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	2-3
A3	Offeror Submission Form	4
A4	Offeror's Signed Signature Page(s) for **each** Solicitation Amendment, if applicable	5-53
PART B	PROGRAMMATIC - NARRATIVE SUBMISSION	
B1	2-page limit	54-55
B2	2-page limit	56-57
B3	3-page limit	58-60
B4	4-page limit	61-64
B5.a (North GSA)	2-page limit	N/A
B5.b. (South GSA)	2-page limit	N/A
B5.c. (Central GSA)	2-page limit	65-66
B6	1-page limit for each of a through g	67-73
B7	5-page limit	74-78
B8	3-page limit	79-81
B9	3-page limit	82-84
B10	2-page limit	85-86
B11	2-page limit	87-88
B12	2-page limit	89-90
PART C	CAPITATION AGREEMENT/ADMINISTRATIVE COST BID SUBMISSION	
C1	Agreement accepting capitation rates	91
C2	Administrative Cost Bid Submission Workbook	92
C3	Actuarial Certification (The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid)	93-94

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.: Not applicable

Federal Employer Identification No.: 86-0527381

E-Mail Address: Lorry.Bottrill@mercycareaz.org

Mercy Care
Company Name

4500 E. Cotton Center Blvd.
Address

Phoenix | AZ | 85040
City | State | Zip

For clarification of this Offer, contact:

Name: Lorry Bottrill

Title: CEO

Phone: 602-400-7082

Lorry Bottrill
Lorry Bottrill (Sep 20, 2021 13:10 PDT)
Signature of Person Authorized to Sign Offer

Lorry Bottrill
Printed Name

CEO
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.

Mercy Care 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:	
☐	**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:	1st Choice

Lorry Bottrill
Lorry Bottrill (Sep 20, 2021 06:44 PDT)
Authorized Signature

9/20/21
Date

Lorry Bottrill
Print Name

CEO
Title

SOLICITATION AMENDMENT #1

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

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

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

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

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL: Lorry Bottrill Lorry Bottrill (Sep 20, 2021 13:04 PDT)	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Lorry Bottrill	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: CEO	TITLE: Chief Procurement Officer
DATE: Sep 20, 2021	DATE: August 26, 2021

BANNER RESEARCH

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	Sponsored Projects Banner Research ADRC Administrative Director	09/09/21	N/A	N/A	N/A	Hello, is this award program subject to Federal Uniform Guidance (formerly called the A-133 audit) rules and regulations? https://www.azahcccs.gov/PlansProviders/HealthPlans/YH20-0002.html	**The SABG, MHBG and Federal Discretionary Grants are subject to the Federal Uniform Guidance rules and regulations (2 CFR Part 200). In addition, AHCCCS requires SABG and MHBG to be treated as a major program for single audit purposes. Refer to the Non-Title XIX/XXI Contract, Section D, Paragraph 50. The Non-Title XIX/XXI Contract Section D, Paragraph 50 is revised as follows:** **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.**

MERCY CARE

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	Mercy Care	8/11/2021	Section H: Instructions to Offerors	20. Submission Requirements	Page 17 of 17	There is a label for the Administrative Cost Bid Submission Workgroup on the CCE Library, but it is not an active, downloadable link. When will AHCCCS provide the required Excel workbook?	**The CCE Library has been updated to indicate that this information is available on the SFTP. Refer to Section I, Exhibit F for SFTP Instructions.**
2	Mercy Care	8/11/2021	Section I: Exhibits, Exhibit C: Narrative Submission Requirements	B9.	Page 3 of 4	As a part of the 988 implementation, AHCCCS recently released a Crisis Line survey to obtain the experiences of individuals who have utilized the Crisis Line. The Crisis Line survey runs through August 31, 2021. AHCCCS has also arranged various stakeholder feedback meetings during the month of September which includes the RBHAs. The Crisis System is also the topic of Narrative Submission "B9" of the ACC-RBHA CCE proposal – due October 4. Certain activities related to the Crisis System survey present an actual or potential conflict for certain respondents during an active ACC-RBHA CCE procurement period, insofar as that procurement explicitly requires narrative regarding crisis services, which is information that may be inquired about in the public Crisis Line meetings. 1. Please confirm that the information obtained through the Crisis Line survey and/or stakeholder meetings will not be	**1. AHCCCS is only scoring the information included in the Offeror's CCE response and not considering any comments or feedback made during, or in relation to, the Crisis Line Survey/and or Crisis stakeholder meetings in its scoring unless the comment and/or feedback is included in the Offeror's CCE response.** **2. The CCE Offerors are highly encouraged to consider information they wish to relay to AHCCCS while in the Crisis meetings. Sharing comments is**

						utilized or considered in connection with scoring CCE bidders' narrative responses. 2. Additionally, please confirm what measures AHCCCS will take to avoid potential issues that holding public Crisis Line meetings present during the open CCE proposal period, specifically as it relates to the potential for the Crisis Line meetings to request or require disclosure of competitively sensitive information. 3. May Participating Stakeholders refrain from commenting in the Crisis Line meetings due to this CCE solicitation?	**voluntary; Offerors are not required to give feedback during the meetings and can instead provide this information directly to LeCroy & Milligan facilitators, outside of the meetings.** **3. See response above.**

MOLINA COMPLETE CARE

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	Molina Complete Care	8/11/2021	Section H.19. Contents of Offeror's Proposal	2	15	The State requests that "all proposals be in Calibri 11-point font or larger..." Will the state allow a smaller, readable font size for graphics, callouts, and tables?	**Yes, the font size can be smaller for graphics, callouts, and tables. To be considered, the graphics, callouts, and/or tables cannot occupy more than half of a page.**
2	Molina Complete Care	8/11/2021		n/a	n/a	Please provide the current down dual eligible in the Title XIX/XXI SMI membership counts for Gila and Pinal Counties?	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
3	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	115	Claims: Please provide two years of historical annual of claim adjudication volumes, separately for SMI vs. Crisis.	**The information AHCCCS has available does not include separate historical data by SMI and Crisis; data would also include populations no longer served by the RBHA (CMDP and DDD) which is not separately identified in the reporting. Service detail files for Crisis and SMI was made available in the Title XIX/XXI Data Supplemental Files on the SFTP.**
4	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	116	Court Coordinator: Please provide two years of annual member counts for COE and COT, individually, separately for SMI vs. Crisis by county.	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
5	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	116	Credentialing Coordinator: Please provide two years of annual credentialing counts, separately for SMI vs. Crisis.	**AHCCCS does not have the detailed information requested. The Credentialing Report received by AHCCCS includes the total count of providers credentialed but rolled up for all lines of business for all populations served.**
6	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	117	Dispute and Appeals Manager: Please provide two years of annual grievance counts and annual appeals counts, separately for SMI vs. Crisis.	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**
7	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	117	Encounters: Please provide two years of encounter volume by form type if possible, separately for SMI vs. Crisis.	**AHCCCS has provided service detail files for Crisis and SMI in the Title XIX/XXI Data Supplemental Files on the SFTP.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
8	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	118	Medical Management: Please provide two years of annual authorization counts, by level of care for Prior Authorizations, Concurrent Authorizations, and Retroactive Authorizations.	**The information AHCCCS has available includes total authorization count but does not include separate historical data by level of care or type of authorization and would also include populations no longer served by the RBHA (CMDP and DDD) which is not separately identified in the reporting.**
9	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	119	Member Services: Please provide two years of annual contact center call volume and average handle times.	**No additional data will be provided.**
10	Molina Complete Care	8/11/2021	Section D Program Requirements Section D15	Item 6	119	Transplant: Please provide two years annual transplant case counts.	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
11	Molina Complete Care	8/11/2021	Section D Program Requirements Section D9	6	78	Please provide two years annual member counts, and total of non-capped days, for members with IMD days exceeding 15 days in a month.	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**
12	Molina Complete Care	8/11/2021	Section D Program Requirements Section D53	2	213	Reinsurance: Please provide two years annual catastrophic case counts.	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
13	Molina Complete Care	8/11/2021	Section D Program Requirements Section D.50	4	203	Delivery Supplement: This section notes that there will be a supplemental payment for an enrolled woman who delivers during a prospective enrollment period. Please advise what the current contract period delivery supplemental payment amount is.	**The current contract period delivery supplemental payment amount can be found in the link below.** https://www.azahcccs.gov/PlansProviders/Downloads/CapitationRates/acc/ACCRatesEffectiveOctober012020.pdf **Note: Supplemental payments do not apply to women who deliver in a prior period coverage time period, integrated SMI members, non-integrated SMI members, or State Only Transplant members. Refer to ACOM Policy 310.**
14	Molina Complete Care	8/11/2021	Section D Program Requirements Section D.50	4	204	Please provide a list of the quality measures that were subject to the withhold arrangement in the past two years, by year and by RBHA.	**Refer to ACOM Policy 306, Attachment A. Additionally, the RBHAs were not historically subject to the withhold arrangement.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
15	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.9	3	17	Please provide an average count of members with Tuberculosis Services in the last two years.	**No additional data will be provided.**
16	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.9	5	17	Please provide an average count of members with HIV in the last two years.	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**
17	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.9	1	21	Court Coordinator: Please provide two years of annual member counts for COE and COT, individually by county.	**Refer to #4. AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
18	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.9	3	22	Please provide annual count of pharmacy claims for last two years by county.	**No additional data will be provided.**
19	Molina Complete Care	8/11/2021	Section D Program Requirements Section D9	3	91	Please provide annual count of pharmacy claims for last two years, separately for SMI and Crisis.	**The information AHCCCS has available does not include separate historical data by SMI and Crisis and would also include populations no longer served by the RBHA (CMDP and DDD) which is not separately identified in the reporting. AHCCCS has provided service detail files, including Pharmacy data, for Crisis and SMI in the Title XIX/XXI Data Supplemental Files on the SFTP.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
20	Molina Complete Care	8/11/2021	Section D Program Requirements Section D10	8	91	Please provide annual unduplicated members with special health care needs, separately for SMI and Crisis.	**AHCCCS no longer obtains this reporting and therefore does not have this information.**
21	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.17	3	30	What is the average monthly enrollment and churn for the most recent two years?	**AHCCCS has provided information in the Non-Title XIX/XXI Data Supplemental Files on the CCE Library refer to file named Non-Title XIX/XXI Enrolled and Served Summary SFY 18 SFY21.**
22	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.73	3	45	What is the average daily census in the supervisory care homes for the most recent year?	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
23	Molina Complete Care	8/11/2021	Section G Non-Title XIX/XXI ACC-RBHA Contract Section G.3	3	12	What is the average monthly disenrollment for the most recent two years?	**AHCCCS has provided information in relation to this question on the SFTP. Refer to the Title XIX XXI Data Supplement Folder – Section L.**
24	Molina Complete Care	8/11/2021	Section D Program Requirements Section D3	1	56	What is the average monthly enrollment for the period January 2019 through February 2020 and the average from March 2020 to March 2021?	**Enrollment Reports are available on the AHCCCS website -** https://azahcccs.gov/Resources/Reports/providerpopreport.html
25	Molina Complete Care	8/11/2021	Section D Program Requirements Section D3	6	56	What is the average disenrollment for the period January 2019 through February 2020 and the average from March 2020 to March 2021?	**The information AHCCCS has available does not include separate disenrollment information by SMI.**

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26	Molina Complete Care	8/11/2021	Section I B6	g	3	Please clarify what type of initiative AHCCCS is seeking for B6.g.: "g. Dual alignment of Medicare and Medicaid enrollment." For example, is AHCCCS looking for an *enrollment* initiative that improved outcomes for dually eligible members?	**Section I, Exhibit C, Narrative Submission Requirement B6 is revised as shown below:** 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,

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							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]

AZ COMPLETE HEALTH

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	Arizona Complete Health	8/11/2021	Section D: Program Requirements	9. Scope of Services	74	The ACC-RBHA Contractors are expected to jointly select and oversee a single statewide crisis phone vendor. Will all the Contractors negotiate rates and fees jointly or separately?	**The ACC-RBHA shall jointly select and oversee a single statewide crisis phone vendor that will provide consistent operations and reporting across the state in alignment with the CCE and AMPM Policy 590, Behavioral Health Crisis Services and Care Coordination. ACC-RBHAs will jointly negotiate a standard rate of reimbursement with the selected crisis phone vendor.**
2	Arizona Complete Health	8/11/2021	Section D: Program Requirements	50. Compensation	199	The first sentence in this paragraph separately identifies PPC capitation and prospective capitation. Please confirm that there is one single capitation rate for both PPC and prospective.	**The PPC capitation rate will be the same rate as the prospective capitation rate.**

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	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
3	Arizona Complete Health	8/11/2021	Section D: Program Requirements	50. Compensation	201	This paragraph describes using risk adjustment to best match payment to risk. Please confirm that AHCCCS will use separate base data for each GSA and will not utilize risk adjustment for the SMI members.	**Model weights are based on statewide data. Risk adjustment takes place at the GSA and risk group level. Since there will be only one Contractor per GSA serving the SMI rate cell, the risk adjustment factor will be set at 1.0 (the same as not risk adjusting).**
4	Arizona Complete Health	8/11/2021	Section D: Program Requirements	50. Compensation	202	This paragraph states AHCCCS will make cost-settlement payments to the Contractors for COVID vaccine administration. Please confirm that this includes the ingredient cost should CMS stop covering those expenses.	**Refer to ACOM Policy 302. Cost Settlement payments for COVID-19 vaccine applies to CYE 22 only. If the Federal Government discontinues covering the costs of the vaccination during CYE 22, these costs will be included in the COVID-19 vaccine cost settlement.**

5	Arizona Complete Health	8/11/2021	Section D: Program Requirements	50. Compensation	203	The Reconciliation of Costs to Reimbursement section states that total medical cost expenses will be reconciled to total capitation paid excluding COVID-19 Vaccine expenses. Please confirm this should be net capitation paid, not total capitation paid. Please confirm the revenue components included in the calculation.	**For CYE 22, the tiered reconciliation will exclude COVID-19 Vaccine and Vaccine Administration from all expenses consistent with not including any revenue for COVID-19 vaccines and their administration. Please see ACOM Policy 311.** **For CYE 23, decisions regarding COVID-19 vaccine administration and the continuation of the cost settlement methodology have not been made.** **We recognize that the contract language references total capitation paid and ACOM Policy 311 references net capitation. ACOM Policy 311 does not make explicit reference to total capitation, but it is implicit in the net capitation description, since total capitation is equal to "PPC and prospective capitation, risk adjusted if applicable, plus Delivery**

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							Supplemental payments" as shown in ACOM Policy 311, Attachment A. **The CCE contract will be revised to say "net capitation paid" to make this clearer as follows: Model weights are based on statewide data. Risk adjustment takes place at the GSA and risk group level. Since there will be only one Contractor per GSA serving the SMI rate cell, the risk adjustment factor will be set at 1.0 (the same as not risk adjusting).** AHCCCS will reconcile the Contractor's total medical cost expenses (prospective and PPC) to ~~total~~ net capitation paid (prospective and PPC) to the Contractor.

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6	Arizona Complete Health	8/11/2021	Section D: Program Requirements	50. Compensation	204	For the withhold and incentive arrangements, will the performance be measured for ACC and ACC-RBHA combined, or will the ACC-RBHA be measured separately?	**A decision has not been made whether SMI will be included in the ACC withhold/incentive calculation or whether SMI will be measured separately for the withhold/incentive calculation.**
7	Arizona Complete Health	8/11/2021	Section D: Program Requirements	50. Compensation	206	This section states that AHCCCS anticipates that most delivery system and provider payment initiatives will involve payments to the Contractor outside of the monthly base capitation payments, made as a separate lump sum payment. Differential Adjustment Payments are currently in the monthly base capitation rates. Please confirm whether Differential Adjustment Payments will be in or out of the monthly base capitation payments.	**Differential Adjustment Payments (DAP) will continue to be included in the monthly base capitation payments.**

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8	Arizona Complete Health	8/11/2021	Section D: Program Requirements	53. Reinsurance	212	Reinsurance as specified in this paragraph applies to all members receiving physical health services covered under this Contract. Please confirm that ACC-RBHA Contractors can receive reinsurance recoveries for non-integrated SMI members even though they do not provide physical health services to these members.	**ACC-RBHA Contractors cannot receive reinsurance recoveries for non-integrated SMI members. The majority of non-integrated SMI members will no longer be the responsibility of the ACC-RBHA plan, as the American Indian Health Program (AIHP) is integrating services for American Indians and Alaska Natives (AI/AN) members with SMI effective 10/1/22.**
9	Arizona Complete Health	8/11/2021	Data Supplement	F Rate Development Information		In the Rate Development Documentation, it states "AHCCCS actuaries have historically used RBHA projected expenditures along with actuarial certifications of the projections from the RBHAs for the first 24 hours of main crisis services…" Does AHCCCS plan to continue with that methodology?	**AHCCCS actuaries will be reviewing multiple methodologies, including the continuation of the historical methodology, for developing capitation rates for the first 24 hours of main crisis services.**

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10	Arizona Complete Health	8/11/2021	Data Supplement	F Rate Development Information		Should the administrative dollars submitted in the Administrative Cost Bid Submission be total dollars or per member per month?	**Administrative dollars submitted in the Administrative Cost Bid should be total dollars. The Administrative Cost Bid Submission template requires that the Bidders include the Projected Member Months used to develop the total dollars. Refer to Section F of the Title XIX XXI Data Supplement for Capitation Rate Setting.**

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11	Arizona Complete Health	8/11/2021	Data Supplement	H Enrollment and Member Month Information		What is AHCCCS' assumption regarding the PHE's impact on membership? Does AHCCCS assume the PHE will end and re-determination process will be complete by October 2022? The crisis enrollment projection looks consistent with that line of thinking (October 2022 is projected to be lower than December 2020), but the SMI enrollment projection does not.	**For purposes of the enrollment projection as shown in the data released with the CCE, AHCCCS had assumed that the PHE will end with redetermination processes completed by October 2022. Additional federal guidance was received after the release of the CCE which is expected to impact the length of the redetermination process such that it is now expected to extend into the first quarter of CYE 23 before the process is completed. The current projections include the expectation that SMI enrollment will be less impacted by the redetermination process than other risk groups.**

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12	Arizona Complete Health	8/11/2021	Data Supplement	H Enrollment and Member Month Information		Please provide the projected monthly enrollment for CYE 23 by GSA.	**Projected monthly enrollment for CYE 23 by GSA is not available. Historical enrollment data was provided by county in the Title XIX XXI Data Supplement for Capitation Rate Setting. Aggregating the data into the ACC GSAs is the only available proxy at this time.**

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13	Arizona Complete Health	8/11/2021	Data Supplement	H Enrollment and Member Month Information		Please explain why there are no member months for crisis for CYE 18. There are associated costs in the Data Book.	**The historical member month information is based on paid member months. Per footnote on Section H - Member Month Summary Report: "There were no crisis-specific rate cells in CYE 18, hence no paid member months. Additionally, the crisis-specific rate cell populations have changed over the years. Starting in CYE 21, the crisis-specific rate cell populations cover all eligible TXIX/TXXI members."**

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14	Arizona Complete Health	8/11/2021	Crisis Services	Section D. Crisis Services, #2	75	Currently, the crisis drug list is specific for the standard of care for a behavioral health crisis situation. Will the crisis drug list need to provide access to all FDA approved MAT dosage forms on the AHCCCS drug list, or will providing at least one dosage form (or all oral dosage forms) as determined by the RBHA Pharmacy Directors continue to meet the requirement? For example, can the crisis drug list cover oral naltrexone and exclude Vivitrol? Can the crisis drug list cover oral buprenorphine products, but exclude Sublocade?	**AHCCCS does not anticipate any changes to the current process.**

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15	Arizona Complete Health	8/11/2021	Section D, Specialty and Biosimilar Drugs last paragraph		185	The solicitation notes that specialty drugs available at retail pharmacies, shall not be reimbursed to a specialty pharmacy for a greater amount than reimbursed under the retail rates. Would limited distribution specialty drugs available through a small number of retail pharmacies like Walgreens Specialty for example, be excluded from this requirement?	**No, limited distribution specialty drugs available through a small number of retail pharmacies are not excluded from this requirement. If limited distribution drugs are available at a retail pharmacy, then the requirement that they shall not be reimbursed to a specialty pharmacy for a greater amount than reimbursed under the retail rates applies. Many, if not most, limited distribution drugs are not available at retail pharmacies.**

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16	Arizona Complete Health	8/11/2021	Section H	INSTRUCTIONS TO OFFERORS	15	All Proposals shall be in Calibri 11-point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement shall be limited to the page limit specified for each submission requirement and be provided on 8½" x 11" one sided, single spaced, type written pages. May a respondent include graphics or tables that have a smaller font size?	**Yes, a respondent may include graphics or tables that have a smaller font size than Calibri 11-point font. To be considered, the graphics and/or tables cannot occupy more than half of a page.**

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17	Arizona Complete Health	8/11/2021	Section H	INSTRUCTIONS TO OFFERORS	15	All Proposals shall be in Calibri 11-point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement shall be limited to the page limit specified for each submission requirement and be provided on 8½" x 11" ***one sided***, single spaced, type written pages. Erasures, interlineations, or other manual modifications in the Proposal are prohibited. Question: Given that this is an electronic submission, is it truly AHCCCS' intent that responses be one-sided? Would AHCCCS prefer that respondents leave a blank page between each response page for questions that allow for a page limit greater than one page? If the answer to that is yes, than please confirm that the blank page between will not count towards the page limit, and is not required to be paginated?	**It is not preferred that respondents leave a blank page between each response page for questions that allow for a page limit greater than one page. However, if this is done, the blank page will not count towards the page limit and is not required to be paginated.**

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18	Arizona Complete Health	8/11/2021	SECTION I: EXHIBITS – B8	EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS	3	Question B.8., requires the respondent to detail network adequacy and ability to address gaps in the network and describe collaboration. It has a 2-page limit. Given the variances in geography, network make-up and needed collaborations in GSAs, would AHCCCS expand the page limit to allow for one additional page per GSA in which a respondent is bidding? This would mean a respondent submitting a bid for one GSA has 3 pages, respondent submitting for two GSAs has 4 pages, and a respondent submitting in all 3 GSAs has 5 pages in which to respond.	**The page limit is revised, CCE Section I: Exhibit C, Narrative Submission Requirement B8, and Section I, Exhibit A, Offeror Checklist are revised to indicate 3 pages.**
	Arizona Complete Health	8/11/2021	SECTION I: EXHIBITS – B9	EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS	3	Question B.9., regarding Arizona's Crisis System is a multi-part question that may require additional space to provide the necessary detail. Would AHCCCS consider allowing 4-page limit?	**The page limit for B9 will not be revised.**

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19	Arizona Complete Health	8/11/2021	SECTION I: EXHIBITS – B10	EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS	3	Question B.10., regarding American Indian/Alaska Native members unique status within the Medicaid system is a multi-part question that may require additional space to provide the necessary detail. Would AHCCCS consider allowing 3-page limit?	**The page limit for B9 will not be revised.**
20	Arizona Complete Health	8/11/2021	SECTION I: EXHIBITS – B11		4	Question B.11., regarding use of Medicaid compensable services as well as non-covered services and supports to address social risk factors impacting AHCCCS members is a multi-part question that may require additional space to provide the necessary detail. Would AHCCCS consider allowing 3-page limit?	**The page limit for B9 will not be revised.**
21	Arizona Complete Health	8/11/2021	SECTION I: EXHIBITS – B12	4		Question B.12. Regarding the role and strategies for supporting the State's recovery from the pandemic is a complex question that may require additional space to provide the necessary detail. Would AHCCCS consider allowing 2-page limit?	**The page limit is revised, CCE Section I: Exhibit C, Narrative Submission Requirement B12, and Section I, Exhibit A, Offeror Checklist are revised to indicate 2 pages.**

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22	Arizona Complete Health	8/11/2021	Section H	7. Amendments to CCE, Paragraph 2	6 of 17	Sections 7, Amendments to CCE, states "The Offeror shall acknowledge all amendments to the CCE by signing the signature page of each amendment and by submitting to AHCCCS all signed signature pages with the Offeror's Proposal." Will AHCCCS allow electronic signatures for amendment pages and other documents requiring a signature?	**Yes, electronic signatures are allowed.**

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: Lorry Bottrill Lorry Bottrill (Sep 20, 2021 13:04 PDT)	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Lorry Bottrill	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: CEO	TITLE: Chief Procurement Officer
DATE: Sep 20, 2021	DATE: September 14, 2021

BANNER UNIVERSITY FAMILY CARE

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1	Banner University Family Care	9/2/21	Section C: Databook Information	N/A	1	The Data Book Information document mentions that "The Services Data Book files do not have completion factors added and are based on fully adjudicated and paid encounter data." Does AHCCCS intend to provide completion factors so contractors can calculate the estimated incurred claims.	**AHCCCS does not intend to provide completion factors.**
2	Banner University Family Care	9/2/21	Section C: Databook Information	N/A	2	The Data Book Information document mentions that "Ancillary Crisis services are not included in this Data Book but will be included in the Crisis 24 Hour Group rate cell for CYE 23 capitation rates." Will AHCCCS provide utilization or cost estimates so that we can assess the overall impact of ancillary services on the Crisis 24 Hour risk group? Will additional detail (procedure codes) on the full scope of services that would be categorized as ancillary services be provided?	**Appendix 6 in the RBHA actuarial certifications (available on the AHCCCS website - https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitationrates.html) provides a table that shows how much of each of the crisis rate cell capitation rates is ancillary and non-ancillary. Ancillary crisis services are defined as those services being provided during a crisis episode (defined by at least one of the main crisis codes being provided). Ancillary crisis services can be non-emergency transportation (to a crisis stabilization unit), psychiatric diagnostic evaluations, mental health assessments, peer**

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							support services, among others. These services are not only provided to members in crisis, which is why the defining characteristic for categorizing these services as ancillary crisis is the provision of one of the main crisis codes to a member within the same 24 hour period as the ancillary service.
3	Banner University Family Care	9/2/21	Section H: Enrollment and Member Month Information	N/A	1	Footnote 1 mentions that "There were not crisis-specific rate cells in CYE 18 hence no paid member months". However, we did notice that there were costs included for this group in CYE 18 in the services detail files. Can you comment on what members are associated with the costs included for the Crisis 24-hour group for CYE18?	**For all provided years of crisis costs, AHCCCS pulled historical adjudicated and approved encounter data for the main crisis services (non-ancillary) for *all* TXIX/TXXI Medicaid members since those are the members who will fall into the Crisis 24-hour group with the CCE. These were pulled even for the time frame that did not have crisis-specific rate cells. As noted in the rest of the Title XIX/XXI Data Supplement, Section H: Enrollment and Member Month Information, Footnote 1, "... the crisis-specific rate cell populations have changed over the years. Starting in CYE 21, the crisis-**

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	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
							specific rate cell populations cover all eligible TXIX/TXXI members." Each year's member months are representative of the crisis-specific rate cells for those years.
4	Banner University Family Care	9/2/21	Section H.19. Contents of Offeror's Proposal	2	15	If graphics, callouts, and/or tables remain Calibri 11-point font or larger, can they occupy more than half of a page?	**Yes.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
5	Banner University Family Care	9/2/21	Section C - Databook Information	N/A	N/A	Section "I.2.B.iii.(c) Errors Found in the Data" of the recently released CYE 2022 RBHA Capitation Rate Certification (https://www.azahcccs.gov/PlansProviders/Downloads/CapitationRates/RBHA/CYE_22_RBHA_Capitation_Rate_Certification_SOF.pdf) mentions that there was a "delayed processing of claim payments by the South RBHA due to claims payment system issues related to the ACC integration" in the first six months of CYE 19 (October 1, 2018 through March 31, 2019). Are the encounters in the Databook affected by this issue?	**The rate development process for CYE 23 will include analysis of all encounter data, including checking for issues with claims payment and completion timing. The encounters in the Databook were pulled at a later date than what was used for CYE 22 RBHA capitation rates allowing more time for the MCOs to correct encounter issues or submit the encounters. Additional analysis has not been done to determine whether all additional encounters for the South RBHA for the aforementioned time period have been submitted.**
6	Banner University Family Care	9/2/21	Section H – Instructions to Offerors	N/A	N/A	If a term is defined in the CCE with an acronym, are offeror's required to define them again in the first reference in their response? For example, is it acceptable to use "PRO" for Peer-Run Organization, since that term is defined in the CCE?	**AHCCCS suggests the Offeror define the acronym in the first place it is referenced in its response.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
7	Banner University Family Care	9/2/2021	Section D – Program Requirements	47	196 - 198	Since this is a contract expansion, will the equity requirements for SMI and Crisis 24 Hour rate cells be added to the ACC rate cells yielding a combined equity requirement. Or, will the equity requirements be unique and stand-alone?	**The RBHA equity requirement for SMI/Crisis 24 Hour will be separately calculated from the ACC equity requirement and thus both requirements are stand-alone. The separate total required equity for ACC and the separate total required equity for RBHA, as calculated, will be added together and compared to the ACC-RBHA's total equity balance to determine compliance.**
8	Banner University Family Care	9/2/2021	Section F – Rate Development Information Document – Administrative Cost Bid Requirement		1	Should the Administrative Cost Bid include or exclude the Non-Title XIX / XXI expected administrative expenses?	**The Administrative Cost Bid shall exclude the Non-Title XIX/XXI expected administrative expenses.**

AZ COMPLETE HEALTH

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	Arizona Complete Health	9/2/2021	Data Supplement	F Rate Development Information		Given there is only one tab per GSA in the Administrative Cost Bid Submission template, please confirm that Offerors should bid each GSA assuming they win that GSA only.	**An amended Administrative Cost Bid Submission workbook has been provided. Additional tabs have been added as noted below.** **The administrative cost bids for the tabs labeled North, South, and Central shall be developed with the assumption that the Offeror will win that specific GSA and no other. Thus, each individual GSA administrative cost bid stands alone.** **The tabs labeled North-South, North-Central, and Central-South have been added. The administrative cost bids for the combined GSAs shall be developed with the assumption that the Offeror will win that GSA combination and no other.** **Section H, Instructions to Offerors is amended as specified in CCE Amendment 2.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
							Additionally, refer to the revised documents in the CCE Library, Title XIX/XXI Data Supplement for Capitation Rate Setting, Section F, Rate Development Information.
2	Arizona Complete Health	9/2/2021	Data Supplement	F Rate Development Information		How does AHCCCS intend to adjust the Administrative Cost Bid in order to be used for capitation rates if the Offeror is awarded multiple GSAs?	**Refer to the answer to AZCH question #1. Also, per the Administrative Cost Bid Requirements document, AHCCCS will evaluate administrative bids and AHCCCS will set administrative cost components of the capitation rates for each year of the contract in compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
3	Arizona Complete Health	9/2/2021	Data Supplement	F Rate Development Information		How does AHCCCS intend to adjust the Administrative Cost Bid in order to be used for capitation rates if the Offeror's projected member months differs from AHCCCS' projected member months or the actual member months?	**AHCCCS intends to use the Offerors' projected member months to calculate administrative cost PMPMs for consideration in the capitation rates since the administrative cost dollars bid shall be based on the numbers of members that the Offeror assumed in the bid. AHCCCS may adjust administrative cost bids when setting the administration cost component of the capitation rates for each year of the contract to ensure compliance with the Medicaid Managed Care Final Rules, Rate Setting Guidelines, and applicable ASOPs.**
	Note – AZCH's submitted questions did not include a question #4.						
5	Arizona Complete Health	9/2/2021	Section H: Instructions to Offeror	n/a	n/a	Will the State allow an optional transmittal letter/cover letter to be included with the proposal? If yes, please confirm that this will not count towards the page limits.	**No a transmittal letter/cover letter may not be included with an Offeror's Proposal and if submitted, will not be considered.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
6	Arizona Complete Health	9/2/2021	Section I: Exhibits, Exhibit C Narrative Submission Requirements	B5C	Page 2 of 4	Narrative B5c asks the respondent to describe how the Offeror will incorporate additional Arnold vs. Sarn requirements into service planning for members. Is the word "additional" referring to the ADHS and the State of AZ stipulations to terminate the litigation listed below: • Increase ACT teams from 15 in fiscal year 2014 to 23 by the end of fiscal year 2016. • Increase the capacity of supported employment in Maricopa County. By the end of fiscal year 2016, the system will be capable of handling 750 more members with supported employment services. • Increase the number supportive housing slots in Maricopa County. By the end of fiscal year 2016, 1200 more seriously mentally ill members will receive	**In addition to Peer and Family Supports as specified in Narrative B5c, also describe how you will incorporate the other Arnold v Sarn imposed obligations, requirements, and services/benefits to be provided to Class Members as set forth in the Arnold v. Sarn Stipulation for Providing Community Services and Terminating the Litigation, signed by the parties on January 8, 2014.**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						supportive housing services. • Increase the number of peer and family members who may receive these support services in Maricopa County. By the end of fiscal year 2016, space for an additional 1,500 peer and family members to receive the aforementioned support services will be made available. If the stipulations above are not what the word "additional" is referring to, please provide clarification of AHCCCS' intent for the word "additional".	

HEALTH CHOICE

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1	Health Choice Arizona	9/2/2021	N/A	N/A	N/A	If an MCO is bidding for 2 GSAs, how do we account for fixed administrative spend that would cover both service areas? Will AHCCCS be providing an additional spreadsheet for a multiple GSA bid?	**An amended Administrative Cost Bid Submission workbook has been provided. Additional tabs have been added as noted below.** **The administrative cost bids for the tabs labeled North, South, and Central shall be developed with the assumption that the Offeror will win that specific GSA and no other. Thus, each individual GSA administrative cost bid stands alone.** **The tabs labeled North-South, North-Central, and Central-South have been added. The administrative cost bids for the combined GSAs shall be developed with the assumption that the Offeror will win that GSA combination and no other.** **Section H, Instructions to Offerors is amended as specified in CCE Amendment 2. Additionally, refer to the revised documents in the CCE**

COMPETITIVE CONTRACT EXPANSION #YH20-0002 QUESTIONS AND RESPONSES TEMPLATE							
	OFFEROR'S NAME	DATE SUBMITTED	CCE SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
							Library, Title XIX/XXI Data Supplement for Capitation Rate Setting, Section F, Rate Development Information.
2	Health Choice Arizona	9/2/2021	N/A	N/A	N/A	We have noted that some bidders have used a "title" or "separator" page in past bids that included the number and full text of the question. It does not appear that AHCCCS counted these pages as part of the page limit for each question. Will that practice be acceptable in this bid as well?	**Yes, this is acceptable.**

B1. Transitioning a contract to a new health plan has the potential to slow the critical processes of …

Mercy Care's highly developed member- and family-focused service model and distinctive understanding of complex health care systems are pillars for system transformation, delivery of high-quality services, and member, provider, and stakeholder satisfaction. Should AHCCCS award the Competitive Contract Expansion to Mercy Care, **we are in the best position to provide continuity, reliability, and continued innovation for our members and providers on day one as the incumbent in the Central Region.** Based on our implementation of 3 successful transitions for other programs in the past 3 years, more than 30 years serving Arizona Medicaid members, and 7 years delivering SMI, crisis, and grant-funded services as the RBHA, we understand the inherent risks in system transitions and the potential impact of uncertainty for members who may find transitions confusing or overwhelming. We currently administer service to 94 percent of the total future Central Region membership and possess administrative expertise and knowledge of the complex service continuum necessary to operate a smooth transition as we welcome new Pinal and Gila County members. **With close to 20,000 providers, our current comprehensive integrated network meets time/distance standards for 100 percent of Central Region members, greatly exceeding minimum network adequacy requirements.** We will leverage our statewide networks to continually expand in Pinal and Gila counties to ensure services are also accessible to all new members without delay or disruption on day one of the new contract. We look forward to continued partnerships with members, families, providers, stakeholders, and AHCCCS, and will incorporate their feedback into our implementation plan to promote a smooth transition for members.

Mercy Care Offers Operational Stability During Transitions

- AHCCCS Complete Care (ACC) transition success: 96% clean claims paid within 1 week by 30 days post-implementation; Department of Child Safety Comprehensive Health Plan transition success: 98.5% auto-adjudication of claims 4 months post-transition
- Zero member grievances and appeals (G/A) related to transitions; achieved 100% on past 2 SMI G/A quarterly audits
- Achieved top score of all ACC health plans for information technology readiness demonstration
- NTXIX enrollment record acceptance rate near 99%
- Mercy Care ranks in the 98th percentile for Overall Provider Satisfaction; 93% would recommend us to other physicians

To ensure smooth transitions and minimal disruption or delay for members, our transition policies comply with the requirements in 42 CFR 457.1216, 42 CFR 438.62(b)(1)-(2), ACOM Policy 402, and AMPM Policy 520. Our member transition coordinator (MTC) develops a customized Member Transition Plan (MTP) that contains pharmacy and network needs of transitioning members. We monitor the MTP daily and leverage the member data supplied through scheduled data exchanges to identify incoming high-acuity members, members with special health care needs, and members in active treatment plans (e.g., pregnancy, chronic conditions, court-ordered treatment, etc.). The MTP verifies that we appropriately assign members to care management as early as possible and that we engage in warm handoffs with other health plan care management teams. We also use the MTP as a network analysis tool to identify priorities for provider contracting. Additionally, we do the following to support smooth transitions for members:

- To promote **early member engagement** in service, we conduct welcome calls to introduce members to the member portal and show them how to contact Member Services and locate the member handbook; we work in partnership with peer-run organizations to facilitate new-member orientation sessions
- To offer **smooth member clinical transitions**, we proactively identify and outreach all Medicaid-eligible providers for possible contracting months prior to implementation; provide continuity of care for any remaining out-of-network needs at go-live via minimum 180 days of coverage for prescriptions and services (authorizations waived); and continue physical health (PH) treatment with non-participating providers for members with SMI transitioning into Mercy Care
- To preserve and monitor delivery of existing transportation orders, we leverage the NON-DEF file prescribed by AHCCCS to **ensure existing transportation providers honor blanket transportation** during go-live
- To **answer members' transition questions**, we deliver tailored member communication/outreach plans

through a trauma-informed lens, including community listening sessions **and interactive voice response and text campaigns**; we offer availability of our dedicated Member Services team to field members' implementation-related calls and provide bilingual representation and interpretive services

We do the following to minimize disruption and delay for new providers during transitions:

- Align **onboarding specialists as a single point of contact** to assist providers in the initial credentialing, contracting, and provider orientation process; provide expedited credentialing as needed; and subsequently assign dedicated network relations representatives for all providers for ongoing support and education
- **Verify claims configuration ahead of go-live and waive claims denials** during provider credentialing/configuration process
- Facilitate **provider listening sessions** to obtain transition-related feedback and implement solutions to any operational or clinical barriers; offer webinar format for providers who cannot attend live events
- Deliver **comprehensive provider operations training** to support provider readiness on day one
- Utilize our Provider Services Call Center to assist with implementation-related calls

During implementation, our current staff will manage day-to-day operations to ensure continuous operation while our dedicated **Implementation Steering Committee (ISC)** meets weekly to monitor day-to-day implementation activities to proactively identify and resolve issues that could adversely impact smooth member transitions or network provider operations. Cross-functional executives lead the ISC, which includes both a senior project manager and MTC who ensure the readiness of administrative and care management processes. The ISC produces and delivers progress summaries to AHCCCS that include known issues and mitigation plans on a regular schedule during implementation and through go-live. These summaries provide updates in topic areas including, but not limited to, the following: data exchanges, claims processing and resolution, network preparedness, member outreach and care management information systems, and formulary updates. In all previous transitions, **we have met 100 percent of implementation deadlines**. Prior to and after go-live, the ISC and other cross-functional internal subject matter experts convene **daily Situation Rooms** to monitor and resolve issues related to the success of processes in place. Metrics monitored include all identified risks and mitigation plans related to implementation such as membership changes, timely delivery of pharmacy and inpatient services underway, member onboarding, and provider accounts. In addition to the ISC, we also convene **Implementation Steering Advisory Group** meetings composed of external stakeholders from all GSAs, members and family members, key providers, and health plan leadership to collect community feedback and recommendations related to the transition. **Mercy Care is committed to ensuring we maintain and advance successful programs, policies, and initiatives** during the implementation transition and beyond go-live. We have conducted a series of forums and listening sessions with members, community stakeholders, and providers in Pinal and Gila counties to identify the current strengths and needs within these communities. The following is a description of some of the actions we are taking to maintain and advance what is already working:

- **Joined Crisis360 (Pinal County) and sequential intercept (Gila County) processes already in progress**; we plan to support Gila County Probation and Opioid Court through enhancements (such as offering methadone treatment), which meet the critical needs of members with opioid use disorder
- **Build upon existing Pinal/Gila Division of Developmental Disabilities/SMI network**, which includes our Assertive Community Treatment team, 13 health homes, and 21 behavioral health integrated clinics/FQHCs
- Translate our **institutional knowledge** and experience with the Arnold v. Sarn case to deliver service that offers the highest quality and most comprehensive clinical care for members in Pinal and Gila counties
- **Outreach Substance Abuse Block Grant/Mental Health Block Grant** providers to assess and expand opportunities regarding services for NTXIX members
- **Increase access** to mobile/virtual integrated PH and behavioral health (BH) with providers such as Spectrum Healthcare and Terros Health
- Building upon our success over many years providing BH support and collaboration for law enforcement through the Crisis Intervention Training (CIT) program, we have been instrumental in the **rollout of new CIT training** in Gila County

B2. The delivery of comprehensive and effective integrated services (physical health, behavioral …

Mercy Care has more than 30 years of experience delivering solutions for special Medicaid populations and 7 years ago implemented the first integrated plan for adults with an SMI designation in Arizona. Since 2014, we have implemented, monitored, and continuously improved our model of integrated care by addressing culturally relevant, whole-person needs of members, focusing on member outcomes using best practice and collaborative team approaches with member and family choice driving policy and practice. Our model ensures care delivery options that resonate with members and families, such as in-office, home, community, or telehealth.

Delivering Integrated Services to Members with an SMI Designation

Mercy Care's highly developed member- and family-focused service model and understanding of complex health care systems are pillars for system transformation, delivery of high-quality services, and member and provider satisfaction. **Table B2.1** describes our experience delivering integrated services to members with an SMI designation.

Table B2.1: Experience Delivering Services to Members with an SMI Designation in Arizona

Line of Business	Geographic Region	Current SMI Enrollment	Population	Years
RBHA	Central Region	26,686 Title XIX/XXI; 6,535 Non-Title XIX/XXI	Individuals with SMI designation	7
Dual Eligible	Statewide	1,562 Title XIX/XXI	Individuals with SMI designation and Medicare- and Medicaid-eligible	15
Arizona Long Term Care System	Maricopa, Gila, Pima, and Pinal	983 Title XIX/XXI	Individuals with SMI designation and long-term care-eligible	20
Developmentally Disabled	Statewide	432 Title XIX/XXI	Individuals with SMI designation and Division of Developmental Disabilities-eligible (integrated contract 3 years)	7

Mercy Care's **efforts to advance integration** use a comprehensive oversight structure that facilitates review of data, identification of trends, and solutions focused on improving member outcomes through better care coordination. Based on eligibility and other factors (i.e., member preference, proximity, or service history), **we panel all RBHA members with an SMI designation upon enrollment to physical and behavioral health (BH) providers** who are responsible for integrated service planning, including social service and support referrals. We encourage participation in an integrated model through **our care managers embedded in health homes**, community forums, and information on our website. Providers also discuss options with members to facilitate choice and connection to the model that best meets their needs. Since 2016, we achieved a **357 percent increase** in the number of members participating in specialty integrated models. We leverage technology to increase care team coordination and facilitate sharing data through electronic population health management platforms with **real-time access for providers to information needed for care coordination**, such as inpatient authorizations, emergency department (ED) utilization, preventive care, member paneling, and referrals. A comparative analysis of member outcomes over the past 4 years demonstrates the positive impact of our integrated model. Results demonstrate that **PCP utilization increased 204 percent, ED utilization decreased 9 percent, hospital admissions decreased 11 percent, and preventive health care showed a 66 percent relative reduction in disparity.** Comparison of ED and inpatient costs from 2018 and 2020 **demonstrated a $1.4 million cost savings** for members participating with a health home. **Members involved in an ACT with PCP or Medical ACT (M-ACT)**—an ACT team with physical health professionals—**showed a 73 percent greater decrease in medical hospitalizations/1000** compared to ACT services without a PCP partnership. For members choosing

Specialty Integrated Care Models

Integrated health homes: Physical and behavioral health services delivered and coordinated onsite, including addressing social factors.

Virtual health homes (VHHs): Partnership between physical and behavioral health providers and health coach liaisons with shared clinical protocols for care coordination, including addressing social factors.

Assertive Community Treatment (ACT) teams with a co-located PCP for members with the most complex conditions, including addressing social factors.

VHHs, diabetes control (HbA1c<9) improved from 47 percent in 2019 to 55 percent in 2020. In 2020, 76 percent of health home members responding stated that it was "quite or very easy to work out what is best care for you," and 53 percent stated their health was good to excellent—an increase from 32 percent in 2016. To support providers as they develop integrated processes, Mercy Care promotes workforce development by offering training on integrated care through our health home toolkit and a train-the-trainer curriculum focused on clinical and operational knowledge and skills in the delivery of integrated care. Subsequently, **80 percent of health homes reached the highest level of integration** (Integrated Practice Assessment Tool), demonstrating collaboration and integration within the practice. Consequently, providers embraced the specialty integrated care models and we increased our network capacity by **123 percent** from 22 to 49 providers, including a **specialty M-ACT team.**

> "Mercy Care has engaged with family members to ensure that persons with SMI have the services and support needed to succeed. We are forever grateful that our son received a voucher to live in a Copa Lighthouse. That has made a tremendous difference in his and our lives."
>
> —Dr. Charles and Laurie Goldstein

Service Delivery Using Non-Title XIX/XXI Funding

Mercy Care provides access to the full continuum of services outlined in the AMPM Exhibit 300-2b for eligible members in the Central Region and leverages this funding for additional services (e.g., crisis services and court-ordered evaluation and treatment). For Non-Title XIX members not eligible for physical health benefits through the RBHA, we expanded our FQHC network and developed a non-compensable Non-Title XIX/XXI plan focused on services not covered by Medicaid (e.g., doula services, tablets, and member education) to address needs related to social determinants of health and to supplement physical and BH services. Over the past 7 years, we facilitated services to 230,501 members through Non-Title XIX/XXI funding (Non-Titled SMI, crisis, county, and grants including Mental Health Block Grant [MHBG], Substance Abuse Block Grant [SABG], Opioid State Target Result, State Opioid Result, Medication-Assisted Treatment [MAT]-Prescription Drug and Opioid Addiction, and Governor's Office-Substance Use Disorder Services [GO-SUDs]) and recently through Children's Behavioral Health Services Fund and eCOVID funding. We expanded service delivery in conjunction with State initiatives, including three 24/7/365 MAT access points serving an average of 1,800 members monthly; the Oxford House recovery housing model (expanded by 20 houses and 182 beds); expanded peer support staff to aid engagement and non-encounterable outreach to 700 members; and expanded grant-funded school-based services to 390 schools. Additionally, crisis services served 199,855 distinct members from 2014 to 2021.

Administration of Non-Title XIX/XXI Funding Sources including Federal Grants

Mercy Care successfully manages nearly $160 million in Non-Title XIX/XXI resources (please refer to **Table B2.2**) and demonstrates an ability to scale programming with a 32 percent increase in funding managed since 2014. Effective administration involves working with all stakeholders to define service needs and a suite of reports monitoring utilization, fiscal processes, and outcomes. Oversight starts with the grant award, the identification of providers' expertise, and review and approval of budgets and program descriptions—and continues once funding is allocated. To ensure consistent application of policies, Mercy Care conducts ongoing monitoring of provider policy reviews; chart audits and case reviews to assess efficacy of treatment services; monitoring of fidelity to best practices; member surveys; secret shopper calls in partnership with the Office of Individual and Family Affairs; network access to care and capacity analysis; and fraud, waste, and abuse data mining. Our experience in Gila and Pinal counties, recent county assessments, stakeholder focus groups and member engagement provide insight into unique needs, which will be utilized in the delivery of grant-funded services in the expanded Central Region.

Table B2.2: Impact of Mercy Care's Administration of Non-Title XIX/XXI Funding Sources

Funding Source	Timeframe for Administration	Services Rendered	Members Served
MHBG	2014-2021	179,621	12,607
SABG	2014-2021	635,907	36,032
GO-SUDS	2017-2021	239,792	4,373

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

Non-Title XIX/XXI funds are critical for meeting the service needs of the targeted members they serve. While accounting for just under 15 percent of RBHA revenues, Mercy Care's administration of these funding streams translated to over 352,000 enrollment transactions between 2014-2021, for over 230,000 eligible Non-Title members in need of crisis, behavioral health (BH), or substance use treatment services. Mercy Care complements our titled benefit with Non-Title XIX/XXI resources to ensure a comprehensive continuum of care that is accessible, person-centered, and recovery-oriented for individuals with SMI or SED, who are experiencing their first episode of psychosis (FEP), and/or have a substance use disorder (SUD). Mercy Care prioritizes these resources for innovative programming to address the needs of our most vulnerable members. In partnership with our provider network, we ensure conversion to Title XIX/XXI enrollment when applicable to maximize our ability to strategically expand service access and system infrastructure and ensure service coordination when the member is referred by another MCO.

a. Non-Title XIX/XXI Funding Sources

Non-Title XIX/XXI funding provides critical BH and substance abuse services to Arizonans in times of extraordinary need. Since 2014, Mercy Care has administered Non-Title XIX-XXI resources to eligible Non-Title and Title XIX/XXI members. Currently, we administer the Non-Title funding sources identified in **Table B3.1**. Mercy Care understands the unique priority populations, monitoring requirements, and reporting associated with the different Non-Title XIX/XXI funding streams as well as operational adherence to AMPAMPM directives, AMPM 320-T1, AMPM 320-T2, and provision of covered services outlined in AMPM Exhibit 300-2b. Mercy Care recognizes the inherent responsibility of Non-Title XIX/XXI resource administration and our role in expanding or complementing access to care for eligible populations.

Table B3.1: Non-Title XIX/XXI Funding Sources by (AMPM 320-T2) Non-Title XIX/XXI Eligible Populations

Funding	SMI	GMH	SUD	Child	Select Planned Initiatives
MHBG	x	x		x	FEP expansion, SED crisis pilot, Behavioral Health Residential Facility expansion, and Incarceration Plan
SABG	x		x	x	American Society of Addiction Medicine Continuum, Pregnant and Postpartum Women (PPW) service expansion, Oxford House, Juvenile Justice Plan, and Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)
eCOVID	x	x	x		Sustained treatment for individuals impacted by COVID-19
SOR			x	x	Mobile medication-assisted Treatment (MAT), inpatient discharge navigation, 24/7 MAT, and Barbell Saves Gym
Non-Title County	x	x	x	x	Sustain Intergovernmental Agreement (IGA) requirements; court-ordered evaluations/treatment (COE/COT)
Non-Title SMI	x				Non-Title SMI services; Non-Title Non-Encounterable Spend Plan
Non-Title Crisis	x	x	x	x	Supplement 'no-wrong door' crisis system and supports
CBHSF		x	x	x	Expand beyond 395 current school and district partners
GO-SUDs			x	x	Expansion of MAT access for Non-Title individuals
PASRR	x	x	x	x	Sustained partnership with District Medical Group

b. Prioritization and Delivery of Non-Title XIX/XXI Funding

Mercy Care's prioritization of services is driven by a commitment to health equity, cultural considerations of the eligible population(s), grant objectives, encounter volume, and addressing geographic needs of the care continuum for Non-Title XIX/XXI-eligible members. **Member and stakeholder dialogue informs program development** through the Block Grant Planning Council, Mercy Care's Member Advocacy Committee, Advisory Council meetings, and member satisfaction

surveys. Notably, this open and inclusive dialogue prompted the launch of the Oxford House recovery housing model, augmented jail navigation efforts, expansion of school-based services, extended 24/7/365 operating hours for opioid use disorder treatment at three MAT access points, the launch of a community-based crisis intervention model for children with SED, and funding for the county's first nursery for babies who are substance-exposed and for their mothers in substance abuse recovery.

Mercy Care will continue to prioritize Non-Title XIX/XXI resources consistent with ACOM requirements, our community needs assessment, funder priorities, and other community-facing listening sessions and forums, which inform the work of Mercy Care's Network Strategy and Sufficiency workgroup and Non-Title Spend Committee. Once service priorities are confirmed, Mercy Care expeditiously executes contracts with our provider network to ensure funding immediately translates to services for our members. As an illustration of tangible impact, discretionary federal funding affiliated with MAT-Prescription Drug and Opioid Addiction, Opioid State Target Result, and SOR alone have directly funded over 365 clinical and recovery support personnel across the Non-Title XIX/XXI network, while supporting over 1,300 unique housing interventions such as rental assistance.

Mercy Care will continue to support the State in meeting the requirements of their IGA with Maricopa County and provide a unified system of BH service delivery. Specifically, we prioritize funds for supplementing the GSA's crisis system, COE/COT, state hospital transitions, and services intended to divert individuals from the criminal justice system into treatment. Non-Title XIX//XXI funding will also be prioritized to expand sustained access to programs delivering high-fidelity, evidence-based practices identified within the Arnold v. Sarn exit stipulation criteria for individuals with SMI designation.

Delivery of Non-Title XIX/XXI services are made possible through an established Non-Titled network of 93 providers, who support members to complete eligibility and enrollment processes that allow access to the most robust service array available to them. Recognizing the importance of whole-person care and the covered service limitations affiliated with most Non-Title XIX/XXI funding, we educate our Non-Title network partners of the State's 23 FQHCs that can deliver complementary physical health services to our members who are not Medicaid-eligible. **In rural and frontier areas of Pinal and Gila counties, we will award block grant dollars to existing FQHCs, creating one-stop access to integrated care for Non-Title members.** Mercy Care's claims system ensures that covered services outlined within AMPM Exhibit 300-2b are aligned with corresponding ICD-10 diagnosis codes of identified Non-Title XIX/XXI eligibility populations. Mercy Care complies with ACOM 434, coordinating benefits for over 46,900 encounters for close to 11,000 members since spring 2014. Mercy Care actively pursues third-party liability recoveries for care provided to members with Non-Title resources, optimizing Non-Title XIX/XXI funds through $10 million in savings since 2015 for BH and pharmacy services through our partnership with HMS/Gainwell. Mercy Care will supplement delivery of Non-Title XIX/XIX services with our clinical efficacy dashboard, which will support monitoring of clinical outcomes and access to care.

Lastly, Mercy Care will collaborate with the State to implement the AHCCCS CRRSAA and ARPA Supplemental Block Grant spend plans. Mercy Care has engaged with prospective providers to meet the State's proposed objectives. Current efforts include creation and expansion of mobile crisis wraparound services and 23-hour crisis stabilization for children with SED designation; expansion of the peer workforce for justice-navigation and non-encounterable outreach for SMI and SUD populations; East Valley expansion of FEP programming; funding maternal mental health programs, Halle Empowerment Affirmation Legacy (HEAL) and Alium Health, to support obstetrics and SUD needs for PPW; and expansion of infant detox services and supportive parental services through Hushabye Nursery.

c. Member Support for Titled Conversion

Our experience managing Non-Title resources and monitoring of titled conversion rates has taught us that less than 5 percent of Non-Title members convert to Title XIX/XXI status, with upwards of 65 percent of individuals being over the income limit for AHCCCS. These figures further illustrate the importance of sustained access to care delivered through Non-Title funds as a critical safety net for Arizonans. Mercy Care recognizes the importance of accessing and maintaining

health care benefits for our members, especially in anticipation of the end of the public health emergency. Titled conversion maximizes treatment opportunities available to the community through finite Non-Title XIX/XXI resources. Mercy Care's Provider Monitoring team validates that those members receiving Non-Title XIX/XXI-funded services have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter. Mercy Care contractually requires our provider network to assist Non-Title XIX/XXI-eligible members with the processes to apply for Title XIX/XXI eligibility and other public benefits including federal exchanges, per AMPM 650. Mercy Care funds benefit navigators within 24/7/365 MAT access points and oversight to 19 benefit navigators within SMI health homes. These benefit navigators also evaluate eligibility for other benefits, including health care coverage through the federal exchange, and assist in gathering necessary documents for these applications. Mercy Care will continue to fund these positions within the defined Non-Title XIX/XXI-funded network and support Non-Title providers to apply for Health-e-Arizona Plus (HEAplus) Community Partner designation to support conversion.

Additional efforts to support Title XIX/XXI enrollment for eligible individuals include the following:

- Distribution of a Non-Title XIX/XXI report to our provider network, identifying members for screening
- Aggregated title conversion reporting, identifying providers for conversion technical assistance
- Monitoring member status transitions on QNXT™, Mercy Care's administration platform, and AHCCCS online
- A dedicated care manager for justice-involved members alerting clinical teams for conversion upon reentry
- Distributing eligibility renewal reports to health homes to activate member benefit renewals
- Provider training through our AHCCCS eligibility liaison and written guidance within our provider manual
- Benefit specialists within health homes to support HEAplus applications for conversion

d. Coordination of Non-Title XIX/XXI Services for Members Enrolled with AHCCCS MCOs

Whether a member is MCO- or self-referred for Non-Title XIX/XXI services, Mercy Care ensures coordination of these benefits through targeted activities with our provider and MCO partners. Providers are required to close the loop on MCO referrals, providing an electronic copy of the final disposition to the referring entity no longer than 30 days from the member's initial assessment. Mercy Care convenes quarterly meetings with MCOs that include a focus on coordination activities. Mercy Care gains MCO feedback on current processes and provides training on current requirements and participation in collaborative problem-solving for system challenges. Between 2014 and Q3 2021, for State-only services, Mercy Care paid 2,505,382 claims with 2,780,828 distinct service lines for a total of 55,227 members. **Beginning in Q4 2021, Mercy Care will provide MCOs with a report of their members utilizing State-only services** to support treatment planning and care coordination efforts. Mercy Care promotes technology systems that facilitate communication between crisis providers, Mercy Care, and a member's MCO. Consistent with proposed AMPM 590, this will include planning, intervention, and referral information in an electronic record; tracking of referrals; and utilization of the HIE to support information sharing. The MCO will be notified within 24 hours of an individual engaging in the crisis system, with a post-crisis care plan (PCCP) sent to the member's MCO and PCP. For fee-for-service (FFS) members, the PCCP is provided to the member's FFS provider, Tribal RBHA, Indian Health Service/638 provider, or the American Indian Medical Home.

Mercy Care's Grants staff also facilitates provider-facing meetings and didactic training to educate the network on the availability and value of integrating Non-Title resources with covered services available to Title XIX and Non-Title XIX/XXI members. In addition to provider-facing meetings, Mercy Care reinforces care coordination expectations and available resources through our online learning platform, Relias. Since 2014, there have been over 21,300 successfully completed SABG Relias trainings and over 4,600 successfully completed MHBG trainings launched in spring 2020. Curricula for these face-to-face and virtual activities are based on AMPM 320-T1 and 320-T2. Also consistent with AHCCCS policy, Mercy Care includes written policies, procedures, workflows, and Non-Title XIX/XXI enrollment guides within our provider manual for educating our network on accepting and responding to referrals from other AHCCCS contractors.

B4. There are many opportunities for clinical quality improvement for care of individuals living …

Mercy Care uses innovations such as telehealth and digital outreach solutions, as well as evidence-based practices such as trauma-informed care (TIC), to serve members with an SMI designation and improve outcomes for behavioral health, maternal health, diabetes management, and other conditions.

Mercy Care's Quality Structure and Approach

Mercy Care approaches clinical quality improvement as a plan-wide commitment in alignment with AMPM 910. Mercy Care's chief medical officer provides clinical leadership and accountability in overseeing our quality program. Our Member Advisory Committee, Culturally and Linguistically Appropriate Services Committees, and Health Disparities Workgroup play an active role in monitoring, evaluating, and improving our performance—serving as a vehicle to formally solicit input from members and their families, stakeholders, and external experts. The Mercy Care board of directors is the governing body and has ultimate accountability for the Quality Management/Quality Improvement (QI) program and related processes, activities, policies, and systems.

a. Methods to Assess Disparities and Related Action Taken

Mercy Care's comprehensive quality performance management system connects multiple data inputs, such as our health equities dashboard, to identify care needs and utilization patterns, and allows for comprehensive data sharing with provider partners. Our advanced evaluation and data analysis focuses on identifying gaps in care through utilization review; race, ethnicity, language, and disability data; HEDIS outcomes compared to national benchmarks; grievances and appeals (e.g., trends and physician profiling trend reports); and data from the Arizona HIE, **Health Current**. Additionally, we collect information and member feedback using comprehensive member screenings and assessments, stakeholder dialogue through Mercy Care's Member Advisory Committee and Advisory Council meetings, and listening sessions from members and providers, as well as provider satisfaction surveys.

Mercy Care will be collaborating with **Socially Determined (SD)** to identify risk, quantify opportunities, prioritize action, measure impact at the individual level, and analyze social risk factors across the following domains: financial strain, food insecurity, housing instability, health literacy challenges, and transportation barriers. The robust data provided by SD supports our evaluation of quality gaps related to social determinants of health and will assist by supporting Mercy Care's efforts to design, deploy, and evaluate solutions to mitigate risk and advance health equity and social justice for individuals living with SMI.

Mercy Care's approach to health equity is framed by an established Plan-Do-Study-Act (PDSA) quality improvement framework. We review data for the SMI population, which is at greater risk for health disparities due to factors such as the stigma of mental illness and the associated barrier to seeking treatment; smoking; lack of physical activity; poor nutrition; transportation; language barriers; and homelessness; and we also compare it to data for our other Medicaid populations to identify disparities.[1] We know these risk factors impact the rate at which members with SMI access health care, which may also contribute to premature death. The following are examples of initiatives undertaken by Mercy Care:

Cervical Cancer Screening (CCS) Disparity

Mercy Care's analysis of HEDIS outcomes identified a disparity in the rate of CCS for the SMI population (18.4 percent) as compared to the total AHCCCS Complete Care population (57.2 percent). We recognize that women with an SMI designation are more likely to be fearful of CCS screening given the common history of trauma and lack of support. Additionally, data analysis demonstrated a disparity in the rate of CCS amongst the American Indian (AI)/Alaska Native (AN) population at 51.9 percent compared to the White population at 54.0 percent.

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[1]SMI Advisor, "Health Disparities Among People With Serious Mental Illness": accessed September 25, 2021; https://smiadviser.org/knowledge_post/health-disparities-among-people-with-serious-mental-illness

ACTIONS TAKEN: Mercy Care's member-facing staff are trained in TIC with skills in empathic, resiliency-supporting communications to support women with an SMI designation. Our tribal specialist and peer recovery support specialists (PRSSs) use motivational interviewing to engage women who are fearful of CCS to gently support their decision. Mercy Care engages members with an SMI designation in the ways they prefer—whether face-to-face, digitally based, or via telephone or video—to help close gaps in care.

OUTCOME: We improved our Women with SMI CCS HEDIS scores 191 percent from CYE 2015 to a rate of 53.5 percent in CYE 2020.

Condition Management Disparity

Through data analysis, Mercy Care identified that SMI members experience a higher prevalence of some chronic conditions as compared to our other Medicaid populations. These include hyperlipidemia, which has a 27.9 percent prevalence for members with an SMI designation compared to 12.0 percent for other populations; and hypertension, which has a 31.9 percent prevalence for members with an SMI designation as compared to 11.8 percent for other populations. We also identified a significantly higher prevalence of chronic conditions within the following ethnicities, as compared to the White population: the Hispanic population shows a higher incidence of hyperlipidemia and hypertension at 34.94 percent and 37.29 percent respectively, compared to 28.99 percent and 32.06 percent. The Black population demonstrates a higher incidence of hypertension at 34.58 percent. The AI population shows a higher incidence of diabetes at 17.71 percent compared to 16.46 percent in the White population. Mercy Care also identified opportunities to address disparities within the following quality metrics: Performance in Statin Therapy for Members with Cardiovascular Disease and Controlling High Blood Pressure.

ACTIONS TAKEN: Mercy Care uses evidence-based practices such as utilizing community-based health workers, who specialize as PRSSs, and tribal specialists, who use sensitive, targeted outreach and education. Additionally, we offer enhanced care coordination to assist members in making appointments to close gaps in care.

PROPOSED ACTIONS TAKEN: Mercy Care will conduct a performance improvement project (PIP) to address hypertension and hyperlipidemia and a second PIP for diabetes (please refer to **Section d**). Our actions include interventions to address the SMI disparity as well to offer a cultural focus for our racial and ethnic disparities. Mercy Care will also bring **community resource centers (CRCs)** to these areas to offer physical and behavioral health care in a familiar setting. CRCs offer a place where members can connect with a PRSS, providers, care managers (CMs), and pharmacists to discuss medication side effects; to reassure members have no costs; and to address barriers to following a special diet.

b. Opportunities Identified for Systemwide Improvement and Related Actions Taken

Mercy Care assesses opportunities for the health and well-being of our members by collection of data, conducting root cause analysis, and implementation of the PDSA cycle. We compare indicators of our members' utilization, outcomes, and experiences to established State and national benchmarks at the individual and population level to identify concerns that may arise from specific providers, communities, and cultural group norms. We use integrated solutions that are culturally relevant to address whole-person needs such as the following examples:

Postpartum Care Opportunity

Mercy Care focused on improving a low rate of postpartum care (15.5 percent in 2015) since the SMI population is often at risk for worse fetal outcomes, substance use disorder (SUD), and postpartum depression.

SOLUTION: We established our **comprehensive women's health strategy** to better support maternal mental health, provide SUD treatment, and address food insecurity and lack of transportation that negatively affect women during the postpartum period. This strategy includes high-risk perinatal care management by experienced maternal child health registered nurses skilled in perinatal TIC as well as neonatal and postpartum medication-assisted treatment. We ensure that our members have ongoing access to evidence-based treatment.

Mercy Care contracts with Icario to create and perform **digitally based, targeted outreach campaigns** to members in need of postpartum care. We provide Icario with demographic data for members with gaps in care. Among eligible

women with an SMI designation engaged by Icario, **31 percent** indicated they would take action to get postpartum care.

CHEEERS doula program: Mercy Care offered financial support for startup of 21 PRSSs to the CHEEERS program, supporting diversity to perinatal women with SUD and/or mental health-related disorders.
OUTCOME: Mercy Care's women with SMI designation for postpartum care **improved 284 percent** in HEDIS measure from CY 2015 to a rate of **59.9 percent** in CY 2020.

Follow-up after Mental Health Hospitalization Opportunity

Mercy Care members' 30-day Follow-Up After Hospitalization for Mental Health HEDIS measure was 51.7 percent in 2015. Our QI team identified gaps in care and provider feedback identified access to care, transportation, language barriers, and ineffective care coordination as root causes for poor care continuity for people with an SMI designation. Provider feedback indicated they were often unaware of members being admitted and/or discharged.
SOLUTION: Our comprehensive solution includes care coordination, reporting, and engagement with members. Mercy Care sends providers a **Tableau alert report** of members who were recently admitted or discharged to actively inform the member's clinical team to an inpatient episode to ensure care coordination. Additionally, embedded CM staff at the health home work actively with the member's clinical team on member status and recommended services, updating care plans, scheduling of follow-up appointments, offering transportation, or arranging any needed interpreters. We support this process with technology and digital virtual tools such as **Icario** for member engagement. Our CMs support members who have frequent hospitalizations or readmissions and work closely with them so they understand which services can best meet their needs.

OUTCOME: Mercy Care's interventions resulted in a **67 percent improvement** in the HEDIS measurement of 30-Day Follow-Up After Hospitalization for Mental Health from CYE 2015 to a rate of **86.4 percent** in CYE 2020.

Access to Care Opportunity

Telehealth services were crucial to ensure member access to services with the impact of COVID-19. Mercy Care recognizes the need to expand access to Wi-Fi and technology to increase member ability to connect with providers and language services through accepted telehealth modalities. Telehealth services also help address social isolation and improve access to care in and among racial and ethnic minority communities. Mercy Care offers telehealth to all members, but not all members have proper equipment, such as a smartphone.

SOLUTION: Mercy Care reallocated part of our Non-Title XIX spend plan to provide 1,110 tablets to members to promote the use of telehealth services. Mercy Care saw an over **205 percent increase** in telehealth visits between April 2020 and March 2021 as compared to 2019 for all our members, including **Black and Hispanic members, as compared to the 196 percent seen in White members.** Telehealth is vital during the COVID-19 pandemic to provide safe access to care. We will implement a telehealth hotspot at a CRC in an area of need to improve access. Mercy Care will provide 300 tablets per year through community reinvestment dollars to support telehealth use.

c. Experience in Achieving Quality Outcomes for Individuals with SMI

As the RBHA in Maricopa County since 2014, Mercy Care has been improving health outcomes for members with an SMI designation for years. For example, in 2019, we exceeded the goal for **66 percent** of AHCCCS-calculated performance measures, as compared to other RBHAs that met goals for only 50 percent. And in 2020, we met or exceeded **76 percent** of our work plan goals.

Diabetes Monitoring and Prenatal Care Opportunity Identified

Mercy Care identified opportunities in **diabetes monitoring and prenatal care** for members with an SMI designation through our gaps in care monitoring, health risk assessments, provider feedback, and QI HEDIS program.
ACTIONS TAKEN: Mercy Care implemented a multipronged approach to improve diabetes management and prenatal care for individuals with an SMI designation that led to a significant improvement in our HEDIS scores. **RBHA registered nurse CMs** implemented a **diabetes disease management** educational program for the care teams in the health home. CMs assist the member's community case manager with coordinating diabetes care, screenings, and services; monitoring

medication with our pharmacy advisor; and referring all members discharged from a nursing facility with a diabetes diagnosis to the **Scottsdale Physicians Group Chronic Condition Program** for in-home evaluation within seven days of discharge. We are expanding this program and offering a home monitoring option.

We identified our health homes as a source of strength for access to care, increasing the volume of membership **118 percent** from 2018 to 2020. We also increased virtual health home membership by **40 percent** during this timeframe, ensuring more members were being seen and gaps in care addressed. Mercy Care's newly developed health home with **Alium Health** includes a comprehensive continuum of care—primary care, obstetrics, and gynecology; behavioral health; case management; and support for postpartum or depression.

OUTCOMES ACHIEVED: **Table B4.1** describes improved outcomes for diabetes and prenatal care since 2017.

Table B4.1: Improvements in SMI Diabetes and Prenatal Care Outcomes

HEDIS® Measure	CYE 2017	CYE 2018	CYE 2019	CYE 2020	Relative Change
Comprehensive Diabetes Care HbA1c Test	81.85%	83.0%	84.4%	86.62%	5.83%
Comprehensive Diabetes Care HbA1c>9% (lower rate indicates improved performance)	53.0%	51.8%	51.2%	33.58%	36.6%
Prenatal Care	49.64%	66.5%	61.4%	79.04%	59.2%

d. Approach to PIPs for Individuals with SMI

Mercy Care's proposed approach is based on years of experience conducting AHCCCS-mandated and self-selected PIPs in accordance with AHCCCS requirements AMPM Chapter 980 Attachment A.

Mercy Care Proposed PIP: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications

Rationale for PIP selection: Our topic impacts approximately 6,000 of the population of individuals with an SMI designation, which is 22.0 percent of the total population. The prevalence of diabetes in the AI population is twice that of the Arizona population at 20.9 percent versus 10.5 percent.[2] Current performance falls below the NCQA HEDIS Medicaid mean. Through our data analysis, which is both readily available and stable for reporting, we identified that 29.0 percent of the total eligible population resides in 1 of 10 ZIP codes but demonstrates a rate of performance (78.6 percent) statistically lower than that of the total measure population (81.1 percent).

Proposed interventions: Mercy Care will conduct targeted outreach and education to providers, ensuring they understand the significance of the disparity. Providers will receive a review of the following best practices:

- Ordering a member diabetes screening test every year and building gaps-in-care follow-up alerts in their electronic medical record
- Coordinating care between health homes via the remote home monitoring and disease management CM
- Providing member and/or caregiver education of the risk of diabetes while taking antipsychotic medication

Mercy Care proposes the following **member-faced** intervention practices, leveraging our **tribal specialists' engagement** to address barriers to behavior change:

- Members will receive a remote monitoring bundle with an iPad mini™ kit with up to two peripheral devices such as a weight scale and glucometer
- Members will receive an incentive for achievement of annual HbA1c testing.

We regularly assess for improvement of our baseline following our initiatives as per AMPM Chapter 980 Attachment Protocol Activity.9.2, conducting any necessary changes or updates to our plan until we reach our intended goal.

[2] Arizona Department of Health Services, "Leading Causes of Death and Health Disparities Among the AI/AN Population in Arizona", 8-9 (2019).

B5. GSA Specific Submission Requirement: c. If submitting a Proposal for Central GSA Contractors …

By listening to members, families, providers, and community stakeholders, Mercy Care successfully addressed the Arnold v. Sarn settlement (Arnold) exit stipulation requirements by ensuring fidelity and expanding network capacity beyond expectations for the four evidence-based practices (EBPs). With our work and partnership with AHCCCS, the decades-long lawsuit ended in June 2016 and remains compliant with increased fidelity scores and service utilization. We demonstrate unwavering commitment and expertise with our performance improvement responses to annual Mercer Service Capacity Assessment and Quality Service Review (QSR) and Western Interstate Commission for Higher Education (WICHE) audits. We remain committed to improving members' health, the delivery system, and its alignment with the Nine Guiding Principles for Recovery Oriented Adult Services, as well as expanding these fidelity practices with our collaborative approach in Pinal and Gila counties.

Individualized service planning: Mercy Care drives innovative, integrated solutions that focus on member recovery and deliver positive outcomes. To further promote person-centered individual service plans (ISPs), we will implement two major initiatives focused on member-driven goals and family engagement in service planning. The first initiative requires health homes to add certified **personal medicine coaches**—an EBP aligned with the SAMHSA recovery model. The model, created by Patricia Deegan, emphasizes empowerment and self-advocacy as a foundation for person-centered planning to facilitate the member's voice and choice in treatment. This approach recognizes members' knowledge of what works best to meet their needs, driven by their inner wisdom and capacity to self-heal and participate in activities that are medicinal to their well-being. Eighty-six percent of respondents report improved self-care and increased involvement in treatment planning, and describe the approach as very helpful.[1] We will sponsor training for personal medicine coaches and require all ISPs to include a personal medicine goal defined by the member. Our second initiative modifies the ISP process to parallel the **person-centered approach** recently adopted by the Arizona Long Term Care System. Using this model with personal medicine coaches, the ISP process will inspire collaborative discussions driven by the member's needs and choices, rather than a process based solely on requirements. Mercy Care requires providers to comply with AMPM 320-0 when creating member ISPs, and we require teams to include family members in the ISP process. We verify compliance through audits to ensure ISPs address all members' needs, member and family input, and data source monitoring (e.g., QSR). We offer training and technical assistance and will have an additional monitoring process, including sample ISP reviews to ensure ISPs are person-centered and aligned with members' strengths and needs. We will continue to annually host a conference for members, families, and providers focused on core EBP education and how to access them. We will leverage our Member Advocacy Committee, community forums, Advisory Councils, Welcome to the System orientations, and input from health homes and peer-run organizations to obtain direct feedback from members and families regarding how well the ISP process empowers them and aligns ISPs with their goals. Additionally, to ensure assessment per Arnold requirements, our Quality Provider Monitoring (QPM) team audits the four EBPs quarterly and monitors ISP completion rates, with performance improvement requirements to address noted concerns. Our value-based contracts address EBP-related outcomes. Part of our 2019 performance improvement actions included creating an ISP provider training focused on assessing strengths and needs, core principles, and developing individualized goals and interventions. As a result, there was a 54 percent increase in completion of ISPs. We remain committed to ensuring a 100 percent rate of ISP completion with the described actions driving this outcome.

Delivery/utilization of peer and family support services impact member engagement and health outcomes. **Peer support:** The 2020 QSR noted peer support utilization to be strong year-over-year and is a national best practice benchmark at a penetration rate of 35 percent, indicating that members have desired access. Mercy Care promotes innovative peer-focused program expansion, training, and support of peer providers, resulting in 7 times the number of members using peer support since 2014 and a 44 percent increase in the number of network-certified peer support

[1] MacDonald-Wilson K.L., Deegan P.E., Hutchison H.L., Parrotta N., and Schuster J.M., "Integrating Self-Management Strategies into Mental Health Service Delivery: Empowering People in Recovery," Psychiatric Rehabilitation Journal, 36(4) 258-263 (2013).

specialists since 2016. From April 2019 to March 2021, there was a **20 percent reduction in crisis services** for members who received peer support services from our Arnold expansion providers. In 2020, our partnership with Correctional Health Services' post-booking jail diversion program (with referral to forensic peer support) diverted 674 members into treatment. We enhanced the jail data link file interface to send electronic notification to peer providers, enabling staff to promptly reach out to identified members with an SMI designation and provide reach-in services to facilitate jail release into treatment. Further, we continue to collaborate with local police for pre booking jail diversion to connect members to treatment rather than arrest.

Family support: Family and friends play a significant role in creating a strong foundation for members' holistic well-being. In the 2020 Mercer findings, contributing factors to low family support utilization include the number of available or engaged family members and clinical teams' understanding of benefits of family support. **Mercy Care's planned strategies** to address these findings include increasing access and utilization through education and engagement. We will do the following: 1) create an internal extended hours family phone line to assist family members with urgent needs; 2) create an internal family support line with a consumer-operated organization, allowing families to connect with a family support specialist to learn about available services, how to navigate the system, and receive direct support; 3) offer the Mercy Care Connect application to allow for real-time referral tracking and sharing treatment information for care coordination; 4) develop trainings with the Peer and Family Career Academy for family support specialists working with members with special health care needs; and 5) ensure peer and family support certification training availability in Gila and Pinal counties. We will foster clinical team understanding of the value of engagement with families by doing the following: 1) requiring family support services at subacute and inpatient settings to support families at this critical point in care; 2) expand family support programs; 3) provide education through forums and clinical workshops; and 4) monitor family support utilization monthly and satisfaction through ongoing member and family forums to identify opportunities to increase access and the use of family support.

> "I am a family member of six people living with mental illness … I could not do half the things I do for my family members if it were not for the support I receive from Mercy Care and their network. The network Mercy Care has put together for the community is large and covers many areas that need help. Their 24/7 customer service is major [as well as] the patience of those people answering the phones for the clients that call in."
>
> —Gloria H. Abril

Settlement compliance and EBP fidelity: Mercy Care's expertise with system transformation and quality improvement efforts addressing the annual Arnold reports lead to an increase in the number of members with an SMI designation receiving required EBPs and improved member outcomes (e.g., 51 percent of current members receiving supported employment [SE] are working). Since 2014 in Maricopa County, utilization across the EBPs increased seven-fold for consumer-operated services, 19 percent for SE, 55 percent for assertive community treatment (ACT), and 75 percent for permanent supportive housing. Currently, penetration rates for ACT (7 percent) **exceed national best practice standards** and utilization for SE (4 percent) exceeds the national average. Mercy Care requires provider deliverables to monitor fidelity compliance and provides systemic and individualized technical assistance to address noted barriers. Using a suite of dashboard reports, our EBP subject matter administrators and QPM team ensure compliance with Arnold requirements. To ensure compliance with additional Arnold requirements, our specialized Integrated Care Management staff oversee Arizona State hospital admissions and work with health homes to ensure member needs are met. We track supervisory care homes and ensure a unified behavioral health service delivery system by incorporating functions traditionally delivered through the county in our crisis continuum, including involuntary behavioral health and alcohol evaluations—thereby facilitating connection to treatment rather than arrest. To maintain settlement compliance**,** Mercy Care will continue our robust continuous performance improvement processes based on Mercer service capacity and WICHE and QSR results; we implement actions to address findings and drive ongoing systemic improvement. We will continue to measure compliance, tailor provider assistance, host annual trainings with experts, work with stakeholders, and assess local needs to promote these services. Mercy Care's mature compliance strategies will provide continuity and reduce risk of system disruption and settlement noncompliance while maintaining members and families at the center of policy.

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

Mercy Care drives innovative, integrated solutions that focus on member recovery and deliver positive outcomes for members with an SMI designation.

a. Mercy Care's Integrated Care Management Program

To improve health outcomes for members with an SMI designation, Mercy Care launched an **ENHANCED, HIGH-TOUCH INTEGRATED CARE MANAGEMENT INITIATIVE** that exceeds the requirements of the AMPM Chapters 500 and 1020, on January 1, 2021. The initiative serves members with SMI who are at high risk for comorbidity and mortality and would benefit from a higher-touch approach with consistent monitoring. During the pilot period, Mercy Care supported 359 members with an SMI designation and co-occurring chronic conditions (e.g., diabetes, hypertension, high cholesterol, etc.) through this initiative.

Identifying an opportunity: Mercy Care conducted an analysis of utilization and cost data for members with SMI in the top 5 percent of total cost of care and identified approximately 30 percent not engaging in an appropriate level of outpatient services at their assigned health home. This resulted in high utilization of avoidable inpatient (IP), emergency department (ED), and crisis services, especially for members with comorbid conditions. We also identified social determinants such as chronic homelessness and social isolation as factors contributing to the under-utilization of integrated services and over-utilization of the crisis system for many individuals with SMI.

Initiative: Using a sophisticated and robust analysis in addition to the minimum high-needs/high-cost criteria (i.e., a $50,000 threshold in a rolling 12-month period), Mercy Care created care management predictive modeling and risk stratification algorithms that consider data from a whole-person view to identify the top tier of members at risk for poor outcomes. This data provides the Care Management team with service utilization data identifying members that are under-utilizing medical care for chronic conditions. Care managers use a complete range of data sources, including available comprehensive assessment (per 42 CFR 438.208(c)(2)) and treatment information, health home electronic health records (EHRs), and HIE data to understand key drivers of over- and under-utilization of services and the member's whole-person needs. Based on members' interests and needs, we actively engage members with community-based, family-centered, culturally responsive, multispecialty, and interdisciplinary services, including the following: 1) integrated health care team supports (including community health workers) via Catalytic Health Partners; 2) in-home visits for monitoring of chronic conditions via Scottsdale Physicians Group; and 3) a residential program for adults 55 or older via Copa Health's Terrace Program at BridgeWater. Care managers engage members using motivational interviewing and principles of trauma-informed care (TIC) to educate members on their options and work with members to choose the best treatment options for their recovery. This includes identifying and considering potential health disparities and members' cultural preferences. Once the member begins receiving services, Care Management staff monitor the member's utilization of appropriate services with the member's health home clinical team and coordinate weekly or monthly staffing with the clinical team and recovery partner to review the member's progress. Ongoing, Care Management consistently reviews HIE data, gaps in care reports, and our electronic population health management platform, and monitors updated care plans at least quarterly to determine any change in level of services.

When fully launched, Mercy Care **ANTICIPATES SUPPORTING APPROXIMATELY 2,200 MEMBERS** (~8 percent of our total RBHA membership) in our enhanced, high-touch integrated care management initiative when it is fully operational.

Impact: Outcomes for the enhanced, high-touch care management initiative pilot have been impressive, demonstrating improved outcomes for our members with SMI and savings to the State. Pre- and post-analysis of available data for members with SMI who have participated for at least six months demonstrate the following:

- **1: Integrated Health Care team supports via Catalytic Health Partners (24 total members):** 39 percent decrease in crisis services and 64 percent decrease in IP admissions
- **2: Home visits via Scottsdale Physicians Group (280 total members):** 46 percent decrease in crisis services and 19 percent decrease in IP admissions
- **3: Residential program via Copa's Terrace Program at BridgeWater (55 total members):** 43 percent reduction in crisis services and 81 percent decrease in IP admissions

Across programs with available data, there was a 31 percent reduction in cost of care for participating members.

b. Provider Case Management

Mercy Care designed, and will soon implement, our **NEXT GENERATION HEALTH HOME PROVIDER CASE MANAGEMENT MODEL** to create a new level beyond those outlined in AMPM 570 (effective October 2021) to improve health outcomes for members with an SMI designation. Through this initiative, Mercy Care is doing the following: 1) creating an **INTENSIVE LEVEL OF CASE MANAGEMENT** to serve members whose needs fall between the assertive community treatment (ACT) and supportive levels of case management; 2) ensuring members at the intensive level are served by appropriately licensed case managers to enhance clinical service delivery; and 3) using an advanced stratification algorithm to better identify the appropriate level of case management based on each member's clinical need.

Identifying a need: Through provider, member, and family feedback via stakeholder discussions with family advocates and our Member Advocacy Committee, Mercy Care learned of an opportunity for a subpopulation of members to better align integrated service delivery at more appropriate levels of care. In addition, the 2020 Mercer Government Human Services Consulting Annual Service Capacity Assessment recommended developing processes to evaluate ACT members for step-down to a lower level of care, if appropriate.

Initiative: The next-generation case management model to be implemented at all health homes will do the following: 1) incorporate an intensive level of case management for members who require a high degree of support and coordination of care to improve their health outcomes but who do not meet ACT criteria, could be stepped down from ACT, or are not in agreement for ACT services; 2) make sure members needing the intensive level of case management are assigned to a clinically licensed case manager (e.g., a behavioral health [BH] professional as defined in AMPM 310-B); and 3) use a whole-health approach to identify the appropriate level of case management for members, including the new intensive level. We created a stratification algorithm that includes the following:

- **Future risk of avoidable utilization:** Combined chronic illness and pharmacy payment system; IP admissions, ED utilization, and use of crisis services; incarceration in the past 12 months; and social determinants of health (SDOH)
- **Future likelihood of engagement:** Engagement with physical (PH) and BH providers; comparison of financial risk to clinical risk (high financial risk, low clinical risk); and level of BH medication adherence

To increase active engagement, clinical management, quality care, and supports for a meaningful day, health home-licensed clinical case managers will adopt the evidence-based, recovery-oriented practice of personal medicine created by Patricia Deegan. In addition, we will encourage members to access peer support (AMPM 963), counseling, and skills development services. As recognized by Mercer as a valuable BH service, peer and recovery support specialists provide social and personal support, using their shared experience of living with BH conditions and/or other traumatic experiences to help members on their journey to recovery. In addition, the case manager will work with the member's assigned **EMBEDDED MERCY CARE INTEGRATED CARE MANAGER**, using motivational interviewing and the principles of TIC to develop rapport with members. The clinical case manager will be able to access the **Mercy Care Connect application,** which aggregates all available data sources into a consolidated view of member information. At this level, the maximum caseload of 20:1 is lower than all ratios (per AMPM 570, effective October 2021) other than ACT and in alignment with suggested ratios for intensive case management. At this ratio, members needing an intensive level of service will be more likely to receive the right level of clinical care and necessary care coordination to address their whole-health needs with at least biweekly contacts, or more often as needed.

Impact: Our next-generation health home provider case management model will better align the level of case management with the clinical needs of members and address the recommendations of the Service Capacity Assessment. Mercy Care anticipates about 10 percent of members with an SMI designation (around 2,700 individuals) will be stratified to the intensive level of case management. Goals of our intervention include the following: reduced IP admissions, ED visits, and use of crisis services and recidivism; improved engagement in treatment plan activities and self-management of chronic conditions; improved use of preventive services; and closure of gaps in social care, such as overcoming language barriers, transportation access, securing housing, etc. Achieving outcomes will not only improve the health of our members and community but also contribute to good stewardship of State resources.

c. Outreach and Education

Mercy Care's **TECHNOLOGY-ENABLED TARGETED OUTREACH AND EDUCATION INITIATIVE** contributes to improved health outcomes for members with an SMI designation by connecting with them on a personalized level to close gaps in care. The targeted outreach campaign uses technology, data science, and behavioral insights to prompt members to take action regarding their health. These tools help determine a custom outreach approach for each member that is tailored to how they want to receive information (e.g., text message, email, interactive voice response [IVR], or phone call) and what type of message content will resonate with them.

Identifying an opportunity: Through review of our quality data, Mercy Care's Quality Management department identified underperformance in several clinical performance measures for RBHA members, including postpartum care, flu vaccination rates, and follow-up visits after hospitalization (for adults). We identified a need to improve outreach and education for members with SMI to close gaps in care, and owing to the impact of the COVID-19 public health emergency, we determined that a digital campaign would be beneficial to assist members with SMI to access needed health care resources and services.

Initiative: Mercy Care contracted with Icario, a nationally recognized leader in health care digital outreach, to create and perform targeted outreach campaigns based on the identified underperformance on key measures previously described. Icario has proven success in multiple Medicaid markets in improving engagement in preventive care, closing gaps in care, improving quality scores, and increasing member satisfaction, including for hard-to-reach members.[1] Mercy Care provides Icario with available data (e.g., phone numbers and email addresses) for members with gaps in care. Icario combines Mercy Care member data with publicly available data and applies proprietary behavioral research and data analysis to create a personal profile for each RBHA member. Icario identifies the best method to contact each member and the type of message that is most likely to result in modified health behavior. For each campaign, Icario designed a diverse set of messages, websites, and educational materials. Icario created multiple text messages, emails, and IVR messages for members based on their personal profile and offered them in their preferred language (e.g., Arabic, English, Spanish, and Vietnamese). Icario runs readability analysis on all messages to ensure they are at or below a sixth-grade reading level. Messages in the postpartum care program include the following: "Congratulations on the new addition to your family! Your new baby's health is a top priority. But remember that your health is important, too" and "Your doctor can answer your questions, connect you to resources, and give you peace of mind during this special time." All text messages and emails contain a link to a Mercy Care micro-website with additional information and resources, such as the Member Services call center numbers and the online provider directory. For all outreach channels, if the member indicates they are not planning to schedule the service they need, they can indicate the reason and receive education on the topic. For example, if a member indicates they do not intend to get a prenatal care visit because they are worried it will be expensive, they receive the following message: "As a Medicaid member, you won't pay anything for this visit. It's covered with no additional cost to you. That's how important we believe this visit can be." In 2021, Mercy Care is continuing this initiative for members with SMI, working with Icario to create trauma-informed campaigns to improve cervical cancer screening, chlamydia screening, and postpartum care rates, which we have identified as areas for improvement for members designated with an SMI. We are also augmenting the program so members not engaged by Icario receive outreach by our Care Management team to provide education and assist with connection to services.

Impact: Through this initiative, Mercy Care outreached over 23,500 members with SMI across all campaigns, with positive results. For example, of eligible women with SMI engaged by Icario, 31 percent indicated they would take action to get postpartum care. This rate exceeded the rate for AHCCCS Complete Care members by 24 percent, indicating our technology-enabled targeted outreach and education initiative is effective for members with SMI. This initiative contributed to a 112 percent increase in postpartum care for members with SMI (59.9 percent in 2020 versus 28.2 percent in 2018).

[1] Icario, Case Studies: accessed September 25, 2021; https://icariohealth.com/case-study/

d. Stakeholder Input

To reduce avoidable police involvement and improve access to timely BH treatment for individuals during a mental health crisis, Mercy Care established a COLLABORATIVE DISPATCH AND COMMUNICATION INITIATIVE with the Phoenix Police Department (PPD) and Solari Crisis and Human Services (Solari). Research finds that individuals with an SMI are more than 50 percent more likely of being arrested in encounters with law enforcement than other citizens.[2] When police respond to a 911 call that could otherwise have been handled by a crisis responder, individuals with an SMI can unnecessarily end up incarcerated, delaying their access to needed mental health treatment. We established a program, in collaboration with Solari, to train the staff at PPD dispatch centers to divert calls related to mental health crisis to Solari and assisted PPD in updating its dispatch and communications policies to support transferring 911 calls to the crisis center.

> In 2018, Mercy Care trained all 250 of PPD communications staff in crisis services, mental health and psychiatric disorders, and crisis intervention.

Identifying a need: Since becoming the RBHA in 2014, Mercy Care has continuously solicited and received stakeholder input related to the interaction of individuals with SMI and public safety departments. Through feedback provided by members, families, advocacy groups, participation in PPD committees and workgroups, and the findings of the 2019 National Police Foundation Report, Mercy Care identified the importance of increasing proactive connection of individuals experiencing a BH crisis to BH services instead of engaging public safety personnel.

Initiative: Recognizing that an estimated 20 percent of calls to 911 involve mental health or substance use disorder concerns, we built upon the training Mercy Care provided to PPD communications personnel in 2018 to enhance processes for transferring calls directly to the crisis line where appropriate and when a law enforcement officer is not necessary. Mercy Care participated in 14 planning sessions with PPD and Solari to design a collaborative dispatch and communication initiative. Through February and March 2019, Mercy Care coordinated with PPD and Solari to roll out a new dispatcher training, with follow-up training in March 2020 to increase the appropriate diversion of 911 calls to Solari. PPD revised its policies in early 2021 to support 911 call diversion to the crisis line. Mercy Care regularly shares data about this initiative and solicits stakeholder input at monthly PPD Crisis Intervention Team trainings, Crisis Community Collaborative meetings, and Crisis Services and Public Safety workgroup meetings. We use this feedback to identify opportunities for refinement in the 911 call diversion process. This initiative, a precursor to the 988 crisis line, aligns with the International Association of Chiefs of Police One Mind Pledge of ensuring successful interactions between police and persons with SMI.

Impact: Our collaborative dispatch and communication initiative has resulted in system change. Now, 911 dispatchers relay calls to a Solari specialist instead of first dispatching an officer for the many calls that do not require police intervention, where safety is not a concern, and an on-scene response may not be needed. In 2019, there was an average of 454 calls per month diverted to the crisis line by PPD. This increased to an average of 484 in 2020 and 576 in 2021 (January through June), representing a 26.9 percent increase for 2021 year-to-date over 2019. To replicate the program's success, the city of Mesa implemented the same approach within their 911 call center and have been diverting an average of 78 calls per month to the crisis line since January 2019. Based on the disproportionate likelihood of arrest for individuals with SMI during a police encounter, diversion of 911 calls to Solari is likely to prevent avoidable arrest and potentially inappropriate jail placement of individuals with an SMI designation experiencing a mental health crisis. Response by crisis experts provides more timely evaluation and treatment for BH issues, including getting individuals evaluated for an SMI designation if they do not have one. This program has been HIGHLIGHTED AS A UNIQUE APPROACH TO REDUCE POLICE INVOLVEMENT IN CRISIS CALLS BY THE VERA INSTITUTE OF JUSTICE.

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[2] Hall, D., Lee, L.W., Manseau, M.W., Pope, L., Watson, A.C., and Compton, M.T., "Major Mental Illness as a Risk Factor for Incarceration," Psychiatric Services, 70(12), 1088-1093 (2019): accessed August 31, 2021; https://doi.org/10.1176/appi.ps.201800425

e. Justice System/Justice-Involved Individuals

Mercy Care created a **FORENSIC** ACT **(F/ACT) INITIATIVE** to improve whole-person outcomes (e.g., increasing access to PH services to address chronic conditions and addressing SDOH) and better meet the justice-related needs of individuals with SMI experiencing justice involvement and requiring an ACT level of care to do the following: 1) refine criteria for participation in F/ACT; 2) increase collaboration with justice system partners to identify members who would benefit from F/ACT; 3) expand access to F/ACT teams; and 4) increase fidelity to the F/ACT model.

In 2017, Mercy was awarded the Institute for Medicaid Innovation's Most Innovative Medicaid Managed Care Best Practice and Best in Behavioral Health awards for our F/ACT program. SAMHSA invited Mercy Care to serve on a panel in 2018 to present our F/ACT collaboration with justice partners.

Identifying a need: Through feedback with justice system stakeholders, findings in Mercer's Service Capacity Assessment reports, and review of internal data, Mercy Care identified that standard ACT teams or the existing F/ACT team were not meeting the unique needs of individuals with SMI involved with the justice system. We recognized that criteria for referral and participation in F/ACT needed to include an assessment of criminogenic needs and the risk of recidivism. Mercy Care also identified the need for forensic peers who have experience with criminal justice and recovery to provide both members with SMI and F/ACT team staff with the unique perspective success beyond justice involvement.

Initiative: The F/ACT initiative incorporates the following improvements in the delivery of F/ACT services:

- **Refining criteria for participation in F/ACT:** Mercy Care established criteria to identify individuals meeting the threshold for ACT-level service who would be better served by a F/ACT team: a risk recidivism score of 3 or above as identified by the Maricopa County Sheriff's Office at the time of booking; an Offender Screening Tool recidivism risk score of medium or above identified by the Maricopa County Adult Probation Department; or release from the Arizona Department of Corrections, Rehabilitation, and Reentry after two years of incarceration.
- **Increasing collaboration with the justice system:** Our justice liaisons collaborate with Arizona Department of Corrections and county probation departments to identify members leaving incarceration to coordinate release planning and make referrals to F/ACT.
- **Expanding access to F/ACT teams:** Mercy Care added two additional teams and restructured the preexisting F/ACT team to improve fidelity to evidence-based practices established with our justice partners and added PCP partnership to address members' PH needs.
- **Providing F/ACT services with fidelity:** Since 2014, Mercy Care has engaged the Western Interstate Commission for Higher Education to evaluate all F/ACT teams to fidelity, using findings for continuous improvement, which has resulted in above an 80 percent fidelity average. We will continue this process to ensure fidelity to the model.

"The Adult Probation Department of the Judicial Branch of Arizona in Maricopa County has numerous ongoing collaborations with Mercy Care. Of those, one of the most impactful partnerships is the F/ACT program."

—Jason Walker, Chief of Specialized Services, Maricopa County, Adult Probation

Impact: F/ACT members are doing better on probation than their non-SMI counterparts; 75 percent of F/ACT members successfully completed probation compared to a 54 percent success rate of the general population with similar risk scores assigned to intensive probation supervision. Other key whole-person outcomes for the F/ACT initiative are provided in **Table B6.1** (for homelessness, a decrease in percentage is a positive outcome).

Table B6.1: Mercy Care F/ACT Outcomes

Measure	F/ACT Team 1			F/ACT Team 2			F/ACT Team 3		
	2016	2019	Change	2016	2019	Change	2018	2019	Change
Access to PH Services	71.8%	97.0%	35.2%	76.5%	90.0%	17.6%	97.0%	98.0%	1.0%
Employment	1.1%	6.0%	443.5%	0.0%	18.0%	N/A	3.0%	7.0%	133.3%
Homelessness	11.9%	0.2%	-98.1%	4.5%	0.3%	-93.3%	5.0%	0.3%	-94.1%

f. Court Ordered Treatment (COT) including Court Ordered Evaluation (COE)

In 2018, Mercy Care implemented our 'NO WRONG DOOR' PRE-PETITION SCREENING APPLICATION INITIATIVE to improve COE- and COT-related outcomes for both RBHA members and the general population of Maricopa County. In our 'no wrong door' process, if an application is determined to be non-emergent, the crisis facility completes a warm handoff, forwarding the application directly to La Frontera-EMPACT Suicide Prevention Center (EMPACT), a screening agency, if not currently enrolled in SMI services, or to the Mercy Care adult court liaison for enrolled members. This initiative exceeds the requirements related to COT/COE (Arizona Revised Statutes, Title 36, Chapter 5 Articles 4 and 5 and Arizona Administrative Code, Title 9, Chapter 21, Article 5).

Identifying a need: Based on feedback from family advocates, we learned people with debilitating mental health symptoms who needed treatment faced barriers in receiving COE services due to the bifurcation of the application process. In the previous COE process, when an applicant presented to a crisis facility to apply for emergency admission, and if the admitting officer did not deem the proposed patient to be an immediate danger to self or others, the crisis facility would not complete the application for COE. Instead, the applicant was directed to a crisis line or EMPACT. The applicant was tasked with calling EMPACT, leaving a phone message, and attempting to arrange for a time to meet with EMPACT staff in person to complete the application for COE. Then, EMPACT would move forward with pre-petition screening. This created confusion for family members, case managers, and others in the community. We identified the need to establish a 'no wrong door' approach for pre-petition screening to minimize delays and duplication.

Initiative: In our 'no wrong door' pre-petition screening application initiative, staff at crisis facilities assist with timely access to non-emergent pre-petition screening by collaborating with pre-petition screening agencies to conduct a warm handoff for appropriate applicants. Crisis facility staff provide psychosocial support to applicants and help them to understand the pre-petition screening, COE, and COT processes. Crisis facility staff send an electronic copy of the completed and notarized application to the pre-petition screening agency. Screening agency staff schedule a meeting with the proposed patient and complete the pre-petition screening. The pre-petition screening agency reaches out to the applicant to provide updates, but inability to reach the applicant does not result in delay of the process. Our adult court liaison works together with the assigned pre-petition screening agency (health home or EMPACT) to ensure they understand the process and that tight pre-petition screening timeframes are met. This change reduces confusion on the part of the applicant and eliminates delays inherent in having the applicant navigate the non-emergency process on their own. Mercy Care's updated and streamlined pre-petition screening process is part of the nationally recognized 'no wrong door' crisis system we oversee in Maricopa County that promotes evidence-based, best practice care and provider partnerships. We will leverage this experience in Pinal and Gila counties where administration includes coordinating with the county and providers who perform pre-petition screening and COE services. We will build relationships with providers, learn about the unique COE/COT system needs, and collaboratively develop strategies to enhance COE and COT service provision.

Impact: Improvements to the 'no wrong door' pre-petition screening application initiative result in a more efficient process for applicants and pre-petition screening agencies. Streamlining this process has improved the experience of an average of 300 applicants annually since 2018 who have benefited from a warm handoff, avoiding unnecessary delays or the need to repeat steps in the pre-petition screening process.

Thomas (not his real name) had not bathed in seven weeks and was displaying increasingly aggressive but not dangerous behavior. His parents went to a community psychiatric emergency center (CPEC) and the CPEC staff assisted them in completing an application for COE. CPEC completed a warm handoff of the application to EMPACT. The EMPACT team met Thomas' parents in person and went to their home twice to complete a pre-petition screening with Thomas but could not locate him. The EMPACT team filed a petition for COE, which was accepted, resulting in a detention order. The police picked up Thomas without incident and took him to CPEC. Thomas was referred to a health home for an SMI evaluation and a petition for COT was completed. Thomas received an SMI designation during his IP stay and began engaging in services. He is now employed and has increased his social relationships.

g. Dually Aligned (Medicare and Medicaid) Members

Our **MERCY WHOLE HEALTH INITIATIVE** targets the opportunity to better align Medicare and Medicaid benefits in an integrated care delivery system to improve health outcomes for dual-eligible individuals with an SMI designation. Mercy Care's dual-eligible special needs plan model of care identifies individuals with SMI as a highly vulnerable subpopulation and identifies specific services and supports they need to meet their PH, BH, social, and functional needs. For example, dually eligible members may use Medicare benefits for nursing facility services but transition to Medicaid-funded personal assistance and housing supports when their condition improves, allowing for a return to their home or community-based setting. Coordination of Medicare and Medicaid benefits requires sophisticated information collection and sharing. Our easy-to-use, mobile-friendly, interactive Mercy Care Connect application will enhance the member and provider experience.

Identifying a need: The Contract Year Ending 2020 External Quality Review Annual Report for RBHAs states that for dual-eligible members, "navigating these two separate systems of care can be overwhelming....inefficient care is provided, and optimal health outcomes are not achieved." To improve member outcomes, Mercy Care identified the need to better coordinate benefits across the member's entire care team.

Initiative: Serving over 1,500 members with an SMI designation who are dually eligible, we understand the importance of improved coordination of Medicare and Medicaid benefits and decreased health care fragmentation to improve health outcomes and address whole-person needs. In our Mercy Whole Health initiative, Mercy Care is deploying **Mercy Care Connect**, a system application that aggregates all available data related to member care into a single source of truth for member information. The portal includes the capabilities and mechanisms to give members and/or their health care decision-maker and their entire care team (e.g., their care manager, PCP, specialists, pharmacist, and other providers) convenient access to the following Medicare and Medicaid information and functions in a web-based portal:

- Care management assessments, including SDOH
- A unified care plan, individual service plan, and medication list
- Prior authorization and claims information
- Two-way communication capabilities
- Preventive care reminders
- Connection to telehealth services through participating integrated health providers
- Linkage to non-emergency transportation vendor services, with dialing capabilities
- EHR and HIE data
- Health resources (e.g., health education materials and self-management tools)
- Member enrollment and benefits information
- Social resource referrals via Aunt Bertha and NowPow

Mercy Care will provide information to members/health care decision-makers on the benefits of the portal and how to use it through a variety of mechanisms, including the member handbook, contact with Member Services, or their care manager. Our care managers will educate members, providers, and health home case managers about the portal through interdisciplinary care team meetings to encourage collaboration. We will use the Member Advisory Committee to learn about the member's experience with the portal and identify ways to improve its functionality and utility.

Impact: Improving access to comprehensive member information in one platform, the Mercy Whole Health initiative will address fragmentation in the health care delivery system for dual-eligible members with SMI. It will increase access to information for both members and providers, resulting in improved coordination of Medicare and Medicaid benefits to address the member's whole-person needs. Our goals for the deployment of this attractive and easy-to-use tool are to better serve dual-eligible members using shared care planning documents, making sure services provided are aligned with members' treatment goals and are not duplicative, and ensuring better quality of care. We anticipate claims and utilization data to demonstrate improved access to care, increased use of preventive care, decreased use of inpatient and ED services, and decreased hospital readmission. By accomplishing these goals, we also expect the following outcomes: increased use of special supplemental benefits such as rental support or general supports for living (per 42 CFR 422.102(f)) and increased member use of self-management tools (e.g., Pyx Health) and social resources.

B7. AHCCCS expects contractors to continually strive to improve the system of care for individuals …

Our members have the right to high-quality, accessible, integrated, culturally appropriate care and deserve a system that will continually evolve and improve to meet their needs. Mercy Care is committed to continuous quality improvement in the system of care. Our strategies are based on member input, population health management with special attention to improving individual member outcomes, strengthening access to the full continuum of care through a multivariate delivery model, and maximizing member and family engagement.

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

Opportunity for improvement: Our data shows our highest risk members (not including assertive community treatment [ACT]) have complex physical and behavioral health (BH) comorbidities and use avoidable services at crisis facilities, emergency departments (EDs), and hospitals. These members comprise about 8 percent of our SMI population. To advance an enhanced integrated care model and improve outcomes, we will implement a new model of care, launch an integrated accountable care organization (ACO), and invest in workforce development.

New model of integrated care: We created a new care model in 2021 to engage members with SMI in preventive, clinical, and support services anywhere they want to receive care. This could include in-office, at home, virtual care only, and hybrid care (virtual and in-person services). We identify members through our risk stratification tool, which aggregates data composed of utilization, care engagement, projected future risk, social determinants, and clinical diagnoses. Once identified, members receive a new **intensive level** of case management support at the health home (HH). The intensive level of care falls between the current ACT and supportive levels of care. The HH intensive level case manager is a licensed clinician, supported by a team of peer support, rehabilitation specialists, nurses, prescribers, and others as needed. At the intensive level, members are matched with a **Mercy Care care manager, who is embedded in the HH** to coordinate care. Everyone on the care team, including the member, participates in person-centered, culturally responsive treatment planning based on each member's unique needs/preferences. Prior to enrollment in the pilot, the initial 643 members selected had a total of 1,472 crisis events, 635 inpatient (IP) admissions, and 1,646 ED visits over a 12-month period. During the first 6 months of the pilot, members experienced a **42 percent reduction in crisis service utilization, a 42 percent reduction in IP admissions, a 10 percent reduction in ED visits**, and a **31 percent reduction in overall cost**. Additionally, **PCP visits increased by 62 percent**. As a result of these initial outcomes, we will expand this care model to all HHs for members with SMI.

Improving coordination of care: In January 2022, Mercy Care will launch an **integrated ACO** called **ONEcareAZ.** ONEcareAZ is a unique collaboration of our HH providers. It is designed to improve standards of care, access, and quality and care coordination for members with complex physical health (PH), BH, and social needs. ONEcareAZ is a technology-enabled network of existing outpatient, IP, crisis, BH, primary care, and social service providers. The network will launch with 15,000 members with SMI. ONEcareAZ will use a shared referral and care coordination platform that crosswalks member needs to providers with matching capabilities, including the capacity to meet any unique and diverse cultural needs while maximizing engagement. ONEcareAZ will establish common screening and risk management protocols to ensure high-risk members are seen timely and receive the additional support they may need. As a result, ONEcareAZ will improve access to care and lower costs by coordinating services, facilitating transitions of care, and ensuring members receive timely, culturally responsive, and effective services from a multidisciplinary team. ONEcareAZ's platform also provides a mobile application for interested members with smartphones (text for others), which automatically conducts regular check-ins, provides disease education, allows for crisis response, and offers connection to a care team portal with shared plans and tasks. Further, Mercy Care will advance efforts to improve member outcomes using a value-based contracting approach with targeted health and social determinant performance measures that drive member health improvements, such as increasing quarterly BH medical provider visits and follow-up after hospitalization rates.

Workforce development—customized training: Customized training is necessary to support a skilled workforce caring for members with SMI. Based on member, provider, and stakeholder feedback, this training will highlight the impact of trauma and a trauma-informed approach as a key component in ongoing workforce development. To accomplish this,

Mercy Care will implement the Adverse Childhood Experiences (ACEs) Interface train-the-trainer model, inclusive of unique cultural perspectives of our members such as American Indian/Alaska Natives (AI/AN). We will require clinical staff who complete assessments to be trained on ACEs, and have ACE scores included in the evaluation of treatment needs. We will also provide access to training on secondary trauma to mitigate its effects for service providers. To promote workforce knowledge of integrated care service delivery across BH and PH providers, Mercy Care will continue to offer provider training through our HH toolkit, and a train-the-trainer curriculum focused on clinical/operational knowledge and skills in the delivery of integrated care. Our PH provider training includes BH screenings, covered services, navigating the health care system, and how to obtain added support from Mercy Care. Mercy Care will also be launching a collaborative, educational opportunity with **HonorHealth's Academic Affairs and Arizona State University**, which will include the following:

- Use of data analysis to identify high-needs/high-cost, complex populations affected by mental illness
- Expanded educational programs to include learning tracks for this population (e.g., forensic psychiatry)
- Expanded clinical rotations and training for medical, nursing, and BH staff serving members in community settings by convening partnerships with education programs for medical/allied health residency programs
- Support of practice transformation using evidence-based approaches (e.g., telehealth, care coordination, population health, technology)
- Enhanced caregiver support by providing resiliency training and care options to prevent burnout

b. Co-occurring SMI/SUD Service Delivery

Opportunity for improvement: Our data from the most recent 12 months indicates 43.2 percent of members with an SMI designation have at least 1 substance use disorder (SUD) and are 2.6 times more likely to have ED encounters, 6.1 times more likely to have IP BH admissions, and 7.3 times more likely to experience a crisis episode, compared to members without a co-occurring SUD. Our strategy includes development of complexity-capable programs, strategies to promote services for members/families, use of peer support specialists, and promotion of the AHCCCS treatment locator with members and providers. The objective is to ensure accurate assessment; culturally responsive, recovery-based, and comprehensive programs; and increased access to co-occurring services.

Implementation of evidence-based best practices: To improve treatment outcomes, we will promote best practice assessment and level of care placement through continued implementation of the AZ-Web Infrastructure for Treatment Systems and American Society of Addiction Medicine (ASAM) Continuum project and promote the evidence-based practice (EBP) **Integrated Dual Disorder Treatment (IDDT)**. The ASAM Continuum project will be implemented by October 1, 2022 and will continue to monitor through provider oversight, technical assistance, training, and ongoing monitoring. Additionally, **IDDT** will be available to all members through HHs and will be monitored for fidelity practices.
Expansion of complexity-capable programs: **Complexity-capable programs** address holistic needs, including co-occurring and medical conditions, social determinants, and justice involvement. We will expand these, aligning with the SAMHSA EBP. We will pair supported employment (SE) providers with BH residential providers to enable discharge planning to help members in obtaining meaningful vocations and employment goals. We will continue to expand **opioid treatment programs** (OTPs) based on need and in accordance with AMPM 660 based on hotspot data of opioid utilization and member diagnosis and partner with tribal communities that received Tribal Opioid Response Grant funding. We will offer **intensive treatment service** as an HH for members with SMI and we will add medication-assisted treatment (MAT) to each of our existing HH provider locations. For rural and frontier areas, we will collaborate with correctional agencies to leverage discretionary State opioid funding to promote solutions that improve timely access to care, including **OTP mobile vans**. In Gila and Pinal counties, we will collaborate with providers to add services that include full ambulatory detoxification services, BH crisis stabilization in residential facilities, and post-discharge peer navigation services. To address the connection between pain management and opioid use, Mercy Care offers two designated **Center of Excellence (COE)** programs for integrated pain management for adults with chronic pain. Care managers will engage members based on preferences and needs to connect and offer education about the benefits of COEs' non-pharmacological approaches to chronic pain.

c. Improving Access to Evidence-based OP BH Services and the Delivery System Framework to Access Meaningful Services

Opportunity for improvement: Our data shows that 5 percent of members with SMI had more than 10 crisis visits in a 1-year period. Based on 2 years of recent claims data, up to 4,654 individuals experienced a psychotic episode and could benefit from a first episode of psychosis (FEP) program. Of eligible members, 42.2 percent have at least 1 claim during the past 12 months with a principal or secondary diagnosis of trauma-related disorders. Our strategy to address these opportunities includes population-specific programs, expanding available EBP, and fidelity monitoring of EBP programs.

Population-specific programs: Wherever appropriate, we will provide information on the benefits and connect members to HHs. In 2022, we will offer a HH on the campus of **Connections Health Solutions Urgent Psychiatric Center**, which will immediately assist members accessing the crisis system as a point of entry for care. We have launched and will expand a new mobile community-based HH option with **Spectrum Healthcare**, which dispatches a multidisciplinary, bilingual team and provides care in the member's preferred location. Members can choose from a continuum of in-person or virtual services. If the member chooses virtual services, Spectrum's team provides technical support to enable members to use devices, connect to internet for service delivery, and use applications, delivering the technology to support 24/7/365 telehealth capability as needed. In collaboration with the Arizona Department of Corrections, Rehabilitation, and Reentry, we continue to offer **forensic peer support** to facilitate pre-release contact and enhance coordination of care and member engagement. We will leverage existing relationships with Pinal County courts and the Gila County BH criminal justice collaborative through outreach and collaborate to expand both justice programs, based on community need.

Expanding EBP and best practice programs and monitoring fidelity: We will leverage our success improving access and fidelity monitoring under Arnold v. Sarn and expand the four SAMHSA EBPs—ACT, permanent supportive housing, SE, and Consumer Operated Services (peer and family)—to Pinal and Gila counties. We will also add an additional FEP location in the East Valley with Valleywise Health and will continue to monitor all FEP programs for fidelity using annual internal fidelity reviews based on the National Institute of Mental Health Coordinated Specialty Care model fidelity recommendations. Mercy Care will expand our required general **trauma-informed care (TIC)** to all direct care providers to include training on using ACEs in the assessment process. For a true TIC approach, our trainings include indigenous perspectives and cultural sensitivity, ensuring all perspectives of health are honored. As a key partner in AHCCCS' Zero Suicide Task Force, we will continue to offer Applied Suicide Intervention Skills training and safeTALK (Suicide Alertness for Everyone) in Maricopa County and expand this training to Pinal and Gila counties. Lastly, we will build on our current environmental scan process to monitor our network for available EBP and best practices by conducting quality improvement evaluations of fidelity to these practices.

d. Ensuring Equitable Health Care and Eliminating Existing Disparities

Opportunity for improvement: Mercy Care has an established cultural competency plan that drives our strategy for ensuring equitable health care and eliminating disparities for our members. Our strategy includes comprehensive data analytics and culturally responsive, best practice care. To enhance our health equities dashboard, there is an opportunity to refine current data capabilities of utilization review; race, ethnicity, language, and disability data; HEDIS® outcomes; grievance and appeals trends; physician profiling trend reports; and data from the Arizona HIE. Based on SAMHSA data, utilization of BH services was lower among non-Hispanic Black adults (57.9 percent) and Hispanic adults (52.8 percent) compared to non-Hispanic Whites (70.5 percent).[1] In review of our ED data, there are higher incidences of annual ED

[1]Elinore F. McCance-Katz, MD, PhD, "The National Survey on Drug Use and Health 2019": accessed September 25, 2021; https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf

visits for AI/AN males (4.96 visits), Hispanic females (4.0 visits), and Black males (3.52) compared to White females (3.3 visits) and White males (3.2 visits).

Continued efforts to refine data through partnership with Socially Determined (SD): Mercy Care is collaborating with SD to identify risk, quantify opportunities, prioritize action, and measure impact at the individual level, and analyze social risk across the following domains: financial strain, food insecurity, housing instability, health literacy challenges, and transportation barriers. SD supports our evaluation of quality gaps using data related to social determinants of health (SDOH), geography, member-specific claims, chronic diseases, COVID-19 vulnerability, race, and ethnicity data to design, deploy, and evaluate solutions to mitigate risk and advance health equity and social justice for members with SMI. Using this analysis, we will continue to implement specific programs with compensable Medicaid services and non-compensable services funded through partnerships with municipalities, other entities, and community reinvestment including the following:

Connecting members to services – **support through peer navigators and community health workers (CHWs):** In partnership with CommonSpirit Health, Mercy Care will advance efforts to provide culturally appropriate member outreach and engagement through its **Pathways Community Hub (PCH)**. The PCH is an integrated model that utilizes CHWs to connect members to neighborhood resources addressing SDOH and clinical needs through 21 different pathways. Recognizing the growing need for navigation across a complex health care system, Mercy Care will collaborate with community colleges such as Scottsdale Community College to support a CHW certificate of completion, offer scholarships, and provide on-the-job, practical experience.

Offering customized support based on community disparities: In 2022, in partnership with CVS Health, we will make targeted service dollar investments to **Health Zones** in Arizona's highest-need communities as identified through SDOH data, assessing their impact over a five-year period. In 2023, Mercy Care and Valle del Sol—an FQHC and leader in culturally competent, whole-person care—will establish a **Community Resource Center** to offer tailored services to local Hispanic residents such as broadband, a telehealth hotspot, supported by a licensed practical nurse and bilingual navigators to connect members to social services.

Addressing women who are pregnant and experiencing health disparities through best practice care: Nearly one-third of our pregnant members with SMI experienced perinatal complications, such as gestational diabetes, hypertension, or preeclampsia, and 2 percent had a SUD. Improving health disparities in maternal health remains a priority in advancing health outcomes. Our program with **Alium Health** will expand to include MAT and short-term childcare services allowing moms to attend counseling and obstetrics appointments. Registered dietitians support specialized nutritional counseling and **Mom's Meals** provides home-delivered meals for members on bed rest or experiencing gestational diabetes, hyperemesis, and preeclampsia. Outcomes for Mom's Meals in other markets demonstrate a 41 percent decline in premature birth, and 38 percent experienced improved blood sugar control. Members with SDOH needs are also provided support like home repairs, utility assistance, rental assistance, and baby safety products such as diapers, wipes, car seats, and infant formula. Mercy Care will further expand the program in collaboration with the CHEEERS Doula program to include peer support, in-home services, online and in-person parenting classes, newborn care, post-partum support, and life skills development.

Addressing the needs of members experiencing homelessness: Each night in Maricopa County, between 7,000-8,000 people experience homelessness—and homelessness is one of our top five Z-Code diagnoses. According to the Maricopa County Race and Homelessness Report of 2021, people of color are more likely to return to homelessness, with African Americans experiencing homelessness at 3.9 times the rate of the general population and AI/AN more than twice the general population. Through the Non-Title, Non-Encounter Plan, Mercy Care funds the use of the Homeless Management Information System, enabling HHs to connect members to housing services and resources. Mercy Care is also funding a new partnership with **Cloud Covered Streets (CCS)**, a mobile trailer that will offer showers, clothing, haircuts, and laundry accessibility for members experiencing homelessness. CCS hires those experiencing homelessness to help operate the trailer for a two-month period while they assist in securing them employment. Point-in-time count

data will be leveraged to ensure CCS is available in all Central GSAs where there is the greatest need, and we will collaborate with the Continuum of Care Board to obtain race and ethnicity data in working to address equity for those experiencing homelessness.

Social isolation: In alignment with AHCCCS and Arizona Department of Health Services' social connectedness campaign, we will implement a Social Isolation Task Force to address the impact of loneliness, which has been shown to increase risk of depression, anxiety, substance use, and poor health outcomes. This task force will bring members, providers, and community stakeholders together to examine member needs, current policies, and programs, and have conversations around addressing and reversing the impact of loneliness.

e. Maximizing Member Engagement through Technology

Opportunity for improvement: The COVID-19 pandemic highlighted the need for reliable access to technology to assist members in getting information and access to care via telehealth services. With the distribution of tablets and phone/data cards, Mercy Care experienced a **21 percent increase in visits to our website** since January 2020; an increase in Facebook, Twitter, LinkedIn, and Instagram followers in comparison to prior years; and more members were engaged in community listening sessions held on virtual platforms by our Office of Individual and Family Affairs team. Our opportunities include increasing access to and comfort with technology, continuing targeted outreach and health promotion, and enhancing self-management and self-determination.

Device acquisition and usage support: We will continue efforts that promote device acquisition and usage by building on our existing strategies. To address the inequities with access to devices, we redirected $44,000 in community reinvestment funds to 12 HHs for members with SMI to purchase phone cards, make calls, connect with loved ones, and get virtual appointment access in 2020. Through our Non-Title Plan, we funded CHEEERS, Copa Health, and Terros Health to purchase and distribute over 1,700 tablets and provide training in their use. We saw a telehealth increase of 208 percent between April 2020 and March 2021, over 2019. Mercy Care also is providing electronic **blood pressure cuffs** and training on use to help members achieve health goals for Copa Health members in their HHs and on ACT/Medical-ACT teams. Mercy Care will continue to facilitate member enrollment in the federal Lifeline subsidized cell phone program for low-income households through Assurance Wireless. We will continue to partner with peer-run organizations to help increase members' access and comfort with using technology.

> "Initially, I struggled using the technology … my team helped me get access to an iPad [and] walked me through getting signed into email, installing Zoom … my coach and I have added some new computer skills to my resume. Now that I am comfortable using Zoom, my coaches have helped me connect to online groups, and my depression levels have decreased."
>
> —Mercy Care member

Data-driven, customized engagement, and member education: Mercy Care supports members' educational needs by updating information about whole-person health needs on an ongoing basis, and sharing information across multiple digital platforms (e.g., Mercy Care website available in Spanish, Arabic, and Vietnamese), and social media (Instagram, Facebook), which concurrently creates an opportunity to engage members in preventive care. We offer programs that aid members to self-manage chronic conditions through text campaigns, interactive voice responses (IVRs), emails, etc. We will continue to work with a **member engagement vendor**, Icario, to provide multimodal digital outreach programs, customized to each member (including their language preference, e.g., Spanish, Arabic, and Vietnamese) to use digital communication to increase members' likelihood to engage in their own health care and self-management. Icario's methods have been successful in engaging members using targeted preventive and episode closure service campaigns. From August of 2020 to January of 2021, we engaged **236,781 members to participate in health care actions**, which resulted in 63 percent member engagement with the Icario outreach across 5 metrics (i.e., flu shots, post-hospitalization follow-up, cervical cancer screening, chlamydia screening, and postpartum care). Mercy Care will continue to provide **tablets** and additional funding to improve, sustain, and increase access to telehealth appointments, peer and support group meetings, exercise, and other valuable resources including email, IVR, and text messaging outreach strategies.

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

As the incumbent RBHA, **we currently meet time and distance standards for 100 percent of members in the Central GSA**, far exceeding the minimum network adequacy standards required by ACOM 436. **Almost 5,000 Mercy Care RBHA members receive coordinated care through integrated models**. Our network of physical health (PH) and specialty providers, in addition to our foundational behavioral health (BH) network, engages in bidirectional coordination of care to offer services in the least restrictive setting. Our Network Development and Management Plan (NDMP) sets our priorities for proactive development and implementation of innovative network enhancements to meet the unique needs of members through holistic means and in alignment with member choice. We leverage data and feedback collected from and regarding members, providers, and stakeholders to guide our collaborative work with these partners to ensure a continuum of integrated, interactive, and well-coordinated service delivery and improved health outcomes across systems.

Network Adequacy and Ability to Serve Members with Complex or Special Health Care Needs

Mercy Care's comprehensive integrated provider network for the Central Region provides more than adequate network availability and accessibility for all our members, including those with complex or special health care needs, limited English proficiency, and cognitive or physical disabilities. Leveraging our statewide network, we have established sizeable integrated networks in Gila and Pinal counties, inclusive of an array of subspecialties, such as board-certified psychiatrists, addictionologists, and endocrinologists. We recognize the importance of delivering care in the least restrictive setting and offer services such as Spectrum Healthcare's Anywhere Care integrated in-home and mobile services; Copa Health's Terrace program at BridgeWater, which provides integrated health care in assisted living sites and supports members with SMI aged 55 and over who are otherwise at risk for homelessness or residential treatment; and Valleywise Health's first episode psychosis programs for adolescents and young adults. We continually project our anticipated member growth, and will strive to offer members extensive provider choice by offering contracts to all eligible Medicaid providers in Gila and Pinal counties with the aim to exceed time and distance standards for all new transitioning members on day one.

Monitoring and Addressing Gaps or Deficiencies

Our RBHA population and the needs of their communities change over time—and our Network Management department monitors network needs to anticipate, identify, and address gaps, recruit providers, and proactively develop network enhancements. Our NDMP is the roadmap for our network development strategy. We review it frequently to prioritize network enhancements based on the needs of our members and we monitor the plan to verify successful outcomes. Our team also collects and analyzes data including, but not limited to, the following: GeoAccess® and health service delivery reports; network inventory; workforce shortages and unexpected panel closures; emergency department utilization; provider appointment availability surveys and evaluation of physical accommodations; special health care needs report; SMI member proximity reports; provider performance; utilization of non-par providers; information received from Member Services and the Member Advisory Committee; feedback in provider visits and Provider Advisory Council meetings; stakeholder/first responder feedback; system of care dashboard metrics from internal SMI, crisis, tribal, Office of Individual and Family Affairs, and cultural competency representatives; and information from our Care Management and Grievance and Appeals teams.

While time, distance, and appointment timeliness standards do not apply to non-covered social services for social determinants of health, we do monitor access to these services and incorporate community- and member-level social determinants risk data provided by **Socially Determined**, as our findings may prompt development of relevant covered social services. We also review our **Provider Services Profile**, which captures providers' ability to offer culturally competent care, services in languages other than English, and BH super specialties. We are implementing this profile with PH providers in 2022 to more effectively monitor the cultural competency of our larger network. We are also developing tools to **analyze member service at the episodic level** over the course of a year; these utilization trends will further inform future network development.

Our Network Management team reviews all the data described daily and in monthly meetings and collaborates with our **Network Strategy and Sufficiency (NSS) workgroup—**which also provides information from several subcommittees that monitor various aspects of network adequacy—to develop recommendations, address gaps, and enhance the network. The Network Management team documents goals, defines the proposed timeline, and initiates contracting efforts to resolve the deficiency or to implement the recommended enhancement, reporting progress back to the NSS workgroup. The NSS workgroup is comprised of chief-level executive leadership members (clinical, operational, innovation, and financial), as well as administrator-level leadership from the Medical Management, Systems of Care, Value-Based Solutions, Provider Payment, and Network Relations teams. The workgroup meets bimonthly. The NSS is responsible for generating overall network strategy and monitoring the performance of the network against organizational priorities; regulatory requirements; strategic initiatives such as value-based rate enhancements, which consider providers' accessibility, use of technology, and advanced practices; market rules; and development and promotion of Centers of Excellence. Collectively, our Network Management team and NSS workgroup successfully enhanced the network to resolve gaps for members with complex or special health care needs through several network development initiatives including, but not limited to, the following:

- **Behavioral health residential facilities (BHRF):** To address BHRF bed shortages, we created a tool to identify and initiate contracting with all BHRF providers who were licensed with Arizona Department of Health Services, registered with AHCCCS, and not currently in our network. As a result, we added more than 45 new BHRF network providers, increasing bed capacity by over 200 beds and reducing the time from approval to placement. **We now exceed minimum time/distance standards for this service**. Our network includes BHRF specialization for polydipsia, eating disorders, and co-occurring disorders; we continue to assess for new specialty needs.
- **Telehealth services:** In response to the global COVID-19 pandemic, we expanded our existing telehealth services in a matter of weeks, allowing our members to maintain the same levels of care they were receiving prior to the pandemic. To support providers, we offered numerous webinars, resources, and one-on-one meetings to discuss changes to allowable billing codes and service delivery and offered technical assistance to providers who were new or inexperienced in using these service platforms. We also reallocated part of our Non-Title XIX Spend Plan to provide more than 1,700 tablets to members to promote the use of telehealth services. **Telehealth visits between April 2020 and March 2021 increased 208 percent as compared to all of 2019.**
- **Health homes for members with SMI:** Mercy Care continues to expand health home options for members with SMI. In addition to our traditional health homes, our members have access to integrated clinics, FQHCs, certified community BH clinics, BH homes, and primary care practices. Most recently, we added 3 SMI health homes in geographically convenient locations and expanded the number of assertive community treatment teams with PCP partnerships by 10.
- **Integrated pain management:** To address the opioid crisis and the need to offer service alternatives to address chronic pain, we contracted with Recovia to offer additional pain management services, inclusive of medication-assisted treatment and identification of Danger in Me and Safety in Me triggers.
- **Alium Health's Integrated Health Home for Women:** This integrated health home serves women and includes primary care, obstetrics/gynecology care, BH care, case management, support for postpartum or perinatal depression, and access to baby items and supplies as well as home-delivered meals during pregnancy.
- **New Freedom for justice-involved individuals:** This adult service provider offers intensive outpatient services with transitional living opportunities for members being released from the Department of Corrections. In partnership with Gold Canyon Heart & Home, they created a state-of-the-art BH campus to offer clinical supports, case management, employment skills, anger management, peer support, relapse prevention, budgeting skills, and family reunification to support members' community reintegration.

Based on our ongoing network monitoring activities, we have identified additional network enhancement opportunities and plan to implement the following programs:

- **ONEcareAZ:** Beginning January 2022, this integrated administrative care organization of health homes, outpatient BH providers, and primary care will collaborate to provide clinical and administrative services to improve health care quality and cost. They will offer technology to allow participants to update member profiles, access care navigator decision logic, receive real-time alerts from the HIE, and manage transitional care.
- **Community resource center (CRC):** In 2023, Mercy Care will establish a CRC to expand access to care and telemedicine for PH and BH in underserved geographies. In close collaboration with Valle del Sol—an FQHC and leader in culturally competent, whole-person care—CVS Health will provide a CRC inside a retail store in a high-need community, as identified through Socially Determined risk exposure data, Robert Wood Johnson Foundation health equity ZIP code analysis, and other metrics. The CRC will provide a tailored, one-stop-shop experience for local Hispanic residents using the CVS Pharmacy y más® brand with warmer and more personal customer service, meeting the member where they are. The CRC will deliver best-in-class integrated services in an environment that feels like home, with bilingual staff and signage throughout the store. It will also offer broadband and expand access to care through a telehealth hotspot supported by a licensed practical nurse.

Existing Relationships with Providers and Stakeholders

We seek input about our network from providers through a variety of meetings, provider forums, and trainings, as well as through ad hoc contracting discussions. Many of our provider partners, such as Community Bridges, Inc. (CBI), Horizon Health and Wellness, and Spectrum Healthcare operate integrated services in the Central Region and/or in Pinal and Gila counties. We attend meetings with stakeholders such as Pinal County Wellness, the Human Services Campus, the Arizona Department of Corrections, Rehabilitation & Reentry Services Administration, Adult Protective Services, federal, state, county, municipal, tribal, and private courts, jails, prisons, and detention centers, probation and pretrial service agencies, tribal nations, schools, advocacy groups such as the Alliance for the Chronically Mentally Ill and the National Alliance for the Mentally Ill, law enforcement, fire departments, and lawmakers to discuss the health of our network and align our collaboration with these entities according to all mandated stakeholder protocols. We engage in transparent, open discussion, facilitating cross-provider/stakeholder collaboration to identify network needs and develop, implement, and monitor progress of network programs to enhance coordination of care, confirm timely access to the broad continuum of Mercy Care services, and identify gaps where we need to strengthen the network. As a result of collaborative discussions with providers and stakeholders, we have developed new programs or expanded existing programs, and will continue to do so, including, but not limited to, the following:

Collaboration with Providers and Stakeholders to Expand Less Restrictive Services

"Mercy Care went beyond their commitments and became a statewide leader in focusing on post-crisis care by partnering with CBI, La Frontera/EMPACT, and the city of Phoenix in creating a peer-led navigation program for complex and chronically homeless members with SMI to have access to housing, have their social determinants of health addressed, and provide ongoing wraparound service, ultimately decreasing use of the crisis system and increasing use of behavioral health and primary care services."

—John Hogeboom
Chief Executive Officer, Community Bridges, Inc.

- To **enhance care coordination** efforts for members within the Arizona Care Network, we added health coaches to the virtual health home program for members with SMI; health coaches facilitate communication and coordination with and between PH and BH providers and provide coaching to members.
- Based on stakeholders/providers' **assessment of access to care** in rural areas of Gila/Pinal counties, we enhanced our non-emergency specialty transportation network by five providers.
- Based on feedback from Avondale police and fire departments, we expanded CBI's West Valley program.
- Based on feedback from crisis providers, **we strengthened the network** by adding outpatient services with ConnectionsAZ, CBI, and Recovery Innovations to provide injections, intravenous fluids, electrocardiograms, and urgent outpatient services, reducing the need for emergency department transfers.

B9. Describe the best practices of Arizona's crisis system. Describe how the Offeror will maintain …

No one expects to find themselves in a crisis. **Arizona's crisis system ensures there is a safety net to serve all in crisis regardless of health care coverage**. Arizona leads the nation in the delivery of crisis services providing for crisis telephone, mobile team response, and facility-based intervention. In Maricopa County and western Pinal County, Mercy Care operates a 'no wrong door' crisis system. Our crisis services can be accessed **anytime, anywhere, by anyone**. We understand that crisis is self-defined and that each event is unique. To best address the needs of each individual, Mercy Care follows the national **best practices** in the SAMHSA National Guidelines for Behavioral Health (BH) Crisis Care Best Practice Toolkit.[1] We use our Crisis360 approach, which is science- and research-based, to collaborate with crisis stakeholders and continually monitor and identify areas for improvement. The Crisis360 approach allows us to build upon existing strengths and further evolve a comprehensive, community-based crisis continuum. We will continue our work with stakeholders to refine primary objectives, actionable steps, and timelines to address crisis system needs for each community within the Central GSA. As illustrated in **Table B9.1**, we have deployed best-practice improvements in our existing crisis system.

> "Through Mercy Care's leadership, Maricopa County has evolved to the country's highest fidelity to SAMHSA's national guidelines."
>
> —Paul Galdys
> Lead writer for SAMHSA's National Guidelines for Behavioral Health Crisis Care

Table B9.1: Crisis Continuum Improvements 2014-2021

Arizona Crisis System	Mercy Care Crisis System Improvements
Crisis Telephone Services	• Introduced 4HOPE text and chat line with capacity to impact 129 texters per day • In the past 4 years, average speed to answer decreased by 57 percent and abandonment rate decreased to less than 1 percent, exceeding 3 percent requirement • Expanded peer-run warm line hours to 24/7/365 • 1,000 outpatient (OP) follow-up appointments scheduled with providers each month
Mobile Crisis Intervention Services	• Added real-time global positioning system tracking for more efficient dispatch by the crisis call center • Co-located mobile crisis teams at crisis facilities to improve collaboration • Mobile crisis teams dispatched at the same time as police • Feedback loop to schools with consent from parents/guardians, enhancing schools' ability to support ongoing needs
Facility-based Crisis Intervention Services	• Appropriate staffing, accepting all referrals with no upfront medical clearance • Average police drop-off times significantly under the AMPM 590 required 15 minutes: 1-2 minutes at community psychiatric emergency center, 2-4 minutes at recovery response center, and 9-10 minutes at urgent psychiatric center • Involuntary admissions that converted to voluntary status increased from an average 67 percent in 2018 to 75 percent in 2020, reflecting care that promotes peer engagement and supports member voice and choice • Decrease in hospital hold time by 8 percent from 2015-2021, with timely access to the right care • Peer navigator program that addresses health inequities such as homelessness • Launched a Human Trafficking Collaborative, creating a unique process where police can take a child to St. Luke's 23-hour observation unit for specialized assessment and referral

A true 'no wrong door' crisis system offers real-time, easily accessible, trauma-informed crisis services delivered by appropriate professionals that are available 24/7/365 and does not burden our public safety system. Our strong partnership with local, county, State, federal, and tribal law enforcement and first responders dates to 2014 and has

[1] "SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit": accessed September 26, 2021; https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

been recognized by national experts including the **Vera Institute of Justice**[2] and **Crisis Intervention Team (CIT) International.** We collaborate with all CIT programs in the Central GSA and achieved **national certification** by CIT International in March 2021. We have trained approximately **1,500 officers** since 2014.

Maintain and Drive Continued Improvement by Building on Strong Foundation

Crisis call center: Our current state includes continuous evaluation that crisis line services promote a true **'no wrong door' system**. On average, 17,000 calls come to the crisis call center each month and 90 percent of calls are resolved on the phone. Building on our partnership with Solari Crisis and Human Services (Solari), Phoenix police communication personnel, and city of Mesa police through training, transferring calls from 911 to the crisis line has increased year-over-year from **5,815 in 2019** to **6,936 in 2020**. We met with the city of Tempe on September 16, 2021, which is interested in a similar 911 transfer initiative. Our experience provides valuable feedback that our best-practice crisis system has the capability to handle 911 transfer calls, which we will leverage to prepare our community for the 988 national mental health resource implementation.

Mobile crisis intervention services: Our current state includes continuous evaluation that mobile crisis intervention service delivery is available to **anyone, anywhere, at any time**. We added 140 hours of mobile team availability to support faster response times, and continue to enhance specialty teams for children and individuals who have intellectual and developmental disabilities (I/DD). Our strong partnership with law enforcement is reflected in a current average response time of 34 minutes. We promote connection to community and ongoing resources, with our average **community stabilization rate** increased from 68 percent in 2015 to our highest rate in 2020 at 78 percent.
Facility-based crisis intervention services: Our current state includes continuous evaluation that facility-based crisis intervention service delivery accepts all referrals and ensures **quick first responder drop-off**. We identified the need to expand crisis facility services for children that provides families with options for timely, appropriate care outside of local emergency departments (EDs). Partnering with **MIND 24-7**, we now offer an additional specialized 23-hour crisis stabilization facility for **children**, which includes meeting with a BH medical professional within minutes of arrival, services for children with I/DD, and telehealth capabilities to facilitate assessments in schools, shelters, or group homes. For **adults**, we added an involuntary option at West Valley Access Point in Avondale.

Detailed Strategy to Drive Continued Improvements

We will comply with the AMPM BH Crisis Services and Care Coordination Policy (AMPM 590) and AHCCCS Administration Request for Proposal Section D, Program Requirements, and base future development of the BH crisis system on these requirements. As part of our Crisis360 approach, within 60 days of award, our **community outreach and engagement plan** is to respectfully approach established groups in each community, understanding that years of work and assessment have already resulted in a strong foundation for the Arizona crisis system. We will host and participate in community forums and ongoing work of sequential intercept mapping in Maricopa, Pinal, and Gila counties. Building upon our **crisis services provider training** that includes police culture, Nonviolent Crisis Intervention training, motivational interviewing, and trauma-informed care, we will schedule an initial meeting with crisis providers and other awarded contractors to create a single, statewide, competency-based training program within 60 days of award. We propose a program like Spectrum Healthcare's innovative workforce development approach, **Compassionate Care in Behavioral Health**, which builds upon the existing workforce, operates under BH professional/BH medical practitioner (BHMP) supervision, and offers specialized certification unique to Arizona's crisis system following completion of an 8- to 10-week course in partnership with local community colleges.

Crisis telephone services: Our objective to drive continued improvement is to jointly participate with other awarded contractors in selecting a single, statewide crisis phone line vendor that **advances real-time coordination** through partnership with crisis providers, OP providers, inpatient psychiatric facilities, EDs, and law enforcement to advance

[2] Beck, J., Rueland, M., and Pope, L., "Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses," Vera Institute of Justice: accessed September 26, 2021; www.vera.org/behavioral-health-crisis-alternatives

technology toward a crisis hub where each person experiencing a crisis is followed throughout the crisis continuum until connected to ongoing care. Actionable steps and timelines include 988 implementation by July 1, 2022, as well as completing outreach and extending invitations to collaborate on CIT training with all law enforcement agencies within 30 days of award. We will advance technology according to SAMHSA best practices and AMPM 590, which allow data and information to be shared throughout the crisis continuum, such as interface with the State HIE and **real-time performance dashboards.** The dashboards display crisis call disposition, outcomes, reporting metrics, and appointment scheduling, as well as sharing post-crisis care plans with MCOs and providers within 24 hours. Actionable steps and timelines include meeting with other awarded contractors within 60 days of award to develop a plan and timelines for jointly selecting a vendor in advance of the AHCCCS statewide crisis line go-live date. Once the vendor is selected, we will establish a plan within 60 days for joint implementation oversight. This includes offering support from our Implementation team to establish goals and timelines, develop a meeting schedule, and assign responsible parties to ensure tasks occur pre- and post-go-live, enabling a smooth transition.

Crisis mobile intervention services: Our objective to drive continued improvement is to evaluate and expand capacity based on feedback from local communities, such as the Gila County Sequential Intercept Mapping and Pinal County schools, and demonstrated success with the youth engagement crisis specialists through Horizon Health and Wellness (HHW) in Casa Grande, which we will expand to the city of Maricopa in collaboration with crisis stakeholders and according to AMPM 590. Actionable steps and timelines include completing outreach and developing a plan with Pinal and Gila county jails, EDs, crisis providers, and other stakeholders by December 16, 2021. Mercy Care launched a **Child and Adolescent Mobile Crisis Intervention team** with Spectrum Healthcare on October 1, 2021 to increase outreach for individuals with SED, with a dedicated line through Solari. The team will provide in-home supports to the family during the immediate crisis and coordination of ongoing supports through OP providers in the community. Building on our partnerships with rural providers, we will expand services in Pinal and Gila counties, such as a 24/7/365 web portal option for accessing services, satellite phones to mitigate technology coverage issues, and assigning BHMP to consult while mobile crisis teams are on the scene. Our **tribal crisis services honor tribal sovereignty** by consulting with tribal nations to be permitted right of entry, and when permitted, offering a full range of crisis services including mobile crisis services and a **DEDICATED TRIBAL CRISIS HOTLINE NUMBER**. Actionable steps include completing outreach to each Central Arizona tribal nation, developing agreements for service delivery in collaboration with each nation, and re-engaging tribal leaders annually to evaluate the need for crisis services.

Facility-based crisis intervention services: Our objective to drive continued improvement is to **expand facility-based crisis service delivery** based on feedback from family advocates, Department of Developmental Disabilities, and Department of Children's Services to meet the unique needs of local communities and populations with special needs, by serving as an alternative to EDs, and by supporting families caring for those in crisis. In September of 2021, Mercy Care and **MIND 24-7** opened a crisis observation and stabilization center serving children and adolescents. The first location near Phoenix Children's Hospital has 25 23-hour crisis observation chairs with 24/7/365 availability. We will open 2 more locations near Metro Center and in Mesa to increase the total crisis observation chairs to 75 by the end of 2021, including respite care expansion. They will offer a family/caregiver waiting center on campus to support families while their child is stabilized and preparing for discharge. For adults, actionable steps and timelines include adding respite shelter beds at West Valley Access Point in the first quarter of 2022 and in Pinal County in late 2022. In Gila County, we will expand the existing Community Bridges Inc. (CBI) 23-hour observation and crisis stabilization units in Payson and Globe to each accommodate 7 23-hour crisis observation (voluntary/involuntary) chairs, and to include full ambulatory detoxification services and post-discharge peer navigator services. With CBI, we will also add 4 beds (bringing the total to 20) for crisis residential services and co-located services with probation in Gila County in the first quarter of 2022. In Casa Grande, we will add 5 chairs to the current CBI crisis facility in the second quarter of 2022. Further collaboration with CBI and HHW will expand crisis services to cover all of Pinal County with the addition of a transition point (crisis residential) and 24/7/365 immediate access to OP appointments.

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

Mercy Care honors the sovereignty of tribal nations and the unique choices that American Indian/Alaska Native (AI/AN) members are entitled to in receiving health care from MCOs, as well as the American Indian Health Plan (AIHP), the Indian Health Service (IHS), Tribal 638 Facilities, and Urban Indian Clinics. AI/AN people, suffering centuries of policies and actions aimed at eradication, elimination, and assimilation, cope with the effects of historical trauma and unique health disparities. Mercy Care acknowledges that Maricopa, Pinal, and Gila counties have been the homelands of AI/ANs since time immemorial—and we honor the enduring strength and resilience of all AI/AN nations. Since 2014, Mercy Care has been privileged to join with the 22 tribal nations in Arizona and all AI/ANs in serving whole-health needs of AI/ANs in kinship with our sister health plans in the assigned GSAs.

Experience Serving the Tribal Health Care Delivery System

Mercy Care values AI/AN culture and that all lands are tribal lands while serving members through collaborative relationships to facilitate integrated, coordinated care. We have continued to add tribal support staff to aid Tribal Coordinator Faron Jack, who has served in the role since 2014. We know that earning trust takes time—time to listen, share, and learn. This means doing what you say you will do and being an active participant focusing on their unique tribal, community, and individual needs. Our systems and programs reflect AI/AN member needs and streamline navigation with a tailored customer services option for tribal members.

Mercy Care's tribal relations efforts are integral to connecting our care coordination and integration activities with other MCOs, the Tribal RBHA, and Tribal 638 Facilities. We have supported behavioral health (BH) crisis mobile teams since 2014 and collaborate with Fort McDowell Yavapai Nation and the San Lucy District of the Tohono O'odham Nation per established written permission, including protocols drafted in collaboration with both tribal communities. We offer outpatient BH services to the San Lucy District by Native Health including telehealth, which increased 204 percent for AI/ANs since the start of the COVID-19 public health emergency. As a community partner, Mr. Jack convenes and engages stakeholders, leading quarterly collaborative meetings with each Tribal RBHA—including all tribal liaisons representing other AHCCCS Complete Care health plans, which leads to improved care coordination and integration. Mercy Care's Tribal Relations team invited the participation of IHS, Tribal 638 Facilities, and provider partners for recurring meetings. These collaborative meetings help align strategies among IHS, tribal representatives, and Mercy Care to partner with the AIHP to facilitate care coordination for complex BH and physical health (PH) needs. Our Tribal Relations team researched member monthly claims for substance use detoxification to identify AI/AN individuals incurring high utilization or service usage rates of crisis services to improve care coordination and outcomes.

We will initiate efforts to collect tribal affiliation data to improve member demographic data not otherwise available and accelerate care coordination between providers and tribal nations. We collected data from our 2020 Community Needs Assessment that underscores specific needs and disparities with AI/AN communities in Central Arizona, including the following:

- Increased stress, anxiety, anger, and frustration due to the COVID-19 pandemic
- Need for more spiritual and grief support and counseling

Mercy Care has a long-term partnership with the Native American Committee of the Arizona Suicide Prevention Coalition and a proven record connecting with Central Arizona GSA tribes. We focus on suicide prevention and the disproportionate impact of suicide among AI/ANs through safeTALK and Applied Suicide Intervention Skills Training programs. Since 2018, a total of 440 total calls have been made to our tribal crisis hotline number; of those, 74 percent have occurred since 2020. During the pandemic, we provided $76,000 to 11 tribal communities to assist with COVID-19 needs such as grocery gift cards and personal protective equipment. We donated to the 2021 San Carlos Wildfire Relief effort when the tribe was battling one of the largest wildfires in Arizona history.

Addressing Tribal Member Needs to Reduce Health Disparities

Mercy Care's approach to engaging and collaborating with tribes is proactive and high-touch in the spirit of kinship. Arizona's AI/AN population overall has a lower life expectancy driven by many chronic diseases such as diabetes and chronic heart disease. In Arizona, on average, mortality due to all causes for AI/AN was 15 years younger than the State

average in 2017. Since 2014, mortality due to heart disease has increased for AI/AN from 107.5 in 2014 to 150.9 in 2017, surpassing the State rate in 2017. The prevalence of diabetes in the AI/AN population is twice that of the Arizona population as a whole—20.9 percent vs 10.5 percent.[1] Our data shows disparity in diabetes control rates among the SMI AI/AN population as compared to the RBHA SMI population as a whole.

To best reduce health disparities exacerbated by COVID-19 and barriers to care in tribal communities, we engage AI/AN persons with an SMI designation in the community, tribal events, and health fairs. Although this was challenging during the COVID-19-related tribal community shutdowns, we continually engage tribal partners to improve access to testing and vaccinations as well as meet food needs and need for firewood. Through social media, we help drive support of community opportunities to benefit tribal nation donation activities.

Mercy Care focuses on health disparities impacting AI/AN members living with SMI through wearable health technology, mobile dental clinics, traditional healing benefit, and Tribal Specialist staff. These initiatives honor choice; address systemic, cultural gaps; and demonstrate our commitment to being active participants in the care of AI/AN members. These proposals are based on our seven years partnering with AI/AN communities and with sensitivity of social determinants of health needs that were particularly acute during the COVID-19 pandemic:

- **Our traditional healing supplemental benefit of $300** per member annually will help those who choose traditional healers to meet PH, BH, or spiritual needs and bridge systemic cultural care gaps.
- **Adding tribal specialists:** As research suggests, "a significant contributor to an individual's perception and report of overall health is their mental health and well-being." AI/AN individuals in Arizona reported higher rates of frequent mental health distress (12.6 percent) than White non-Hispanic (12.2 percent) and Asians/Pacific Islanders (6.3 percent). In addition, AI/ANs had the highest age-adjusted rates of suicide in Arizona, at 26.2 deaths per 100,000 population, compared to a statewide average of 18.0.[2] To focus on this disparity, we will add to our Tribal Relations department to improve AI/AN member navigation and health supports. With tribal specialists' unique understanding of the indigenous health perspective, they will help holistically meet AI/AN health care needs, including BH.
- Fostering an integrated care approach, Mercy Care will propose a Fitbit® and traditional healing benefits to AI/AN members with an SMI designation to integrate wearable data and care management that honors tribal culture. Based on member health metrics, we **will provide a member stipend toward Fitbit purchases to improve health and wellness**. Fitbit technology includes an application and will help interested AI/AN members to track physical activity, heart rate (resting and non-resting), blood oxygen saturation, and record glucose levels to aid in diabetes management, as well as provide future appointment and medication reminders. Fitbit data will help inform member choice in future care and inform meaningful dialogue with their provider. By implementing this strategy, AI/AN members will increase self-awareness to support managing both their PH and BH and improve efficiency and efficacy of AI/AN member and primary care interactions.

Oral health is an important component of overall health, which is why we will initiate a mobile dentistry program. Dental care is important to overall health. AI/AN individuals are more likely to have severe periodontal disease, report poor oral health than compared to the US population and have twice the prevalence of untreated dental decay than any other racial/ethnic group[3]. Additionally, oral health and dental disease, including cavities and periodontitis, are often exacerbated for individuals experiencing BH conditions. To address this, Mercy Care will cover the cost of **preventive dental care in partnership with DentaQuest** to deliver mobile dental care to serve an approximate 1200 AI/AN members with an SMI designation.

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[1] "Leading Causes of Death and Health Disparities Among the AI/AN Population in Arizona," Arizona Department of Health Services, 8-9 (2019).

[2] "2019 Arizona State Health Assessment," Arizona Department of Health Services; https://www.azdhs.gov/documents/operations/managing-excellence/2019-state-health-assessment.pdf

[3] Phipps KR, Ricks TL. The Oral Health of American Indian and Alaska Native Adult Dental Patients: Results of the 2015 IHS Oral Health Survey, http://www.aaiohi.org/wp-content/uploads/2015/07/IHS-Data-Brief-March-2016-2016-Oral-Health-Survey-of-AIAN-Adults-35.pdf. Accessed September 29, 2021.

B11. Describe how the Offeror will use existing Medicaid compensable services as well as …

Mercy Care understands the impact of social determinants of health (SDOH), stigma, and trauma on the health outcomes of our Arizona members. As a community partner, we convene members, providers, and stakeholders to holistically identify and address SDOH such as poverty and homelessness. In alignment with the AHCCCS Whole Person Care Initiative and the Arizona Health Improvement Plan, our **Population Health Management (PHM)** framework, which is based upon NCQA guidelines and the Institute for Healthcare Improvement's Pathways model, addresses SDOH and social risk through comprehensive **data analysis**, **social service program development and implementation, and continual monitoring to ensure members receive the services they need**, with prioritization on member and family choice. We braid multiple funding sources, inclusive of federal grants, partnerships with municipalities and community-based organizations, and community reinvestment (CRI) dollars to provide **compensable and non-covered services and supports**.

At the population level, we identify community social-need hotspots and subpopulation disparities through integration of State Medicaid race/ethnicity data, Z-code diagnoses on claims, health risk assessments, Robert Wood Johnson Foundation health equity ZIP code analysis, housing status files, and internal risk stratification. We couple this information with member feedback from our Member Advisory Committee and Clinic Advisory Council to obtain a well-rounded view of our members. We utilize **Socially Determined (SD)** to create social risk profiles for members and communities. SD aggregates community-level social risk, inclusive of claims, demographics, commercial business data, consumer data, and race/ethnicity/language data, with individual-level details to generate a social risk score. The risk score identifies risk exposure with respect to financial strain, food insecurity, housing instability, transportation barriers, health literacy challenges, and COVID-19 vulnerability. All of our population-level assessment methods highlight high-impact strategic opportunities to drive program development, investments to address gaps, and targeted member outreach to ensure members have timely access to needed social services. We encourage provider engagement around SDOH through value-based payment (VBP) incentives that promote inclusion of Z-code diagnostic information and referrals to resources as well as specific SDOH outcomes. We will continue to educate and closely track provider use of Z-codes.

On the individual level, we assess all our members' social needs during the new member welcome process in care management and ongoing in health homes using our health risk assessment and SD risk score. We are adopting the standardized PRAPARE® assessment, an evidence-based SDOH tool, as well. Through the assessment and treatment planning process, interdisciplinary clinical teams (including providers and peer support specialists) empower member-driven identification of social services that meet their needs and make appropriate referrals to social services based on member and family choice, cultural worldview, and through a trauma-informed (TI) and health literacy lens. Through adoption of TI principles in our referral practices, we seek to avoid re-traumatization, acknowledging members' past or generational trauma backgrounds. We will also educate providers on the expectation to screen members for SDOH through PRAPARE® and our Quality team will monitor provider adoption of PRAPARE® and referrals to appropriate services. We are also an early adopter of NowPow and will support the State's implementation of the closed-loop referral system through provider, stakeholder, and member education, supporting provider adoption of NowPow through VBP contracting.

Our PHM strategy includes regular monitoring of outcomes data and utilization of a Plan-Do-Study-Act approach to ensure our PHM strategies remain appropriately aligned with the needs of the community and **to verify members received the social services to which they were referred in a timely manner**. For example, we track members receiving supported employment (SE) services and find that **86 percent currently maintain employment as a result of SE support**.

At the population level, we monitor trends over time with respect to member-specific demographics, SDOH needs, Z-codes, community data, quality of care, cultural needs/language preferences, risk stratification intensity, and risk exposure so that we can adjust our investments and interventions to be responsive. We share population and individual-level data with providers to support their ability to coordinate social services and to evaluate their own efforts. We incorporate feedback from Mercy Care committees as well as member, provider, and stakeholder listening sessions to verify our programs meet the SDOH needs of members in the community.

This feedback also drives social service program development. **At the individual member level, our electronic care management platform captures and reports SDOH needs and referrals data to confirm member access to and connection with the social services identified in the care plan**, with prompts for care managers to outreach members for whom a referral is not yet completed. In the future, our electronic care management platform will interact with NowPow to strengthen verification that members have been connected to their needed social services. Our contracts with all health homes, permanent supportive housing (PSH), and SE providers will include expanded **VBP goals** that will continue to target member SDOH outcomes.

> Joshua (not his real name) missed work due to COVID-19 illness, resulting in loss of income and housing. We helped him apply to the HOME program which—through Temporary Housing Assistance Program (THAP) funds—paid for his security deposit, first month's rent, and needed household items. Joshua now has stable housing and is looking into volunteer opportunities at local social service and peer support agencies to give back.

We offer compensable and non-covered social services and supports to address all social risk areas—a few of which are described in this response (all services are compensable unless otherwise noted as non-covered). Often, these services address multiple SDOH needs simultaneously, such as our THAP, which uses Non-Title XIX subsidy and encounterable funding to address low income, housing, and employment.

We offer comprehensive housing services and supports, working with the AHCCCS Housing Program to prioritize members experiencing homelessness for housing referrals in communities of their choice:

- PSH to assist members in obtaining and maintaining housing; reviews of provider fidelity to the SAMHSA PSH model found **all our providers meet or exceed these standards**, representing an **increase in fidelity of 20 percent** since 2014. We increased Scattered Site housing subsidies from 107 to 1,222.
- We supported the development and implementation of Copa Health's **Lighthouse Model**, which offers Community Living programs to provide rental subsidies and evidence-based wraparound in home services; the program provides a service cost savings of nearly 30 percent. We will support expansion through additional dollars.
- Utility assistance (a non-covered support) to help members obtain discounts on monthly utility bills in collaboration with Arizona Public Service, Salt River Project, and Southwest Gas; discounts provide monthly **cost savings of up to 35 percent**.
- Above and beyond allocation of $500,000 in CRI dollars to Home Matters to increase PSH, Mercy Care sourced **an additional $20 million** through our plan administrator and sponsor to benefit Home Matters.

Enhanced transportation mitigates access barriers, social isolation, and unemployment. Members receive bus passes to travel to locations such as peer drop-in centers, socialization with family and natural supports, food banks, and mobility training to utilize the bus system. In collaboration with our transportation provider, Veyo, and for the entire GSA, we will offer **up to three trips per month**, for locations not normally covered, to serve the member's overall health goals. Veyo will also provide **food delivery services** (a non-covered support).

We currently assist more than 1,100 members through our SE services, which include creation of resumes, job search skills, and modeling regarding job tasks. Mercer's evaluation of our SE program showed **the employment rate for our members receiving SE exceeds the national average**. In addition to compensable SE services, health home rehabilitation specialists conduct meaningful day evaluations with members and link them to meaningful community activities and/or compensable vocational rehabilitation, based on member preference.

We address food insecurity and health disparities related to COVID-19 and diabetes through CRI funding of operational expenses to Farm Express, which delivers fresh produce and nutrition education in food deserts in Maryvale, Central City/Phoenix, and Tempe. We also provide matching funding of Supplemental Nutrition Assistance Program benefits through Double Up Food Bucks.

In 2022, in partnership with CVS Health, **we will make targeted service dollar investments to Health Zones (HZ)** in Arizona's highest-need communities as identified through community SDOH data, assessing their impact over a five-year period. In 2023, HZ will include a **community resource center within a CVS retail location** to offer tailored services to local Hispanic residents such as broadband, a telehealth hotspot supported by a licensed practical nurse, and bilingual navigators to connect members to social services.

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

The COVID-19 pandemic and resulting economic fallout has amplified health inequities and the impacts of social determinants of health (SDOH) in our systems. Ongoing stress has increased rates of substance use, mental health issues such as anxiety and depression, and delays in preventive care due to disruptions in the provision of structured supports and service providers.

Mercy Care will play a vital and collaborative role in the state's recovery, alleviating member whole-person needs exacerbated by the pandemic to deliver positive outcomes and build resiliency via upstream prevention and health promotion in a sustainable multivariate care delivery model. Since the pandemic, we have partnered with AHCCCS to promote vaccinations, expand telehealth, improve access to care, ensure transportation, and provide redetermination assistance and payment support. Upon ARPA funding approval, we will support expanded programs to address the pandemic's impact on substance use disorder (SUD) prevention and treatment, women's services, workforce development, and others. Our strategies moving forward focus on advancing whole-person care and access to behavioral health (BH) services through three key priorities: enhancing access to whole-person care, addressing biopsychosocial needs, and strengthening a sustainable and integrated health delivery system. These priorities align with AHCCCS' strategic plan, initiatives, and best practices. We will approach the Arizona Health Improvement Plan in partnership with public and private stakeholders.

Enhancing Access to Whole-Person Care

Mercy Care improves health disparities and outcomes while mitigating COVID-19 disparate impacts connecting with larger State actions such as the 2-1-1 referral program. In 2020, we allocated $410,000 of our community reinvestment dollars (CRI) for COVID-19 support and enhanced whole-person care access through the following:

- **Preventive services and COVID-19 vaccination:** We will continue to outreach and engage members through care managers, interactive voice response, newsletters, texts, and social media, with clear, culturally and linguistically appropriate messages. Appointment assistance and transportation will be offered to assist members to receive COVID-19 and flu vaccinations; attend well visits, dental visits, and age-appropriate screenings; and manage chronic health needs through in-person office, home, mobile, or virtual visits. In collaboration with faith-based organizations, medical and health plan associations, and public and private stakeholders, we will promote vaccination and preventive care.
- **SDOH:** Socially Determined is a social risk intelligence platform that provides Mercy Care with member- and community-level data to aid in addressing SDOH. Combined with NowPow, which supports closed-loop referrals, we will continue to implement responsive and innovative programs with compensable Medicaid services and non-compensable services through braided funding in partnerships with municipalities, other entities, and CRI including the following:
  - **Social isolation:** We will launch a Social Isolation Task Force with members, providers, and community stakeholders examining member and family needs and current policies to identify opportunities. We engage members through **Pyx Health**, an interactive application focusing on social isolation, uniting artificial intelligence and a trained intervention team. We will utilize **peer and family support groups** and a **pet companion program** to create meaningful experiences while also alleviating loneliness. Our peer-run providers will expand **support groups on grief and loss**, an area of need from the COVID-19 impact to help members heal through sharing their personal experiences.
  - **Food insecurities:** We will deliver home meals to members through a partnership with Veyo and Mom's Meals. We also contract with Farm Express, a mobile produce store, to increase access to healthy food in identified food deserts and fund the Double Up Food Bucks Arizona Program, which matches the federal Supplemental Nutrition Assistance Program.
  - **Housing:** Using CRI funds, we will partner with the following: **1) Community Bridges, Inc.** to implement an integrated care program, inclusive of **street outreach, bridge housing,** and services like SMI evaluation, connection to benefits, and integrated care; and **2) Cloud Covered Streets** to connect members to a mobile

trailer that offers showers, clothing, haircuts, and laundry accessibility. Our care managers coordinate high-risk seniors experiencing homelessness at Project Haven shelter for integrated services.

Addressing Biopsychosocial Needs

We will address members' biopsychosocial needs, based on their preferences, through the following:

- **Crisis system enhancement:** In partnership with MIND 24-7 and Spectrum Healthcare, 23-hour crisis stabilization and child and adolescent mobile crisis services, respectively, were expanded to children with SED to prevent avoidable emergency department visits. Text and chat options were added to enhance crisis service access through Solari Crisis and Human Services, and our air traffic control model will connect members timely to identified services. We will continue our collaborative dispatch and communication initiative, directing calls to crisis rather than 911 and scheduling clinic appointments. **In July and August 2021, 2,806 clinic appointments were completed.**
- **SUD:** We will promote the use of the AHCCCS treatment locator and support provider integration of the American Society of Addiction Medicine continuum. Supportive parental and infant detox services are available through Hushabye Nursery, and moving forward, medication-assisted treatment (MAT) will be available at all health homes; MAT providers will have telehealth capability; and **mobile vans** functioning as outpatient MAT will deliver timely services to the community. We will expand complexity-capable outpatient programs such as the **Halle Empowerment Affirmation Legacy**, a specialty maternity program, and will offer a 12-week intensive outpatient program inclusive of MAT and co-occurring residential.
- **Children with SED:** Through our administration of the Children's Behavioral Health Services Fund, BH services are available as an expansion of school-based support programs to connect students to a health home and/or specialty provider to meet their diverse needs. We will offer integrated telehealth for children in schools through grant funding to Hazel Health, as we continue to support children returning to school.
- **Justice system integration:** Based on increased reduction in Failures to Appear, we will continue to advocate for a virtual option for members and staff to participate in the 13 problem-solving courts.
- **Personal medicine coach:** To support member self-determination and resiliency, we will require health homes to have certified personal medicine coaches—a recovery and evidence-based practice position by Patricia Deegan, celebrating members and their intrinsic strengths and empowering them to 'get and stay well'.

Strengthen a Sustainable and Integrated Health Delivery System

We will strengthen access and integration of BH care through the following:

- **Care delivery transformation:** The COVID-19 pandemic illustrated the need for virtual, mobile care among numerous clinical entry points. We will fund and implement a **telehealth hotspot** at a community resource center to improve access. Tablets (300/year) will be provided through CRI to support telehealth use. Through **Spectrum Healthcare**, we will deliver community-based physical and behavioral health services to members where they are and at times of need. We will offer **peer navigators and community health worker (CHW) support through the Pathways Community Hub program** and expand health homes.
- **Workforce (providers and plan staff):** We will create a Workforce Development Task Force, inclusive of providers, trade associations, and other stakeholders, and collaborate with AHCCCS to focus on ongoing challenges with recruitment and retention, in support of also reducing the impact of vicarious trauma. We will contract with Arizona's Peer and Family Career Academy to curate curricula for unique skills and community treatment needs, and collaborate with community colleges to support CHW training starting in 2021. Our crisis mobile teams will continue providing resiliency skills training to support first responders and hospital staff. All Mercy Care staff will have continued flexible work schedules and locations, as well as comprehensive succession plans, with 96 percent transitioning to remote work in 2021.
- **Data and analytical integration:** We will continue to use data to guide clinical advancement and scarce resource allocation. We combine COVID-19 test results from the HIE (Health Current) with internal data using predictive and risk modeling to assist outreach to impacted members, identify any disparity, monitor network adequacy, coordinate transportation hotspots, conduct provider outreach, and close care gaps.

4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

October 1, 2021

Arizona Health Care Cost Containment System Administration (AHCCCS)
Procurement Office (First Floor)
Meggan LaPorte, CPPO, MSW
Chief Procurement Officer
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

RE: Competitive Contract Expansion (CCE) Solicitation #YH20-0002 – C1, Agreement of Capitation Rates

Dear Ms. LaPorte,

The undersigned Offeror hereby agrees to accept the capitation rates set by AHCCCS that are actuarily sound and set pursuant to the Competitive Contract Expansion (CCE) Solicitation (YH20-0002).

Lorry Bottrill, Chief Executive Officer (CEO), Mercy Care
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Office: 602-400-7082
Lorry.Bottrill@mercycareaz.org

Lorry Bottrill
Lorry Bottrill (Sep 22, 2021 11:24 PDT)

Sep 22, 2021

Lorry Bottrill
CEO, Mercy Care
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Date

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	$ 1,135,006.27	$ 1,198,282.87	$ 1,265,087.14	$ 1,335,615.75	$ 1,410,076.32	$ 99,659.82	$ 104,702.60	$ 110,000.56	$ 115,566.58	$ 121,414.25
Care Management/Care Coordination	$ 14,944,228.14	$ 15,777,368.86	$ 16,656,957.17	$ 17,585,582.53	$ 18,565,978.76	$ 1,730,420.95	$ 1,817,980.25	$ 1,909,970.05	$ 2,006,614.53	$ 2,108,149.23
Claims and Encounters	$ 285,853.43	$ 301,789.76	$ 318,614.54	$ 336,377.30	$ 355,130.33	$ 25,099.51	$ 26,369.54	$ 27,703.84	$ 29,105.66	$ 30,578.40
Clinical Management	$ 466,613.69	$ 492,627.40	$ 520,091.38	$ 549,086.47	$ 579,698.04	$ 40,971.26	$ 43,044.40	$ 45,222.45	$ 47,510.71	$ 49,914.75
Compliance/Legal	$ 100,889.45	$ 106,514.03	$ 112,452.19	$ 118,721.40	$ 125,340.12	$ 8,858.65	$ 9,306.90	$ 9,777.83	$ 10,272.59	$ 10,792.38
Dental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Executive	$ 256,427.34	$ 270,723.17	$ 285,815.98	$ 301,750.22	$ 318,572.80	$ 22,515.74	$ 23,655.03	$ 24,851.98	$ 26,109.49	$ 27,430.63
Health Care Quality Improvement	$ 2,154,266.71	$ 2,274,367.08	$ 2,401,163.04	$ 2,535,027.88	$ 2,676,355.68	$ 267,301.17	$ 280,826.61	$ 295,036.44	$ 309,965.28	$ 325,649.53
Information Services / Technology	$ 605,336.68	$ 639,084.20	$ 674,713.14	$ 712,328.40	$ 752,040.71	$ 53,151.90	$ 55,841.39	$ 58,666.96	$ 61,635.51	$ 64,754.27
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 865,967.75	$ 914,245.45	$ 965,214.63	$ 1,019,025.35	$ 1,075,836.01	$ 76,036.75	$ 79,884.21	$ 83,926.35	$ 88,173.02	$ 92,634.58
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 59,692.92	$ 63,020.80	$ 66,534.21	$ 70,243.49	$ 74,159.57	$ 5,241.37	$ 5,506.58	$ 5,785.21	$ 6,077.95	$ 6,385.49
Provider Relations and Network Management	$ 559,936.43	$ 591,152.88	$ 624,109.66	$ 658,903.77	$ 695,637.65	$ 49,165.51	$ 51,653.28	$ 54,266.94	$ 57,012.85	$ 59,897.70
Other [1]	$ 386,742.88	$ 408,303.79	$ 431,066.73	$ 455,098.70	$ 480,470.45	$ 33,958.16	$ 35,676.44	$ 37,481.67	$ 39,378.24	$ 41,370.78
Total MCO Compensation	$ 21,820,961.67	$ 23,037,480.28	$ 24,321,819.81	$ 25,677,761.26	$ 27,109,296.45	$ 2,412,380.78	$ 2,534,447.25	$ 2,662,690.28	$ 2,797,422.41	$ 2,938,971.98
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	$ 10,491,271.47	$ 11,076,159.86	$ 11,693,655.77	$ 12,345,577.08	$ 13,033,843.00	$ 1,312,853.19	$ 1,379,283.56	$ 1,449,075.31	$ 1,522,398.52	$ 1,599,431.89
Care Management/Care Coordination	$ 317,917.32	$ 335,641.21	$ 354,353.21	$ 374,108.40	$ 394,964.94	$ 39,783.43	$ 41,796.47	$ 43,911.37	$ 46,133.29	$ 48,467.63
Claims and Encounters	$ 5,510,566.83	$ 5,817,780.94	$ 6,142,122.22	$ 6,484,545.54	$ 6,846,058.95	$ 689,579.45	$ 724,472.17	$ 761,130.47	$ 799,643.67	$ 840,105.64
Clinical Management	$ 1,342,317.56	$ 1,417,151.77	$ 1,496,157.98	$ 1,579,568.78	$ 1,667,629.74	$ 167,974.48	$ 176,473.99	$ 185,403.58	$ 194,785.00	$ 204,641.12
Compliance/Legal	$ 600,510.49	$ 633,988.95	$ 669,333.83	$ 706,649.19	$ 746,044.89	$ 75,146.48	$ 78,948.89	$ 82,943.70	$ 87,140.66	$ 91,549.97
Dental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Executive	$ 282,593.17	$ 298,347.74	$ 314,980.63	$ 332,540.80	$ 351,079.95	$ 35,363.05	$ 37,152.42	$ 39,032.33	$ 41,007.37	$ 43,082.34
Health Care Quality Improvement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Information Services / Technology	$ 7,700,663.91	$ 8,129,975.92	$ 8,583,222.08	$ 9,061,736.71	$ 9,566,928.53	$ 963,643.08	$ 1,012,403.42	$ 1,063,631.04	$ 1,117,450.77	$ 1,173,993.78
Interpretive Services	$ 3,410,908.75	$ 3,601,066.92	$ 3,801,826.40	$ 4,013,778.22	$ 4,237,546.36	$ 503,304.66	$ 528,771.88	$ 555,527.73	$ 583,637.44	$ 613,169.49
Member Services	$ 1,872,179.76	$ 1,976,553.78	$ 2,086,746.65	$ 2,203,082.78	$ 2,325,904.64	$ 234,280.20	$ 246,134.78	$ 258,589.20	$ 271,673.81	$ 285,420.51
Pharmacy Benefit Manager Expenses [2]	$ 3,194,650.15	$ 3,372,751.90	$ 3,560,782.82	$ 3,759,296.46	$ 3,968,877.24	$ -	$ -	$ -	$ -	$ -
Pharmacy Management	$ 1,271,669.27	$ 1,342,564.83	$ 1,417,412.82	$ 1,496,433.59	$ 1,579,859.76	$ 159,133.72	$ 167,185.89	$ 175,645.49	$ 184,533.15	$ 193,870.53
Program Integrity (Fraud, Waste & Abuse)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Provider Relations and Network Management	$ 706,482.93	$ 745,869.35	$ 787,451.57	$ 831,351.99	$ 877,699.87	$ 88,407.62	$ 92,881.05	$ 97,580.83	$ 102,518.42	$ 107,705.85
Subcontractors [2]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other [1]	$ 1,165,696.83	$ 1,230,684.43	$ 1,299,295.09	$ 1,371,730.79	$ 1,448,204.78	$ 145,872.58	$ 153,253.73	$ 161,008.37	$ 169,155.39	$ 177,714.65
Total Professional and Outside Services	$ 37,867,428.45	$ 39,978,537.59	$ 42,207,341.06	$ 44,560,400.32	$ 47,044,642.64	$ 4,415,341.95	$ 4,638,758.25	$ 4,873,479.42	$ 5,120,077.48	$ 5,379,153.40
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ 208,848.32	$ 220,491.61	$ 232,784.02	$ 245,761.73	$ 259,462.95	$ -	$ -	$ -	$ -	$ -
Non-Capital Equipment and Licenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Compensation Health Care Quality Improvement	$ 1,436,177.80	$ 1,516,244.72	$ 1,600,775.36	$ 1,690,018.59	$ 1,784,237.12	$ 178,200.78	$ 187,217.74	$ 196,690.96	$ 206,643.52	$ 217,099.68
Occupancy & Depreciation	$ 1,621,471.49	$ 1,711,868.52	$ 1,807,305.19	$ 1,908,062.46	$ 2,014,436.94	$ 207,488.75	$ 217,987.69	$ 229,017.86	$ 240,606.17	$ 252,780.84
Office Supplies, Equipment Repair, Maintenance	$ 1,582,816.37	$ 1,671,058.38	$ 1,764,219.89	$ 1,862,575.15	$ 1,966,413.71	$ 156,568.93	$ 164,491.32	$ 172,814.58	$ 181,559.00	$ 190,745.88
Printing, Postage, Fulfillment	$ 161,027.74	$ 170,005.04	$ 179,482.82	$ 189,488.99	$ 200,053.00	$ -	$ -	$ -	$ -	$ -
Travel, Marketing, Insurance	$ 1,038,976.65	$ 1,096,899.60	$ 1,158,051.75	$ 1,222,613.14	$ 1,290,773.82	$ 69,697.52	$ 73,224.21	$ 76,929.36	$ 80,821.98	$ 84,911.58
Other [1]	$ 1,247,481.98	$ 1,317,029.10	$ 1,390,453.48	$ 1,467,971.26	$ 1,549,810.65	$ 164,620.36	$ 172,950.15	$ 181,701.43	$ 190,895.52	$ 200,554.83
Total Non-Compensation	$ 7,296,800.36	$ 7,703,596.98	$ 8,133,072.51	$ 8,586,491.30	$ 9,065,188.19	$ 776,576.35	$ 815,871.11	$ 857,154.19	$ 900,526.19	$ 946,092.82
Total Admin Dollars	$ 66,985,190.48	$ 70,719,614.85	$ 74,662,233.38	$ 78,824,652.89	$ 83,219,127.29	$ 7,604,299.08	$ 7,989,076.61	$ 8,393,323.89	$ 8,818,026.08	$ 9,264,218.20
Total Management Fees Included Above [3]	$ 65,954,649.09	$ 69,631,620.78	$ 73,513,583.63	$ 77,611,965.92	$ 81,938,833.02	$ 7,487,309.86	$ 7,866,167.74	$ 8,264,195.83	$ 8,682,364.14	$ 9,121,691.77
Management Fee arrangement percentage (contracted)	7.68%	7.68%	7.68%	7.68%	7.68%	7.68%	7.68%	7.68%	7.68%	7.68%
Projected Member Months	334,110	344,134	354,458	365,091	376,044	13,333,712	13,733,723	14,145,735	14,570,107	15,007,210

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.

4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

September 24, 2021

Arizona Health Care Cost Containment System Administration (AHCCCS)
Procurement Office (First Floor)
Meggan LaPorte, CPPO, MSW
Chief Procurement Officer
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

RE: Competitive Contract Expansion (CCE) Solicitation #YH20-0002 – C3, Actuarial Certification

ACTUARIAL CERTIFICATION

I, Jason Strandquist, am an employee of Aetna Life Insurance Company, the contracted administrator for Mercy Care. I am also a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have reviewed the assumptions and methods used to develop the non-benefit cost proposal submitted for the CCE Solicitation No. YH20-0002. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

In developing the assessment, I relied upon certain data and information provided by AHCCCS and Mercy Care. I have reviewed the data without audit and have relied upon AHCCCS and Mercy Care for the accuracy of the data.

In my opinion, the assumptions used in developing the non-benefit cost proposal for CCE No. YH20-002 are actuarially sound for the purposes of 42 CFR 438.5(e), according to the following criteria:

- "*The development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP, or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services identified in § 438.3(c)(1)(ii) to the populations covered under the contract*."

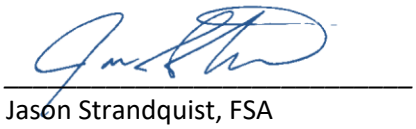
To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial Standards of Practice (ASOP) applicable to Medicaid managed care rate setting: ASOP 5 (Incurred Health and Disability Claims), ASOP 23 (Data Quality), ASOP 25 (Credibility Procedures), ASOP 41 (Actuarial Communications), ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies) and ASOP 49 (Medicaid Managed Care Rate Development and Certification).

- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

For the purposes of this attestation, and consistent with the requirements under 42 CFR § 438.4(a), "actuarial soundness" is defined as in ASOP 49:

> *"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."*



Jason Strandquist, FSA
Member, American Academy of Actuaries

September 24, 2021
Date