, HCA will collaborate with providers to: 1) develop a pilot Youth Crisis Center (YCC) in the Northern GSA; and 2) expand emergency respite services in both GSAs. The YCC will be designed to reduce avoidable inpatient admissions, out of home placements, and lengthy ED stays by providing a safe, short-term facility for pediatric crisis care. HCA will also expand emergency respite services for families who need assistance in reducing immediate stress in the home using the best practice Stanford "Headspace Model".

3. Enhanced Tribal Partnerships: HCA's strong rapport with Tribal communities has led to the ongoing development of formal crisis protocols with five Tribes, including the Havasupai Tribe. Tribal crisis protocols are critical for increasing awareness, ensuring ease of access, and ensuring culturally sensitive care. For example, the Havasupai Crisis Protocol provides guidance for requesting and delivering crisis services, and includes details on how to contact community resources and coordinate helicopter transport of crisis teams in the Grand Canyon. HCA will work with all Tribal partners to expand crisis protocols over the next two years. Within 90 days of award, HCA will contact all Tribal communities in any awarded GSAs to offer to co-develop crisis protocols and services as they request.

4. Broadened Stakeholder Partnerships: Our current crisis system is founded on three decades of partnership with stakeholders, first responders, health care workers, Tribal partners, and national organizations (i.e., the Red Cross). HCA has partnered with counties in Sequential Intercept Mapping and Step Up projects, as well as Criminal Justice Coalition meetings, to identify issues, implement solutions, and provide support. We are collaborating closely with the City of Flagstaff regarding their proposed development of additional crisis-related resources, and will do likewise with the City of Phoenix regarding similar expanded mobile crisis services. HCA will continue to expand 911 diversion services, and continue collaborations with Mohave and Yavapai counties to develop co-located crisis and justice centers.

5. Expanded Telehealth Crisis Services: HCA will expand telehealth crisis services in additional rural and frontier areas of Arizona, including Tribal communities. HCA will offer to implement telehealth crisis response protocols with additional Tribal partners and EDs throughout the North and Central GSAs.

6. Enhanced Peer and Case Manager Supports: Credentialed peers are instrumental in providing support to an individuals in crisis. Peer supports are currently integrated in several northern psychiatric inpatient facilities to support individuals through their stay and reentry to the community. HCA will identify opportunities to expand these evidence-based practices and incorporate peers and case managers in crisis services, and at least 25% of total contracted mobile crisis teams will be staffed by peer and recovery support specialists.

Summary: Having served diverse Tribal, urban, rural, and frontier communities, HCA understands what it means to provide timely, person-focused, trauma informed crisis care. HCA is uniquely positioned to successfully deliver the full continuum of evidence-based crisis care in the North and Central GSAs.

B10.

NARRATIVE SUBMISSION REQUIREMENTS

B10: American Indian/Alaska Native members have a unique status within the Medicaid system. Describe the Offeror's knowledge of the unique aspects of the tribal health care delivery system and how the Offeror has and will address the specific needs of this population and act to reduce health disparities.

Response B10. Health Choice Arizona's (HCA) comprehensive understanding of the Indian health care delivery system, in conjunction with our cooperative relationships with Tribal leadership, considerably enhance our ability to address the unique needs and reduce health disparities for American Indians/Alaskan Natives (AI/ANs) in Arizona. Our long-standing collaboration with Tribal programs has improved access to integrated physical and behavioral health services based on culturally and linguistically appropriate care approaches, and is designed to quickly identify, escalate, and resolve any barriers to service delivery for Tribal members both *on* and *off* Tribal lands. With 29 years as the RBHA in the North GSA, HCA understands the importance of actively collaborating with each unique Tribal community, through the establishment of trust and respect-based relationships focusing on clinical and preventive care for Tribal members.

Unique Aspects of the Tribal Health System. Tribal members who are enrolled with AHCCCS can choose to receive services through the I/T/U (IHS, Tribal 638, and Urban Indian Health Organization) delivery system or non-I/T/U providers, and can move at any time between the American Indian Health Program (AIHP) and AHCCCS-contracted health plans. Because of this, HCA has chosen to employ a highly flexible and inclusive approach to working with Tribes and their members — because any Tribal member may become *our* member on any given day. Currently, 16,000 Tribal members have chosen HCA, including over 450 RBHA-enrolled members from many different federally recognized Tribes in Arizona and the U.S., and we share enrollment for more than 60 members with American Indian Health Plan (AIHP). But our commitment to culturally sensitive healthcare extends to all Tribal members, as is evidenced through an array of consultation and service engagements with Tribes, collaborations with the 32 individual I/T/U hospitals and clinics located in the North GSA, and our innovative outreach and service programs for Tribal members and their rural and urban communities. The reality is that we serve *all* Tribal members, regardless of provider or payor.

Engagement and Collaboration. HCA is committed to delivering whole person, family-centered, culturally relevant, and trauma-informed healthcare services to help achieve positive outcomes for all members, families, and communities. We acknowledge the current and generational trauma that many Tribal members have experienced, and which may make members reluctant to engage in services. To that end, HCA's provider network and Health Homes include Tribal providers who also speak Tribal languages and embrace native cultures. These resources are published in our provider directory for all members. Prompt and appropriate delivery of integrated behavioral health and physical health services that consider the unique cultural and geographical landscape of each Tribal community is accomplished through:

Memorandums of Understanding. HCA develops formal Memorandums of Understanding (MOAs) and Letters of Agreement (LOAs) with Tribes to address care coordination needs and document specific services that Tribes wish HCA to provide on Tribal lands. Our relationships with the Tribes are founded upon HCA's respect for the sovereignty of all the Tribes. HCA's level of respect for Tribal sovereignty is exemplified by our willingness in 2015 to respect the San Carlos Tribal Nation's wish to remain in the South GSA, even though the ADHS procurement had designated it as being in the North GSA. (We will, of course, do the same again if selected for the Central GSA and it is requested). While we offer all Tribal communities the opportunity to enter into agreements, we respect that the decision is the Tribe's – not ours. When a Tribe is interested in an agreement, HCA develops a MOU or LOA with them in accordance with Federal and AHCCCS policy guidelines. These agreements identify applicable expectations for use in service delivery and program development. Currently, we maintain formal written MOUs/LOAs with four of the twelve Tribes in the North GSA: the Havasupai Tribe, Hopi Tribe, Fort Mojave Indian Tribe, and the Hualapai Tribe. These agreements are the result of years of dialogue and trust-building. The MOU with the Havasupai Tribe, for example, supports the implementation of customized crisis protocols in the Grand Canyon which were developed over many years. These protocols have aided the delivery of urgent behavioral health services during the pandemic and other critical incidents.

Tribal Consultation. We value our partnerships with all 22 of Arizona's Tribal communities, although we focus most heavily on the 17 Tribal communities whose sovereign lands are located within the North and Central GSAs. We hold a Tribal Summit every year, and offer regular consultation and support for all Tribal organizations at any time, regardless of whether we have an established MOU/LOA or not. Our consultation process emphasizes trust and respect, and encourages an exchange of information, candid expressions of views, and a commitment to active listening. Our Tribal Coordinator plays an instrumental role in relationship-building, and serves as the primary interface with Tribes to ensure members' voices are heard, barriers to care are removed, and assistance to Tribal community is regularly offered.

The HCA Tribal Coordinator attends AHCCCS Tribal Consultation meetings, and works with our HCA Tribal Services Team (which involves participation from all HCA departments) to provide consultation and follow-up specific to the issues that are prioritized by Tribal leadership. The HCA Tribal Coordinator reports directly to the HCA CEO and meets regularly with the CEO and executive team to review details of the comprehensive Tribal Coordinator Report and Work Plan, which covers health education initiatives and our efforts supporting food and fuel security. The work plan is also an effective tool to identify and address barriers to care affecting Tribal members.

Assistance with Access to Resources: HCA staff routinely assists Tribal members and communities in navigating AHCCCS resources, working with non-Tribal health facilities off Tribal lands, interfacing with local governments, and drafting policies or protocols related to care. HCA ensures its providers recognize Tribal court orders and coordinate care when Tribal members on court ordered treatment are transitioned between on-and-off reservation services, so members can easily access care. HCA has facilitated the creation of Tribal protocols for crisis services, giving "step by step" guidance on how to best use the region's crisis response system. HCA also has worked to ensure the regional crisis response hotline and our provider networks are responsive to the many unique situations impacting Tribal communities, including the incorporation of cultural and language considerations throughout the systems of crisis care. HCA developed a traditional practitioner and sweat lodge program ten years ago**,** which now includes 73 Traditional Practitioners from 10 Tribes and Nations, to provide healing and protection-related Traditional Services for all Tribal members. Financial support is provided through HCA's Community Reinvestment Program and grant funds from The NARBHA Institute.

Facilitating Telehealth Services: HCA supports remote access to covered services through use of telehealth, especially for geographically isolated or underserved regions. For example, HCA provided computers and broadband service funding to facilitate video conferencing for the Havasupai Tribe. HCA also assisted the Hopi Health Care Center's ED and Hopi Behavioral Health Crisis Services through the development of telehealth protocols and training. We continue to expand telehealth services for all members, built upon the 700 telehealth access points we have already established.

Addressing Health Disparities. Tribal members disproportionately face many health burdens and challenges in accessing services. Data for Tribal members enrolled in HCA demonstrates the existence of disparities that are in line with national Indian Health Service rates for diabetes (31% higher), behavioral health and substance use disorders (22% higher) and other chronic conditions. HCA continues to develop and implement initiatives to reduce health disparities through education and cultural awareness. For example, HCA has built a network of SUD behavioral health residential treatment facilities and two Rural Substance Abuse Transitional Agencies, with specialized Tribal programming, including an on-site Hogan for healing practices. HCA's Tribal Coordinator and our population health model also help identify disparities that our Tribal members may experience and develop targeted interventions, in collaboration with Tribal and community programs and agencies, to promote equitable service delivery through culturally sensitive care management programs. For example, early in the pandemic, HCA identified disparities in COVID hospitalization rates of Tribal members. HCA provided intensive post-hospital care management to members with COVID to connect members to care.

HCA will continue expanding the equitable delivery of care for Tribal members through the following:

- Identifying and Addressing Social Determinants: Ongoing collaboration with Tribes and I/T/U leadership, in support of development of best practice protocols for COVID-19 vaccination outreach and delivery of food/fuel/PPE.
- Increasing Health Literacy: Member-specific culturally relevant care plans and education on chronic self-management
- Enhanced Data Sharing: Promotion of IHS/Tribal 638 facility participation in Contexture's HIE, American Indian Medical Home model, and the confidential use of Tribal member information in care management.
- Building Trust: Proactive outreach and communications, with robust participation in Tribal community events and the delivery of culturally relevant educational and outreach materials (in print and online).
- Healthcare Delivery System Education: Customized trainings, for providers, HCA staff, and community service organizations and county agencies, to identify disparities related to disease burden.

HCA is committed to continuing our collaborative relationship with every Tribal community to improve access to health care and social resources, and eliminate disparities. Above all, we are committed to serving *all* Tribal members.

B11.

NARRATIVE SUBMISSION REQUIREMENTS

B11: Describe how the Offeror will use existing Medicaid compensable services as well as non-covered services and supports to address social risk factors impacting AHCCCS members. Include how the Offeror will capture data related to Social Determinants of Health to ensure members are connected and have timely access to needed social services.

Response B11. HCA members living with Serious Mental Illness (SMI) often face complex health and social challenges. The influence of SDOH risk factors is especially significant for members with chronic, co-occurring physical and behavioral health conditions. A comprehensive understanding of an individual member's socio-economic, housing, educational, built environment, and health care access needs is vital for the effective and timely delivery of person-centered, trauma informed, and culturally competent care. Other important considerations, such as loneliness and justice involvement, must also be part of individualized care planning. A biopsychosocial model that seeks to understand the dynamic and changing priorities in a member's life – in other words, a ***whole person care*** approach – is the most effective framework for successful interventions and optimal member health.

Assessment Followed by Reassessment. As the only NCQA-accredited AHCCCS health plan, HCA requires that providers annually complete individual Health Risk Assessments (HRAs), which we have expanded to include an assessment of each member's SDOH needs. All HCA providers also routinely screen for member SDOH needs during outpatient visits, using standardized screening tools (e.g., PCAM) recommended through the AHCCCS Targeted Investment Program. Information from HRAs and SDOH screenings guides individualized member service plan development and updating. However, assessments are not just performed annually. Screening and updates occur regularly thought the year, to ensure that changes in member needs are identified, supported, and documented in the individual service plan. In 2019/20 case file reviews, all Health Homes scored 100% for SDOH assessment, using evidence-based screening tools.

Collecting Data to Understand SDOH Needs. Each region of Arizona has unique geographical, cultural, political, and socioeconomic conditions affecting SDOH resources. To understand trends at a macro level, HCA collaborated with The NARBHA Institute in the development of a comprehensive *Regional Health Equity Assessment* (RHEA). Commissioned in 2017 and updated in 2021, the RHEA was conducted by the Northern Arizona University Center for Health Equity Research, and led by a PhD researcher who is also a registered Tribal member. Using the SDOH model as the overarching assessment framework, findings summarized county and community variations in access to care and the impact of SDOH factors on individual wellbeing and community health. The RHEA has guided numerous innovation and community grant opportunities, including a study on supported employment in the hospitality industry. (If awarded, we will extend this process to the Central GSA, and continue using community reinvestment grants to support it.) HCA also collects data from many sources: HRAs, SDOH screenings, Blue Cross Blue Shield of Arizona's (BCBSAZ) Community Health Management Hub, member and provider requests for assistance, and provider claims data (including ICD-10 Z codes) to direct referrals. We use our QlikSense's real-time tool to match resources with emerging needs. We also gather input through meetings with community stakeholders, including Tribal communities and peer run organizations.

Cross-Sector Innovations. Complex problems require collaborative solutions that leverage funding from both compensable and non-covered service options. We rely heavily on covered services, such as provider case management, to coordinate SDOH services with members. In addition, since 2018, HCA has administered over $86 million in federal, state, and local grants to supplement the needs of AHCCCS members, by building capacity and addressing gaps not covered by Medicaid. In collaboration with BCBSAZ's MobileAZ health improvement initiative, The NARBHA Institute, HCA Community Reinvestment funds, and other funding partners, HCA has facilitated health advancement initiatives to implement innovative solutions designed to address a range of SDOH challenges, including:

Social Isolation: As identified by the RHEA update, number of members living with SMI have experienced increased isolation during the COVID pandemic. An often under-recognized social determinant, loneliness can significantly limit a member's ability to seek timely care, make regular appointments, and attain service plan goals.

- *Improvement strategies:* To support members living with SMI, HCA launched a partnership with Arizona-based Pyx Health, a scalable mobile technology platform that reduces loneliness and member isolation. Early results show a 30% reduction in loneliness, 40% decrease in depression, and 53% reported avoidance of emergency and/or crisis services. The Pyx Health team works with HCA's Care Management program staff, to ensure a collaborative approach to member care and outreach regarding key service needs and initiatives, such as COVID vaccination.

Food Insecurity: As noted in the RHEA, "limited local access to health food options contributes to high food insecurity." Strong evidence shows that living in a food desert is closely correlated with obesity and premature death. Over 25% of families in the North GSA experience some level of food insecurity.

- *Improvement strategies:* (1) HCA will enhance our long-standing Community Resource Guide to include education materials and an expanded directory of food banks, pantries, and others distributing emergency food including contact information, programs, hours of operation, and maps. This will involve collaborative efforts with Coconino and Mohave counties, and with Solari's 211 data base; (2) HCA will continue to host Mobile Food Pantry Drives and will again partner with the Arizona Coalition for Military Families and Real Hope to provide food and financial support. HCA delivered nearly 3,000 food boxes and drinking water to Tribal members during the height of the pandemic and will continue to support this effort; and (3) BCBSAZ has funded over $2.5M toward food security intiaitves since 2018, and along with The NARBHA Institute will continue to fund grants for Tribal community-based organizations and providers, to enhance access to healthy food options in both rural and urban settings.

Employment Supports: As identified in the RHEA, high unemployment and poverty rates across the region, and in particular among Tribal communities, strongly influence mental and physical health status of residents.

- *Improvement strategies:* HCA addresses member employment needs through partnerships with ADES-Rehabilitation Services Administration, and NACOG Economic Development Council membership and coverage of Supported Employment Services (SES). This partnership resulted in the creation of a "Vocational Counselor" initiative to train specialized provider case managers to educate and assist members. Results show members living with SMI who are receiving SES consistently earn more than minimum wage and average 25-30 work hours per week. Since 2015, HCA's program has resulted in a 127% increase in members reaching their employment goals.

Housing is Healthcare: HCA's permanent supportive housing (PSH) and wrap-around service programs have proven effective for members experiencing homelessness or who at risk of becoming homeless. An analysis of 208 members living with SMI, and 32 ACC members, found that housing decreased health care claims by 16% and inpatient care by 33% in the first year after obtaining housing resources.

- *Improvement strategies:* (1) HCA and The NARBHA Institute are active members of the Arizona Balance of State Continuum of Care, and the Home Matters to Arizona Fund (which has a focused goal of raising $100 million in loans and grants for affordable housing); and (2) Along with BCBSAZ and The NARBHA Institute, we will continue our long-term collaborative financial support of not-for-profit housing organizations to expand our already extensive network of housing units that are not funded with state dollars. Almost 60% of units in our network are *not* state funded.

Criminal Justice Innovation: Individuals involved with the justice system experience significantly higher behavioral health challenges, lower employment, increased avoidable emergency visits, and increased total cost of care.

- *Improvement strategies:* HCA funds jail re-entry coordinators in county jails and in all of our Health Homes to coordinate the care of individuals with opioid or stimulant use who are transitioning from incarceration. Early results are promising: of 7,200 voluntary post-release inmates screened in 2020 for SUD and SDOH needs, nearly 900 of screened individuals agreed to coordinated services for opioid and/or stimulants use upon release. In collaboration with counties, HCA's innovative Court Ordered Treatment Oversight Program provides care management to individuals from initial identification through court ordered evaluation and court ordered treatment. This ensures delivery of appropriate care-coordinated outpatient services, and resulted in an 18% reduction in unduplicated court ordered evaluation readmissions in Coconino County over a two year period.

The Referral Loop Must Be Closed. Directing members to resources is an important task, but the referral loop between plan care managers, providers, members, and community service providers ***must be closed***. HCA has already identified solutions that will complement the Contexture/NowPow closed loop referral system (CLRS) – and is prepared to implement them. We have already implemented new quality measures, worked with providers to include SDOH ICD-10 codes, and use CLRS screening tools. HCA is committed to accompanying members and providers on the important journey through the implementation of NowPow in our communities, and will continue to deploy emerging resources, service innovations, and collaborative partnerships to support the whole person health of each person we serve.

B12.

NARRATIVE SUBMISSION REQUIREMENTS

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.

Response B12. While the pandemic has been extremely challenging for all Arizonans, it has been especially difficult for vulnerable community members, including individuals living with Serious Mental Illness (SMI) and members with un-recognized and under-treated behavioral health conditions. The data tells an alarming story. Tribal communities have suffered disproportionate rates of serious COVID illness. Five Arizonans now die every day from opioid overdoses, and national rates of youth anxiety and depression have almost doubled. And although crisis line call volumes in the North GSA have remained at pre-pandemic levels, calls due to anxiety and suicidal ideation have increased. Emergency room boarding times for children with behavioral health emergencies have increased. Bed capacity for inpatient psychiatric and substance abuse treatment has at times been limited due to a staff shortages and other factors. Finally, the impact of social, economic, housing, and other stressors has been significant for many individuals with SMI and their families. As a result, the process of pandemic recovery is likely to be a long and challenging one.

Our Collaborative Response. From the pandemic's onset, Health Choice Arizona (HCA), our parent organization Blue Cross Blue Shield of Arizona (BCBSAZ), and key community partners such as The NARBHA Institute, have engaged in targeted, innovative solutions that emphasize collaboration, continuous coalition-building, and a comprehensive commitment to recovery. Developing individual and community resiliency has guided HCA and its partners' efforts since the announcement of the public health emergency (PHE) declaration. Our commitment to a trauma and resiliency-informed pandemic recovery process is evidenced by our continued dedication to the following:

- *Population health risk stratification:* HCA's use of the John Hopkins ACG predictive analytics platform enabled early identification of vulnerable members living with SMI who also have on co-occurring physical health conditions. Updated registry information for members was shared with providers throughout the pandemic, and has guided our collective outreach efforts. Ongoing interventions will be tailored to subpopulations based on risk, with a special focus on members living with SMI and other behavioral health needs, and will continue to include those living in congregate care and residential settings. HCA will to use this data-driven approach to address evolving care management needs as the COVID recovery process develops.
- *Expanded care management:* HCA's direct outreach to members at high risk from COVID illness supports ongoing member care and timely access to vaccinations. HCA provides continuous education on prevention measures and assistance with prescriptions and medical supplies. These combined efforts appear to have mitigated the severity of COVID on our members: To date, ***the COVID mortality rate for RBHA members in the North GSA is less than 50% of the reported rate for Arizona's general population***. HCA will continue to deploy high-touch care management resources to provide support through the recovery process.
- *Increased surveillance and services:* HCA leverages QlikSense real-time analytics and other systems to identify impactable trends in the behavioral needs of our members, such as emergency department visits, admissions, crisis utilization, psychiatric bed availability, opioid use, and naloxone prescription patterns. Review of these trends, along with sharing of key resources (e.g., AZ OAR line and the Resilient AZ Crisis Counseling Program), and the use of best practice interventions occurs through: the HCA Provider Medical Professionals workgroup, HCA Provider CEO meetings, opioid risk mitigation efforts, participation in county, Tribal, and community town halls, delivery of CISM/D to county stakeholders, and the use of telehealth to augment mobile crisis response. HCA will share our surveillance data with AHCCCS, other health plans, and providers as the recovery process continues and the long-term challenges associated with COVID become better defined.
- *Culturally sensitive outreach:* In response to the early 2020 outbreak of COVID in Tribal communities, HCA conducted outreach to members living on the Navajo and Hopi reservations, using culturally appropriate print and radio messaging. Through the HCA *Traditional Practitioner Program*, trusted infection control information was shared with many of the program's 70 traditional healers – along with 5,000 food boxes, more than 150 gallons of hand sanitizer, thousands of rubber gloves, and many other vital supplies. Tribal leader consultation continues to occur regularly, including the September 2021 *HCA Tribal Summit on Strengthening Tribal Resiliency*. HCA will continue consultation and stakeholder meetings with Tribal communities, and the providers serving them, to support their priorities.
- *Timely information and resource sharing:* Immediately after the PHE declaration in March 2020, HCA convened the *Northern Arizona Health Leaders Coalition*, a collaboration of over 50 leaders from hospitals, Indian health

organizations, health departments, behavioral providers, PCPs, science and educational leaders, philanthropy, and community organizations. The coalition has facilitated diverse response and recovery efforts, including PPE distribution, COVID testing, shared staffing arrangements, protocols for use of homeless shelter beds, and behavioral health facility quarantine protocols. This work has modeled collaboration, rather than competition. Through more than 50 meetings, the Coalition has identified priority topics for response, ranging from situational awareness on organizational capacity to emerging trends on social needs. The Northern Arizona Social Services Safety Net Coalition developed as an outgrowth of the Health Leaders Coalition conversation, helping bring special focus to SDOH challenges. In support of timely information-sharing, HCA and The NARBHA Institute also launched the *Arizona Community Grand Rounds (AzCGR)*, a monthly learning series for a broad stakeholder group featuring experts from a variety of disciplines. HCA will continue to expand our role in supporting regional collaboration and education to accelerate Arizona's pandemic recovery.

- *Collaborative testing and vaccine delivery:* Within five days of the March 11, 2020 Declaration of Emergency in Arizona, the state's first drive-thru COVID testing site was launched in Coconino County. This site relied on testing developed by the Translational Genomics Institute (TGEN) through financial support from HCA, Blue Cross Blue Shield Arizona (BCBSAZ), The NARBHA Institute, and other funders. To date, over 63,000 PCR tests have been completed by TGEN in support of many county and Tribal agreements. In 2021, BCBSAZ embraced another challenge: COVID vaccinations. In partnership with ADHS, BCBSAZ volunteers logged more than 145,000 hours at multiple state mass vaccination sites, helping Arizonans receive more than 491,000 vaccines. HCA is now supporting motivational interviewing and culturally-informed education for providers and communities to help vaccine hesitant members overcome concerns and get vaccinated. HCA will work with ADHS, AHCCCS, health plans, and providers to reduce barriers to receiving vaccinations such as transportation.

Support for Health Professionals. Arizona's health professional workforce is essential to recovery, and has experienced continued strain under the burdens of care delivery during a lengthy pandemic. HCA has proactively engaged partners to facilitate and collaboratively develop several initiatives supporting *health professional wellbeing*. This work is collaborative with the AZ System CMO group, BH COVID Task Force, ADHS Vaccine Equity Task Force, AZ Medical Association (ArMA), AZ Nurses Association (AzNA), Stronger As One, and others. It includes:

- Promotion of provider participation in the *Resilient AZ Crisis Counseling Program*, the AzNA *RNConnect2Wellbeing* initiative, ArMA's *Virtual Doctors' Lounge*, the AzDHS *Social Connectedness Campaign*, & statewide *Mental Health First Aid* trainings and planning events.
- Dissemination of inpatient behavioral health care protocols during the pandemic, such as the work plan developed by The Guidance Center on inpatient psychiatric care for members testing positive for COVID.
- Facilitation of the *AZ Monoclonal Antibody workgroup*, a learning collaborative whose purpose is to share information on emerging trends, challenges, and best practices related the timely and equitable use of monoclonal antibody therapies for COVID treatment and prevention.
- Formation of the *AZ Wellbeing Collaborative for Health Professionals*, with active participation from major health systems, public health, and professional associations across Arizona. This group of over 20 organizations is committed to supporting a professional fulfillment-informed foundation for recovery that highlights the critical role of workforce well-being in the health of Medicaid members and all Arizonans.

Our Commitment to a Sustainable Recovery. HCA and BCBSAZ are privileged to participate in the Arizona Health Improvement Plan (AzHIP), with invited engagement in the Pandemic Recovery and Resiliency Priority Core Team. The Core Team has identified a comprehensive set of recovery activities, within four strategic goals: (1) strengthen public health capacity and infrastructure; (2) rebuild a stronger system to support health; (3) advance health equity; and (4) enhance resilience in Arizona communities. HCA's longstanding role as regional convener and trusted partner has enabled rapid implementation of data-driven service innovations in support of recovery. Through responsive partnerships and culturally-respectful interventions advancing member satisfaction and outcomes, cost efficiencies, and provider fulfillment, we are committed to supporting a long-term recovery for our members – and our state – that is ***inclusive, whole person-oriented, and sustainable***.

PART C: CAPITATION AGREEMENT/ADMINISTRATIVE COST BID SUBMISSION

Health CHOICE

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health CHOICE

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

October 1, 2021

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

RE: Statement of Acceptance of Rates (Solicitation # CCE YH20-0002)
Expansion of AHCCCS Complete Care Contract # YH19-19-0001

Dear Ms. LaPorte:

As indicated in Section H, subsection 19 in AHCCCS Solicitation # CCE YH20-0002:

"The AHCCCS actuaries will develop components of the capitation rates including the medical services component, reinsurance offset, underwriting gain, and premium tax. These components will not be bid by the Offeror. The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice and will follow generally accepted actuarial principles and practices."

Additionally, AHCCCS intends to complete capitation rates, and publish the rates prior to October 1, 2022.

I, Shawn Nau, Chief Executive Officer of Health Choice Arizona, Inc., understand that these actuarially-sound rates will be calculated by AHCCCS and will not be negotiated. Health Choice Arizona, Inc. will accept these capitation rates developed by AHCCCS for the contract.

This agreement satisfies the submission requirement of signed agreement accept capitation rates per Solicitation # CCE YH20-0002, Section H, Instructions to Offerors.

Health Choice Arizona, Inc.
Company Name

Signature of Person Authorized to Sign Agreement

410 N.44th Street, Suite #900
Address

Shawn Nau
Printed Name

Phoenix | Arizona | 85008
City | State | Zip

Chief Executive Officer
Title

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
MCO Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 822,079.80	$ 846,742.19	$ 872,144.46	$ 898,308.79	$ 925,258.06	$ 81,304.60	$ 83,743.73	$ 86,256.05	$ 88,843.73	$ 91,509.04
Care Management/Care Coordination	$ 2,811,773.40	$ 2,896,126.60	$ 2,983,010.40	$ 3,072,500.71	$ 3,164,675.73	$ 278,087.48	$ 286,430.10	$ 295,023.01	$ 303,873.70	$ 312,989.91
Claims and Encounters	$ 125,095.99	$ 128,848.87	$ 132,714.34	$ 136,695.77	$ 140,796.64	$ 12,372.13	$ 12,743.30	$ 13,125.59	$ 13,519.36	$ 13,924.94
Clinical Management	$ 1,271,837.39	$ 1,309,992.51	$ 1,349,292.29	$ 1,389,771.06	$ 1,431,464.19	$ 125,786.12	$ 129,559.70	$ 133,446.49	$ 137,449.88	$ 141,573.38
Compliance/Legal	$ 132,401.85	$ 136,373.91	$ 140,465.13	$ 144,679.08	$ 149,019.45	$ 13,094.69	$ 13,487.53	$ 13,892.16	$ 14,308.92	$ 14,738.19
Dental	$ 14,190.69	$ 14,616.41	$ 15,054.91	$ 15,506.55	$ 15,971.75	$ 1,403.48	$ 1,445.58	$ 1,488.95	$ 1,533.62	$ 1,579.62
Executive	$ 295,597.98	$ 304,465.92	$ 313,599.90	$ 323,007.90	$ 332,698.13	$ 29,234.97	$ 30,112.01	$ 31,015.37	$ 31,945.84	$ 32,904.21
Health Care Quality Improvement	$ 1,651,740.08	$ 1,701,292.28	$ 1,752,331.05	$ 1,804,900.98	$ 1,859,048.01	$ 163,358.91	$ 168,259.68	$ 173,307.47	$ 178,506.69	$ 183,861.89
Information Services / Technology	$ 215,408.90	$ 221,871.16	$ 228,527.30	$ 235,383.12	$ 242,444.61	$ 21,304.18	$ 21,943.30	$ 22,601.60	$ 23,279.65	$ 23,978.04
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 52,260.26	$ 53,828.07	$ 55,442.91	$ 57,106.20	$ 58,819.38	$ 5,168.60	$ 5,323.65	$ 5,483.36	$ 5,647.87	$ 5,817.30
Pharmacy Management	$ 29,634.82	$ 30,523.87	$ 31,439.58	$ 32,382.77	$ 33,354.26	$ 2,930.92	$ 3,018.84	$ 3,109.41	$ 3,202.69	$ 3,298.77
Program Integrity (Fraud, Waste & Abuse)	$ 8,452.14	$ 8,705.70	$ 8,966.87	$ 9,235.88	$ 9,512.95	$ 835.93	$ 861.00	$ 886.83	$ 913.44	$ 940.84
Provider Relations and Network Management	$ 72,018.33	$ 74,178.88	$ 76,404.25	$ 78,696.38	$ 81,057.27	$ 7,122.69	$ 7,336.37	$ 7,556.46	$ 7,783.16	$ 8,016.65
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total MCO Compensation	$ 7,502,491.63	$ 7,727,566.37	$ 7,959,393.39	$ 8,198,175.19	$ 8,444,120.43	$ 742,004.70	$ 764,264.79	$ 787,192.75	$ 810,808.55	$ 835,132.78
Professional and Outside Services	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 362,255.92	$ 373,123.60	$ 384,317.31	$ 395,846.83	$ 407,722.23	$ 35,827.51	$ 36,902.33	$ 38,009.40	$ 39,149.69	$ 40,324.18
Care Management/Care Coordination	$ 471,803.11	$ 485,957.20	$ 500,535.92	$ 515,551.99	$ 531,018.55	$ 46,661.85	$ 48,061.70	$ 49,503.55	$ 50,988.66	$ 52,518.32
Claims and Encounters	$ 50,435.88	$ 51,948.95	$ 53,507.42	$ 55,112.64	$ 56,766.02	$ 4,988.16	$ 5,137.81	$ 5,291.94	$ 5,450.70	$ 5,614.22
Clinical Management	$ 7,519.85	$ 7,745.44	$ 7,977.81	$ 8,217.14	$ 8,463.66	$ 743.72	$ 766.03	$ 789.01	$ 812.68	$ 837.06
Compliance/Legal	$ 2,539.58	$ 2,615.76	$ 2,694.24	$ 2,775.06	$ 2,858.32	$ 251.17	$ 258.70	$ 266.46	$ 274.46	$ 282.69
Dental	$ 3,530.51	$ 3,636.43	$ 3,745.52	$ 3,857.89	$ 3,973.62	$ 349.17	$ 359.65	$ 370.44	$ 381.55	$ 393.00
Executive	$ 618,162.69	$ 636,707.57	$ 655,808.80	$ 675,483.07	$ 695,747.56	$ 61,136.97	$ 62,971.08	$ 64,860.21	$ 66,806.02	$ 68,810.20
Health Care Quality Improvement	$ 33,776.67	$ 34,789.97	$ 35,833.67	$ 36,908.68	$ 38,015.94	$ 3,340.55	$ 3,440.77	$ 3,543.99	$ 3,650.31	$ 3,759.82
Information Services / Technology	$ 85,519.59	$ 88,085.17	$ 90,727.73	$ 93,449.56	$ 96,253.05	$ 8,457.98	$ 8,711.72	$ 8,973.07	$ 9,242.26	$ 9,519.53
Interpretive Services	$ 4,139.94	$ 4,264.14	$ 4,392.07	$ 4,523.83	$ 4,659.54	$ 409.45	$ 421.73	$ 434.38	$ 447.41	$ 460.83
Member Services	$ 19,812.14	$ 20,406.50	$ 21,018.70	$ 21,649.26	$ 22,298.74	$ 1,959.44	$ 2,018.23	$ 2,078.77	$ 2,141.14	$ 2,205.37
Pharmacy Benefit Manager Expenses [2]	$ 157,612.11	$ 162,340.48	$ 167,210.69	$ 172,227.01	$ 177,393.82	$ 15,588.01	$ 16,055.65	$ 16,537.32	$ 17,033.44	$ 17,544.44
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 5,533.94	$ 5,699.95	$ 5,870.95	$ 6,047.08	$ 6,228.49	$ 547.31	$ 563.73	$ 580.64	$ 598.06	$ 616.00
Provider Relations and Network Management	$ 6,742.04	$ 6,944.30	$ 7,152.63	$ 7,367.21	$ 7,588.22	$ 666.79	$ 686.80	$ 707.40	$ 728.62	$ 750.48
Subcontractors [2]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 1,829,383.97	$ 1,884,265.46	$ 1,940,793.46	$ 1,999,017.25	$ 2,058,987.76	$ 180,928.08	$ 186,355.93	$ 191,946.58	$ 197,705.00	$ 203,636.14
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ 89,236.66	$ 91,913.76	$ 94,671.17	$ 97,511.31	$ 100,436.64	$ 8,825.60	$ 9,090.37	$ 9,363.08	$ 9,643.98	$ 9,933.29
Non-Compensation Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Occupancy & Depreciation	$ 560,190.98	$ 576,996.71	$ 594,306.61	$ 612,135.81	$ 630,499.88	$ 55,403.50	$ 57,065.61	$ 58,777.58	$ 60,540.90	$ 62,357.13
Office Supplies, Equipment Repair, Maintenance	$ 6,995.09	$ 7,204.94	$ 7,421.09	$ 7,643.72	$ 7,873.03	$ 691.82	$ 712.58	$ 733.95	$ 755.97	$ 778.65
Printing, Postage, Fulfillment	$ 40,385.64	$ 41,597.20	$ 42,845.12	$ 44,130.47	$ 45,454.39	$ 3,994.18	$ 4,114.01	$ 4,237.43	$ 4,364.55	$ 4,495.49
Travel, Marketing, Insurance	$ 122,406.24	$ 126,078.43	$ 129,860.78	$ 133,756.60	$ 137,769.30	$ 12,106.11	$ 12,469.29	$ 12,843.37	$ 13,228.67	$ 13,625.54
Other [1]	$ 1,942.46	$ 2,000.73	$ 2,060.76	$ 2,122.58	$ 2,186.26	$ 192.11	$ 197.87	$ 203.81	$ 209.93	$ 216.22
Total Non-Compensation	$ 821,157.07	$ 845,791.77	$ 871,165.53	$ 897,300.49	$ 924,219.50	$ 81,213.32	$ 83,649.73	$ 86,159.22	$ 88,744.00	$ 91,406.32
Total Admin Dollars	$ 10,153,032.67	$ 10,457,623.60	$ 10,771,352.38	$ 11,094,492.93	$ 11,427,327.69	$ 1,004,146.10	$ 1,034,270.45	$ 1,065,298.55	$ 1,097,257.55	$ 1,130,175.24
Total Management Fees Included Above [3]	$ 10,153,032.67	$ 10,457,623.60	$ 10,771,352.38	$ 11,094,492.93	$ 11,427,327.69	$ 1,004,146.10	$ 1,034,270.45	$ 1,065,298.55	$ 1,097,257.55	$ 1,130,175.24
Management Fee arrangement percentage (contracted)	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
Projected Member Months	79,085	79,085	79,085	79,085	79,085	2,811,550	2,811,550	2,811,550	2,811,550	2,811,550

1) If "Other" is greater than 5% of the total then please provide a detailed list describing what's included, with amounts.

2) Please refer to the MLR reference/guidance tool (https://www.azahcccs.gov/PlansProviders/Downloads/FinancialReporting/MedicalLossRatioReportAndGuidance.xlsx Tab: SubContractors and PBMs) for costs which must be reported as non-claims administrative expenses.
3) Total management fees included above, already counted in total admin dollars.

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
MCO Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 2,832,359.05	$ 2,917,329.82	$ 3,004,849.72	$ 3,094,995.21	$ 3,187,845.06	$ 280,123.42	$ 288,527.13	$ 297,182.94	$ 306,098.43	$ 315,281.38
Care Management/Care Coordination	$ 24,343,385.90	$ 25,073,687.48	$ 25,825,898.10	$ 26,600,675.04	$ 27,398,695.30	$ 2,407,587.62	$ 2,479,815.25	$ 2,554,209.70	$ 2,630,835.99	$ 2,709,761.07
Claims and Encounters	$ 1,747,919.69	$ 1,800,357.28	$ 1,854,368.00	$ 1,909,999.04	$ 1,967,299.01	$ 172,871.18	$ 178,057.31	$ 183,399.03	$ 188,901.00	$ 194,568.03
Clinical Management	$ 5,233,832.38	$ 5,390,847.35	$ 5,552,572.77	$ 5,719,149.95	$ 5,890,724.45	$ 517,631.77	$ 533,160.73	$ 549,155.55	$ 565,630.22	$ 582,599.12
Compliance/Legal	$ 469,935.12	$ 484,033.18	$ 498,554.17	$ 513,510.80	$ 528,916.12	$ 46,477.10	$ 47,871.41	$ 49,307.56	$ 50,786.78	$ 52,310.39
Dental	$ 54,724.36	$ 56,366.09	$ 58,057.07	$ 59,798.78	$ 61,592.75	$ 5,412.30	$ 5,574.67	$ 5,741.91	$ 5,914.17	$ 6,091.59
Executive	$ 295,598.12	$ 304,466.07	$ 313,600.05	$ 323,008.05	$ 332,698.29	$ 29,234.98	$ 30,112.03	$ 31,015.39	$ 31,945.85	$ 32,904.23
Health Care Quality Improvement	$ 6,674,165.64	$ 6,874,390.61	$ 7,080,622.32	$ 7,293,040.99	$ 7,511,832.22	$ 660,082.32	$ 679,884.79	$ 700,281.33	$ 721,289.77	$ 742,928.46
Information Services / Technology	$ 1,061,617.81	$ 1,093,466.34	$ 1,126,270.33	$ 1,160,058.44	$ 1,194,860.20	$ 104,995.17	$ 108,145.02	$ 111,389.37	$ 114,731.05	$ 118,172.99
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 403,605.26	$ 415,713.42	$ 428,184.82	$ 441,030.37	$ 454,261.28	$ 39,917.00	$ 41,114.51	$ 42,347.95	$ 43,618.39	$ 44,926.94
Pharmacy Management	$ 233,053.82	$ 240,045.44	$ 247,246.80	$ 254,664.21	$ 262,304.13	$ 23,049.28	$ 23,740.76	$ 24,452.98	$ 25,186.57	$ 25,942.17
Program Integrity (Fraud, Waste & Abuse)	$ 59,022.63	$ 60,793.31	$ 62,617.11	$ 64,495.62	$ 66,430.49	$ 5,837.40	$ 6,012.53	$ 6,192.90	$ 6,378.69	$ 6,570.05
Provider Relations and Network Management	$ 394,859.04	$ 406,704.81	$ 418,905.95	$ 431,473.13	$ 444,417.32	$ 39,051.99	$ 40,223.55	$ 41,430.26	$ 42,673.17	$ 43,953.36
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total MCO Compensation	$ 43,804,078.82	$ 45,118,201.20	$ 46,471,747.21	$ 47,865,899.63	$ 49,301,876.62	$ 4,332,271.53	$ 4,462,239.69	$ 4,596,106.87	$ 4,733,990.08	$ 4,876,009.78
Professional and Outside Services	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 2,539,473.45	$ 2,615,657.65	$ 2,694,127.38	$ 2,774,951.20	$ 2,858,199.74	$ 251,156.71	$ 258,691.42	$ 266,452.16	$ 274,445.72	$ 282,679.10
Care Management/Care Coordination	$ 14,416,348.78	$ 14,848,839.25	$ 15,294,304.42	$ 15,753,133.56	$ 16,225,727.56	$ 1,425,792.74	$ 1,468,566.52	$ 1,512,623.51	$ 1,558,002.22	$ 1,604,742.29
Claims and Encounters	$ 365,129.86	$ 376,083.75	$ 387,366.26	$ 398,987.25	$ 410,956.87	$ 36,111.74	$ 37,195.10	$ 38,310.95	$ 39,460.28	$ 40,644.09
Clinical Management	$ 14,282.60	$ 14,711.08	$ 15,152.41	$ 15,606.99	$ 16,075.20	$ 1,412.57	$ 1,454.94	$ 1,498.59	$ 1,543.55	$ 1,589.85
Compliance/Legal	$ 4,794.56	$ 4,938.40	$ 5,086.55	$ 5,239.15	$ 5,396.32	$ 474.19	$ 488.41	$ 503.07	$ 518.16	$ 533.70
Dental	$ 25,559.09	$ 26,325.86	$ 27,115.64	$ 27,929.11	$ 28,766.98	$ 2,527.82	$ 2,603.66	$ 2,681.77	$ 2,762.22	$ 2,845.09
Executive	$ 1,378,120.41	$ 1,419,464.02	$ 1,462,047.94	$ 1,505,909.38	$ 1,551,086.66	$ 136,297.62	$ 140,386.55	$ 144,598.15	$ 148,936.09	$ 153,404.18
Health Care Quality Improvement	$ 232,264.73	$ 239,232.67	$ 246,409.65	$ 253,801.94	$ 261,416.00	$ 22,971.24	$ 23,660.37	$ 24,370.19	$ 25,101.29	$ 25,854.33
Information Services / Technology	$ 464,051.59	$ 477,973.14	$ 492,312.33	$ 507,081.70	$ 522,294.15	$ 45,895.21	$ 47,272.07	$ 48,690.23	$ 50,150.94	$ 51,655.47
Interpretive Services	$ 29,971.08	$ 30,870.21	$ 31,796.31	$ 32,750.20	$ 33,732.71	$ 2,964.17	$ 3,053.10	$ 3,144.69	$ 3,239.03	$ 3,336.20
Member Services	$ 143,429.72	$ 147,732.61	$ 152,164.59	$ 156,729.52	$ 161,431.41	$ 14,185.36	$ 14,610.92	$ 15,049.24	$ 15,500.72	$ 15,965.74
Pharmacy Benefit Manager Expenses [2]	$ 1,141,030.80	$ 1,175,261.72	$ 1,210,519.58	$ 1,246,835.16	$ 1,284,240.22	$ 112,849.20	$ 116,234.68	$ 119,721.72	$ 123,313.37	$ 127,012.77
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 40,062.86	$ 41,264.74	$ 42,502.69	$ 43,777.77	$ 45,091.10	$ 3,962.26	$ 4,081.13	$ 4,203.56	$ 4,329.67	$ 4,459.56
Provider Relations and Network Management	$ 35,123.86	$ 36,177.58	$ 37,262.90	$ 38,380.79	$ 39,532.21	$ 3,473.79	$ 3,578.00	$ 3,685.34	$ 3,795.90	$ 3,909.78
Subcontractors [2]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 20,829,643.39	$ 21,454,532.68	$ 22,098,168.65	$ 22,761,113.72	$ 23,443,947.13	$ 2,060,074.62	$ 2,121,876.87	$ 2,185,533.17	$ 2,251,099.16	$ 2,318,632.15
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ 309,357.13	$ 318,637.84	$ 328,196.98	$ 338,042.89	$ 348,184.17	$ 30,595.76	$ 31,513.63	$ 32,459.04	$ 33,432.81	$ 34,435.80
Non-Compensation Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Occupancy & Depreciation	$ 950,235.61	$ 978,742.68	$ 1,008,104.96	$ 1,038,348.11	$ 1,069,498.55	$ 93,979.35	$ 96,798.73	$ 99,702.69	$ 102,693.77	$ 105,774.58
Office Supplies, Equipment Repair, Maintenance	$ 36,226.02	$ 37,312.80	$ 38,432.19	$ 39,585.15	$ 40,772.71	$ 3,582.79	$ 3,690.28	$ 3,800.99	$ 3,915.02	$ 4,032.47
Printing, Postage, Fulfillment	$ 291,863.91	$ 300,619.83	$ 309,638.42	$ 318,927.58	$ 328,495.40	$ 28,865.66	$ 29,731.63	$ 30,623.58	$ 31,542.29	$ 32,488.56
Travel, Marketing, Insurance	$ 477,905.17	$ 492,242.32	$ 507,009.59	$ 522,219.88	$ 537,886.48	$ 47,265.35	$ 48,683.31	$ 50,143.81	$ 51,648.12	$ 53,197.56
Other [1]	$ 3,196.21	$ 3,292.09	$ 3,390.86	$ 3,492.58	$ 3,597.36	$ 316.11	$ 325.59	$ 335.36	$ 345.42	$ 355.78
Total Non-Compensation	$ 2,068,784.05	$ 2,130,847.56	$ 2,194,773.00	$ 2,260,616.19	$ 2,328,434.67	$ 204,605.02	$ 210,743.17	$ 217,065.47	$ 223,577.43	$ 230,284.75
Total Admin Dollars	$ 66,702,506.26	$ 68,703,581.44	$ 70,764,688.86	$ 72,887,629.54	$ 75,074,258.42	$ 6,596,951.17	$ 6,794,859.73	$ 6,998,705.51	$ 7,208,666.67	$ 7,424,926.68
Total Management Fees Included Above [3]	$ 66,702,506.26	$ 68,703,581.44	$ 70,764,688.86	$ 72,887,629.54	$ 75,074,258.42	$ 6,596,951.17	$ 6,794,859.73	$ 6,998,705.51	$ 7,208,666.67	$ 7,424,926.68
Management Fee arrangement percentage (contracted)	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%
Projected Member Months	358,925	358,925	358,925	358,925	358,925	13,625,202	13,625,202	13,625,202	13,625,202	13,625,202

1) If "Other" is greater than 5% of the total then please provide a detailed list describing what's included, with amounts.

2) Please refer to the MLR reference/guidance tool (https://www.azahcccs.gov/PlansProviders/Downloads/FinancialReporting/MedicalLossRatioReportAndGuidance.xlsx Tab: SubContractors and PBMs) for costs which must be reported as non-claims administrative expenses.
3) Total management fees included above, already counted in total admin dollars.

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
MCO Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 3,360,282.60	$ 3,461,091.08	$ 3,564,923.81	$ 3,671,871.53	$ 3,782,027.67	$ 332,335.64	$ 342,305.71	$ 352,574.88	$ 363,152.13	$ 374,046.69
Care Management/Care Coordination	$ 27,065,437.80	$ 27,877,400.94	$ 28,713,722.96	$ 29,575,134.65	$ 30,462,388.69	$ 2,676,801.54	$ 2,757,105.59	$ 2,839,818.75	$ 2,925,013.32	$ 3,012,763.72
Claims and Encounters	$ 1,863,621.72	$ 1,919,530.37	$ 1,977,116.28	$ 2,036,429.77	$ 2,097,522.66	$ 184,314.24	$ 189,843.66	$ 195,538.97	$ 201,405.14	$ 207,447.30
Clinical Management	$ 6,111,210.21	$ 6,294,546.52	$ 6,483,382.92	$ 6,677,884.40	$ 6,878,220.93	$ 604,405.41	$ 622,537.57	$ 641,213.69	$ 660,450.11	$ 680,263.61
Compliance/Legal	$ 555,940.53	$ 572,618.74	$ 589,797.30	$ 607,491.22	$ 625,715.96	$ 54,983.13	$ 56,632.62	$ 58,331.60	$ 60,081.55	$ 61,884.00
Dental	$ 64,252.43	$ 66,180.00	$ 68,165.40	$ 70,210.36	$ 72,316.67	$ 6,354.64	$ 6,545.27	$ 6,741.63	$ 6,943.88	$ 7,152.20
Executive	$ 295,597.98	$ 304,465.92	$ 313,599.90	$ 323,007.90	$ 332,698.13	$ 29,234.97	$ 30,112.01	$ 31,015.37	$ 31,945.84	$ 32,904.21
Health Care Quality Improvement	$ 7,804,863.48	$ 8,039,009.38	$ 8,280,179.66	$ 8,528,585.05	$ 8,784,442.60	$ 771,909.57	$ 795,066.86	$ 818,918.87	$ 843,486.43	$ 868,791.03
Information Services / Technology	$ 1,222,684.65	$ 1,259,365.19	$ 1,297,146.15	$ 1,336,060.53	$ 1,376,142.35	$ 120,924.86	$ 124,552.60	$ 128,289.18	$ 132,137.85	$ 136,101.99
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 453,075.62	$ 466,667.89	$ 480,667.93	$ 495,087.96	$ 509,940.60	$ 44,809.68	$ 46,153.97	$ 47,538.59	$ 48,964.74	$ 50,433.69
Pharmacy Management	$ 261,404.41	$ 269,246.54	$ 277,323.94	$ 285,643.65	$ 294,212.96	$ 25,853.18	$ 26,628.78	$ 27,427.64	$ 28,250.47	$ 29,097.99
Program Integrity (Fraud, Waste & Abuse)	$ 66,578.53	$ 68,575.88	$ 70,633.16	$ 72,752.15	$ 74,934.72	$ 6,584.69	$ 6,782.23	$ 6,985.70	$ 7,195.27	$ 7,411.13
Provider Relations and Network Management	$ 451,550.45	$ 465,096.96	$ 479,049.87	$ 493,421.37	$ 508,224.01	$ 44,658.84	$ 45,998.60	$ 47,378.56	$ 48,799.92	$ 50,263.91
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total MCO Compensation	$ 49,576,500.41	$ 51,063,795.41	$ 52,595,709.28	$ 54,173,580.54	$ 55,798,787.95	$ 4,903,170.39	$ 5,050,265.47	$ 5,201,773.43	$ 5,357,826.65	$ 5,518,561.47
Professional and Outside Services	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 2,861,160.32	$ 2,946,995.13	$ 3,035,404.98	$ 3,126,467.13	$ 3,220,261.15	$ 282,971.90	$ 291,461.06	$ 300,204.89	$ 309,211.04	$ 318,487.37
Care Management/Care Coordination	$ 14,887,742.39	$ 15,334,374.66	$ 15,794,405.90	$ 16,268,238.08	$ 16,756,285.22	$ 1,472,414.08	$ 1,516,586.51	$ 1,562,084.10	$ 1,608,946.62	$ 1,657,215.02
Claims and Encounters	$ 415,565.73	$ 428,032.70	$ 440,873.69	$ 454,099.90	$ 467,722.89	$ 41,099.91	$ 42,332.90	$ 43,602.89	$ 44,910.98	$ 46,258.31
Clinical Management	$ 10,782.35	$ 11,105.82	$ 11,439.00	$ 11,782.17	$ 12,135.63	$ 1,066.39	$ 1,098.38	$ 1,131.33	$ 1,165.27	$ 1,200.23
Compliance/Legal	$ 3,604.54	$ 3,712.67	$ 3,824.06	$ 3,938.78	$ 4,056.94	$ 356.49	$ 367.19	$ 378.20	$ 389.55	$ 401.24
Dental	$ 29,089.60	$ 29,962.29	$ 30,861.16	$ 31,786.99	$ 32,740.60	$ 2,876.99	$ 2,963.30	$ 3,052.20	$ 3,143.77	$ 3,238.08
Executive	$ 1,146,376.36	$ 1,180,767.65	$ 1,216,190.68	$ 1,252,676.40	$ 1,290,256.69	$ 113,377.88	$ 116,779.22	$ 120,282.59	$ 123,891.07	$ 127,607.80
Health Care Quality Improvement	$ 262,676.68	$ 270,556.98	$ 278,673.69	$ 287,033.90	$ 295,644.91	$ 25,979.01	$ 26,758.38	$ 27,561.13	$ 28,387.97	$ 29,239.61
Information Services / Technology	$ 507,017.30	$ 522,227.82	$ 537,894.66	$ 554,031.50	$ 570,652.44	$ 50,144.57	$ 51,648.91	$ 53,198.37	$ 54,794.32	$ 56,438.15
Interpretive Services	$ 34,111.02	$ 35,134.35	$ 36,188.38	$ 37,274.03	$ 38,392.25	$ 3,373.62	$ 3,474.83	$ 3,579.07	$ 3,686.44	$ 3,797.04
Member Services	$ 163,241.86	$ 168,139.11	$ 173,183.28	$ 178,378.78	$ 183,730.15	$ 16,144.80	$ 16,629.14	$ 17,128.02	$ 17,641.86	$ 18,171.11
Pharmacy Benefit Manager Expenses [2]	$ 1,298,642.91	$ 1,337,602.20	$ 1,377,730.27	$ 1,419,062.18	$ 1,461,634.04	$ 128,437.21	$ 132,290.33	$ 136,259.04	$ 140,346.81	$ 144,557.21
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 45,596.80	$ 46,964.70	$ 48,373.64	$ 49,824.85	$ 51,319.60	$ 4,509.57	$ 4,644.86	$ 4,784.21	$ 4,927.73	$ 5,075.56
Provider Relations and Network Management	$ 38,110.40	$ 39,253.71	$ 40,431.32	$ 41,644.26	$ 42,893.59	$ 3,769.16	$ 3,882.24	$ 3,998.70	$ 4,118.66	$ 4,242.22
Subcontractors [2]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 21,703,718.26	$ 22,354,829.79	$ 23,025,474.71	$ 23,716,238.95	$ 24,427,726.10	$ 2,146,521.58	$ 2,210,917.25	$ 2,277,244.74	$ 2,345,562.09	$ 2,415,928.95
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ 352,848.97	$ 363,434.44	$ 374,337.47	$ 385,567.60	$ 397,134.62	$ 34,897.15	$ 35,944.07	$ 37,022.39	$ 38,133.06	$ 39,277.05
Non-Compensation Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Occupancy & Depreciation	$ 1,096,683.40	$ 1,129,583.90	$ 1,163,471.42	$ 1,198,375.56	$ 1,234,326.83	$ 108,463.19	$ 111,717.09	$ 115,068.60	$ 118,520.66	$ 122,076.28
Office Supplies, Equipment Repair, Maintenance	$ 39,265.34	$ 40,443.30	$ 41,656.60	$ 42,906.30	$ 44,193.49	$ 3,883.39	$ 3,999.89	$ 4,119.88	$ 4,243.48	$ 4,370.78
Printing, Postage, Fulfillment	$ 332,110.32	$ 342,073.63	$ 352,335.84	$ 362,905.91	$ 373,793.09	$ 32,846.08	$ 33,831.46	$ 34,846.40	$ 35,891.79	$ 36,968.55
Travel, Marketing, Insurance	$ 488,277.06	$ 502,925.37	$ 518,013.13	$ 533,553.53	$ 549,560.13	$ 48,291.14	$ 49,739.87	$ 51,232.07	$ 52,769.03	$ 54,352.10
Other [1]	$ 2,156.72	$ 2,221.42	$ 2,288.07	$ 2,356.71	$ 2,427.41	$ 213.30	$ 219.70	$ 226.29	$ 233.08	$ 240.07
Total Non-Compensation	$ 2,311,341.81	$ 2,380,682.06	$ 2,452,102.53	$ 2,525,665.61	$ 2,601,435.57	$ 228,594.25	$ 235,452.08	$ 242,515.63	$ 249,791.10	$ 257,284.83
Total Admin Dollars	$ 73,591,560.48	$ 75,799,307.26	$ 78,073,286.52	$ 80,415,485.10	$ 82,827,949.62	$ 7,278,286.22	$ 7,496,634.80	$ 7,721,533.80	$ 7,953,179.84	$ 8,191,775.25
Total Management Fees Included Above [3]	$ 73,591,560.48	$ 75,799,307.26	$ 78,073,286.52	$ 80,415,485.10	$ 82,827,949.62	$ 7,278,286.22	$ 7,496,634.80	$ 7,721,533.80	$ 7,953,179.84	$ 8,191,775.25
Management Fee arrangement percentage (contracted)	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%
Projected Member Months	438,010	438,010	438,010	438,010	438,010	16,436,752	16,436,752	16,436,752	16,436,752	16,436,752

1) If "Other" is greater than 5% of the total then please provide a detailed list describing what's included, with amounts.

2) Please refer to the MLR reference/guidance tool (https://www.azahcccs.gov/PlansProviders/Downloads/FinancialReporting/MedicalLossRatioReportAndGuidance.xlsx Tab: SubContractors and PBMs) for costs which must be reported as non-claims administrative expenses.
3) Total management fees included above, already counted in total admin dollars.

October 4, 2021 AHCCCS Competitive Contract Expansion (CCE) YH20-0002

Actuarial Certification
Health Choice Arizona, Inc.
AHCCCS ACC-RBHA Bids
October 1, 2022 – September 30, 2027

I, Matthew H. Smith, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its qualification standards for rendering this opinion. I have been retained by Health Choice Arizona, Inc. (HCA) to provide a certification that the non-benefit costs bid submissions for the Expansion of the Complete Care Contract under the Arizona Health Care Cost Containment System (AHCCCS) meet the requirements of 42 CFR 438.5 (e) for the North, Central, and North/Central GSA.

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

The non-benefit costs to which this certification applies are attached in AHCCCS's required Non-Benefit Costs Bid Submission workbook and shown in Attachments 1-3. The administrative non-benefit costs apply to the period October 1, 2022 through September 30, 2027.

It is my opinion that the attached non-benefit cost components are adequate to fund administrative expenses for HCA during the time period for which they are intended, for the Expansion of the Complete Care Contract as outlined in the RFP. If the Expanded Complete Care program were to change materially from that described in the RFP, the attached rates may not be adequate. In addition, I am relying on AHCCCS's statement that the medical cost component of the capitation rate will be "actuarially sound" as defined in the RFP, its amendments, and ASOP 49 "Medicaid Managed Care Capitation Rate Development and Certification".

Development of the Non-Benefit Costs

HCA developed the projected non-benefit costs shown in Attachments 1-3 for the North, Central, and North/Central GSA. I reviewed the methodology and assumptions and found them to be reasonable. HCA provided the following description of their methodology:

HCA has developed the HCA RBHA administrative bid costs for CCE YH20-0002 by using actual experience, trended assumptions, and known variables.

Vendor and FTE costs were reviewed with department leaders and determined to be either fixed or variable expense. Examples of fixed costs include office space rent, staff salary and benefit costs, annual financial audits and actuary work, and some costs associated with IT services. If costs were plan specific, 100% of those expenses were charged directly to that plan. If costs were utilized by multiple lines of business, costs were allocated based on member months, usage, or management estimation. FTE costs were allocated based on department support by line of business. For example, claims processing was allocated based on claims adjudication experience, member services were allocated based on call volume.

After known costs were identified as fixed or variable they were applied to projected membership, increases were made to the central GSA fixed costs for office space and facility operations. Experienced data was used, and adjustments were applied to account for membership changes, cost trends, expected changes in salary & benefits, number of FTEs, corporate overhead allocation, rent and other fixed costs.

Reasonableness of the Non-Benefit Costs

In forming my opinion, I performed several reasonableness tests. While performing these tests, I relied on HCA's description of the process used to develop the estimates, HCA's budgeted amounts, and the Supplemental data provided by AHCCCS.

1) I compared the projected administrative cost budget for the bid to the plan's current administrative costs as provided in the financial documents, as well as the audited financial statements of the other RBHA contractors in Arizona.

2) I also compared HCA's projected PMPM costs to the PMPM amounts that AHCCCS is paying current RBHA contractors in their CYE 21 and CYE 22 rates in the North and Central regions.

3) As an additional test of reasonableness, I compared the anticipated administrative costs to projected medical and behavioral claim costs levels under the RBHA portion of the Expanded Complete Care contract. In doing so I used claim cost levels provided in the AHCCCS Supplemental data. I projected claims costs accounting for: programmatic and fee schedule changes; efficiency gains; completion; and overall trend.

I further considered the anticipated impact of the combined ACC-RBHA risk corridor. This included potential risk corridor payable or receivable amounts under the ACC contract in the absence of the ACC-RBHA combined contract, and the anticipated impact of the additional ACC-RBHA experience on the overall projected risk corridor payable or receivable amounts.

4) I also conducted scenario testing around various assumptions relating to claims trend, revenue trend, administrative cost variability vs bid, and in which regions HCA will be a successful bidder.

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

Caveats

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

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

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

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

Matthew H. Smith, FSA, MAAA
October 4, 2021

Actuarial Certification
Health Choice Arizona, Inc.
Attachment 1
Projected RBHA Administrative Costs - North Region

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
MCO Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 822,079.80	$ 846,742.19	$ 872,144.46	$ 898,308.79	$ 925,258.06	$ 81,304.60	$ 83,743.73	$ 86,256.05	$ 88,843.73	$ 91,509.04
Care Management/Care Coordination	$ 2,811,773.40	$ 2,896,126.60	$ 2,983,010.40	$ 3,072,500.71	$ 3,164,675.73	$ 278,087.48	$ 286,430.10	$ 295,023.01	$ 303,873.70	$ 312,989.91
Claims and Encounters	$ 125,095.99	$ 128,848.87	$ 132,714.34	$ 136,695.77	$ 140,796.64	$ 12,372.13	$ 12,743.30	$ 13,125.59	$ 13,519.36	$ 13,924.94
Clinical Management	$ 1,271,837.39	$ 1,309,992.51	$ 1,349,292.29	$ 1,389,771.06	$ 1,431,464.19	$ 125,786.12	$ 129,559.70	$ 133,446.49	$ 137,449.88	$ 141,573.38
Compliance/Legal	$ 132,401.85	$ 136,373.91	$ 140,465.13	$ 144,679.08	$ 149,019.45	$ 13,094.69	$ 13,487.53	$ 13,892.16	$ 14,308.92	$ 14,738.19
Dental	$ 14,190.69	$ 14,616.41	$ 15,054.91	$ 15,506.55	$ 15,971.75	$ 1,403.48	$ 1,445.58	$ 1,488.95	$ 1,533.62	$ 1,579.62
Executive	$ 295,597.98	$ 304,465.92	$ 313,599.90	$ 323,007.90	$ 332,698.13	$ 29,234.97	$ 30,112.01	$ 31,015.37	$ 31,945.84	$ 32,904.21
Health Care Quality Improvement	$ 1,651,740.08	$ 1,701,292.28	$ 1,752,331.05	$ 1,804,900.98	$ 1,859,048.01	$ 163,358.91	$ 168,259.68	$ 173,307.47	$ 178,506.69	$ 183,861.89
Information Services / Technology	$ 215,408.90	$ 221,871.16	$ 228,527.30	$ 235,383.12	$ 242,444.61	$ 21,304.18	$ 21,943.30	$ 22,601.60	$ 23,279.65	$ 23,978.04
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 52,260.26	$ 53,828.07	$ 55,442.91	$ 57,106.20	$ 58,819.38	$ 5,168.60	$ 5,323.65	$ 5,483.36	$ 5,647.87	$ 5,817.30
Pharmacy Management	$ 29,634.82	$ 30,523.87	$ 31,439.58	$ 32,382.77	$ 33,354.26	$ 2,930.92	$ 3,018.84	$ 3,109.41	$ 3,202.69	$ 3,298.77
Program Integrity (Fraud, Waste & Abuse)	$ 8,452.14	$ 8,705.70	$ 8,966.87	$ 9,235.88	$ 9,512.95	$ 835.93	$ 861.00	$ 886.83	$ 913.44	$ 940.84
Provider Relations and Network Management	$ 72,018.33	$ 74,178.88	$ 76,404.25	$ 78,696.38	$ 81,057.27	$ 7,122.69	$ 7,336.37	$ 7,556.46	$ 7,783.16	$ 8,016.65
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total MCO Compensation	$ 7,502,491.63	$ 7,727,566.37	$ 7,959,393.39	$ 8,198,175.19	$ 8,444,120.43	$ 742,004.70	$ 764,264.79	$ 787,192.75	$ 810,808.55	$ 835,132.78
Professional and Outside Services	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 362,255.92	$ 373,123.60	$ 384,317.31	$ 395,846.83	$ 407,722.23	$ 35,827.51	$ 36,902.33	$ 38,009.40	$ 39,149.69	$ 40,324.18
Care Management/Care Coordination	$ 471,803.11	$ 485,957.20	$ 500,535.92	$ 515,551.99	$ 531,018.55	$ 46,661.85	$ 48,061.70	$ 49,503.55	$ 50,988.66	$ 52,518.32
Claims and Encounters	$ 50,435.88	$ 51,948.95	$ 53,507.42	$ 55,112.64	$ 56,766.02	$ 4,988.16	$ 5,137.81	$ 5,291.94	$ 5,450.70	$ 5,614.22
Clinical Management	$ 7,519.85	$ 7,745.44	$ 7,977.81	$ 8,217.14	$ 8,463.66	$ 743.72	$ 766.03	$ 789.01	$ 812.68	$ 837.06
Compliance/Legal	$ 2,539.58	$ 2,615.76	$ 2,694.24	$ 2,775.06	$ 2,858.32	$ 251.17	$ 258.70	$ 266.46	$ 274.46	$ 282.69
Dental	$ 3,530.51	$ 3,636.43	$ 3,745.52	$ 3,857.89	$ 3,973.62	$ 349.17	$ 359.65	$ 370.44	$ 381.55	$ 393.00
Executive	$ 618,162.69	$ 636,707.57	$ 655,808.80	$ 675,483.07	$ 695,747.56	$ 61,136.97	$ 62,971.08	$ 64,860.21	$ 66,806.02	$ 68,810.20
Health Care Quality Improvement	$ 33,776.67	$ 34,789.97	$ 35,833.67	$ 36,908.68	$ 38,015.94	$ 3,340.55	$ 3,440.77	$ 3,543.99	$ 3,650.31	$ 3,759.82
Information Services / Technology	$ 85,519.59	$ 88,085.17	$ 90,727.73	$ 93,449.56	$ 96,253.05	$ 8,457.98	$ 8,711.72	$ 8,973.07	$ 9,242.26	$ 9,519.53
Interpretive Services	$ 4,139.94	$ 4,264.14	$ 4,392.07	$ 4,523.83	$ 4,659.54	$ 409.45	$ 421.73	$ 434.38	$ 447.41	$ 460.83
Member Services	$ 19,812.14	$ 20,406.50	$ 21,018.70	$ 21,649.26	$ 22,298.74	$ 1,959.44	$ 2,018.23	$ 2,078.77	$ 2,141.14	$ 2,205.37
Pharmacy Benefit Manager Expenses	$ 157,612.11	$ 162,340.48	$ 167,210.69	$ 172,227.01	$ 177,393.82	$ 15,588.01	$ 16,055.65	$ 16,537.32	$ 17,033.44	$ 17,544.44
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 5,533.94	$ 5,699.95	$ 5,870.95	$ 6,047.08	$ 6,228.49	$ 547.31	$ 563.73	$ 580.64	$ 598.06	$ 616.00
Provider Relations and Network Management	$ 6,742.04	$ 6,944.30	$ 7,152.63	$ 7,367.21	$ 7,588.22	$ 666.79	$ 686.80	$ 707.40	$ 728.62	$ 750.48
Subcontractors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 1,829,383.97	$ 1,884,265.46	$ 1,940,793.46	$ 1,999,017.25	$ 2,058,987.76	$ 180,928.08	$ 186,355.93	$ 191,946.58	$ 197,705.00	$ 203,636.14
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ 89,236.66	$ 91,913.76	$ 94,671.17	$ 97,511.31	$ 100,436.64	$ 8,825.60	$ 9,090.37	$ 9,363.08	$ 9,643.98	$ 9,933.29
Non-Compensation Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Occupancy & Depreciation	$ 560,190.98	$ 576,996.71	$ 594,306.61	$ 612,135.81	$ 630,499.88	$ 55,403.50	$ 57,065.61	$ 58,777.58	$ 60,540.90	$ 62,357.13
Office Supplies, Equipment Repair, Maintenance	$ 6,995.09	$ 7,204.94	$ 7,421.09	$ 7,643.72	$ 7,873.03	$ 691.82	$ 712.58	$ 733.95	$ 755.97	$ 778.65
Printing, Postage, Fulfillment	$ 40,385.64	$ 41,597.20	$ 42,845.12	$ 44,130.47	$ 45,454.39	$ 3,994.18	$ 4,114.01	$ 4,237.43	$ 4,364.55	$ 4,495.49
Travel, Marketing, Insurance	$ 122,406.24	$ 126,078.43	$ 129,860.78	$ 133,756.60	$ 137,769.30	$ 12,106.11	$ 12,469.29	$ 12,843.37	$ 13,228.67	$ 13,625.54
Other	$ 1,942.46	$ 2,000.73	$ 2,060.76	$ 2,122.58	$ 2,186.26	$ 192.11	$ 197.87	$ 203.81	$ 209.93	$ 216.22
Total Non-Compensation	$ 821,157.07	$ 845,791.77	$ 871,165.53	$ 897,300.49	$ 924,219.50	$ 81,213.32	$ 83,649.73	$ 86,159.22	$ 88,744.00	$ 91,406.32
Total Admin Dollars	$ 10,153,032.67	$ 10,457,623.60	$ 10,771,352.38	$ 11,094,492.93	$ 11,427,327.69	$ 1,004,146.10	$ 1,034,270.45	$ 1,065,298.55	$ 1,097,257.55	$ 1,130,175.24
Total Management Fees Included Above	$ 10,153,032.67	$ 10,457,623.60	$ 10,771,352.38	$ 11,094,492.93	$ 11,427,327.69	$ 1,004,146.10	$ 1,034,270.45	$ 1,065,298.55	$ 1,097,257.55	$ 1,130,175.24
Management Fee arrangement percentage (contracted)	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
Projected Member Months	79,085	79,085	79,085	79,085	79,085	2,811,550	2,811,550	2,811,550	2,811,550	2,811,550

Actuarial Certification
Health Choice Arizona, Inc.
Attachment 2
Projected RBHA Administrative Costs - Central Region

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
MCO Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 2,832,359.05	$ 2,917,329.82	$ 3,004,849.72	$ 3,094,995.21	$ 3,187,845.06	$ 280,123.42	$ 288,527.13	$ 297,182.94	$ 306,098.43	$ 315,281.38
Care Management/Care Coordination	$ 24,343,385.90	$ 25,073,687.48	$ 25,825,898.10	$ 26,600,675.04	$ 27,398,695.30	$ 2,407,587.62	$ 2,479,815.25	$ 2,554,209.70	$ 2,630,835.99	$ 2,709,761.07
Claims and Encounters	$ 1,747,919.69	$ 1,800,357.28	$ 1,854,368.00	$ 1,909,999.04	$ 1,967,299.01	$ 172,871.18	$ 178,057.31	$ 183,399.03	$ 188,901.00	$ 194,568.03
Clinical Management	$ 5,233,832.38	$ 5,390,847.35	$ 5,552,572.77	$ 5,719,149.95	$ 5,890,724.45	$ 517,631.77	$ 533,160.73	$ 549,155.55	$ 565,630.22	$ 582,599.12
Compliance/Legal	$ 469,935.12	$ 484,033.18	$ 498,554.17	$ 513,510.80	$ 528,916.12	$ 46,477.10	$ 47,871.41	$ 49,307.56	$ 50,786.78	$ 52,310.39
Dental	$ 54,724.36	$ 56,366.09	$ 58,057.07	$ 59,798.78	$ 61,592.75	$ 5,412.30	$ 5,574.67	$ 5,741.91	$ 5,914.17	$ 6,091.59
Executive	$ 295,598.12	$ 304,466.07	$ 313,600.05	$ 323,008.05	$ 332,698.29	$ 29,234.98	$ 30,112.03	$ 31,015.39	$ 31,945.85	$ 32,904.23
Health Care Quality Improvement	$ 6,674,165.64	$ 6,874,390.61	$ 7,080,622.32	$ 7,293,040.99	$ 7,511,832.22	$ 660,082.32	$ 679,884.79	$ 700,281.33	$ 721,289.77	$ 742,928.46
Information Services / Technology	$ 1,061,617.81	$ 1,093,466.34	$ 1,126,270.33	$ 1,160,058.44	$ 1,194,860.20	$ 104,995.17	$ 108,145.02	$ 111,389.37	$ 114,731.05	$ 118,172.99
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 403,605.26	$ 415,713.42	$ 428,184.82	$ 441,030.37	$ 454,261.28	$ 39,917.00	$ 41,114.51	$ 42,347.95	$ 43,618.39	$ 44,926.94
Pharmacy Management	$ 233,053.82	$ 240,045.44	$ 247,246.80	$ 254,664.21	$ 262,304.13	$ 23,049.28	$ 23,740.76	$ 24,452.98	$ 25,186.57	$ 25,942.17
Program Integrity (Fraud, Waste & Abuse)	$ 59,022.63	$ 60,793.31	$ 62,617.11	$ 64,495.62	$ 66,430.49	$ 5,837.40	$ 6,012.53	$ 6,192.90	$ 6,378.69	$ 6,570.05
Provider Relations and Network Management	$ 394,859.04	$ 406,704.81	$ 418,905.95	$ 431,473.13	$ 444,417.32	$ 39,051.99	$ 40,223.55	$ 41,430.26	$ 42,673.17	$ 43,953.36
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total MCO Compensation	$ 43,804,078.82	$ 45,118,201.20	$ 46,471,747.21	$ 47,865,899.63	$ 49,301,876.62	$ 4,332,271.53	$ 4,462,239.69	$ 4,596,106.87	$ 4,733,990.08	$ 4,876,009.78
Professional and Outside Services	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 2,539,473.45	$ 2,615,657.65	$ 2,694,127.38	$ 2,774,951.20	$ 2,858,199.74	$ 251,156.71	$ 258,691.42	$ 266,452.16	$ 274,445.72	$ 282,679.10
Care Management/Care Coordination	$ 14,416,348.78	$ 14,848,839.25	$ 15,294,304.42	$ 15,753,133.56	$ 16,225,727.56	$ 1,425,792.74	$ 1,468,566.52	$ 1,512,623.51	$ 1,558,002.22	$ 1,604,742.29
Claims and Encounters	$ 365,129.86	$ 376,083.75	$ 387,366.26	$ 398,987.25	$ 410,956.87	$ 36,111.74	$ 37,195.10	$ 38,310.95	$ 39,460.28	$ 40,644.09
Clinical Management	$ 14,282.60	$ 14,711.08	$ 15,152.41	$ 15,606.99	$ 16,075.20	$ 1,412.57	$ 1,454.94	$ 1,498.59	$ 1,543.55	$ 1,589.85
Compliance/Legal	$ 4,794.56	$ 4,938.40	$ 5,086.55	$ 5,239.15	$ 5,396.32	$ 474.19	$ 488.41	$ 503.07	$ 518.16	$ 533.70
Dental	$ 25,559.09	$ 26,325.86	$ 27,115.64	$ 27,929.11	$ 28,766.98	$ 2,527.82	$ 2,603.66	$ 2,681.77	$ 2,762.22	$ 2,845.09
Executive	$ 1,378,120.41	$ 1,419,464.02	$ 1,462,047.94	$ 1,505,909.38	$ 1,551,086.66	$ 136,297.62	$ 140,386.55	$ 144,598.15	$ 148,936.09	$ 153,404.18
Health Care Quality Improvement	$ 232,264.73	$ 239,232.67	$ 246,409.65	$ 253,801.94	$ 261,416.00	$ 22,971.24	$ 23,660.37	$ 24,370.19	$ 25,101.29	$ 25,854.33
Information Services / Technology	$ 464,051.59	$ 477,973.14	$ 492,312.33	$ 507,081.70	$ 522,294.15	$ 45,895.21	$ 47,272.07	$ 48,690.23	$ 50,150.94	$ 51,655.47
Interpretive Services	$ 29,971.08	$ 30,870.21	$ 31,796.31	$ 32,750.20	$ 33,732.71	$ 2,964.17	$ 3,053.10	$ 3,144.69	$ 3,239.03	$ 3,336.20
Member Services	$ 143,429.72	$ 147,732.61	$ 152,164.59	$ 156,729.52	$ 161,431.41	$ 14,185.36	$ 14,610.92	$ 15,049.24	$ 15,500.72	$ 15,965.74
Pharmacy Benefit Manager Expenses	$ 1,141,030.80	$ 1,175,261.72	$ 1,210,519.58	$ 1,246,835.16	$ 1,284,240.22	$ 112,849.20	$ 116,234.68	$ 119,721.72	$ 123,313.37	$ 127,012.77
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 40,062.86	$ 41,264.74	$ 42,502.69	$ 43,777.77	$ 45,091.10	$ 3,962.26	$ 4,081.13	$ 4,203.56	$ 4,329.67	$ 4,459.56
Provider Relations and Network Management	$ 35,123.86	$ 36,177.58	$ 37,262.90	$ 38,380.79	$ 39,532.21	$ 3,473.79	$ 3,578.00	$ 3,685.34	$ 3,795.90	$ 3,909.78
Subcontractors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 20,829,643.39	$ 21,454,532.68	$ 22,098,168.65	$ 22,761,113.72	$ 23,443,947.13	$ 2,060,074.62	$ 2,121,876.87	$ 2,185,533.17	$ 2,251,099.16	$ 2,318,632.15
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ 309,357.13	$ 318,637.84	$ 328,196.98	$ 338,042.89	$ 348,184.17	$ 30,595.76	$ 31,513.63	$ 32,459.04	$ 33,432.81	$ 34,435.80
Non-Compensation Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Occupancy & Depreciation	$ 950,235.61	$ 978,742.68	$ 1,008,104.96	$ 1,038,348.11	$ 1,069,498.55	$ 93,979.35	$ 96,798.73	$ 99,702.69	$ 102,693.77	$ 105,774.58
Office Supplies, Equipment Repair, Maintenance	$ 36,226.02	$ 37,312.80	$ 38,432.19	$ 39,585.15	$ 40,772.71	$ 3,582.79	$ 3,690.28	$ 3,800.99	$ 3,915.02	$ 4,032.47
Printing, Postage, Fulfillment	$ 291,863.91	$ 300,619.83	$ 309,638.42	$ 318,927.58	$ 328,495.40	$ 28,865.66	$ 29,731.63	$ 30,623.58	$ 31,542.29	$ 32,488.56
Travel, Marketing, Insurance	$ 477,905.17	$ 492,242.32	$ 507,009.59	$ 522,219.88	$ 537,886.48	$ 47,265.35	$ 48,683.31	$ 50,143.81	$ 51,648.12	$ 53,197.56
Other	$ 3,196.21	$ 3,292.09	$ 3,390.86	$ 3,492.58	$ 3,597.36	$ 316.11	$ 325.59	$ 335.36	$ 345.42	$ 355.78
Total Non-Compensation	$ 2,068,784.05	$ 2,130,847.56	$ 2,194,773.00	$ 2,260,616.19	$ 2,328,434.67	$ 204,605.02	$ 210,743.17	$ 217,065.47	$ 223,577.43	$ 230,284.75
Total Admin Dollars	$ 66,702,506.26	$ 68,703,581.44	$ 70,764,688.86	$ 72,887,629.54	$ 75,074,258.42	$ 6,596,951.17	$ 6,794,859.73	$ 6,998,705.51	$ 7,208,666.67	$ 7,424,926.68
Total Management Fees Included Above	$ 66,702,506.26	$ 68,703,581.44	$ 70,764,688.86	$ 72,887,629.54	$ 75,074,258.42	$ 6,596,951.17	$ 6,794,859.73	$ 6,998,705.51	$ 7,208,666.67	$ 7,424,926.68
Management Fee arrangement percentage (contracted)	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%
Projected Member Months	358,925	358,925	358,925	358,925	358,925	13,625,202	13,625,202	13,625,202	13,625,202	13,625,202

Actuarial Certification
Health Choice Arizona, Inc.
Attachment 3
Projected RBHA Administrative Costs - North+Central Region

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
MCO Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 3,360,282.60	$ 3,461,091.08	$ 3,564,923.81	$ 3,671,871.53	$ 3,782,027.67	$ 332,335.64	$ 342,305.71	$ 352,574.88	$ 363,152.13	$ 374,046.69
Care Management/Care Coordination	$ 27,065,437.80	$ 27,877,400.94	$ 28,713,722.96	$ 29,575,134.65	$ 30,462,388.69	$ 2,676,801.54	$ 2,757,105.59	$ 2,839,818.75	$ 2,925,013.32	$ 3,012,763.72
Claims and Encounters	$ 1,863,621.72	$ 1,919,530.37	$ 1,977,116.28	$ 2,036,429.77	$ 2,097,522.66	$ 184,314.24	$ 189,843.66	$ 195,538.97	$ 201,405.14	$ 207,447.30
Clinical Management	$ 6,111,210.21	$ 6,294,546.52	$ 6,483,382.92	$ 6,677,884.40	$ 6,878,220.93	$ 604,405.41	$ 622,537.57	$ 641,213.69	$ 660,450.11	$ 680,263.61
Compliance/Legal	$ 555,940.53	$ 572,618.74	$ 589,797.30	$ 607,491.22	$ 625,715.96	$ 54,983.13	$ 56,632.62	$ 58,331.60	$ 60,081.55	$ 61,884.00
Dental	$ 64,252.43	$ 66,180.00	$ 68,165.40	$ 70,210.36	$ 72,316.67	$ 6,354.64	$ 6,545.27	$ 6,741.63	$ 6,943.88	$ 7,152.20
Executive	$ 295,597.98	$ 304,465.92	$ 313,599.90	$ 323,007.90	$ 332,698.13	$ 29,234.97	$ 30,112.01	$ 31,015.37	$ 31,945.84	$ 32,904.21
Health Care Quality Improvement	$ 7,804,863.48	$ 8,039,009.38	$ 8,280,179.66	$ 8,528,585.05	$ 8,784,442.60	$ 771,909.57	$ 795,066.86	$ 818,918.87	$ 843,486.43	$ 868,791.03
Information Services / Technology	$ 1,222,684.65	$ 1,259,365.19	$ 1,297,146.15	$ 1,336,060.53	$ 1,376,142.35	$ 120,924.86	$ 124,552.60	$ 128,289.18	$ 132,137.85	$ 136,101.99
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 453,075.62	$ 466,667.89	$ 480,667.93	$ 495,087.96	$ 509,940.60	$ 44,809.68	$ 46,153.97	$ 47,538.59	$ 48,964.74	$ 50,433.69
Pharmacy Management	$ 261,404.41	$ 269,246.54	$ 277,323.94	$ 285,643.65	$ 294,212.96	$ 25,853.18	$ 26,628.78	$ 27,427.64	$ 28,250.47	$ 29,097.99
Program Integrity (Fraud, Waste & Abuse)	$ 66,578.53	$ 68,575.88	$ 70,633.16	$ 72,752.15	$ 74,934.72	$ 6,584.69	$ 6,782.23	$ 6,985.70	$ 7,195.27	$ 7,411.13
Provider Relations and Network Management	$ 451,550.45	$ 465,096.96	$ 479,049.87	$ 493,421.37	$ 508,224.01	$ 44,658.84	$ 45,998.60	$ 47,378.56	$ 48,799.92	$ 50,263.91
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total MCO Compensation	$ 49,576,500.41	$ 51,063,795.41	$ 52,595,709.28	$ 54,173,580.54	$ 55,798,787.95	$ 4,903,170.39	$ 5,050,265.47	$ 5,201,773.43	$ 5,357,826.65	$ 5,518,561.47
Professional and Outside Services	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Business and Finance	$ 2,861,160.32	$ 2,946,995.13	$ 3,035,404.98	$ 3,126,467.13	$ 3,220,261.15	$ 282,971.90	$ 291,461.06	$ 300,204.89	$ 309,211.04	$ 318,487.37
Care Management/Care Coordination	$ 14,887,742.39	$ 15,334,374.66	$ 15,794,405.90	$ 16,268,238.08	$ 16,756,285.22	$ 1,472,414.08	$ 1,516,586.51	$ 1,562,084.10	$ 1,608,946.62	$ 1,657,215.02
Claims and Encounters	$ 415,565.73	$ 428,032.70	$ 440,873.69	$ 454,099.90	$ 467,722.89	$ 41,099.91	$ 42,332.90	$ 43,602.89	$ 44,910.98	$ 46,258.31
Clinical Management	$ 10,782.35	$ 11,105.82	$ 11,439.00	$ 11,782.17	$ 12,135.63	$ 1,066.39	$ 1,098.38	$ 1,131.33	$ 1,165.27	$ 1,200.23
Compliance/Legal	$ 3,604.54	$ 3,712.67	$ 3,824.06	$ 3,938.78	$ 4,056.94	$ 356.49	$ 367.19	$ 378.20	$ 389.55	$ 401.24
Dental	$ 29,089.60	$ 29,962.29	$ 30,861.16	$ 31,786.99	$ 32,740.60	$ 2,876.99	$ 2,963.30	$ 3,052.20	$ 3,143.77	$ 3,238.08
Executive	$ 1,146,376.36	$ 1,180,767.65	$ 1,216,190.68	$ 1,252,676.40	$ 1,290,256.69	$ 113,377.88	$ 116,779.22	$ 120,282.59	$ 123,891.07	$ 127,607.80
Health Care Quality Improvement	$ 262,676.68	$ 270,556.98	$ 278,673.69	$ 287,033.90	$ 295,644.91	$ 25,979.01	$ 26,758.38	$ 27,561.13	$ 28,387.97	$ 29,239.61
Information Services / Technology	$ 507,017.30	$ 522,227.82	$ 537,894.66	$ 554,031.50	$ 570,652.44	$ 50,144.57	$ 51,648.91	$ 53,198.37	$ 54,794.32	$ 56,438.15
Interpretive Services	$ 34,111.02	$ 35,134.35	$ 36,188.38	$ 37,274.03	$ 38,392.25	$ 3,373.62	$ 3,474.83	$ 3,579.07	$ 3,686.44	$ 3,797.04
Member Services	$ 163,241.86	$ 168,139.11	$ 173,183.28	$ 178,378.78	$ 183,730.15	$ 16,144.80	$ 16,629.14	$ 17,128.02	$ 17,641.86	$ 18,171.11
Pharmacy Benefit Manager Expenses	$ 1,298,642.91	$ 1,337,602.20	$ 1,377,730.27	$ 1,419,062.18	$ 1,461,634.04	$ 128,437.21	$ 132,290.33	$ 136,259.04	$ 140,346.81	$ 144,557.21
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 45,596.80	$ 46,964.70	$ 48,373.64	$ 49,824.85	$ 51,319.60	$ 4,509.57	$ 4,644.86	$ 4,784.21	$ 4,927.73	$ 5,075.56
Provider Relations and Network Management	$ 38,110.40	$ 39,253.71	$ 40,431.32	$ 41,644.26	$ 42,893.59	$ 3,769.16	$ 3,882.24	$ 3,998.70	$ 4,118.66	$ 4,242.22
Subcontractors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 21,703,718.26	$ 22,354,829.79	$ 23,025,474.71	$ 23,716,238.95	$ 24,427,726.10	$ 2,146,521.58	$ 2,210,917.25	$ 2,277,244.74	$ 2,345,562.09	$ 2,415,928.95
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ 352,848.97	$ 363,434.44	$ 374,337.47	$ 385,567.60	$ 397,134.62	$ 34,897.15	$ 35,944.07	$ 37,022.39	$ 38,133.06	$ 39,277.05
Non-Compensation Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Occupancy & Depreciation	$ 1,096,683.40	$ 1,129,583.90	$ 1,163,471.42	$ 1,198,375.56	$ 1,234,326.83	$ 108,463.19	$ 111,717.09	$ 115,068.60	$ 118,520.66	$ 122,076.28
Office Supplies, Equipment Repair, Maintenance	$ 39,265.34	$ 40,443.30	$ 41,656.60	$ 42,906.30	$ 44,193.49	$ 3,883.39	$ 3,999.89	$ 4,119.88	$ 4,243.48	$ 4,370.78
Printing, Postage, Fulfillment	$ 332,110.32	$ 342,073.63	$ 352,335.84	$ 362,905.91	$ 373,793.09	$ 32,846.08	$ 33,831.46	$ 34,846.40	$ 35,891.79	$ 36,968.55
Travel, Marketing, Insurance	$ 488,277.06	$ 502,925.37	$ 518,013.13	$ 533,553.53	$ 549,560.13	$ 48,291.14	$ 49,739.87	$ 51,232.07	$ 52,769.03	$ 54,352.10
Other	$ 2,156.72	$ 2,221.42	$ 2,288.07	$ 2,356.71	$ 2,427.41	$ 213.30	$ 219.70	$ 226.29	$ 233.08	$ 240.07
Total Non-Compensation	$ 2,311,341.81	$ 2,380,682.06	$ 2,452,102.53	$ 2,525,665.61	$ 2,601,435.57	$ 228,594.25	$ 235,452.08	$ 242,515.63	$ 249,791.10	$ 257,284.83
Total Admin Dollars	$ 73,591,560.48	$ 75,799,307.26	$ 78,073,286.52	$ 80,415,485.10	$ 82,827,949.62	$ 7,278,286.22	$ 7,496,634.80	$ 7,721,533.80	$ 7,953,179.84	$ 8,191,775.25
Total Management Fees Included Above	$ 73,591,560.48	$ 75,799,307.26	$ 78,073,286.52	$ 80,415,485.10	$ 82,827,949.62	$ 7,278,286.22	$ 7,496,634.80	$ 7,721,533.80	$ 7,953,179.84	$ 8,191,775.25
Management Fee arrangement percentage (contracted)	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%
Projected Member Months	438,010	438,010	438,010	438,010	438,010	16,436,752	16,436,752	16,436,752	16,436,752	16,436,752