Expansion of AHCCCS Complete Care Contract #YH19-0001

Response to: Competitive Contract Expansion #YH20-0002

Due: Monday, October 4, 2021 at 3:00 P.M. Arizona Time

Submitted by: Molina Healthcare of Arizona, Inc.
(fka Magellan Complete Care of Arizona, Inc.)

MOLINA® HEALTHCARE

Part A

A1. Offeror's Checklist (CCE Section I, Exhibit A)

The Offeror shall complete and submit CCE Section I, Exhibit A, Offeror's Checklist. The Offeror shall submit all items delineated in CCE Section I, Exhibit A, Offeror's Checklist using the forms and specifications provided in this CCE. This document is provided separately on the CCE Library.

Molina Healthcare of Arizona, Inc.'s (aka Molina Complete Care [MCC]) completed CCE Section I, Exhibit A, Offeror's Checklist, follows this page.

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	3
A2	Offeror's Completed, Signed Solicitation, and Offer Page	5
A3	Offeror Submission Form	8
A4	Offeror's Signed Signature Page(s) for **each** Solicitation Amendment, if applicable	10
PART B	PROGRAMMATIC - NARRATIVE SUBMISSION	
B1	2-page limit	17
B2	2-page limit	19
B3	3-page limit	21
B4	4-page limit	24
B5.a (North GSA)	2-page limit	-
B5.b. (South GSA)	2-page limit	-
B5.c. (Central GSA)	2-page limit	28
B6	1-page limit for each of a through g	30
B7	5-page limit	37
B8	3-page limit	42
B9	3-page limit	45
B10	2-page limit	48
B11	2-page limit	50
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PART C	CAPITATION AGREEMENT/ADMINISTRATIVE COST BID SUBMISSION	
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C2	Administrative Cost Bid Submission Workbook	57
C3	Actuarial Certification (The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid)	59

A2. Offeror's Completed, Signed Solicitation, and Offer Page (CCE Section A)

The Offeror shall complete and submit CCE Section A, Solicitation and Offer Page. This document is provided separately on the CCE Library.

Molina Healthcare of Arizona, Inc.'s completed CCE Section A, Solicitation and Offer Page, follows this page.

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

SECTION A: SOLICITATION AND OFFER PAGE

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

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

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

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

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

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

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

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

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

Late Proposals shall not be considered.

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

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

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final Proposal revisions (if any). Signature also certifies Small Business Status. The undersigned Offeror hereby attests to its understanding that this Solicitation is an amendment to AHCCCS Complete Care Contract #YH19-0001 and the requirements of Contract #YH19-0001 apply in addition to those delineated in this Competitive Contracts Expansion #YH20-0002.

Arizona Transaction (Sales) Privilege Tax License No.: N/A

Federal Employer Identification No.: **45-5337737**

E-Mail Address: **Minnie.Andrade@MolinaHealthCare.Com**

Molina Healthcare of Arizona, Inc.
Company Name

5055 E Washington St, Suite 210
Address

Phoenix, AZ 85034
City State Zip

For clarification of this Offer, contact:

Name: **Minnie Andrade**

Title: **Chief Executive Officer**

Phone: **602-830-0067**

Minnie Andrade
Signature of Person Authorized to Sign Offer

Minnie Andrade
Printed Name

Chief Executive Officer
Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

Award Date: _____

_____

MEGGAN LAPORTE, AHCCCS Chief Procurement Officer

A3. Offeror's Completed Offeror Submission Form (CCE Section I, Exhibit B)

The Offeror shall complete and submit CCE Section I, Exhibit B, Offeror CCE Submission Form. This document is provided separately on the CCE Library.

Molina Healthcare of Arizona, Inc.'s completed CCE Section I, Exhibit B, Offeror CCE Submission Form, follows this page.

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.

Molina Healthcare of Arizona, Inc. 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

Minnie Andrade
Authorized Signature

October 2, 2021
Date

Minnie Andrade
Print Name

Chief Executive Officer
Title

A4. Offeror's Signed Signature Page for Each Solicitation Amendment

The Solicitation Amendment Signature Page(s), if applicable, are provided separately on the CCE Library.

Molina Healthcare of Arizona, Inc.'s completed Solicitation Amendment Signature Pages follow this page.

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Jami Snyder, Director

SOLICITATION AMENDMENT #1

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

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

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

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

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: Minnie Andrade	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Minnie Andrade	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: October 2, 2021	DATE: August 26, 2021

SOLICITATION AMENDMENT #2

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

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

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

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

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

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL: Minnie Andrade	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: Minnie Andrade	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: October 2, 2021	DATE: September 14, 2021

Part B –
Narrative Submission

B1. Contract Transition

MCC draws on Molina Healthcare's national experience **serving more than 430,000 members with SMI** in 15 states.

430,000 members

023.AZ21

Molina Complete Care (MCC) has decades of combined staff experience in and knowledge about transitioning managed care contracts to prevent delay and disruption and maintain existing best practices while innovating and advancing states' goals and priorities. **CEO Minnie Andrade,** supported by her team of Arizona experts, will lead our overall expansion and Contract transition effort to ensure ACC-RBHA members receive, and providers can deliver, coordinated care and uninterrupted services.

Efforts to Minimize Delays and Disruptions to Members and Providers

MCC's tailored transition management approach prioritizes continuity of care for ACC-RBHA members supported by dedicated staff and a strong provider network. As demonstrated by our solid organizational performance as an ACC plan, we employ an early and frequent communication approach with all stakeholders to ensure a broad, consistent understanding of expectations for providing services to the population, and we pride ourselves on **living up to our commitments to AHCCCS, members, providers, and the larger communities we serve**.

We document our rigorous program management approach—built on industry-standard methodologies such as the Project Management Institute® Project Management Body of Knowledge (PMBOK®)—in our ACC-RBHA Program Transition Plan. The Plan details our tailored roadmap, including project scope, resources, tasks, time frames, deliverables, critical paths, and dependencies to ensure we deliver a timely, seamless transition with no delays or disruptions to members or providers. Our ACC-RBHA Governance Committee will hold us accountable for transition activities by comparing our performance and progress against the transition metrics and commitments (e.g., accurate transition of SMI Health Home and PCP assignments) contained in the transition plan we deliver to AHCCCS 180 days before the Contract effective date.

Dedicated Staff to Oversee Member Transitions. Our **dedicated Clinical Transition team will be available 24/7/365** to oversee all member transition activities, including coordination of transportation services and working with the relinquishing Contractor and the State to ensure a seamless transition for Health Home assignments. Our Medical Management and Clinical Transition teams will collaborate to work with Health Homes to understand members' levels of care, particularly ACT teams and priority population receiving services through Non-Title XIX/XXI funding. The Medical Management Manager will work closely with inpatient facilities, stabilization units, crisis, and justice-involved agencies to obtain current census registries and be ready to assume all levels of care on Day 1.

Continuity of Care with a Trauma-informed Focus. Ensuring both physical health and behavioral health continuity of care for members is a top priority during the transition, especially for members with long-term conditions, as it promotes the provider–patient relationship and reduces fragmentation of care. As a leader among ACC plans in recovery and resiliency practices and evidence-based care, we focus on integrated, trauma-informed care and ensuring the member's and family's voice is at the heart of our service delivery. Because trauma-informed care improves patient engagement, health outcomes, and provider and staff wellness, and decreases unnecessary utilization, **Josh Sprunger, Individual and Family Affairs Administrator (OIFA)**, is directing our effort to become **the first health plan to pursue certification as a trauma-informed organization**.

To ensure no member is "lost" during the transition, MCC will use all AHCCCS data sources (DEX File, Active Care Notification, Unique Population File, and the DUGless File) to identify member needs and existing services for continuity efforts and priority outreach. We will work closely with the outgoing health plan to identify high-need members who would benefit from care management and to ensure members transitioning in care management remain there. Our multidisciplinary team of clinical and non-clinical staff, and OIFA team, including Peer and Family Support Specialists, will prioritize community outreach to make referrals that connect members to appropriate services and supports and to conduct assessments and interventions. Members in active treatment with a non-participating provider for serious physical health, behavioral health, or developmental conditions will continue receiving services throughout their treatment from that provider. MCC will contract with the provider, or alternatively, work with the member and provider to determine whether to transition them to a contracted provider or complete a single case agreement.

MCC's **Pharmacy Director will oversee the crisis formulary for members who present in crisis** at any facility-based psychiatric urgent care center, detox facility, or access point during the transition. For individuals experiencing homelessness or are at risk of being homeless, such as transition-age youth and members within the justice system, our **dedicated Transition Liaisons will ensure members have access to stable housing** and manage the housing waitlist.

Established Network that Supports Delivering Care in the Least Restrictive Setting. MCC's network of culturally competent and experienced providers understands the nuances of the ACC-RBHA Program and aligns with the current RBHA Title XIX/XXI and Non-Title XIX/XXI network. Our network and least restrictive setting approach maximize member choice and continuity. Further, **our network includes a hybrid model for members with complex conditions by incorporating telehealth services with face-to-face follow-up care.** Our **Provider Network team** has configured the network to provide a seamless transition, deliver successful continuity of care, and offer timely access to other services. Upon award, this team will work with AHCCCS to review the last two years of RBHA claims to identify utilization patterns with out-of-network providers and prioritize them for contracting.

Comprehensive Provider Support Strategy. MCC's comprehensive provider support strategy delivers the information and support providers need to continue focusing on care during the transition, preventing administrative burden and ensuring provider satisfaction. All providers have 24/7/365 access to tools and resources, e.g., electronic prior authorizations and service requests and the ability to receive real-time authorization status updates, and **SMI Health Home CEOs have direct access to MCC's CEO and AVP of System Transformation**. Our Practice Transformation Team will educate and support providers on continuity policies and procedures and offer them easy escalation and quick resolution processes. To minimize delays and disruption for providers, our transition plan includes pre-transition claims testing and system configuration protocols to ensure timely, accurate payment processing upon go-live. We will maintain the current payment structure during Year 1 to avoid confusion.

Frequent, Informative Communication with All Stakeholders. MCC is a leader in stakeholder engagement, having spent the past two years meeting with key individuals across the SMI and Non-Title XIX/XXI systems to better understand and meet the needs of ACC-RBHA stakeholders. MCC has received dozens of letters from organizations supporting our ACC-RBHA efforts, including Health Homes, PROs, law enforcement, advocate, AI/AN leaders, universities, and FQHCs. Before transition, MCC will begin a culturally and linguistically appropriate communication campaign targeting all stakeholders, including members, I/T/U, providers, ACC MCOs, CBOs, advocacy groups, and other system partners. Our multichannel communication campaign will include monthly townhall meetings for SMI Health Homes, CBOs, and advocates; an interactive MCC website FAQ; on-the-ground Community Engagement teams; and our Practice Transformation Team. Our Community Engagement teams will inform members on how to obtain services and will provide 24/7/365 crisis phone line numbers. Our Practice Transformation Team will educate and support providers to continue care without delay or disruption. Moving forward as the new ACC-RBHA in the Central GSA, our message to stakeholders will be that providers should continue delivering existing authorized services with no change to members.

Efforts to Ensure Advances Made in Recent Years Continue

At the heart of our approach to the ACC-RBHA Contract is a focus on true measurement-based care. Building upon AHCCCS' progress in advancing integration and outcomes-based care, we are continuing the transition of the system from one of "process measures" to one that focuses on recovery and resiliency outcomes of the people it serves. MCC will ensure that advances made in recent years continue in the transfer of responsibility, including strengthening our work with Health Current; advancing whole person initiatives ensuring alignment of provider payment models to enhance the Targeted Investment Program; and continuing MCC's CEO Roundtables to encourage active provider engagement in system transformation. Our integrated, quality-driven programs support the Triple Aim and advance whole person care; expand EBPP fidelity; promote health equity; align with the Arizona COVID-19 project, which includes the Center of Excellence Model of Care; personalize ISPs; prioritize referral pathways to get at-risk members into services quickly; expand crisis system best practices to Gila and Pinal counties; invest in workforce development; formalize relationships with tribal communities; and address disparities through enhanced accountability, training, transparency, and member empowerment. MCC looks forward to continuously adding value to the ACC-RBHA Program by providing high-quality healthcare to Arizona's most vulnerable citizens through innovation and best practices.

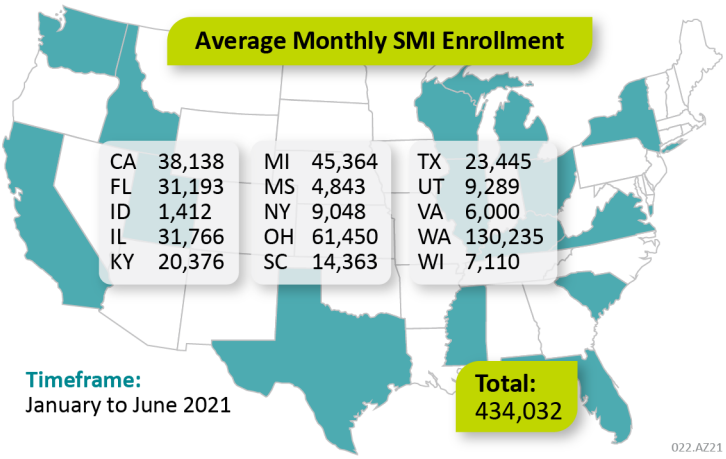
B2. Integrated Services

MCC's Phoenix-based team has the expertise and experience required to manage the delivery of fully integrated physical health, behavioral health, social service referrals, and supports to individuals with an SMI designation and those served through Non-Title XIX/XXI funds. As described below, our team has both experience with the RBHA system and a unique understanding of how to improve service delivery and outcomes for individuals with an SMI designation.

a. Experience with Service Delivery to Individuals with an SMI Designation

Our team has more than **150 years of combined experience serving individuals with an SMI designation** at the health plan, provider, or agency level, including 104 years of Arizona-specific RBHA experience. We are a leader among ACC plans in promoting recovery and resiliency principles through our leadership in OIFA, the integration of peers and recovery principles into our care management programs, and our effort as **the only health plan in Arizona to seek national certification as a Trauma Informed Organization.** We also include individuals in leadership roles with lived experience, including those certified as Peer Support Specialists with Intentional Peer Support certification and with Family Support credentials. The design of our ACC-RBHA approach is further supplemented by the experience of consultants, such as Eddy Broadway and Nick Margiotta, who have decades of experience across the system of care for individuals with an SMI designation.

Exhibit 1. Molina Healthcare Medicaid Plans Serving SMI Population.
Geographic coverage and average monthly SMI enrollment.



41% decrease in opioid use

115% increased naloxone use

Proven Outcomes Across Molina

Our Virginia affiliate implemented a series of care coordination interventions to reduce opioid use among their most complex members. The program decreased opioid use across their membership by 41% year over year and increased the use of naloxone by 115%.

Our Washington affiliate has the **lowest rate of 30-day readmissions after a psychiatric inpatient stay** of the state's five health plans.

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We supplement our Arizona experience with **Molina Healthcare's 24 years of experience serving individuals with an SMI diagnosis** by tailoring program innovations and best practices that have been successful in other states to ACC-RBHA member needs (Title XIX/XXI and Non-Title XIX/XXI). As shown in **Exhibit 1, Molina Healthcare delivers a full range of integrated physical health, behavioral health, and social services to more than 430,000 Medicaid members with an SMI diagnosis each month across 15 states**. For example, our affiliate in Florida is one of only two plans in that state that delivers behavioral health, physical health, pharmacy, and support services to members in a fully integrated SMI Medicaid specialty health plan—one of the first of these plan types in the nation. Further, Molina Healthcare serves the largest number of Medicare-Medicaid Plan members in the country. **The experience of our affiliated health plans includes serving individuals with an SMI diagnosis who have complex needs**, including pregnant women, those with first-episode psychosis, individuals experiencing homelessness, those with SUD, housing recipients, justice-involved individuals, members in COT, and individuals with co-occurring conditions (e.g., COPD, diabetes).

An Integrated Behavioral Health Program That Delivers Results

Our MCC affiliate in Florida created the Integrated Behavioral Health Home Program in partnership with providers delivering truly integrated models to ensure the most complex members have immediate access to all physical health and behavioral health services, where and when they need them. Our affiliate measures providers' ability to engage members, provide comprehensive services, and keep members healthy in the community. **Results for this program show reduced inpatient cost by more than 50% and ED cost by more than 40%.**

50% reduced inpatient cost

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Efforts to Advance Healthcare Integration. Within our ACC plan, we've advanced healthcare integration through

creative contracting arrangements and initiatives with providers to better serve members with the most complex and chronic co-morbid needs (as described throughout our response). For example, we contract with providers, such as Copa Health and Catalytic Health Partners, to incentivize integrated care at the point of service. We've also integrated peer services into our care management program for high-risk individuals with high needs transitioning from inpatient or behavioral health residential services, and we're working with providers such as CHEEERS Recovery Center to offer a fully integrated experience for pregnant women with SUD. We also leverage Molina Healthcare's extensive experience as a fully integrated Medicaid MCO. As a Molina Healthcare company, MCC's **approach to advancing healthcare integration is unique because we manage physical health, behavioral health, and social service referrals in-house rather** than delegating those services to vendors as many other health plans do.

b. Experience with Service Delivery Using Non-Title XIX/XXI Funding Sources

Our team comprises several leaders who have spent their careers working in Arizona specifically with the RBHA system. Their experience with service delivery using Non-Title XIX/XXI funding sources has allowed us to design a transformative approach to Non-Title XIX/XXI service delivery, which we describe in detail in our answer to question B3. Our team is well versed in the nuances of the service delivery system across all funding sources (e.g., MHBG, SABG, federal discretionary grants, State funds, county funds), and has close relationships with the providers who use that funding today. We also have significant experience with crisis services both in Arizona and across the country through our affiliates. Several of our current MCC leaders helped establish the national best-practice crisis system in Arizona. We currently coordinate care for all MCC ACC members with behavioral health needs, including those with an SED or SUD diagnosis, and contract with every provider in the Central GSA that receives Non-Title XIX/XXI funding to provide covered services. As other states don't contract Non-Title-funded services to MCOs, we leverage the experience from our affiliated plans responsible for coordinating services for populations similar to those served through Arizona's Non-Title XIX/XXI funds. For example, each month, our affiliated health plans serve more than 62,000 members with an SED; 183,000 members with HIV; 188,000 members with hepatitis C; and 76,000 members with an SUD diagnosis.

c. Experience with Administration of Non-Title XIX/XXI Funding Sources

Our MCC team has more than **two decades of combined Arizona experience administering Non-Title XIX/XXI funding, including federal grants.** We are knowledgeable about the complexity and intricacies of all Non-Title-XIX/XXI-required processes because we established the systems needed to effectively track and manage these funds, including fund allocation, enrollment and eligibility, reconciliation, and reporting. During his previous work on the RBHA program, our VP, IT Applications developed the enrollment, eligibility, and reconciliation processes for the Non-Title XIX/XXI system, which gives us a unique understanding of how to match member enrollment and eligibility to their benefits; how best to allocate funds; and how to use reconciliation processes necessary to ensure Non-Title XIX/XXI funds are the payer of last resort. This experience will enable us to maximize limited Non-Title XIX/XXI funds to ensure they're available throughout the Contract year. We will ensure an adequate network to deliver services to priority populations established for each Non-Title XIX/XXI funding source in compliance with AMPM 320-T1 and 320-T2. As shown in **Table 1**, our staff are experienced with meeting the wide array of administrative and operational Non-Title XIX/XXI requirements. We also have contracted with **Mr. Broadway**, who has more than 30 years of experience guiding and directing healthcare strategy and operations, including within fully integrated MCOs.

Table 1. Experience with Non-Title XIX/XXI Requirements. MCC has the experience to ensure compliance with all Non-Title XIX/XXI requirements.

Key Personnel	Prior RBHA Contract Experience in Maricopa County
VP, IT Applications	Built the benefit configuration for each State and federal grant; built the Non-Title XIX/XXI enrollment process
Market Chief Financial Officer	Oversaw administration of provider payments and encounter reconciliation; managed reporting systems needed to perform robust data analysis, track performance, and meet ad hoc reporting needs
AVP of System Transformation	Managed the operational infrastructure for Non-Title XIX/XXI funding contract requirements and the enrollment process; ensured appropriate eligibility assignment of the RBHA and GMH/SU populations; monitored status changes in Title XIX/XXI and Non-Title XIX/XXI and supported reconciliation processes; supported plan initiative to ensure contracted providers routinely screened their members for AHCCCS eligibility

B3. Non-Title XIX/XXI Funding

Using Limited Non-Title XIX/XXI Funding to Maximize Timely Provision of Quality Services

MCC has spent two years meeting with stakeholders and advocates and is leveraging the deep experience of our leadership team and consultants to design a broad-based transformative approach to the delivery of services funded through Non-Title XIX/XXI funding. Our approach to maximizing timely provision of quality services for ACC-RBHA members is grounded in our dedication to **measurement-based care.** We will use Medicaid managed care principles of measurement, continuous quality improvement, accountability, payment reform, network accessibility, and capacity management as well as care management protocols to reshape the Non-Title XIX/XXI system of care. Critical goals of our approach are to expand capacity and access to services funded by Non-Title XIX/XXI; enhance coordination between systems and payers; ensure quality delivery of services at the right time, in the right quantity, in the most appropriate setting; support member and family choice; and provide education and service navigation to ensure people receive needed services.

Today, the Non-Title XIX/XXI system of care struggles with inconsistent funding with some sources of funding running short while others aren't used. Too often, members aren't aware of the services available, and there are knowledge gaps in how to navigate those services and lack of communication with members' providers. There is an opportunity to improve the quality of services delivered and reduce providers' administrative burden and struggle with reconciling funds and reporting. **Led by our Chief Quality and Outcomes Officer,** we will address these opportunities through the following strategies.

Payment and Funding Allocation Reform. We are developing a glide path to move from allocating Non-Title XIX/XXI funds in block payments to a FFS model that will eventually transition to a model of outcomes-based payments. We understand this payment transformation will require collaboration with providers and take time; however, it's critical to opening up the network of providers who are able and willing to provide Non-Title-XIX/XXI-funded services, which in turn enhances quality and member access to services.

Capacity Management. MCC is building an advanced capacity management system using our custom-built member data exchange hub, Collective. We will collect records biweekly of all members in active treatment and organize each service by fund, so we can identify in near real time the system's capacity for any particular service funded through a Non-Title XIX/XXI funding source. This advanced capacity will support prioritization of services as described below, as well as network accessibility analysis and network deficiency remediation.

Expanding Network of Non-Title XIX/XXI Providers. Our Grant Administrator will provide technical assistance as we develop a prospective membership analysis and forecast utilization to guide network development to include additional providers that serve SMI subpopulations, such as pregnant women with SUD, those with co-occurring SMI/SUD, children with SED, elderly members, individuals with eating disorders, justice-involved individuals, and American Indian/Alaska Native (AI/AN) individuals. A critical element of getting more providers to accept Non-Title XIX/XXI funds is helping to reduce the administrative burden of using those dollars. To address this challenge, we will hire a third party to support provider processes for reconciliation and reporting and leverage our Collective solution to make these processes more seamless to providers.

Quality Service Delivery. We will monitor under- and overutilization of Non-Title XIX/XXI services to ensure members receive the right services, in the right quantity, in the most appropriate setting. We will establish Non-Title XIX/XXI services performance metrics and incorporate them into our QM/PI program to increase accountability and guide monitoring and system improvements. Our quality reviews of Non-Title XIX/XXI service assessments and individual service plans (ISPs) will ensure correct prioritization and address the SABG-related recommendations in AHCCCS' FY 2020 Case File Review Findings report conducted by Mercer. We will report all performance data to our ACC-RBHA Governance Committee. The ACC-RBHA Governance Committee will oversee and inform all aspects of our Non-Title XIX/XXI funds administration to ensure continual process improvement.

Care Management. We are creating a dedicated team of **Non-Title XIX/XXI Navigators,** who will coordinate appropriate care for members receiving Non-Title XIX/XXI services, including those members who have been referred or recommended by all other AHCCCS MCOs. The Non-Title XIX/XXI Navigators will assist Non-Title XIX/XXI members with accessing services and streamline the process for other MCOs to access these dollars.

a. Using All Sources of Non-Title XIX/XXI Funding to Maximize Timely and Quality Service Provision

Each of the strategies described above to maximize timely and quality service provision will apply across the Non-Title XIX/XXI system regardless of funding source—grant, federal, State general fund, county, or local. We recognize there are unique requirements and goals depending on funding source, and each specific funding requirement will be built into our administration of each grant. As we bring accountability into Non-Title-XIX/XXI-funded service delivery, expand network service delivery options, and enhance support for member navigation of services, we have looked closely at each grant fund to identify opportunities to improve quality service provision. A few examples include the following:

Federal Funds (MHBG/SABG/Other). There are significant opportunities to ensure use of federal grant funds, which too often aren't fully leveraged across the system. We will align with the Behavioral Health Planning Council and the State's goals for each grant source (i.e., as outlined in the 2021 MHBG and SABG reports) and partner with the ACC-RBHAs in other GSAs and the TRBHAs to leverage best practices across the system to meet those goals. For example, positive results of street-medicine-based outreach in the South GSA for tuberculosis referrals and HIV/hepatitis C screenings inform our decision to model a similar effort using our street medicine partners and outreach staff for the Central GSA. Our Non-Title XIX/XXI Navigators will specifically work with other AHCCCS MCOs, schools, and community stakeholders to support member access to appropriate services. We will continuously measure utilization of services, such as First Episode Psychosis services, for underutilization and design real-time interventions to support additional outreach to enroll individuals in those programs. Finally, we will leverage best practices across the system to expand the network of providers who deliver services like SUD treatment for pregnant women.

State General SMI Funds. These funds often run out, leaving providers without support to manage individuals with SMI. Through a FFS and measurement-based approach to service delivery, we will support the most appropriate use of those dollars, measuring that services received are yielding the right outcomes for individuals with SMI and closing disparities between members with SMI served in the Non-Title XIX/XXI system and those served through Medicaid dollars. By monitoring biweekly who is in active treatment, we will be able to quickly identify members not receiving services or those who need more support to move to other funding sources as they are eligible to do so. Frequent monitoring will also enable us to track service delivery and over- and underutilization of services. Our team of Practice Transformation Specialists (described in our response to question B4) will also support providers to ensure quality service delivery.

Other Funds. Our systems of capacity management, quality measurement, reconciliation support, and service navigation will support more efficient use of grant dollars as they come into the system regardless of source. For example, crisis services across the Central GSA have multiple funding sources, the allocation of which will be further supported by our capacity management system and process to make data in the crisis system more actionable in real time (described in more detail in our response to question B9).

b. Process for Prioritization and Delivery of Services

Our process for prioritizing and delivering Non-Title XIX/XXI services includes the use of sophisticated capacity management and utilization monitoring tools that will facilitate provision of services based on member needs across the system rather than locking funding at the provider level. Our process will comply with all county, federal, and State prioritization requirements for each Non-Title XIX/XXI funding source, including AMPM 300-2B, 320-T1, and 320-T2.

First, we will define prioritization criteria for each service or set of services paid with Non-Title XIX/XXI funding based on the requirements for each funding source, followed by additional clinical criteria of acuity of need and impactability. Second, we will use Molina Insights, our proprietary risk stratification and predictive modeling platform, to create membership profiles that provide a complete, holistic picture, so we can prioritize individuals for each funding source and create pathways to lower-cost services where appropriate. Third, we will match members to appropriate

interventions based on the characteristics shown in their membership profile. For example, for an SABG-eligible pregnant woman in a residential treatment center who has not received wraparound or behavioral health prevention and support services, we will prioritize use of SABG funds to address those unmet needs while reviewing her eligibility for Title XIX/XXI services. We will also use clinical rounds internally and with the provider to prioritize services. This process will allow us to intervene when needed and improve capacity and timely access to care by ensuring that Non-Title XIX/XXI funds are spent where most needed. We will also prioritize Title-XIX/XXI-eligible members who would benefit from Non-Title XIX/XXI services through our priority referral pathway created specifically for other AHCCCS MCOs.

c. Encouraging, Enabling, and Assisting Non-Title XIX/XXI Members to Become Title XIX/XXI Eligible

MCC will encourage, enable, and assist Non-Title XIX/XXI members (particularly underserved, disproportionately affected populations such as those experiencing homelessness, in rural areas, and older adults) with applying for Title XIX/XXI eligibility, leveraging our real-time member eligibility and capacity management tracking systems. We will identify Non-Title XIX/XXI members who have not applied to become Title XIX/XXI eligible, so our Non-Title XIX/XXI Navigators can outreach to those individuals to apply. We will also monitor each member enrolled as a Non-Title XIX/XXI member who will be approaching 120 days with no service, so we can re-engage them in the system as needed, as outlined by AMPM 1040, and ensure they have applied for Title XIX/XXI services. We will leverage our diverse array of community partnerships, including Promotoras and street-medicine partners, to find, outreach to, and engage members to apply for Title XIX/XXI services.

Our Non-Title XIX/XXI Navigators will also work with clinics to increase the frequency with which they offer application assistance to members and include performance metrics related to these activities on our reporting dashboards reviewed monthly by our ACC-RBHA Governance Committee. We will also train providers on how to leverage peer support and MCC Community Health Workers (MCC CHWs) to educate Non-Title XIX/XXI members who refuse to apply, so members are informed about the benefits of Title XIX/XXI coverage and providers can offer application assistance.

d. Coordinating Non-Title XIX/XXI Services Referred or Recommended by All Other AHCCCS MCOs

There is significant opportunity in the Central GSA to streamline and strengthen the process for other AHCCCS MCOs to refer members for Non-Title XIX/XXI services, including enhanced collaboration and communication and closed-loop processes to ensure continuity of coordinated care for members. Our strategy includes the following components:

- **Coordination protocols.** We will form a Joint Operating Committee with other MCOs to assist with building coordination protocols. We will establish an MOU with each AHCCCS MCO that delineates referral, coordination, communication, monitoring, and reporting protocols to track members transitioning between Title XIX/XXI and Non-Title XIX/XXI services, accept and manage referrals, and provide timely Non-Title XIX/XXI services to referred members. This coordination will allow us to identify priority population members about to lose Title XIX/XXI eligibility or who have recently lost it, so we can provide proactive assistance.
- **Priority referral pathway and dedicated call center.** To support timely referrals, assistance, and coordination, we will create a priority referral process whereby other MCOs submit referrals online through the enrollment portal or via a dedicated call center phone number answered by well-trained representatives who can assist the MCO with accessing services for their members or facilitate a warm handoff to one of our Non-Title XIX/XXI Navigators. This process will reduce delays and increase access to Non-Title XIX/XXI services for members of other AHCCCS MCOs.
- **Collaborative monitoring.** To evaluate and improve our joint effectiveness, we will report outcomes for Non-Title XIX/XXI referrals during our monthly Joint Operating Committee meetings with other MCOs. We will also work with other MCOs to further develop and adjust referral and coordination processes as needed. To provide transparency, we will provide the joint workgroup with the amounts allocated and populations served for each Non-Title XIX/XXI funding source. We will monitor metrics related to these activities and submit data to our ACC-RBHA Governance Committee, so they can track our performance.

B4. Quality Improvement

a. Methods Used to Assess Disparities or Improvement Opportunities

Our approach to quality goes beyond traditional, HEDIS-based metrics, to instead focus on individuals' success at reaching their goals. We assess quality from the individual's perspective, analyzing real member outcomes, opposed to just standard measures, to provide true measurement-based care. Since we believe recovery is possible, we expect the system to respond to members' evolving needs along their recovery path. For individuals living with SMI, recovery is about whole person care, and they already face disparities intrinsic to their diagnosis. We bring to the ACC-RBHA Contract a Chief Quality and Outcomes Officer and Director, Health Equity and Cultural Competency who will collaborate with the Quality Management Manager and the Performance/Quality Improvement Manager to identify disparities and improvement opportunities leveraging standard QM/PI data sources, data from quarterly ISP reviews, and data collected from members, such as the Quality of Life scale and DLA-20. We will work with providers and members to make recovery a reality, pushing the system to promote the best, functional-level outcomes tailored for each member.

MCC's QM/PI program, in alignment with AMPM 900, leverages a variety of methods to assess disparities or improvement opportunities used to drive member, provider, and system-wide interventions for continuous quality improvement. Those primary methods include **data and analytics; member, provider, and community feedback; and interdepartmental reporting**. MCC's QM/PI system uses our integrated IT platforms to fully support all standard and ad hoc clinical, quality, population health, and SDOH data collection, analysis, advanced analytics, and reporting. **Table 2** provides examples of tools used in our QM/PI program.

Table 2. QM/PI Program Tools. A variety of advanced tools for continuous quality improvement.

MCC's HEDIS engine, driven by ClaimSphere®	Provides daily verification we are getting the most updated member information from providers
Molina Compass, our clinical quality improvement tool	Pulls data from our comprehensive Data Lake to deliver real-time insights into our programs and allows us to benchmark performance against nationally recognized standards
CHAMP, our quality of care dashboard	Tracks quality of care concerns at the individual level and allows us to review trends and systemic issues and refer them to the Peer Review Committee

We use our Data Lake to drill down on subgroups within our overall population and identify racial, ethnic, and other disparities in health outcomes. We combine all member information with claims, encounters, and other utilization data, including lab and pharmacy data, as well as chart audits, provider EHRs, the DUGless data provided by the State, DEX File (Blind Spot Report), DEX Supplemental File, and Health Current into our Data Lake platform. Our proprietary Molina Insights data analytics engine turns data into actionable business intelligence. Using Molina Insights, we stratify key performance indicators for each population segment by race and ethnicity. For example, we analyze HEDIS measures for prenatal and postpartum care and birth outcomes by race and ethnicity. We conduct root cause analysis on these metrics using demographic factors to fully understand the disparity, address it, and reduce the gap in outcomes.

Other key inputs will include AHCCCS' annual Quality Service Review; feedback from our OIFA team, such as member stories from our SDOH rounds; and feedback from CBOs, including those that work with minority and marginalized populations, such as NAMI Valley of the Sun, Arizona Peer and Family Coalition (specifically their Diversity Committee and Dialogue on Racial Equity), and one·n·ten's LGBTQIA+ and Transgender and Gender Non-Conforming wellness programs. The QM Committee also solicits input from our **ACC-RBHA Governance Committee, including its Disparities Workgroup, bringing member, family, and peer voice** to our assessment and development of interventions.

Related Actions Taken. When we identify a disparity or an opportunity for system-wide improvement, we address it through our continuous quality improvement cycles. Our QM/PI program incorporates best practice analytics and the Institute of Healthcare Improvement Model tools, including Plan-Do-Study-Act cycles. Through data-informed quality monitoring, our continuous quality improvement cycle, and cross-functional teams, we evaluate member, provider, and system-wide interventions and their efficacy; potential over- and underutilization; associated barriers; and outreach opportunities, as well as inform the selection and ongoing monitoring of our PIPs. Areas of focus include potentially preventable ED and inpatient events, access and availability of provider services, SDOH, and health equity. Our health equity metrics measure percent of improvement in achieving health equity and reducing health disparities.

As an example, our **PRO Capacity Assessment Improvement Project** highlights our ability to identify and implement system-wide improvements. After the inception of the new ACC health plans, MCC identified barriers to use of peer support and PRO for members needing GMH/SU services. To better understand the current capacity and capability of our peer support provider network in this new context, our OIFA team developed a capacity assessment tool to identify network strengths and opportunities for improvement. This tool measures capabilities for overall volume, geographic coverage, program strengths for special populations, and strategic planning for innovations. We met with PROs, spending time with their leaders to gather impactful information. Using qualitative data, we mapped the greatest needs for specific populations and service gaps onto our peer-run network's capabilities, illuminating synergies for potential new programs and partnerships. This shifted our approach from increasing referrals to PROs to matching members' specific needs to these critical providers' greatest strengths. **MCC will expand this strategy for capability assessments to FROs and all providers offering peer and family support to bolster strategic partnerships.**

b. Areas of Greatest Opportunities for System-wide Quality Improvement

As we enter the next phase of system-wide quality improvement, MCC has identified opportunities to significantly improve preventive healthcare for individuals with an SMI designation; enhance integration, accountability, and transparency for outcomes at every level of the continuum of care; and improve care coordination and collaboration through related actions: **measurement-based payment models, member engagement activities, advancing integration and care coordination, and community collaboration**, as detailed below. There is opportunity to address gaps found in Mercer's Annual Quality Service Review and Service Capacity Assessment for Maricopa County regarding generic ISPs, better use of family support services, and integration of supportive housing and employment services. Below we show the **Related Actions Taken** as well as initiatives we will expand under the ACC-RBHA contract to address these opportunities for improvement across various preventive and chronic care measures we track.

Measurement-based Payment Models. As an ACC plan, MCC has been a leader in developing creative payment models with integrated providers, behavioral health specialty providers, and Health Homes to promote improved preventive care and enhanced care coordination for individuals with complex needs. Our work with these providers and others like Copa Health, Resilient Health, and CHEEERS Recovery Center, has demonstrated improved results for preventive and chronic care measures and has led to reduced utilization of high-cost services. At the center of our strategy for continuous system-wide quality improvement to address preventive care, integration, and care coordination is how we think about our provider contracts and payment models. Our models target specific opportunities for improvement (i.e., high-risk pregnant women, suicide risk, ED utilization rates, etc.) and meet each individual provider where they are in a collaborative way. Some examples include:

Advancing Payment Models Under the ACC-RBHA Program

We will expand measurement-based payment model agreements with PROs and FROs. Our PRO and FRO VBP arrangements provide flexibility and shared savings to support their expansion and leverage their capacity and capabilities. Key to our approach is providing RBHA-like technical assistance to support providers to succeed and advance along the continuum of risk. We also leverage these arrangements to increase transparency and accountability and support PRO and FRO implementation of continuous quality improvement.

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- The *EMPACT Suicide Prevention Center* arrangement refers individuals significantly involved with hospital-based emergency and crisis services who are not connected with the behavioral health system to community-based services. The contract includes a PMPM and shared savings payment tied to ED and hospital utilization metrics.
- *Crisis Preparation and Recovery* supports members who visit the ED three or more times within 90 days and who have unmet needs through intensive interventions, support services, and an integrated care team supported by Community Health Workers and advanced analytics to engage and provide a coordinated integrated care delivery model. The upside/downside PMPM contract includes an incentive for closing preventive care gaps and improving utilization.
- Our partnership with CHEEERS Recovery Center offers peer support services for women with co-occurring conditions with the overarching goal of abstinence from illegal drugs and alcohol, adequate prenatal healthcare, and recovery planning while ensuring they experience uncomplicated births. Our value-based arrangement includes a PMPY incentive payment tied to achieving prenatal, postpartum, and contraceptive measures; use of DLA-20; access to a PCP; submission of SDOH Z codes; and adoption of technology.

Member Engagement. MCC has a long history of innovating to improve how we connect with and engage members. Whether it's digital tools, outreach events, or programs like our Peer Reach-In Program to support transitions of care, member engagement activities remain a critical part of our strategy to address opportunities for quality improvement. For example, we implemented a **texting campaign in 2020 that doubled reach rates** for individuals with gaps in care; **increased Cervical Cancer Screenings by 10%** and **Well-Child Visits in the First 15 Months of Life by 50%**; and held rates of Adults' Access to Preventive/Ambulatory Care, Child and Adolescent Well-Care, and Annual Dental Visits from 2019 to 2020 even though provider offices were closed and care was suppressed due to COVID-19. **73% of those using our Pyx Health app saying they feel more connected to their health plan**.

Engagement Innovation Under ACC-RBHA

MCC's on-the-ground member engagement strategy provides specially trained professionals and peers to engage members using motivational interviewing and trauma-informed care to re-engage them in their health.

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Advancing Integration and Care Coordination. AHCCCS' decade-long journey toward true integration is at the cornerstone of how MCC thinks about leveraging integration and care coordination activities in our larger strategy to make system-wide quality improvements. Integrated and coordinated care addressing physical health and behavioral health needs along with social risk factors leads to improvements in preventive care measures, overall long-term health outcomes, and decreased utilization of high-cost services. Some actions taken beyond using payment models to drive integration and coordination include our work with the Opioid Assistance and Referral (OAR) Line and the University of Arizona, where we identify members at risk of overdose and partner on harm-reduction activities and more intense care management interventions as needed. For those who enrolled in the program, **we saw a 28% decrease in total cost of care while also seeing a 50% increase in utilization of outpatient behavioral health services and a 23% increase in pharmacy spend**, showing with the right coordination, individuals will access the most appropriate and least restrictive levels of care.

Advancing Integration Under ACC-RBHA

MCC is partnering with Terros Health through the use of a special case rate to build our **Justice-involved Community of Care**. In this initiative, we are advancing an integrated model of services and a priority referral pathway to providers specially equipped to support justice-involved individuals. We will provide technical assistance, the Collective solution for data exchange, and the infrastructure for this specialty community of care.

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We are also launching our Collective solution—a virtual data hub that shares critical member-level health information to support care coordination. We are entering Phase 2 of Collective's launch with five partners and will implement it across the SMI and Non-Title XIX/XXI system of care under the ACC-RBHA Contract.

Community Collaborations. MCC is a true community collaborator. We have assembled dozens of partners in the design of our ACC-RBHA approach and have more than 25 letters of support and/or letters of intent to partner from providers, CBO leaders, advocates, and other community stakeholders. We know that community collaborations lead to real quality improvements because we've seen it work with specific populations. For example, we recently partnered with the University of Arizona and Project ECHO® to train nearly 70 professionals on the unique needs of victims of human trafficking—a critical step in addressing disparities in care for these individuals. Another example is our work with Valley Leadership, who we partnered with to create the Impact Maker initiative. Through our leadership and financial support, this initiative is opening pathways for justice-involved individuals to obtain employment upon release by encouraging private sector employers to remove barriers to hiring felons.

Advancing Community Collaboration Under ACC-RBHA

MCC is partnering with Dr. Cecilia Rosales, Associate Dean, Phoenix Campus, and the Professor & Chair, Division of Public Health Practice & Translational Research at the University of Arizona's College of Public Health to address disparities related to vaccinations and conditions such as cardiovascular disease and diabetes within Latino and Spanish-speaking populations. This collaboration will provide culturally and linguistically appropriate education and materials to underserved communities through the university's Primary Prevention Mobile Health Unit.

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

MCC has been a leader among ACC plans in developing targeted programs and interventions for the GMH/SU population, many of whom have significant behavioral health needs or are living with an SMI, even if they don't meet the requirements for RBHA enrollment. We will bring the best practices below to support ACC-RBHA Program populations.

Program	Description	Statistically Significant Results
Peer Reach-In Program	This program uses best practice peer-driven care coordination, integrated within the Care Management team, at the point of behavioral health admission. Highly trained MCC Peer Support Specialists work real time with facilities and MCC Care Managers to identify and engage high risk / high needs members and elevate member voice and choice. The program responds to the need to reduce avoidable ED use, unnecessary hospitalizations, and hospital readmissions, while integrating care and increasing access to PCPs and outpatient services.	• 39% decrease in BH hospitalizations • 38% increase in outpatient BH services like counseling • 41% increase in supportive BH services • 39% increase in connection to PCP
Resilient Health Suicide Prevention	Launched May 1, 2021, the Driving Suicides to Zero program uses evidence-based practices and enhanced care coordination for the GMH/SU population to reduce suicides. By providing routine C-SSRS screening and prescriptive interventions, the program demonstrates effectiveness by incorporating screening and evidence-based interventions.	• 100% compliance with the FUH–7 Days and FUH–30 Days HEDIS measures, both above the 90th percentile benchmark
Catalytic™ Health Partners	MCC is partnering with CHP to support members by combining personalized in-home face-to-face condition management with convenient digital connectivity. Each member under CHP's care receives a personal health tablet with real-time access to CHP staff.	• 100% compliance with FUH–7 Days and FUM HEDIS measures, both above 90th percentile benchmark
Pyx Health	MCC deployed the mobile Pyx Health application in 2020 to engage members at risk of experiencing adverse health outcomes due to loneliness and social isolation. The Pyx app offers 24/7/365 engagement for members struggling with loneliness. MCC pairs the app with care management, using data from the app to identify members who need additional supports to further improve interventions.	• 41% of members improved loneliness scores • 82% of those also improved their depression score • 57% reduction of medical costs

d. Proposed Approach to Clinical SMI PIPs

According to the Arizona Diabetes Action Plan and Report dated January 1, 2021, diabetes is the state's seventh leading cause of death, greatly contributes to early disability, and costs $6.8 billion per year. As **Table 3** shows, our PIP addresses SMI and diabetes, aligning with AHCCCS' Quality Strategy and AHCCCS AMPM 980 for implementation of PIPs and developed according to 42 CFR 438.330. We use Plan-Do-Study-Act and a rapid-cycle improvement approach.

Rationale. Due to factors such as adverse metabolic effects of psychotropic medications and lack of timely receipt of guideline-concordant diabetes care among those with SMI, people with schizophrenia or bipolar disorder who also have diabetes are at greater risk than individuals without SMI who have diabetes. Screening enables early identification, treatment, and management to prevent or delay diabetes progression. Additionally, non-adherence with antipsychotic medications is associated with poor mental functioning, relapse, victimization, attendant morbidities, and schizophrenia-related hospitalizations and complicates SMI treatment due to uncertainty about medication effectiveness.

Table 3. Proposed Clinical SMI PIP. Our proposed PIP aims to reduce mortality risk and improve quality of care for members with SMI and diabetes.

Aim Statement	MCC will reduce mortality risk and improve quality of care for members with SMI with diabetes by improving antipsychotic medication adherence and receipt of preventive diabetes screening and monitoring.		
Population	All adult members with a schizophrenia or bipolar disorder diagnosis who are continuously enrolled during calendar year 2022 and have a diagnosis of diabetes and one or more antipsychotic medication prescriptions.		
Study Indicators	1: Increase the SAA HEDIS rate for members with schizophrenia or bipolar disorder and diabetes who received one or more antipsychotic medications.	2: Increase the SSD HEDIS rate for members with schizophrenia or bipolar disorder and diabetes who receive appropriate diabetes monitoring.	3: Increase the Diabetes Monitoring for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications HEDIS rate for members with schizophrenia or bipolar disorder and diabetes who receive appropriate diabetes monitoring.
Interventions	MCC will conduct proactive, culturally sensitive member- and provider-focused outreach through our multidisciplinary team of clinical and quality staff who will ensure our members receive timely and appropriate screening and monitoring tests for diabetes while remaining on medications for their SMI diagnoses of schizophrenia or bipolar disorder. Interventions will include: • Referring members to care management and/or disease management to manage diabetes and SMI chronic conditions. • Providing nutritional consultation to members with diabetes and SMI upon diagnosis (as applicable) and/or after diagnosis • Sending providers action lists and report cards, including gaps in care each quarter, for members with diabetes and SMI. • Focusing value-based contracts on diabetes and/or behavioral health medication adherence. • Distributing evidence-based clinical practice guidelines for diabetes and SMI to providers as guidelines are updated. • Offering quarterly and on-line member education programs on healthy lifestyle behaviors (e.g., weight management) • Enrolling members in the Centers of Excellence Integrated Care Management program with Health Homes as applicable to promote recovery and resiliency and connecting members with providers and partners that offer supportive services. • Referring members to MCC's OIFA team as applicable.		

B5.c. Proposal for Central GSA

Ensuring Members' Services Are Aligned with Their Individual Strengths and Needs

There is a critical need to ensure individuals' care aligns with their ISP. Under the leadership of our Adult Healthcare Administrator, MCC will employ the four strategies described in **Table 4** and evaluate success through measurement-based outcomes to validate services are aligned with individual member strengths and needs.

Table 4. MCC Strategies to Align Services with Individuals' Strengths and Needs. Our approach incorporates four key mechanisms to addressing opportunities identified in Mercer's "Service Capacity Assessment Priority Mental Health Services 2020: AHCCCS."

Enhancing Case Management Competency	MCC will fund and facilitate the development of a curriculum for Case Management teams using input from Health Homes and other stakeholders and in partnership with Scottsdale Community College to not only improve the effectiveness of current Case Managers but to create a pipeline of available, qualified Case Managers. Through the curriculum, MCC will retrain Case Managers and their supervisors on the core competencies in the Case Management Plan.
Health Home Practice Transformation	Our Practice Transformation Team will promote accountability and provide oversight through quality reviews and joint clinical rounds to ensure ISPs reflect members' assessed needs and preferences. The Teams will monitor outcomes metrics and provide ongoing feedback and mentoring on identified improvement opportunities. We will promote the State's vision for timely data on services and close loops with service planning by integrating key elements from Health Current, NowPow, and Molina Insights (claims) to improve transparent, data-driven decisions. Using outcomes data, providers and the ACC-RBHA Governance Committee will be able to tie referrals to the ISP, ensuring alignment to individual needs.
Payment Reform	MCC will introduce measurement-based care into our base provider contracts, dictating a payment structure dependent on where the provider is in the continuum plus a differential payment based on the quality of their ISPs (detailed, individualized) and how well they deliver the services in the ISP. Through quarterly audits, we will assess ISPs in practice, analyzing if the assessment and ISP align and if the ISP is being driven by the strengths and needs on the assessment, ultimately ensuring members have services in place to address their individual needs.
Innovations in Member Engagement	Currently, when Case Managers are unable to reach the member to complete an assessment, they will still create a generic ISP in order to meet the requirement that every member has an ISP. MCC will support successful member engagement by providing Case Managers with training and support, and leveraging our innovative Unable to Contact Program, which includes a partnership with Street Medicine Phoenix and other CBOs with demonstrated effectiveness at finding and engaging members with SMI. These initiatives will increase member contact, so ISPs reflect assessment of member strengths, needs, and preferences.

Ensuring Peer and Family Supports Are Offered and Available to Assist in Meeting Member Needs

MCC is a leader at incorporating peer and family voice at every level of our organization and recognizing the importance of self-identified lived experience and peer and family support in improving outcomes. **Joshua Sprunger** leads our OIFA team, staffed with four people with lived experience who are certified in Intentional Peer Support, two of whom are also Credentialed Family Support Partners in Arizona. When the GMH/SU population moved to the ACC plans, MCC led an effort to assess accessibility to Peer and Family Supports for that population and led a system-wide educational effort to ensure GMH/SU members were appropriately referred to services. To ensure Peer and Family Supports are offered more consistently and are more widely available under the ACC-RBHA Contract, we will monitor underutilization of these services at the member segmentation and provider levels to identify outliers and disparities, and then design interventions to boost uptake of the services. Expected interventions include ensuring Peer and Family Supports are integrated into the ISP process and are offered consistently through **educating and holding accountable** Health Homes and their case management teams. It's also critical that members and families are empowered to request services, including credentialed adult family support. Our strategies to achieve these goals are listed below.

Education and Member/Family Outreach. Invest in CBOs to provide outreach and training to families and individuals with SMI in minority and bilingual communities; expand our successful Peer Reach-In Program for high-needs ACC-RBHA members to EDs, so individuals and providers are introduced to Peer and Family Supports at varying levels of care and touch points in the healthcare system; and develop an annual Peer and Family Support Recognition program in collaboration with the community to elevate the importance of Peer and Family Support Specialists across the system.

Accountability. Include in our frequent audits of ISPs a specific measurement for use of Peer and Family Supports, and leverage our Practice Transformation Teams to offer technical assistance to Health Homes who fail to meet or exceed goals for offering Peer and Family Supports.

Through a transformational MolinaCares Accord grant, MCC contributed $100,000 to the Arizona Peer and Family Career Academy to provide the foundation for capable and competent peer support and family support communities of practice. We will continue to expand capacity in the system through **launching our MCC System Transformation Roadmap** (as described in response to question B7) to build ACO-like virtual communities of care that include **integrated referral pathways to PROs and FROs**, supported by our custom portal technology hub, Collective, which allows for the exchange of actionable data for all providers involved in a member's care. We will also establish **creative outcomes-based payment arrangements** with PROs and FROs and providers like Neighborhood Outreach Access to Health (NOAH) who can leverage CHWs as Peer Support and Family Support Specialists, to ensure availability of high-quality services and provide opportunity to infuse additional dollars into the peer and family support system.

Other Arnold vs. Sarn Requirements

Critical to ensuring compliance with the requirements of Arnold vs. Sarn, regarding making services available to members, is ensuring capacity of the services and the creation of priority referral pathways for members with SMI. Our strategies to achieve these goals for each Arnold vs. Sarn service are described below.

> **"The specific goal of the Arnold vs. Sarn litigation was to develop and advance a single, unified system of care for those in our community with a serious mental illness. …Arizona's mental health system will benefit greatly from the technological advances, workforce development, and re-emphasis on peer and family supports proposed by MCC, moving our system toward the vision foreseen by the passing of the statute underlying the case, and the courts interpreting it."**
>
> *– Chick Arnold, lawyer and advocate for the rights of the elderly and mentally ill*
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Supported Employment. MCC will transform the delivery of supported employment services into a transparent and accountable system of training and referrals to improve the average 13-to-15% rate of adult members with SMI who are gainfully employed or attending school full time. Our model integrates high-quality training and incentive-based payment structures to ensure members can obtain and maintain sustainable and meaningful employment. We have a letter of intent with WEDCO Employment Center to implement milestone and outcome-based incentives that go beyond simply placing a member in a job. We will expand "Disability Benefits 101" training for family and peers, so families fully understand they will not lose benefits if they work.

Supportive Housing. MCC will ensure adequate capacity of supportive housing services, focusing on the specific needs identified in the Mercer report. Our approach will first address SMI Health Home Case Managers' understanding of the services available and skills needed to ensure members and families know about the supportive housing benefit to help individuals remain in housing or prevent homelessness, with the goal of increasing community tenure. Through our ASPire PLUS curriculum, Case Managers will be able to build their competencies to both ensure the need for supportive housing services is reflected on members' ISPs and help members negotiate and navigate issues and concerns members may have, including effectively working with landlords and how to be a good neighbor.

ACT. To achieve and measure compliance, MCC will adopt the performance measurements included in the Mercer report but will examine the measures more frequently to allow for better real-time interventions. MCC's approach will ensure ACT teams are functioning at 95% capacity by assessing the appropriate clinical acuity to ensure the right people are in ACT, following SAMHSA guidelines. Using dashboards focused on measurement-based care metrics, we will be able to determine level of functioning and review clinical data to assess clinical practices such as use of preventive care measures, use of the DLA-20 assessment, reduction in ED use, and reduction in duplicative services. Our Behavioral Health Medical Director Dr. Gregory Gale will oversee analysis of ACT over- and underutilization to drive appropriate interventions in accordance with fidelity standards.

We will publish dashboards at least quarterly on our Arnold vs. Sarn measurements and bring them to our ACC-RBHA Governance Committee, of which half the membership will be external stakeholders and advocates, to help hold each of us in the system accountable to ensure our Maricopa members are receiving these services. We will design and implement standard CQI interventions and PIPs when faced with outlier trends. Additionally, through our approach to measurement-based care, which is foundational to our entire ACC-RBHA program strategy, we will not just measure utilization of services but their effectiveness, using standardized and/or evidence-based tools like the DLA-20 and quality of life assessments, as well as outcomes measures like readmission rates and ED utilization. Our Practice Transformation Team will provide technical assistance when a provider is an outlier on Arnold vs. Sarn requirements.

B6. Impactful Initiative

a. Contractor Care Management

Peer Reach-In: Improved Outcomes
Results based on completion of 120-day program

39% Decrease	38% Increase	41% Increase
Behavioral health hospitalization	Outpatient behavioral health services (like counseling)	Supportive behavioral health services

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The single most impactful initiative MCC is undertaking to provide the best care and improve outcomes for individuals with an SMI designation is an expansion of our **Fully Integrated Care Management Program: Peer Reach-In**. This innovative and proven program uses best practice peer-driven care coordination, integrated within the Care Management Team, at the point of behavioral health admission. Members with high needs are identified by and engaged with highly trained MCC peer support specialists (Recovery Health Guides) who work in real-time with facilities and MCC Care Managers to engage members to elevate member voice and choice. The program responds to the need to reduce unnecessary/avoidable ED use, unnecessary hospitalizations, and hospital readmissions. It also powerfully integrates **physical and behavioral healthcare,** increasing access to PCPs and behavioral health outpatient services.

The program is one of personal connection, wrapping the member in care coordination support with a consistent point of contact to assist in recovery work, ultimately increasing post-discharge engagement and reducing unnecessary ED use, hospitalizations, and readmissions. It integrates the principles of recovery and member voice and choice into our Care Management program. **Facilities report that MCC is the only ACC health plan in the Central GSA providing peer engagement to members before discharge**, including referrals to providers offering peer support and peer-delivered services.

In 2019, we started our program to ensure our highest need members, many with serious symptoms and not previously engaged in care, were connected to appropriate natural supports and services. Initially focused on the hospital setting, we expanded the program in 2020 to residential treatment facilities, and under the CCE, will further expand to EDs.

As part of our Care Management Team, Peer Reach-In offers team-based, coordinated care to ensure identified community supports are in place for the member to safely remain in or transition back into the community. **Collaboration between our Recovery Health Guides, MCC Care Managers, and Health Home Case Managers is critical for ensuring the inclusion of member voice.** Key program elements include the following:

- **Pre-discharge member engagement using peers.** Our Recovery Health Guides serve as liaisons and advocates for the member, helping the member with system navigation and collaborating with the Care Management Team, the inpatient team, and the member on coordination of care. The team develops integrated behavioral health and physical health solutions before discharge to build rapport and engage members in transition planning, such as selecting a Health Home. Recovery Health Guides educate members and their families about peer support, harm reduction, and services.

> **"Cameron [Recovery Health Guide] from MCC has been meeting with MCC patients to let them know about all of their options once they leave the hospital, and the patients have been so receptive to it. The collaboration between Cameron, the patient, and the Case Manager here at BBHH has been so beneficial to the patient's discharge plan. We are very grateful to have this extra support for our patients, and I hope to continue the work we have been doing."**
>
> *– Paige N. Sheppard, Transitional Care Navigator, Banner Behavioral Health Hospital*
>
> 021.AZ21

- **Peer advocacy during discharge planning.** Our Recovery Health Guides engage with the member and family to ensure discharge planning reflects member voice and choice and addresses whole person needs. Recovery Health Guides serve as the bridge between the MCC Care Manager and providers offering peer support, counseling, and other community-based services to transition the member to the post-discharge provider, keeping them engaged in care.
- **Ongoing engagement with MCC's Care Management Team.** Our Recovery Health Guides use a recovery perspective while ensuring member voice is prioritized. Our Recovery Health Guides facilitate engagement of the member with MCC Care Managers as part of discharge planning, discussing how to address gaps in care, arranging post-discharge services and medication, establishing care team(s) to ensure a smooth transition, and ensuring the member is scheduled, including transportation as needed, for any necessary post-discharge follow-up appointments.

b. Provider Case Management

The single most impactful provider case management initiative MCC is undertaking to provide the best care and improve outcomes for individuals with an SMI designation is our **ASPire PLUS program, an end-to-end, measurement-based learning and workforce development program with the goal of improving Health Home Case Managers' core competencies and system capacity**.

Mercer's "Service Capacity Assessment Priority Mental Health Services 2020: AHCCCS" identified that ISPs are often generic due to the lack of Case Manager capacity, heavy administrative burden, and difficulty retaining qualified Case Management staff. This concern was echoed in our SMI Health Home CEO Roundtables (a collaboration to hear the perspectives of Health Homes) leading up to the CCE release.

> **"We are excited about the partnership and close relationship we have with MCC in serving our communities by providing educational opportunities that change lives and build a stronger workforce to help improve the lives of the most vulnerable populations."**
>
> *– Christina Haines, President, Scottsdale Community College*
>
> 018.AZ21

MCC's ASPire PLUS will use evidence-based and promising practices in partnership with Scottsdale Community College (SCC) to develop a full ecosystem of multimodal learning solutions and curated content targeted to Arizona Case Manager needs. It will include a comprehensive curriculum to improve SMI Case Managers' core competencies consistent with the requirements of AMPM 570 and ACOM 470. ASPire PLUS will increase the availability of trained Case Managers; enable Case Managers and Case Manager Supervisors to gain skills and improve competency; and provide technical support and incentives to Health Homes to improve Case Manager outcomes. The curriculum and training will advance person-centered ISPs, quality of services, and job satisfaction/retention of Case Managers as recommended in the Mercer report. ASPire PLUS will align with the Maricopa County Case Management Plan, incorporate key community stakeholders / recognized sources for best practices, and leverage learning pathways that providers and Case Managers already access. We will build on the foundation of Relias' training platform to incorporate and expand ongoing training for Case Managers, as well as provide the curriculum via a series of YouTube videos for easy access. **Case Managers will earn academic credits from the SCC program, opening a pathway to further their education and career.**

The end-to-end process, as described in **Table 5**, will follow our model for continuous improvement by developing curriculum based on desired improvements, practice transformation through support and incentives, and monitoring of outcomes with the results driving changes to the curriculum to address identified improvement opportunities.

Table 5. ASPire PLUS. Our end-to-end process of continuous improvement to advance availability and competency of Health Home Case Managers.

Outcome-focused Curriculum Development	Curriculum content will be jointly developed post-award with SCC by evaluating case management outcomes and opportunities for improvement, as well as from collaboration and stakeholder input from SMI Health Homes, SCC, and MCC.
Curriculum for Case Manager Fundamentals and Specialty Topics	Curriculum will comprise core Case Manager competencies, strengths-based assessment and ISP development, reducing health disparities, addressing SDOH needs, leveraging system resources, and trauma-informed care. Focused topics will include Disability 101 and the needs of special populations such as justice-involved members, members with co-occurring physical health and mental health conditions and/or SUD, and members who are experiencing homelessness.
Practice Transformation	Our Practice Transformation Team will work with Health Homes and their Case Managers to apply their learning, such as providing technical support, working to decrease administrative burden, and performing quality reviews and case rounds to ensure ISPs reflect the strengths, needs, and preferences of the member and family.
Value-based Incentives	We will create incentives for Health Homes to achieve desired case management outcomes supporting sustainability of education and process changes. Results will be monitored by the ACC-RBHA Governance Committee and used as inputs to curriculum changes moving forward.

c. Outreach and Education

It is widely recognized that one of the most difficult barriers to providing services and recovery outcomes is finding and engaging members—especially those who are housing insecure, involved in the criminal justice system, or are experiencing chronic, severe symptoms of a behavioral health disorder. The single most impactful outreach and education initiative to provide the best care and to improve outcomes for individuals with SMI is our **Unable to Reach Program**, which uses **MCC Recovery Health Guides** to reach vulnerable and/or temporarily disconnected members; establish an inviting, non-threatening environment; educate them about the health conditions and system navigation; and engage them in care or support based on their own voice and choice.

MCC is investing in our **Unable to Reach Program** by hiring specialized staff, leveraging key partnerships through the Central GSA, including partners such as Street Medicine Phoenix, Human Services Campus, Catalytic™ Health Partners (CHP), and Community Bridges, Inc. (CBI), and connecting them to actionable, real-time data and clinical insights available in our Collective data hub. Collective includes data from Health Current, providers, and CBOs to inform MCC and our partners on best ways to locate and engage vulnerable, high-risk, unable-to-reach members. In concert with these providers, our "boots on the ground" real-world care extenders will provide wellness and preventive care, education about benefits and health promotion, point-of-care testing, and SDOH assessments while coordinating with members' Health Homes, specialists, and PCPs. Our Unable to Reach Program leverages mobile and pop-up clinics to meet members where they are— such as community gathering places like parks, housing complexes, or fast food parking lots—so providers, CBOs, and Nurse Practitioners can successfully deliver care to hard-to-reach populations.

Program Structure. We will hire Recovery Health Guides from the community to find and engage unable-to-reach members and connect them with resources. Recovery Health Guides will locate, sit with, and talk to individuals for as long as needed to establish trust. Recovery Health Guides are skilled at peer support, harm reduction, teaching members and families about system navigation and resources and understand how to bridge the members' needs to the larger clinical team. Our intent is to establish one Recovery Health Guide per county to expand our geographical reach, and scale as needed for any volume of high-risk, unable-to-reach members.

In addition, as part of the Unable to Reach Program, MCC will establish an Unable to Reach Community of Practice that demonstrates deep understanding of the community dynamics differing from county to county as described in **Table 6**. This Community of Practice will monitor performance metrics, provide program oversight and guidance, and serve as a key referral source for SDOH services, Non-Title XIX/XXI services grantees, and/or connection back to Health Homes.

Table 6. Unable to Reach Core Competencies. MCC will establish an Unable to Reach Community of Practice comprising Health Homes and CBOs with the core competencies and experience in finding and serving hard-to-reach individuals.

Expertise in Outreach and Engagement	Demonstrated expertise in knowing where to find people, how to connect with them, and how to walk with them to the next step in support; experience with harm reduction, trauma-informed care, and motivational interviewing.
Expertise in Peer Support, Member Advocacy, and Member Voice and Choice	Demonstrated expertise working with individuals who speak different languages, using cultural sensitivity, and addressing possible drivers of health disparities such as ethnicity, race, gender, and sexual orientation. Demonstrated expertise in national and state-recognized competencies related to lived experience, peer support, mutuality, power dynamics, moving beyond helper/receiver, and member self-navigation and self-advocacy.
Expertise in Harm Reduction	Demonstrated expertise in evidence-based harm reduction techniques, including trauma-informed, culturally responsive practices; safe use of medication; appropriate use of naloxone; best practices in HIV / Hepatitis C screening; and helping housing insecure individuals and people who use drugs (e.g., syringe exchange, injection sites).
Plan for and Experience Working in Collaborative Relationships	Desire to partner with other providers or CBOs to be accountable for improving member outcomes in each Central GSA county; partnerships may include contractual agreements to co-locate services with PROs, a harm reduction organization, or a homeless outreach or service organization, among others.

Our Unable to Reach Program will be supported by MCC's Practice Transformation Team, Recovery Health Guides, and Care Managers, all working together to improve our ability to find members, build trust, engage them in care, and educate them to achieve their personal health goals. Members will retain the choice to opt out of treatment based on self-direction and hard-to-treat symptoms.

d. Stakeholder Input

The single most impactful initiative for stakeholder input is to bring accountability and transparency into the system through MCC's **unique focus on holding the system accountable for the safety, recovery, quality of care, and appropriate level of care** of individuals with an SMI designation. Our ACC-RBHA Governance Committee will comprise knowledgeable, influential system stakeholders who are experts in their field of practice, each with voting rights to provide input on, recommendations for, and oversight of the strategies and initiatives to drive continuous improvement and ensure system fidelity to the process. The committee will meet monthly and include representatives from across the service area, including tribal communities, the crisis system, the education system, housing advocates, family, peers, the criminal justice system, SMI Health Homes, FQHCs, hospital and sub-acute facilities, and community service agencies. Voting members will be paid for their contribution and hold a contract with MCC that outlines their role, expectations, and how they bring value to the committee.

> **"I am a peer and part of the peer community in Arizona. As a longtime advocate who has worked with—and fought with—many health plans and providers, and as former bureau chief of the AHCCCS Office of Individual Affairs, nothing is more important to me than the power of lived experience in shaping how our behavioral health system functions. Listening to the voices of people currently or formerly served is absolutely critical. I believe MCC has the right approach to governance. … I support MCC's strategy and pledge to serve on their Governance Committee and immediately form a succession plan to train a true peer leader to take my place … . I am excited by the future that MCC will create with our peer community in the Central region."**
>
> *– Kathy Bashor, Community Advocate and President, Arizona Peer and Family Coalition*
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Accountability. Our approach is grounded in the principles of partnership and collaboration. Our System Transformation teams, including OIFA, Practice Transformation, Quality, and Provider Relations will support and provide technical assistance to the provider community, as often as needed, to help hold the system accountable for outcomes. MCC will deliver providers technical assistance first, looking for immediate correction. Should concerns continue, MCC will move to a **formal PIP with set goals and timelines**. Should timelines be jeopardized, or goals not met, MCC will move to a CAP, up to and including termination of the contract. MCC will bring concerns to the ACC-RBHA Governance Committee for **shared decision-making and to exercise voting as needed to ensure accountability and drive innovation**.

Transparency. **MCC is re-introducing transparency to the ACC-RBHA program** through a comprehensive system dashboard available to the Governance Committee to help ensure oversight and accountability. Our **ACC-RBHA Governance Committee Chief of Staff** will own development the system dashboard for the Safety, Recovery / Member Voice, Quality, and Right Care / Right Place metrics displayed in **Table 7**.

> **"Our system of care must be built upon accountability to its members. ... MCC is committed to building accountability into the foundation of their system. Through MCC's structure for ACC-RBHA stakeholder participation, the principles of accountability will be brought to life. I am excited that MCC will have a robust ACC-RBHA Governance Committee, which will bring a perspective and the independence necessary to foster continual feedback and improvement. In the end, because of their commitment to accountability, I believe MCC is well suited to improve the outcomes for those we care for."**
>
> *– Josh Mozell, Senior Partner / Mental Health and Guardianship Attorney, Frazer, Ryan, Goldberg & Arnold LLP*
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> 034.AZ21

Table 7. System Metrics. The ACC-RBHA Governance Committee will monitor for incremental improvement and accountability.

Safety	Recovery / Member Voice	Quality	Right Care / Right Place
• #/% homeless • #/% incarcerated • Recidivism rate • #/% unable to reach • #/% COE/COT • # of seclusion and restraint • Crisis utilization	• Functional and quality of life outcomes • % of ISPs that follow the assessment • % accessing priority services as per ISP • # Health Home active member advisory councils • Case Manager turnover	• Timely access to services • #/% of grievances • # of Quality of Cares and TAT • Member satisfaction • % of REL demographics	• Readmission rate/% • Avoidable ED rate • % of service duplication (ACT and residential) • % of members with an active SUD diagnosis in treatment

Our Governance Committee Chief of Staff will be responsible for system outcomes that realize incremental improvement and for reporting progress to the ACC-RBHA Governance Committee.

e. Justice System / Justice-involved Individuals

Today, the post-release support system is underperforming, with individuals being released without needed supports and often becoming unable to reach, which can lead to unmet needs and recidivism. Our single most impactful initiative to provide the best care and improve outcomes for individuals who are justice-involved is our **Justice-involved Community of Care**—a synthetic clinically integrated network—that focuses on making critical community connections for incarcerated members to provide them with supports and services arranged and provided pre-release to help them successfully transition back to the community. Our Justice-involved Community of Care creates a priority pathway for members reentering the community in the Central GSA to access care, connect to supports to address health and SDOH needs, and reduce recidivism.

We will accomplish this through an alternative payment arrangement, using differential rates as needed, with Terros Health that will streamline the process—starting during pre-release—and incentivize accountability and results for connecting members to an expanded array of post-release care and supports.

Under the leadership of our Justice System Liaison, the Justice-involved Community of Care will support members in county jails as well as Department of Corrections and Arizona Department of Juvenile Detention facilities (for those 17 ½+ years with SMI designation) consistent with AMPM 1022. Our support will begin prior to their release to engage them and keep them engaged.

Value-based Approach to Get Results

MCC has **executed an exclusive letter of intent with Terros Health** to serve as the lead agency in our Justice-involved Community of Care to streamline and improve accountability for the process and expedite services for individuals with SMI in preparation for release. We will also contract with a lead agency in each county to provide a network of organizations that offer critical community supports for transitioning individuals: Terros Health in Maricopa; CBI in Gila County; and Horizon Health and Wellness in Pinal. We are building upon the successful model Terros Health has provided through the Targeted Investment Program, which won the National Association of Counties Award in June 2020. Our outcomes-based contract with Terros Health will **incentivize timely and closed-loop referrals for all needed services and provide resources for assistance critical for successful community reintegration**. MCC will refer individuals to Terros Health before their release for engagement, needs assessment, service planning inside jail prior to release and follow-up to ensure all member needs are met. If the member is assigned to a Health Home other than Terros Health for ongoing post-release support, Terros Health will coordinate to transition responsibility once all initial post-release services and supports are in place, thus providing member choice.

Priority Referral Pathways

Collaborating with Terros Health, we will contract with network PCPs with expertise in treating justice-involved members, offering providers a preferential rate to supply priority access to integrated physical health and behavioral health services. Terros Health will serve as a **safety net for all counties** in the Central GSA if capacity limitations occur. The network within the Justice-involved Community of Care will include specialty CBOs such as Arouet Foundation, which helps justice-involved women and their families prepare for re-entry, gain meaningful employment, and access financial resources; Hope Lives, a PRO specializing in forensic peer support; and CBI, which offers Forensic ACT teams. MCC has been collaborating with WEDCO Employment Center, Valley Leadership, and Pipeline AZ to build priority pathways for employment referrals, including a **$100,000 grant to Valley Leadership** to support felon-friendly jobs.

Expansion of Reach-in and Support to Other Justice-involved Populations

MCC will continue the practice of co-locating a Justice System Liaison in the Maricopa County Jail and will expand that practice to Gila and Pinal counties by establishing agreements with the Department of Corrections and Arizona Department of Juvenile Detention for peer reach-in to build on existing DOC peer support programs and engage individuals who are six months (or less) from release.

f. Court Ordered Treatment

Each month, approximately 1,500 individuals are placed either on COE with subsequent COT or have their court orders amended due to non-adherence to COT. Our single most impactful initiative for individuals with COT is our investment in the creation of a **Mobile LAI Team,** which will improve medication adherence and prevent amendment to inpatient treatment for non-adherence by bringing long-acting injectables (LAIs) and other court-ordered medications directly to all members with SMI in coordination with the treating psychiatrist.

Through our Mobile LAI Team, MCC will reduce the number of amendments year-over-year by 5%.

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We will promote access to and integration of care by coordinating Mobile LAI Team services with SMI Health Homes and other providers of care and services. Currently, individuals are picked up from the community, taken to one of three receiving centers, and subjected to involuntary procedures such as medication administration. Our prevention strategy, in collaboration with the member's assigned SMI Health Home, will offer the member voice and choice by meeting them in their home or community to administer medications, including LAI antipsychotic medications, with goals that include:

- Increasing community tenure and avoiding COT amendment or recidivism
- Preventing relapse and crisis events
- Improving symptoms through medication adherence
- Ensuring appropriate treatment of chronic conditions, such as hypertension or diabetes
- Improving quality of life and outcomes, including member and family satisfaction
- Decreasing ED visits and inpatient admissions/readmissions

MCC has executed a letter of intent with Terros Health to implement a Mobile LAI Team beginning in Maricopa County and then expanding GSA wide. **The team will offer in-person visits to members identified by SMI Health Home Case Managers as having difficulty attending clinic visits due to childcare, disabilities, or other barriers, as well as those who miss scheduled appointments for COT.** The mobile visit will occur in the home or other location chosen by the member in collaboration with the assigned SMI Health Home Case Manager.

The team will consist of a nurse and Peer Support Specialist or behavioral health technician. Including peers on the team will support successful engagement of the member to complete COT, promote recovery, and improve health outcomes. The nurse will administer the LAI, coordinating closely with the prescriber and SMI Health Home Case Manager. The Mobile LAI Team will coordinate any behavioral health and physical health needs; complete a medication reconciliation and monitor adherence; provide education on current medications and possible side effects; administer medications when needed including LAI antipsychotic medications; and set up medication sets if the member is on several medications. The team will assist the member with accessing the SMI Health Home behavioral health medical practitioner through telehealth if needed.

MCC will educate all SMI Health Homes and other stakeholders about the availability of the Mobile LAI Team as well as how to refer members to the team. For all members accessing the team's services (whether they receive SMI Health Home services through Terros Health or through another provider), the team will coordinate with the SMI Health Home in advance and provide a disposition report to the Health Home and MCC at the conclusion of the mobile visit. This process will ensure engagement with the SMI Health Home treatment team and that the member's ISP is being followed to support the member's specific recovery goals.

MCC will monitor the success of the program including number of referrals, number of amendments to COT and inpatient treatment, and feedback from members and providers. We will use monitoring results to identify, develop, and implement improvements to avoid disruption for members associated with an inpatient admission.

g. Dually Aligned Medicare and Medicaid Members

Our single most impactful initiative for dually aligned members is to add **Special Supplemental Benefits for the Chronically Ill (SSBCI)** to the MCC D-SNP to broaden the range of services we can offer these high-risk, complex members to address key social needs that impact their recovery and health. We will integrate these benefits into a single ISP, coordinated by a single MCC Care Manager, that includes all Medicare and Medicaid services an aligned member needs to address their physical health, behavioral health, and social needs.

Many dual eligible members face conditions associated with aging such as cognitive changes, agitation, and increased risk of co-occurring physical health conditions as well as SDOH. Our SMI Care Coordination Model addresses these conditions within our integrated model of care by ensuring benefit coordination correlates with elder care and treatment options through active case consultations between treatment providers, MCC's Utilization Management team (regarding behavioral health and physical health conditions), and Care Managers, and by providing step-by-step health literacy education to the member and family supports/caregivers. These services include medication reconciliation, specialized member and caregiver education for increased health literacy and optimal self-management, and enhanced coordination by our internal Care Management team and/or external partners to include psychiatric consultation and specialty behavioral health care when needed.

Using SSBCI to Promote Recovery and Optimal Health Outcomes Through Addressing SDOH

MCC will address key SDOH that can negatively impact recovery and health outcomes such as loneliness, food insecurity, and unsafe, unhealthy, or inaccessible home environments by offering SSBCI such as supplies for service dogs, healthy food, meals, structural home modifications, complimentary (non-traditional) therapies, pest control, and indoor air quality equipment and services. Some specific examples include the following:

- **Individuals with bipolar conditions or schizophrenia** often experience feelings of loneliness and isolation even when surrounded by family and friends who may not understand how to support them. Research has demonstrated positive outcomes from the use of emotional support or companion animals, which provide a nurturing presence. Through SSBCI, MCC will offer services and aligned community relationships that facilitate member acquisition of a companion animal and support for pet ownership such as vaccinations, training, and grooming if the member's situation allows. We will establish agreements with agencies such as animal shelters and training facilities to provide services to support these members and their new companions.
- **Individuals with schizophrenia and obsessive-compulsive disorder** sometimes have difficulty discarding or parting with or discarding possessions, resulting in persistent negative emotional or physical effects and/or unsafe environments; however, attempts to remove items and having strangers in the home may trigger symptoms such as fear and paranoia. **SSBCI benefits will include home and yard abatement using trauma-informed peer support to help the member with support, resolution, and prevention.** Once excess items are cleared, the need for home modifications may become evident, which we will address with other SSBCI benefits our D-SNP will offer.

Educating Members and Families on Navigating Dual Eligibility and Coverage

One of the biggest challenges for unaligned members is understanding their benefits, as some services are paid under Medicaid and others under Medicare. MCC will review all benefits with the member and their family and provide coordination to help them get the most out of their available benefits to improve health outcomes and meet their individual goals.

B7. System of Care Improvement

a. Advancing an Enhanced Integrated Care Model

Opportunities for Improvement

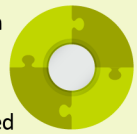
While AHCCCS' efforts to promote an integrated care model through policy changes, technology, and provider supports have advanced the system, opportunities remain to build on those advancements, particularly for individuals with an SMI designation. Through our continuous collaboration with stakeholders across the system, we have learned that too often individuals and families still face fragmented care across the continuum. Below, we detail our strategies for further integration to mitigate blind spots in the holistic view of an individual's needs and reduce generic and inequitable care for a focus on true whole person, measurement-based care.

Proposed Strategies

We know from our meaningful interactions and the long personal history of our staff in the system that there is no single innovation or tool that will solve for the remaining barriers to integration. Instead, to address these silos in care, MCC has designed a transformative approach that is grounded in the very hard **hands-on** work of true collaboration and practice transformation. Our goal in designing our strategies and associated innovations is to make long-lasting change in how individuals with SMI designation experience the system of care and to help manifest AHCCCS' vision for a truly integrated care model.

True integration goes beyond administering physical health and behavioral health services.

Partnering with one the largest FQHCs, Neighborhood Outreach Access to Health (NOAH), MCC is developing the State's first Integrated CHW model. The model will expand resources for all members by allowing CHWs to do more truly integrated work and fill gaps across physical health, behavioral health, and SDOH.



moving forward

Our goal is to expand this model to other FQHCs, I/T/Us, and Promotoras organizations who depend heavily on CHWs to manage more sustained funding.

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MCC is adopting two core strategies to advance integration. First, the **MCC System Transformation Roadmap** helps Health Homes move along SAMHSA's levels of integration and go beyond integration of physical health and behavioral health. The MCC System Transformation Roadmap will improve consistency of available fully integrated services and access to evidence-based practices by establishing a **Centers of Excellence core set of Health Homes capabilities** including level of integration, scope of services, criteria, and competencies. Under the MCC System Transformation Roadmap, we will **incent and support Health Homes to develop ACO-like virtual communities of collaborative care** that include primary care, behavioral health care, HCBS, specialty care, and compensable and non-compensable social supports.

Our second strategy, MCC's **PCP Collaborative Care Model**, ensures members have an integrated experience regardless of where their providers are along the continuum. In the PCP Collaborative Care Model, MCC Practice Transformation Specialists (described below), help create the connection between the member's assigned Health Home team, including the psychiatrist, Case Manager, and the PCP practice, through telehealth, e-consults, and sharing of real-time member data. For members who don't regularly engage in primary care, MCC will offer additional options, taking care to meet members where they are through innovative mobile pop-up clinics and telehealth solutions. MCC is leveraging three primary innovations to forward these strategies:

- **Practice Transformation Team.** MCC is investing in a team of professionals on-site in the Central GSA who will have the full-time job of implementing the MCC System Transformation Roadmap and PCP Collaborative Care Model. They will work side-by-side with each Health Home, FQHC, and other PCP practices to provide the support, training, and tools they need to be successful in providing fully coordinated care to members on their recovery journey. The Practice Transformation Team, led by our **Chief Outcomes and Quality Officer**, will work with providers to determine the current level of integration and coordination of care offered; assess readiness for moving along the continuum; and establish goals and workplans to help practices transform to the next level. Practice Transformation Specialists will provide practice facilitation, training, and technical assistance tailored to providers' needs based on the level of integration, capabilities, and performance to advance integrated care.
- **VBP models.** Provider movement along the SAMHSA continuum of integration will be tied to tiered VBP arrangements that award and incent progression to higher levels of integration and accountability. Payment will also be tied to measurement-based care performance to help drive the adoption of evidence-based practices with the goal of

provider achievement of the Centers of Excellence model. Understanding that Health Homes are at differing levels of readiness for the Centers of Excellence model, MCC will establish contractually agreed-upon division of responsibilities between the Health Homes and MCC with clear delineation of roles and accountability to provide the framework for a seamless integration.

- **Technology and supportive infrastructure.** To build on the success of Health Current and further improve data sharing and coordination of care, **MCC will deploy our custom portal technology hub, Collective**, to exchange data and create seamless real-time alerts and notifications directly into Health Home workflows, which reduces and streamlines administrative processes and efforts, and drives holistic care coordination for members and their families. Collective allows clinicians to share care recommendations, care coordination details, gaps in care, and care histories, and attach pertinent information and documentation to the member record to share with other entities in the Collective network. MCC will cover costs for providers to connect to Collective and support all training. In discussing Collective with Health Current, we identified to use Collective as the hub to share member-specific actionable data with providers, advancing measurement-based care.

b. Co-occurring SMI/SUD Service Delivery

Opportunities for Improvement

There is no one-size-fits-all treatment solution for individuals living with co-occurring SMI and SUD diagnoses, and there are very few Health Homes that offer integrated treatment for SUD. Care often **lacks coordination across SMI and addiction treatment providers. Treatment is delayed** because individuals have a hard time navigating the system and often don't want to admit to substance use due to **stigma and discrimination.** Because of the highly complex needs of this population, providers often don't feel comfortable or feel they are not equipped and trained to manage co-occurring SMI/SUD and may have an **implicit bias** toward individuals with SUD. Below, we detail strategies to improve service delivery, decrease fragmented care, and offer hope and encouragement to individuals with co-occurring SMI/SUD.

Proposed Strategies

MCC's Centers of Excellence core set of Health Home capabilities include accountability for integrated co-occurring treatment options, including the important role of peer support. Our Practice Transformation Team will work with Health Homes to incorporate **universal screening for SUD** and **SUD treatment services at the point of care** and encourage Health Homes to offer **Office-Based Opioid Treatment** by helping their providers obtain a waiver to prescribe buprenorphine. If SUD treatment services are not currently offered by the Health Home, Practice Transformation Specialists will broker a **collaborative agreement between the addiction recovery community and Health Homes, using Collective to share care planning and actionable data**, supported by co-location, telehealth-enabled counseling, therapy, psychiatry, and medication management, including MAT, to treat a range of conditions across the behavioral health spectrum. We also support PCPs in implementing universal screening for SUD and timely referrals and collaboration with the member's Health Home.

MCC will implement an innovative, enhanced level of case management: Intensive Case Management for SUD, which improves engagement with members who are insufficiently engaged with standard or traditional treatment and don't fit the criteria for ACT. This high-touch, ACT-like level of case management has been shown to improve engagement, decrease fragmentation of care, decrease ED use, and increase treatment adherence. The key features are flexibility in designing interventions that can be scaled up or down depending on the need and **critical time intervention, which is** a time-limited evidence-based practice that mobilizes support during periods of transition. The community-based model offers a phased approach with focused treatment that decreases in intensity over time. Teams carry small caseloads and include the Health Homes case management team along with peer support, a dedicated psychiatric medical doctor, nurse practitioner, or addictionologist, and an SUD nurse.

MCCs best-practice approach to improving member engagement is **meeting members where they are in their recovery journey**. Our **Centers of Excellence model** elevates the importance of connecting members to peer support and supportive community connections in the recovery process. Services should be matched to the individual's health status and incorporate MAT for opioid use disorder and other harm reduction strategies, such as member education, naloxone

distribution, overdose prevention training, peer support services, and syringe exchange programs in community mental health and primary care settings. We develop public–private partnerships like the one with the OAR Line and the University of Arizona, where we identify members at risk of overdose. OAR performs harm-reduction-informed outreach and refers members back to our Care Managers as needed. We also recognize that within the SMI/SUD population, certain subpopulations such as pregnant women, AI/AN, and youth require specialized approaches. An example of MCC's approach to best serve the holistic needs of pregnant women with mental health needs and SUD is our collaboration with Banner Health's Heal program, Hushabye Nursery for babies born with neonatal abstinence syndrome, and CHEEERS Recovery Center's peer doula program.

c. Improving Access to Evidence-based Outpatient Behavioral Health Services

Opportunities for Improvement

Over the past two years, through a series of SMI Health Home CEO Roundtable discussions and member and stakeholder listening sessions, we learned about opportunities to improve consistent use of EBPP, evidence-based clinical practice guidelines, and validated, standardized screening and assessment tools, along with opportunities to address inconsistent and inadequately informed care in the system that too often delays individuals in meeting their recovery goals. In addition to the MCC System Transformation Roadmap described above, which will support the use of EBPP through continuous technical assistance and accountability, we have designed five specific strategies to promote the use of EBPPs across the system **under the leadership of our Adult and Children Healthcare Administrators**, as described below.

Proposed Strategies

First, as Apache Junction, the largest city in Pinal County, doesn't have ACT level of care available, we have an LOI with Horizon Health and Wellness to provide an ACT-like level of care. Our second strategy is to expand the use of and linkage to Touchstone to increase the use of multi-systemic therapy for youth with problem sexual behaviors (MST-PSB), by increasing education and collaboration. Thirdly, MCC will establish a Quality Collaborative with the CEOs and clinical leaders of Health Homes and other ACC MCOs to promote and foster collaboration on the use of standardized tools and EBPP for intake, assessment, engagement, treatment planning, service delivery, recovery intervention, discharge planning, relapse planning, harm reduction efforts, data and outcomes collections, post-discharge engagement, trauma-informed care, gender-based treatment, and culturally appropriate practices. Special focus will center on the unique needs of individuals such as adolescents, justice-involved individuals, and LGBTQIA+ individuals. When EBPP is unavailable, the Quality Collaborative will recommend existing practices or develop new Promising Practices recommendations to MCC's Quality Management Committee.

Driving Suicides to Zero: Initiative in Partnership with Resilient

We partner with Resilient to identify behavioral health needs early through use of evidence-based assessments (C-SSRS) and functional outcomes assessments (DLA-20) to get members into treatment faster and measure how they are doing in order to drive suicide to zero. We assessed participating ACC members across 20 functional domains, and there were overall improvements in 18 of the 20 domains with the top average improvements in Coping Skills, Nutrition, Family Relationships, Money Management, Social Network, Communication, and Housing Stability.

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Our fourth strategy will be to deploy VBP tied to measurement-based care targeting member improvement. Measurement-based care requires the adoption of validated, standardized assessment tools to measure functional status, such as the DLA-20, and symptom scales and quality of life surveys. Evidence-based practices and clinical guidelines are used to "treat to target," help providers determine whether the treatment is working, and facilitate treatment adjustments, consultations, or referrals for additional services when needed.

Our fifth strategy is to provide the virtual MCC Resource Center, a one-stop centralized location of information that is managed by our Practice Transformation Team, which offers training and technical assistance to providers. The MCC Resource Center includes easy access to:

- **EBPP and Promising Practices** along with information, tools, and trainings (e.g., on first episode psychosis, TIP) providers need to incorporate EBPP into their clinical settings
- **Evidence-based physical health and behavioral health clinical practice guidelines** that have been reviewed and adopted by the Molina Healthcare's National Quality Improvement Committee

- Information on adoption of **validated, standardized tools** such as ASAM, CALOCUS, LOCUS, and DLA-20 to guide assessments, level of care placement decisions, continued stay criteria, and clinical outcomes
- Links to **national resources**, such as SMI Advisor, Psych Hub, and SAMHSA

As part of our MCC Resource Center, **we will provide a searchable directory of evidence-based programs** by provider on our website and Molina Mobile app.

d. Ensuring Equitable Healthcare and Eliminating Existing Disparities

Opportunities for Improvement

Having an SMI diagnosis is one of the most significant health disparities largely due to individuals' comorbid physical health conditions. When compared to the general public, individuals with SMI have shorter lifespans by 25 years. When member care is fragmented, the disparity deepens as "diagnostic overshadowing" can occur—attributing physical health conditions to a behavioral health diagnosis. Implicit bias may also be present, which can result in untreated physical health conditions. Moreover, having an SMI diagnosis compounds the situation for racial, ethnic, and minority groups who have persistently experienced social disadvantages and systemic discrimination. In the Central GSA, for example, there are significant opportunities to address disparities in addition to SMI among non-English-speaking and immigrant populations, as well as AI/AN and individuals in the LGBTQIA+ community, who may not have supports or know how to advocate for their care, particularly when facing implicit bias.

Eliminating Disparities: Partnership with University of Arizona's College of Public Health

To address disparities related to vaccinations and conditions such as cardiovascular disease within Latino and Spanish-speaking populations, MCC is partnering with Dr. Cecilia Rosales, Associate Dean, Phoenix Campus, and the Professor & Chair, Division of Public Health Practice & Translational Research at the University of Arizona's College of Public Health, to develop online, culturally appropriate tutorial videos—all in Spanish. The partnership will also ensure these videos and other educational materials distributed throughout the community are culturally and linguistically appropriate.

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Proposed Strategies

Through our Centers of Excellence and PCP Collaborative Care Model, we work to minimize the impacts of diagnostic overshadowing. Our **Director, Health Equity and Cultural Competency** will work under the leadership of our Chief Outcomes and Quality Officer to develop **disparity dashboards.** By fully understanding disparities, we can continuously design interventions using data and analytics to reduce inequitable delivery of healthcare. We also **propose to facilitate a Health Equity Collaborative with the North GSA and South GSA ACC-RBHA MCOs to maximize our collective impact** by sharing data and best practices to tackle these tough issues.

MCC's innovative approach to improving equitable access to culturally sensitive services moves beyond online trainings and presentations for providers, which have not been proven to change clinical practice. MCC's hands-on provider **Lived Experience Labs** will use simulations, such as hearing voices, and facilitate interactions with leaders with lived experience to talk openly about what it's like to have a behavioral health condition. **Evidence has shown** that this kind of direct contact can change attitudes, assumptions, and ideas, heighten empathy, and reduce stigma. Sessions teach and model recovery principles, including how clinicians can recognize and support self-advocacy. The Lived Experience Labs incorporate exercises on **intersectionality that highlight the impacts of overlapping and interdependent systems of discrimination** related to race, ethnicity, substance use, sexual orientation, and gender identity.

In addition to the hands-on labs, MCC will provide enhanced provider trainings focused on the potential impacts an SMI diagnosis can have on clinical judgment; how to work with members and families on self-advocacy; the overlay of race, ethnicity, gender identity, and SDOH needs; and trainings on structural racism, recognizing implicit bias in healthcare delivery, cultural humility, and the importance of trauma-informed care. Further, to decrease disparities for our AI/AN members, as an example, we will work with the Gila River Indian Community at the invitation of their tribal council to discuss community needs and help address disparities, building on tribal health best practices.

A critical strategy to improving equitable care and eliminating disparities is **member and family self-advocacy and empowerment**. Our goal is to equip members with the knowledge to make informed, authentic decisions, and empower

them to make those decisions. Under the leadership of **Joshua Sprunger, OIFA Administrator**, MCC already amplifies the critical role of peer and family support to help members and families with self-advocacy and health literacy. This strategy is supported through our work with PROs and FROs as well as CBOs like NAMI, one-n-ten, and the Arizona Peer and Family Coalition, to foster services that recognize cultural heritage and use support from a member's community. We have provided support to NAMI Valley of the Sun to expand their support groups that will focus on minority groups, such as the Spanish-speaking Latinos and the LGBTQI community. Our financial support will provide a part-time Spanish-speaking educator to train, provide educational outreach, and create culturally appropriate materials. We will also leverage our partnership with HOPE Network, a Promotoras organization, to receive advocacy training from the Arizona Peer and Family Coalition. **MCC will encourage and support providers to hire people with lived experience and will seek opportunities to fund/support peer support internships in provider practices.**

e. Utilizing Technology to Maximize Member Engagement

Opportunities for Improvement

The lack of access to technology and knowledge about how to use it negatively impacts members' use of telehealth, online counseling, computer-based therapy, mobile health applications, and our interactive member portal. In the last year, we have experienced an unprecedented scale of technology use in response to the pandemic. Digital devices and the Internet have become an essential part of people's lives and engagement. Yet, as society relies more on technology, the digital divide has become even greater for individuals with SMI, due to lack of access and digital health literacy.

Proposed Strategies

MCC is partnering with **Sano Health** to provide members with access to a new smart mobile device that will be preloaded with MCC apps, including telehealth, and organized in a user-friendly way. Designed for true ease of use, we will maximize engagement because these tools simplify member engagement. Sano Health will provide live customer support for the device, mobile connectivity, and a device management portal for members. Customer support includes digital literacy, such as how to keep information secure; download and log on to apps, portals, and websites; and how to use the apps. This partnership will allow us to bridge the gap of multiple platforms by providing members with a single-use resource with live customer service for ongoing education and engagement. If the member already owns a device, Sano Health will load the apps for them and offer the same level of customer service.

During our initial outreach to new members, our **Peer Concierge Service**, which we are offering to help better engage members during initial onboarding, will ask members about their preferences for communication and review available technology and applications. This effort is intended to help address digital literacy gaps. We will also provide Health Homes, Case Managers, and PCPs with a full orientation on our offerings, including how to help members access technology and broadband when needed; how to assist members with digital health literacy; and a menu of the applications we provide. MCC will connect members, families, and interested providers to additional resources on digital health literacy, such as DOORS' Digital Navigator free online trainings for individuals with behavioral health issues.

Secondly, we deploy a variety of digital and technology solutions to provide members with choices on how and when they want to engage with us and in their care. We use **text messaging** to engage members using interactive two-way SMS instead of static one-way text messaging to evaluate member needs, provide timely information, and improve member engagement. We offer **the Molina Mobile app** that provides members with a variety of resources, including information about their MCC benefits, their Member ID card, list of medications, and ISP. Our Molina Mobile app delivers push messages with information about how to close an identified care gap, e.g., reminders that it's time for a preventive visit. With the touch of the screen, members can connect with their MCC care team. MCC also provides **supportive apps for specific subpopulations,** e.g., Text4baby™ for pregnant and postpartum women and **Pyx Health** for members experiencing social isolation and loneliness. To improve member engagement in care, MCC offers **virtual care solutions** such as the myStrength app by Teladoc® for cognitive behavioral therapy and Mightier™ gamification to help children learn skills to control their emotions. Our apps also support telehealth visits with the member's Health Home or PCP.

B8. Network Adequacy

Assessment of Current Network Adequacy

MCC's current provider network meets the ACC-RBHA network adequacy standards requirements in ACOM Policy 436 (effective date October 1, 2021) **and includes all providers who offer Non-Title XIX/XXI services**. Our robust network ensures we have a sufficient number, mix, and geographic distribution of providers in the Central GSA to serve members with complex or specialized healthcare needs both timely and effectively in the least restrictive setting while offering members provider choice.

Led by our Arizona-based Network Administrator, our current network has the necessary practitioner specialties and facilities to treat the full continuum of care needs from First Episode Psychosis to a diagnosis of a complex, comorbid, or co-occurring condition. We will continue to develop and maintain relationships and contract with any willing providers to offer members additional choice and access and meet their individual needs.

Ability to Serve Members with Complex or Specialized Healthcare Needs

MCC's network already includes all contracted providers offering the full array of services needed for ACC-RBHA members with complex and specialized healthcare needs to receive treatment in the least restrictive setting. These critical community-based services include but are not limited to existing relationships and contracts with ACT providers, psychosocial rehabilitation providers, housing support organizations, SED providers, MAT providers, outpatient and intensive outpatient treatment services, mobile crisis providers, 23-hour crisis stabilization centers, HCBS providers, supportive living organizations, transitional housing programs, pain management providers, field and virtual clinics, and SUD treatment providers specializing in treating pregnant women. While our network includes all the necessary higher levels of care, (e.g., behavioral health residential and inpatient), our measurement-based care strategy focuses on reducing utilization of those services through consistent use of community-based care.

Our work with our provider network goes beyond contracting. We have fostered dozens of meaningful relationships and community partnerships to leverage alternative payment mechanisms and collaborative arrangements to support individuals with complex needs to reach their personal recovery goals in the least restrictive settings of their choice. Just a few examples of partnerships we have developed or are developing to enhance coordination and collaboration, and help us assess and strengthen the network include the following:

- We have a letter of intent **with CHP to offer a 24/7/365 SWAT Program** for individuals with an SMI diagnosis. The SWAT team will respond to real-time alerts and meet the member in the ED. The goal is to ensure appropriate dispositioning and transition the member from the ED to the right level of care. For members who would benefit from MAT services, a licensed provider will initiate treatment and connect members already in treatment with their provider. The SWAT team aims to address the individual's needs in the least restrictive setting and coordinate the transition with MCC's Care Management team and the member's assigned Health Home. Together, we will intervene timely and deepen our engagement with the member.
- We have entered into an **agreement with NOAH to support enhanced use of their CHWs** by cross-training them as behavioral health paraprofessionals, which will provide additional care coordination support in the community and a sustainable funding mechanism for the work of CHWs.
- Our **partnership with CHEERS Recovery Center expands access to community-based and peer support services to pregnant women with co-occurring SUD conditions** to help keep them in their homes and abstain from illegal drugs and alcohol throughout their pregnancy, promoting improved birth outcomes. Our value-based arrangement includes a PMPY incentive payment tied to members achieving prenatal, postpartum, and contraceptive measures; using the DLA-20; providing access to a PCP; submitting SDOH Z codes; and adopting technology.

In partnership with Terros Health, we are **creating a Mobile LAI team** to administer antipsychotic medications to members in their home or community setting to help members on COT avoid being amended to a hospital due to medication non-adherence or support members at risk of relapse.

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Monitoring for Gaps in the Continuum of Care

Our network monitoring approach proactively assesses for gaps in the continuum of care through a combination of analytics and internal and external stakeholder feedback. Information from these diverse sources is ingested and made actionable by our local Network Development, Clinical, Quality, and System Transformation teams to drive meaningful interventions to close gaps and address deficiencies in the care continuum.

Data Analytics. In addition to running traditional network analytics to ensure continued adequacy in every county in the Central GSA, we use a variety of analytic tools to look for gaps in accessibility. Some of the data we will incorporate in our analyses under the ACC-RBHA Contract includes over- and underutilization metrics, daily census reports, bed days, ED hold reports, housing wait lists, Arnold vs. Sarn services capacity audits, our new Non-Title XIX/XXI capacity management system, and out-of-network requests.

Stakeholder Feedback. We continue to receive feedback on the care continuum from a variety of sources including:

- A GSA-wide Community Crisis Collaborative we will develop for all Central GSA counties to focus on crisis system performance, identifying gaps, and determining best practices for the entire crisis system
- Our SMI Health Home CEO Roundtables, which we will expand under the ACC-RBHA Contract to monthly to learn about best practices and address challenges in the crisis system
- Our ACC-RBHA Governance Committee, of which half its membership will comprise community stakeholders
- Our engagement with tribal communities as described in our response to question B9
- OIFA engagement
- Our ongoing relationships with the PROs and FROs
- Regular meetings with advocacy groups and taskforce partners (such as Sonoran Prevention Works, United Arizona Veterans Board—Community Guest, Women Who Lead Women Veteran and Civilian Nationwide Group, Gila County Homeless Task Force, Arizona Housing Coalition—Casa Grande, Pinal County Homeless Task Force, and National Academy for State Policy Health and Housing Institute)

This feedback and data analyses help us understand new and evolving gaps in the continuum of care; promote critical understanding of member engagement during the COVID-19 pandemic, effectiveness of referral pathways, accessibility of COVID-19 vaccines for high-risk/high-needs members, and new and existing workforce challenges; and facilitate real-world knowledge-sharing about the availability and effectiveness of MAT, detox, crisis, naloxone distribution, syringe-service programs, and HIV / hepatitis C testing. Feedback has also helped us identify needs for harm reduction training and advocacy organization in the State, especially for members with SUD who are at risk of overdose.

Addressing Any Identified Gaps and Implementing Strategies to Resolve Network Deficiencies

When our proactive network monitoring identifies a gap in available care or a network deficiency, we take the following actions to resolve it.

Addressing Member Needs. First, we always ensure each member's needs are met. If we identify a gap in services a member needs, we leverage single case agreements with an out-of-network provider to bridge a network gap and immediately begin the process of trying to contract with the provider. In some cases, a specific gap in needed member care may be caused by a geographic challenge (e.g., a rural county with limited access to a provider type, such as dermatologists). In those instances, Care Managers or Service Navigators arrange transportation or telehealth services for the member as appropriate to ensure they have access to every medically necessary service.

Solving a Deficiency. When analytics and stakeholder engagement uncover a more significant deficiency in the continuum of care, we leverage our broad array of network relationships and community partnerships using a three-pronged approach for solving network deficiencies that includes either expanding the capacity of existing services; recruiting providers to deliver services where they don't exist to fill gaps; or empowering and supporting network providers to deliver specialized care for individuals with complex needs. Just a few examples of the network relationships and community partnerships we've already developed or are developing under each of these three approaches are described below.

1. Expanding the Capacity of Existing Services

We are **creating additional physical health respite beds in collaboration with Circle the City** to increase the number of beds available for members with complex physical health needs experiencing housing insecurity who are discharging from acute hospitalization or the ED.

MCC is **increasing the capacity of child/adolescent clinical teams in partnership with Children's Rapid Response Team**. This capacity expansion will enable child/adolescent clinical teams to respond to child/adolescent members presenting at an ED with a behavioral health crisis to assess and coordinate appropriate behavioral health services to stabilize the crisis and allow the child/adolescent to remain in the least restrictive setting appropriate to address their needs.

2. Recruiting Providers to Deliver Services Where They Don't Exist to Fill Gaps

MCC fills gaps in the continuum of care through innovative partnerships, programs, and care delivery models. For example, we are supporting the priority referral process from school-based providers to create access for both Title XIX/XXI and Non-Title XIX/XXI children in partnership with Touchstone Health Services providers. Together, **we will work with EMPACT La Frontera to create a Children's Mobile Crisis Team** in Maricopa County. In Pinal and Gila counties, EMPACT La Frontera will partner with CBI to cover schools.

In partnership with Horizon Health and Wellness, we are developing ACT-like services in Apache Junction, the largest city in Pinal County that currently doesn't offer this level of case management support. We are also **investing a minimum of $500,000 in partnership with CBI to add a crisis receiving facility in Payson** to provide 23-hour observation and crisis stabilization services to fill a gap in care in one of the more populated areas of Gila County.

3. Empowering and Supporting Network Providers to Deliver Specialized Care for Individuals with Complex Needs

MCC supports providers who are using telehealth to expand access to care within members' homes and offer specialty telehealth and consultation hubs in rural areas. We educate members about their care options, including telehealth, to ensure accessibility of services to members in all geographic areas and to assist them with self-management of their healthcare needs. For example, the integrated **myStrength Complete program** by Teladoc® offers multiple care levels in a virtual care setting to address various behavioral health issues and acuity levels and includes stepped care options, such as live coaching and crisis management.

When providers are not equipped with the best information to treat members' needs, MCC offers support by connecting them to **Psych Hub**, which supports the use of evidence-based practices at the provider level through education and training for PCPs, Certified Community Behavioral Health Clinics, and lower-level Qualified Mental Health Professionals who want to level-up evaluation abilities, care treatment plan development skills, and management capabilities.

We have created a partnership with Touchstone Health Services, **a leader in school-based services and complex care for adolescents to strengthen the primary care network and build a priority referral pathway**. This partnership will increase pediatric provider collaboration for training and education for SED, SUD, MST, MST-PSB, evidenced-based assessments and screenings, natural supports, and use of the Child and Family Team during treatment and services.

We have commitments from Adelante Healthcare, Resilient Health, and Salt River Pima-Maricopa Indian Community and are in discussions with NOAH to adopt our technology solution, Collective, where we **exchange clinical insights,** including our risk stratification, actionable data, and care plans, to increase care coordination for members and engage providers who see members with the highest needs to enhance visibility and collaboration.

Additionally, we supplement gaps in the care continuum with our support such as Project ECHO®, which provides specialist case rounding for providers on critical topics. For example, we sponsored the **Human Trafficking ECHO program** to narrow this gap by increasing the knowledge and capacity of ACC-RBHA providers (e.g., physicians, nurses, nurse practitioners, pharmacists, psychologists, social workers, probation officers, law enforcement, first responders) via their "TeleECHO" learning network. An interdisciplinary team of experts in the field of human trafficking integrate case-based learning strategies into each Project ECHO session, so the target audience develops the skills needed to better care for the complex needs of their patients.

B9. Crisis System

MCC's approach to crisis under the ACC-RBHA Contract is to leverage best practices from the Maricopa County crisis system, which leads the nation for its integration with law enforcement and its "Crisis Now" approach to crisis care. Our crisis system strategy, described below, continues to integrate crisis response into the system of care and expands the Maricopa model to Gila and Pinal counties and to the child crisis system.

Best Practices of Arizona's Crisis System

With several facility-based crisis stabilization centers, and a wide array of 2-person mobile crisis teams that can respond 24/7/365, usually without the need for police involvement, Arizona has built a solid foundation on which to advance as the ACC-RBHA Program Contractor. Best practices of Arizona's crisis system include the following:

- **Comprehensive three-part system in Maricopa County.** The Crisis Line, Community Mobile Crisis Teams, and receiving facilities/centers work in concert with law enforcement to provide the member with the right service, at the right place, at the right time. This approach has been a significant factor in reducing avoidable hospital and ED visits for individuals experiencing a behavioral health crisis and providing more appropriate, least restrictive, community-based interventions.
- **Co-located crisis specialists in the Phoenix and Mesa police departments (911 service).** Through the co-location of a crisis specialist in two of the State's largest police departments (Mesa and Phoenix), 911 dispatchers redirect behavioral health calls to the crisis system. This process provides an individual with an intervention that matches the need, which for many, means a crisis team rather than law enforcement, leading to positive outcomes for all.
- **Two-person mobile teams in Maricopa County.** Two-person mobile teams include specialized teams for veterans and for individuals with developmental disabilities, and leverage peer support to help stabilize individuals in the community. These teams travel to the place where an individual is in crisis to offer support, address the crisis, and help coordinate treatment needs and follow-up services.

Strategies for Maintaining and Driving Continued Improvement

MCC's strategy to advance the successful Maricopa crisis model seeks to achieve five primary objectives, described in more detail below, including:

- Measure Health Homes on reduction in crisis events
- Facilitate enhanced data exchange and care coordination
- Prevent crisis events
- Expand best practices into Gila and Pinal counties
- Expand best practices to better address children and families in crisis

> **"We appreciate MCC's efforts to meet in person with the Gila County Sheriff's Office. They are the only AHCCCS health plan that has taken the time to listen to both the challenges we face and where we see opportunities with proximity to higher levels of care, community-based support, and expanding mental health resources to serve our community. We look forward to working with MCC and their provider partners in their efforts to build on the array of crisis services in Gila County and improve the quality of life of those we jointly serve."**
>
> *Lt. Dennis Newman, Gila County Sheriff's Office*
>
> 020.AZ21

To achieve these objectives, we are committing significant investments into the crisis system, including **$500,000 to fund the build of a new crisis receiving center in Gila in partnership with CBI**; support for 2-person crisis teams in Gila and Pinal as well as in schools to enhance the children's crisis system; and refreshed processes for crisis prevention and enhanced connections between the crisis system and the system of care. These strategies were designed in collaboration with community partners and in consultation with **Nick Margiotta**, a pioneering leader in the development of the Maricopa crisis system. Mr. Margiotta has helped us design our solutions to drive continuous improvement and will continue to partner with us to bring best practices from Maricopa to Gila and Pinal counties. To inform our process design, we targeted key stakeholders in the rural counties (Public Defender's Office in Pinal County; Payson Police Chief; Phoenix and Tempe police; and Undersheriff in Gila County) to understand what works and opportunities for advancement. MCC will **maintain the strength of the Arizona crisis system through nurturing our existing relationships with law enforcement, providers, and community stakeholders** to understand and respond to the evolving needs of members and stakeholders, leveraging our Arizona ACC Stakeholder Advisory Committee.

Detailed Strategy to Drive Improvements in the Central GSA Crisis Continuum

Our strategy to drive continuous improvement in the Arizona crisis continuum reflects our four pillars of value aligned with AHCCCS' goals, which are increased accountability, transparency, innovation, and transformation. Key objectives of our strategy, along with actionable steps, stakeholder involvement, and timelines, include the following.

Objective 1: Measure Health Homes on Reduction in Crisis Events

It is critical to ensure individuals are connected through warm handoffs throughout the crisis care continuum and have connection to ongoing care following a crisis episode. Through collaboration with AHCCCS, Health Homes, and providers, MCC will improve the accountability and coordination between the crisis system and Health Homes by taking the following actionable steps:

- Create follow-up-after-crisis metrics, and provide results through a publicly available dashboard to ensure measurement-based care. Our Practice Transformation Team will share best practices and provide technical assistance to any providers with performance outliers. If metrics don't improve, the result could be CAPs up to termination.
- Conduct quarterly sample reviews from each Health Home's amendments to validate engagement efforts. Prior to amending a member's COT, the behavioral health Health Home will attest that all engagement efforts have been exhausted, including home visit, emergency contact, and other resources identified in the member's Special Treatment Plan.
- Require Health Homes to do the seven-day follow-up via a contractual requirement with MCC. We will randomly audit monthly to ensure they are doing the follow-up.

Timeline: We will operationalize Objective 1 within 90 days of the Contract effective date.

Objective 2: Facilitate Enhanced Data Exchange and Care Coordination

We will facilitate exchange of data across system partners in real time to ensure a Crisis Now response for members. We will enhance provider ability to access Health Current information, ensuring the Crisis Line can identify individuals with SMI and their provider attribution; provide seamless access to the ARCP; and support informed, person-centered crisis interventions, such as whether responders can expect dogs or weapons on site. To accomplish this objective, we will **collaborate with stakeholders**, including Health Homes and the Crisis Line vendor, on the following actionable steps:

- Ensure Health Current has a roster of all MCC members, so they know when admission, discharge, transfer data comes to us. We will take the admission, discharge, transfer data and make it actionable by running it through Collective and sharing it with providers and Health Homes through a push notification to ensure timely interventions.
- Discuss super-utilizers during a monthly meeting with all receiving centers and subacute facilities (RI International, CBI, and Connections Health Solutions) serving the Central GSA to proactively connect members with services and expand "friendly-faces" rounds at all three receiving centers.
- Review frequent callers to the Crisis Line with the assigned behavioral health Health Home for clinical appropriateness of interventions and engagement efforts to assist the member with finding the root cause of a crisis episode.
- Require the Crisis Line vendor to contact on-call clinics when they can determine a member is aligned to a specific Health Home. We will also contractually require a more informed and on-call response from the Health Home instead of a reactive call-back approach, which doesn't work well after hours.

Timeline: We will operationalize Objective 2 within 60 days of the Contract effective date.

Objective 3: Prevent Crisis Events

Working with input from the Arizona ACC Stakeholder Advisory Committee and Health Homes, we will **increase member engagement and prevent crisis events** through specific actionable steps:

- Leverage Molina Insights to identify individuals with emerging risk for crisis (missed LAIs, missed appointment patterns, and previous crisis / ED visits), and conduct "at-risk" rounds with the behavioral health Health Home quarterly or as needed to review members' treatment regimen and current interventions.

- Design and implement a specialty community-based COT–LAI team to serve SMI members with complex needs and those on LAI and/or COT. This team will intervene proactively, meeting the member directly in the community in concert with their assigned Health Home. The purpose is to prevent crisis for members who are escalating or who may have missed their injections. This team will administer LAIs in-home, when appropriate.
- Validate every member with SMI has a current, meaningful ARCP developed with the member, and through our ASPire PLUS program curriculum, teach case managers how to develop an actionable, personalized ARCP.
- Incentivize Health Homes to offer expanded hours through our contract to increase their accountability and maintain fidelity to accountability protocols, allowing members to seek and access appropriate treatment outside of EDs.

Timeline: We will operationalize Objective 3 within 120 days of the Contract effective date.

Objective 4: Expand Best Practices into Gila and Pinal Counties

It's MCC's strategy to sustain and innovate the existing Maricopa County crisis system while driving improvement and addressing the disparities in Pinal and Gila counties. While resources and capacity vary in these rural counties, and services may need to be delivered differently, it's critical to ensure consistency with the access and philosophy of Maricopa County. For example, we will maintain the commitment to the No Wrong Door drop-off policy in Maricopa County for law enforcement to bring individuals experiencing behavioral health symptoms to a receiving center (usually in lieu of booking the individual in jail or dropping the individual off at an ED). As services and access to community-based crisis services are markedly different in these rural counties, we will **improve crisis service availability** in Gila and Pinal counties through actionable steps that include the following:

- Support development of two-person mobile teams using a rural payment differential and encourage use of team members with lived experience (peer support) to enhance the effectiveness of crisis response.
- **Commit $500,000 to close the gap of crisis observation services in Gila County by contracting with CBI, an outpatient provider, to open a modified receiving center in Payson**.
- Expand access to a "warm line," offering peer support as a frontline for members who may be heading towards a crisis, which provides opportunity to potentially resolve the situation prior to escalation to a full crisis episode.
- Create a communication campaign with tribal communities to ensure there is awareness of available crisis services.

Timeline: We will implement the differential rate at go-live. The timeline for the crisis receiving center will be determined in collaboration with CBI. Other actions in Objective 4 will be implemented within 180 days of the Contract effective date.

Objective 5: Expand Best Practices to Better Address Children and Families in Crisis

Under the ACC-RBHA Contract, it will be our responsibility to ensure the stabilization of children in crisis, and we are eager to partner with AHCCCS to achieve their vision. By leveraging current or future-state infrastructure, and by collaborating with stakeholders, including school systems, crisis team providers, and Health Homes, we will **improve crisis support to children and families** of the Central GSA through the following actionable steps:

- Expand the children's rapid response team to increase the capacity of child/adolescent clinical teams able to respond to child/adolescent members in the ED for a behavioral health crisis to assess and coordinate appropriate behavioral health services to stabilize the crisis, allowing the member to remain in the least restrictive setting appropriate to address their needs.
- Implement a single-person school-based mobile crisis unit, as schools don't require two-person teams. We have an agreement with EMPACT Suicide Prevention Center for single-person crisis responses to schools to improve scalability.
- Partner with Hazel Health to deliver telebehavioral health directly to schools, including assistance from schools' registered nurses, to help prevent crisis and deliver suicide prevention education.

Timeline: We will operationalize Objective 5 within 180 days of the Contract effective date.

B10. American Indian/Alaska Native Members

Knowledge of Unique Aspects of the Tribal Healthcare Delivery System

Respecting tribal sovereignty is paramount to building and maintaining relationships with tribal communities. We know that because of historical government policies that caused trauma and distrust, we can't improve outcomes or the coordination of care in Arizona's Central GSA unless we fully engage the State's tribal communities.

MCC's Tribal Coordinator, Cassandra Peña, is Hopi and an enrolled member of the Gila River Indian Community. Drawing on these connections and her prior work at IHS, Ms. Peña plays a key role in ensuring MCC strategy and processes reflect the rich culture and sovereignty of tribal communities, such as providing cross-plan training to ensure we deliver culturally relevant services to AI/AN members and interact effectively with the Tribal health care delivery system. 016.AZ21

Through discussions with Salt River Pima-Maricopa Indian Community (SRPMIC) and urban agencies serving all Arizona tribes, such as Native Health and Native American Connections, Phoenix Area Indian Health Service, Ak-ching Indian Community, and the Gila River Indian Community, we have had the opportunity to better understand the multiple tribal delivery systems, the ways each tribal community delivers care differently, and the services AI/AN members most frequently seek off the reservation. We have also learned that the tribal health care system providers are concerned that MCOs will "take away" services and revenue when the desire is for MCOs to enhance (not replace or refer out services) what they already have available/offer.

Because tribal members can choose to receive care from tribal health systems or off the reservation, members can experience care fragmentation as these entities do not coordinate with each other. For example, if an AI/AN member visits an ED off the reservation, there may not be a connection back to their tribal providers who previously treated them. Further, if a member is in crisis, the involuntary commitment process is specific to each tribal community; some tribes do not legally restrict a community member as a sovereign right. We understand that for many AI/AN members, stigma and lack of family support for members with co-occurring SMI/SUD, having a personalized ISP is a priority.

Now that tribal courts acknowledge the State's COTs, we understand there are fewer barriers for members who are justice-involved. Overall, we recognize there is a dearth of tribal knowledge about the service delivery system off the reservation and the availability of Non-Title XIX/XXI services. The design of the system that allows for no boundaries in the delivery system and 100% member choice presents a coordination challenge and complicates healthcare delivery, leading to members getting "lost," which contributes to major health disparities, like diabetes, for this population.

Addressing the Specific Needs of the AI/AN Population

Because each tribal community and tribal health system vary in their capacity and available services, we tailor our solutions and strategies by collaborating with each tribal system to account for specific capacity and address gaps. For example, we have met with **Martin Harvier, President Salt River Pima Maricopa Indian Community** and **Councilmember Terrance Evans, Gila River Indian Community** to understand the community needs and work to collective address them. Below, we describe how we have and will continue to address the needs of AI/AN members in the Central GSA.

Close Relationships with Tribal Entities. MCC routinely meets with various tribes and tribal providers to address the needs of individual members, educate them on MCC benefits, and assist their clinic where needed and requested (e.g., we meet with the Pascua Yaqui TRBHA quarterly). Respecting tribal sovereignty and tribal entry points, we have an established working relationship with tribes, addressing issues identified by them, and will continue pursuing face-to-face meetings with tribal leadership. We will also continue to participate in State-sponsored Tribal Consultations to lend support when needed and stay on top of policy changes. We will continue collaborating with State and community partners in planning educational opportunities to better serve tribal members and communities.

A Dedicated Tribal Team. In addition to our **Tribal Coordinator, Ms. Peña,** MCC will hire Tribal Clinical Coordinators who provide clinical expertise in serving AI/AN members and Tribal Liaisons. We are also partnering with Arizona State University to launch a social work internship program for AI/AN students to work with tribal communities, members, and health systems to improve cross-system coordination. Our team will make welcome calls to newly enrolled AI/AN

members to help educate them and coordinate care. We will also continue to participate in integrated care coordination rounds to provide cultural and clinical support for AI/AN members receiving care in acute and residential facilities.

> **"I wanted to take a moment to thank you and your staff at MCC for helping support the initiatives and concerns expressed by the Salt River Pima-Maricopa Indian Community with respect to mental health services provided to our tribal members. As you know, mental health issues affect Native Americans and Alaska Natives at a disproportionate level, and it is partnerships like this that move the goal of mental wellness forward. I appreciate the collaboration and expect that we will continue to have a mutually beneficial relationship going forward."**
>
> *– John Godfrey, Assistant Director, Health and Human Services SRPMIC*
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> 017.AZ21

A Tailored Population Health Program. We ensure our approaches honor specific AI/AN cultures by working with tribes to tailor our outreach, health and self-management education, and SDOH interventions. Our program addresses many conditions prevalent within the AI/AN population, including depression and suicide prevention, diabetes, asthma, COPD, congestive heart failure, cancer, SUD, chronic kidney disease, smoking cessation, and weight management. Some AI/AN members may want to include a tribal healer in their care to address their spiritual well-being.

Ensuring Culturally Competent Interactions and Culturally Relevant Services. MCC incorporates information about AI/AN culture in staff and provider training along with tribe-specific information to ensure cultural competence in operations, interactions with members, and service delivery. MCC educates our staff about historical trauma in tribal communities and how that may affect a member's or a family's approach to care and/or their perspective about government agencies. MCC trains staff that children in out-of-home placements must have their cultural and linguistic needs met while off tribal land to facilitate successful reintegration with their families. To deepen our knowledge, MCC hosts a quarterly interdepartmental Cultural Competency Committee. MCC's Tribal Coordinator presents standing agenda items such as tribal engagement updates and data and outcome trends and interventions specific to AI/AN members. The Committee looks at trends specific to this population, provides input on cultural factors that may be causing the trend, and gives feedback on culturally appropriate interventions to address them.

Advanced Technology and Support for Data Sharing. MCC uses data sharing and coordination protocols to ensure care is continuous and well coordinated when members receive services from different systems. We are assisting the SRPMIC to establish data exchange through Collective in conjunction with Health Current. Collective provides data from multiple sources, which providers use to obtain a member's clinical and treatment history. We will continue to offer technical assistance to tribal health systems about using Collective and connecting to Health Current.

Payment Strategies to Enhance Tribal System Care Coordination. We offer MOUs or contracts to tribal systems for coordination services. We will offer value-based arrangements to American Indian Health Facilities and I/T/Us for system improvements, such as timely submission of encounter data, if a tribal entity finds this to be mutually beneficial.

Reducing Health Disparities Among AI/AN Members

MCC identifies disparities using our proprietary risk stratification and predictive modeling platform, along with other external data (Arizona Behavioral Risk Factor Surveillance System and the American Indian Health Status Report). MCC has identified disparities among the AI/AN membership in outcomes related to cardiovascular diseases, accidents, cancer, diabetes, and chronic lower respiratory conditions, resulting in a life expectancy that is 15 years less than the State average. We will address tribal health disparities by creating a tribal advisory committee to work with tribal leaders, providers, and communities to plan educational opportunities, develop culturally relevant interventions tailored for each tribe, expand our Cultural Competency Advisory Board, and offer AI/AN cultural training for community and our staff, and ensure the AI/AN–MCC feedback loop is working as intended.

We will **sponsor an AI/AN Social Work Intern program** with Arizona State University School of Social Work. MCC's Tribal Coordinator will supervise and provide the student with tribal field experience to advance an understanding of tribal culture and AI/AN disparities among those who plan to work within the healthcare system. The AI/AN Social Work Interns will support internal and external training and systems change initiatives, ensure culturally appropriate materials are made available to AI/AN members, and support our Tribal Clinical Coordinator as clinically appropriate.

B11. Using Medicaid Compensable and Non-covered Services to Address Social Risk Factors

To address AHCCCS' priority social risk factors and support the goals of the Whole Person Care Initiative, MCC is establishing a first-of-its-kind, outcomes-based payment arrangements and cross-system collaboration with the full continuum of stakeholders and providers to capture and integrate all current and newly identified data sources. These strategies will bring accountability to the provision of SDOH services; increase awareness of the availability of SDOH services for efficient management across the continuum; and increase access to services for SMI members.

Delivery of Services to Address Priority Social Risk Factors

MCC will be the first in Arizona to implement value-based reimbursement models for compensable and non-compensable services to address social risk factors. Our shift to a measurement-based system focused on outcomes will ensure individuals receive meaningful long-term support for social risk factors. For example:

Housing and Homelessness. MCC will transition supportive housing services reimbursement from a block payment structure to an outcomes-based payment methodology that will reward providers for getting members into and keeping them in housing. This payment approach will improve equitable provision of Medicaid, State, and federal housing services as dollars will be directed based on member needs. It will also **provide the funding necessary for providers to build service capacity and allow SMI Health Homes and community service agencies to staff at a 1:700 ratio, an improvement over the current system.** A key strategic goal of this reimbursement innovation is to incentivize providers to pay for full HMIS database access. We will pay initial costs for provider access, but our outcomes-based methodology will incentivize and support providers to maintain access to better support housing members and meet outcomes targets.

Employment Instability. MCC will transform delivery of Supported Employment Services into a transparent and accountable system of employment training and referral. Our model will integrate high-quality training and incentive-based payment structures to ensure members obtain and maintain sustainable and meaningful employment. Our approach will incentivize appropriate ICD-10 billing to monitor service delivery for members and evaluate provider competency to create better employment outcomes. Through our **letter of intent with WEDCO Employment Center,** the largest supported employment services provider in Arizona, we will **enhance employment services outcomes** through a value-based reimbursement model. Our partnership will create efficiency in supported employment services by incentivizing meaningful, long-term placement of members rather than short-term employment. Today, WEDCO Employment Center gets referrals directly from SMI Health Homes; our collaborative model facilitates similar pathways for all providers to offer direct referrals and integrate WEDCO Employment Center services into their care delivery.

Transportation. MCC will partner with Neighborhood Outreach Access to Health (NOAH) to enhance their Community Navigator Program to meet a critical need: providing non-medically necessary transportation for members to address SDOH needs in the community. Leveraging our Practice Transformation and OIFA teams, MCC will provide technical assistance and alternative payment options to NOAH to sustainably expand the scope, capability, and capacity of Community Navigators. NOAH will **cross-train their Community Navigators** (who are also certified CHWs) **as SDOH transportation providers** and **behavioral health providers of supportive services** (peer and family support and health prevention and promotion). Our partnership will create a new kind of workforce of Community Navigators to enable scalability and sustainability for non-billable service provision, especially transportation.

Justice Involvement. MCC will improve accountability for Medicaid, Non-Title XIX/XXI, and TIP services provided to justice-involved members. We have executed a **letter of intent with Terros Health for an outcomes-based model to incentivize timely, closed loop referrals for all needed services** for successful re-entry and community maintenance. Services not reimbursed by Medicaid but critical for re-entry include obtaining a State identification and birth certificate for applications to employment, eligibility assistance for social services, and clothing. Terros Health will conduct reach-in before release to perform assessments and participate in service planning to ensure all needed services are in place on the day of release. Our payment model reimburses not for the post-release referrals themselves but for the outcomes of those referrals to ensure services are provided and meeting members' needs. Our payment approach will improve accountability for outcomes for Medicaid case management and peer support services; State and locally funded

supportive housing, employment, and family and peer support; TIP-funded and other community services; and other SDOH services, including closed loop referrals for non-compensable services. We will use a similar approach with CBI in Gila and Horizon Health and Wellness in Pinal.

Social Isolation. We promote technology solutions and digital access to reduce social isolation and increase access to services. For example, we leverage the Pyx mobile application smart technology to assess SDOH needs with an emphasis on social isolation risk. Our use of Pyx differs from other MCOs as we combine it with high-touch human interaction to drive real-time member engagement when immediate risks are identified. Molina's Health in Touch digital access program connects members to the federal Lifeline program to obtain a smart phone or tablet. For high-need members, such as the SMI population, Health in Touch adds remote device monitoring, SDOH awareness and matching, advanced data collection from assessments and EHRs, alerts and reminders, and simplified two-way communication to critical care management. Our solutions will lead to better health outcomes and lower utilization of emergency and crisis services through effective use of Medicaid and non-covered services to help members re-engage with their community.

Cross-system Collaboration to Expand Access to SDOH Services

In order to build accountability and help AHCCCS' accomplish their vision, we will create and invest in a **Community Resource Consortium** to act as a convener of system leaders, **providing real-time feedback on the SDOH referral and service system**. Through the consortium, we will support the successful implementation of NowPow, and as data comes into NowPow, we will monitor and target issues. This consortium of non-compensable services providers will collaborate to find root causes and understand capacity needs, assessing the SDOH continuum of care and providing feedback on system improvements to drive operationalization in the community. We will share all information gained from the consortium with Health Current / NowPow to further advance AHCCCS' Whole Person Care Initiative.

How We Will Capture SDOH Data to Connect Members and Ensure Timely Access

MCC will innovate how we capture, use, **and promote sharing of meaningful data through full integration of NowPow and Health Current with our comprehensive clinical, State, and community SDOH data sets**. Our data-driven, community-informed approach captures and identifies SDOH needs at the population, community, and member levels to ensure members are connected and have timely access to needed social services. We will require and promote provider and community participation in data sharing to provide real-time insights into member SDOH needs and availability of SDOH resources. Integration of NowPow with our comprehensive data will empower providers to make informed, holistic care decisions and initiate closed loop SDOH referrals.

We capture SDOH data from a wide range of sources, such as the DUGless file; streamlined member screenings and assessments; Z codes from claims; and a variety of public sources. We capture data from MCC Care Manager and Member Services interactions with members; screenings and health risk assessments; care and discharge planning; and the Pyx mobile application. We obtain data from providers by requiring them to capture and share SDOH data from screenings and assessments. We **also incentivize providers for submitting Z codes for SDOH indicators** on claims, which promotes collection of SDOH data at the point of care and prompts providers to make referrals for immediate needs that close SDOH gaps; timely and complete demographic assessments, so the information populating the DUGless file is accurate; and using NowPow to find and refer members to needed resources. Our collaboration with clinical and community providers will support the Whole Person Care Initiative through meaningful integration of SDOH data with NowPow and Health Current.

We combine this data with claims, encounters, and other data, including lab and pharmacy data and data pulled from provider EHRs, DUGless, the HMIS system, and Health Current to amass a comprehensive data resource we can analyze to identify overall population needs, subpopulation needs, and hot spots where specific needs are geographically concentrated. We will use this fully integrated data to create individualized ISPs and then match member needs to relevant resources and identify community or population resource gaps. We will monitor ISP adherence through audits and technical assistance to ensure timely access. We will also make data accessible to providers to inform patient care and support SMI clinical teams, treatment planning teams, and MCC's cross-functional Integrated Rounds team as they evaluate and address member gaps in services.

B12. Pandemic Recovery

MCC's Role and Strategies in Supporting the State's Recovery from the Pandemic

MCC has been active in the community meeting members' whole health needs during the pandemic. Under the ACC-RBHA Contract, we will be the accountable entity and proactive partner to the State and local government, members, and clinical and community providers to address the unique impact of the pandemic on behavioral health through specialized interventions and education. Our educational strategies support communities and providers to understand and address existing inequities; new and compounded traumas experienced by members due to the pandemic; and the long-term impact on recovery. Our specialized intervention strategies, supported by staff trained in trauma-informed care and resiliency, recognize every member will experience the trauma of the pandemic differently.

Addressing the Unique Impacts of the Pandemic on Behavioral Health

Individuals with SMI are uniquely affected by the pandemic. Social distancing can increase feelings of isolation, COVID-19-related information can be overwhelming, and the risk of getting COVID-19 and concerns about vaccination safety can heighten anxiety. These factors can exacerbate SMI symptoms, trigger first episode psychosis, and increase substance use, self-harm, and suicide risk. Below highlights strategies we use to support members' recovery from the pandemic.

Specialized Interventions to Address the Unique Impact of the Pandemic

73% **of MCC members using Pyx feel more connected with their health plan.**
Using Pyx has also meant members utilize fewer crisis teams, behavioral health hotlines, and the ED. Without real-time engagement from Pyx, 60% of those surveyed would have called a crisis team, 20% would have called a behavioral health hotline, and 20% would have visited the ED.
025.AZ21

Social Isolation. The Arizona Health Improvement Plan 2021–2025 recognized the "epidemic of loneliness" impacting the mental health of Arizonans. In alignment with AHIP, MCC implemented an intervention that combines technology and human interaction to address loneliness across all populations. For those with SMI and depression, public health policies, such as social distancing, can cause or enhance loneliness and emotional distress and relapse of psychotic symptoms, resulting in increased ED and hospital utilization and crisis. The Pyx mobile application assesses SDOH needs with an emphasis on social isolation risk. **Our use of Pyx differs from other MCOs as we combine it with high-touch human interaction by integrating Pyx data into our member services and care management workflows to drive real-time member engagement.**

Suicide Prevention. MCC identified an increasing trend of suicide attempts across our population, from 4.9% pre-pandemic to 10.5% after the pandemic began. We quickly intensified our monitoring and outreach, using our Recovery Health Guides for real-time identification of inpatient admissions for suicide attempts to support proactive reach-in that ensures post-discharge support, including peer support, is in place upon discharge. After discharge, a Care Manager continues outreach weekly and follows the member for at least six months. **We have not lost a single member in this program to suicide.** Building on the success of our reach-in program, we partnered with Resilient Health to proactively address suicide risk. Members enrolled in our integrated care program with Resilient Health receive ongoing suicide risk assessments and routine DLA-20 assessments. We build strong relationships between the member, outpatient behavioral health providers, and our health plan to address triggers.

Suicide Prevention: Success Story

Tom, an MCC member from Maricopa County, was admitted for an inpatient hospital stay due to a suicide attempt. Upon release, an MCC Recovery Health Guide connected Tom to an MCC Care Manager, who hearing Tom he was unhappy with his outpatient behavioral health provider, helped him find a new outpatient provider. **Now, Tom feels he is receiving the right services,** and his new provider is helping him process his grief. **Tom called our Care Manager to share they had quite possibly saved his life.**
030.AZ21

Housing and Evictions. Housing insecurity and homelessness have a tremendous impact on the health and well-being of people with SMI. According to a recent Census Household Pulse Survey[1], nearly 120,000 Arizonans were behind on rent and close to 36,000 said they were likely to be evicted. MCC's **Director, Housing** will collaborate with HOM, Inc., and SMI Health Homes to ensure access to Medicaid and Non-Title XIX/XXI housing support services. We will work with HOM,

[1] United States Census Bureau, "Household Pulse Survey Data Tables," https://www.census.gov/programs-surveys/household-pulse-survey/data.html, 2021, accessed September 23, 2021.

Inc., to prioritize SMI housing needs through coordination and oversight of the wait lists and access to all available housing programs. MCC will provide educational support to SMI Health Home Housing Specialists and Case Managers on availability of housing solutions and how best to leverage and connect members to those services. MCC also supports Home Matters to Arizona through funding and operational support; we collaborate with ACC MCOs and their Housing Specialists in the approval process. We also link members to state housing resources, like arizonatogether.org.

Specialized Interventions to Ensure Care Continuity and Access to Vaccinations

MCC will support programs for our members and provide guidance to our network providers to ensure continuous access to preventive physical health and behavioral health services and address whole health needs.

Facilitating Continuous Coverage. Molina's Redetermination team closely monitors for redetermination dates and will coordinate with clinical and community providers to help members navigate the redetermination process and retain Medicaid coverage, so they don't lose access to behavioral health services, particularly during the pandemic. We will use our data platform and analytics to identify and outreach to at-risk members to support them in maintaining eligibility. Under the ACC-RBHA contract, we will educate ACC MCOs on the process to refer members transitioning from Medicaid coverage to Non-Title XIX/XXI services, so we can transition members' services with no gaps in care.

Intensifying Engagement Efforts. The pandemic has undermined our members' ability to access and stay engaged in care. We will leverage our network of PROs to proactively engage adult members with new needs and re-engage members who have lost connection community supports. To address COVID-19-induced trauma among students, we will partner with schools by prioritizing Non-Title XIX/XXI funds for children with SED and educating school-based providers on how MCC can assist children and families to access needed Medicaid and Non-Title XIX/XXI behavioral health services.

Promoting Alternative Service Delivery Models. Early in the pandemic, MCC supported virtual methods of care delivery, leveraging telemedicine as a solution to engage members in physical health and behavioral health services, as well as treatment planning and interactions to gain or retain social services. Our Care Managers provide step-by-step training to members to access platforms for telehealth visits and engage with Case Managers. MCC will expand availability of psychiatric, therapy, and support services through provider partnerships to provide expanded telehealth.

Access to Vaccinations. A top priority of MCC's internal COVID-19 Response Team is to work toward increasing the vaccination rate among the population covered by the CCE. The team will apply innovative solutions to integrate vaccinations into physical health, behavioral health, and community service interactions. Our COVID-19 dashboard monitors rates and trends in COVID-19 positivity and vaccination to identify regional and community health disparities. We use this data to develop and prioritize our efforts to increase vaccination rates, engaging key partners to meet our members where they are, and support them in their vaccination decisions.

Our parent company's in-home nurse practitioners will coordinate with our Peer Reach-In Program staff during behavioral health hospital discharge and re-entry transition planning to schedule vaccination services in locations most accessible to members. We will work with Recovery Health Guides to address the unique issues of distrust and reluctance members with SMI have to vaccination by assisting members in making informed decisions. Recovery Health Guides are also available to support SMI Health Homes and our network of clinical and community providers as they interact with members with SMI. Our partnership with the University of Arizona's Primary Prevention Mobile Health Unit will bring free preventive health screenings and COVID-19 vaccinations to underserved populations.

Educating the Public on the Behavioral Health Impact of the Pandemic

Under the ACC-RBHA Contract, MCC will be the trusted expert on behavioral health in Arizona. Our COVID-19 Response Team will educate and engage the public on key issues such as increased need for behavioral health services; COVID-19-induced trauma in adults and children; potential vaccination concerns among those with SMI; post-eviction moratorium housing stability; increased social isolation; continued expansion of telehealth; and the importance of members engaging with family, peer, and community supports to mitigate the impacts of the pandemic. Through public service announcements, and virtual behavioral health forums, MCC will educate the public on accessing behavioral health services and community resources to address COVID-19-related physical health, behavioral health, and social needs.

Part C –
Capitation Agreement/ Administrative Cost Bid

C1. Agreement Accepting Capitation Rates

The Offeror shall submit an agreement that the Offeror will accept the actuarially sound capitation rates computed prior to October 1, 2022. The agreement shall be signed by each of the ACC Contractor's Chief Executive Officer. This is a required submission.

AHCCCS intends to set the underwriting gain equal to one percent of the capitation rate for each risk group excluding premium tax.

Administrative expenses will be bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative cost component, in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.

AHCCCS is providing Offerors with a Title XIX/XXI Data Supplement For Capitation Rate Setting located in the CCE Library for informational purposes. If the Offeror chooses to use this data source to develop its administrative cost bid, the Offeror shall not consider this the sole source of information in making decisions.

If any moral or religious objections were submitted as part of the ACC Request for Proposal (RFP), the Offeror shall not exclude from the administrative bid submission(s) any related administrative costs.

Molina Healthcare of Arizona, Inc.'s agreement that we will accept the actuarially sound capitation rates computed prior to October 1, 2022, follows this page.

Minnie Andrade
Chief Executive Officer
Molina Complete Care
5055 E. Washington Street
Suite 210
Phoenix, AZ 85034
Minnie.Andrade@molinahealthcare.com
Tel: 602-830-0067

October 2, 2021

Meggan LaPorte, CPPO, MSW
Chief Procurement Officer
Arizona Health Care Cost Containment System Administration
801 E. Jefferson Street
Phoenix, AZ 85034

RE: Expansion of AHCCCS Complete Care Contract #YH19-0001
Agreement to Accept Capitation Rates

Dear Ms. LaPorte:

Molina Complete Care (MCC) agrees to accept the actuarially sound capitation rates computed prior to October 1, 2022. We understand AHCCCS intends to set the underwriting gain equal to one percent of the capitation rate for each risk group excluding premium tax, but that AHCCCS reserves the right to adjust the capitation rates, including the administrative cost component, in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.

We have included our administrative expenses with our bid in Part C2 as directed in Section H: Instructions to Offerors will be bid by the Offerors.

Sincerely,

Minnie Andrade

Minnie Andrade
Chief Executive Officer
Molina Complete Care

C2. Administrative Cost Bid Submission Workbook

The Offeror shall bid the administrative cost portion of the capitation rates. The Offeror shall include an administrative rate for each GSA 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 in which the Offeror submits a bid.

Molina Healthcare of Arizona, Inc.'s Administrative Cost Bid Submission Workbook follows this page.

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	$ 1,288,235.46	$ 1,314,000.17	$ 1,340,280.18	$ 1,367,085.78	$ 1,394,427.49	$ 48,898.25	$ 49,876.21	$ 50,873.74	$ 51,891.21	$ 52,929.04
Care Management/Care Coordination	$ 6,268,986.19	$ 6,394,365.91	$ 6,522,253.23	$ 6,652,698.29	$ 6,785,752.26	$ 647,279.37	$ 660,224.96	$ 673,429.46	$ 686,898.05	$ 700,636.01
Claims and Encounters	$ 3,555,882.60	$ 3,627,000.25	$ 3,699,540.26	$ 3,773,531.06	$ 3,849,001.68	$ 134,972.55	$ 137,672.00	$ 140,425.44	$ 143,233.95	$ 146,098.63
Clinical Management	$ 3,277,248.00	$ 3,342,792.96	$ 3,409,648.82	$ 3,477,841.80	$ 3,547,398.63	$ 124,396.27	$ 126,884.19	$ 129,421.88	$ 132,010.32	$ 134,650.52
Compliance/Legal	$ 921,845.73	$ 940,282.64	$ 959,088.29	$ 978,270.06	$ 997,835.46	$ 34,991.00	$ 35,690.82	$ 36,404.63	$ 37,132.72	$ 37,875.38
Dental	$ 269,064.00	$ 274,445.28	$ 279,934.19	$ 285,532.87	$ 291,243.53	$ 10,213.01	$ 10,417.27	$ 10,625.61	$ 10,838.13	$ 11,054.89
Executive	$ 2,259,814.40	$ 2,305,010.69	$ 2,351,110.90	$ 2,398,133.12	$ 2,446,095.78	$ 85,776.99	$ 87,492.53	$ 89,242.38	$ 91,027.23	$ 92,847.78
Health Care Quality Improvement	$ 5,676,674.30	$ 5,790,207.79	$ 5,906,011.94	$ 6,024,132.18	$ 6,144,614.83	$ 215,472.59	$ 219,782.04	$ 224,177.68	$ 228,661.23	$ 233,234.46
Information Services / Technology	$ 2,142,128.48	$ 2,184,971.05	$ 2,228,670.47	$ 2,273,243.88	$ 2,318,708.76	$ 81,309.93	$ 82,936.12	$ 84,594.85	$ 86,286.74	$ 88,012.48
Interpretive Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Member Services	$ 10,271,570.46	$ 10,477,001.87	$ 10,686,541.90	$ 10,900,272.74	$ 11,118,278.20	$ 389,883.54	$ 397,681.21	$ 405,634.83	$ 413,747.53	$ 422,022.48
Pharmacy Management	$ 804,674.61	$ 820,768.10	$ 837,183.46	$ 853,927.13	$ 871,005.67	$ 30,543.47	$ 31,154.34	$ 31,777.42	$ 32,412.97	$ 33,061.23
Program Integrity (Fraud, Waste & Abuse)	$ 159,014.40	$ 162,194.69	$ 165,438.58	$ 168,747.35	$ 172,122.30	$ 6,035.80	$ 6,156.51	$ 6,279.64	$ 6,405.23	$ 6,533.34
Provider Relations and Network Management	$ 870,700.80	$ 888,114.82	$ 905,877.11	$ 923,994.65	$ 942,474.55	$ 33,049.66	$ 33,710.65	$ 34,384.87	$ 35,072.56	$ 35,774.01
Other [1]	$ 614,920.32	$ 627,218.73	$ 639,763.10	$ 652,558.36	$ 665,609.53	$ 23,340.86	$ 23,807.68	$ 24,283.83	$ 24,769.51	$ 25,264.90
Total MCO Compensation	$ 38,380,759.75	$ 39,148,374.94	$ 39,931,342.44	$ 40,729,969.29	$ 41,544,568.67	$ 1,866,163.28	$ 1,903,486.54	$ 1,941,556.27	$ 1,980,387.40	$ 2,019,995.15
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	$ 655,089.50	$ 668,191.29	$ 681,555.11	$ 695,186.22	$ 709,089.94	$ 41,447.27	$ 42,276.22	$ 43,121.74	$ 43,984.18	$ 44,863.86
Care Management/Care Coordination	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Claims and Encounters	$ 1,610,045.70	$ 1,642,246.62	$ 1,675,091.55	$ 1,708,593.38	$ 1,742,765.25	$ 101,867.00	$ 103,904.34	$ 105,982.43	$ 108,102.07	$ 110,264.12
Clinical Management	$ 555,946.34	$ 567,065.27	$ 578,406.57	$ 589,974.70	$ 601,774.20	$ 35,174.52	$ 35,878.01	$ 36,595.57	$ 37,327.48	$ 38,074.03
Compliance/Legal	$ 66,583.79	$ 67,915.46	$ 69,273.77	$ 70,659.25	$ 72,072.43	$ 4,212.73	$ 4,296.99	$ 4,382.93	$ 4,470.58	$ 4,560.00
Dental	$ 94,620.25	$ 96,512.65	$ 98,442.91	$ 100,411.77	$ 102,420.00	$ 5,986.59	$ 6,106.32	$ 6,228.45	$ 6,353.02	$ 6,480.08
Executive	$ 24,337.83	$ 24,824.59	$ 25,321.08	$ 25,827.50	$ 26,344.05	$ 1,539.85	$ 1,570.64	$ 1,602.06	$ 1,634.10	$ 1,666.78
Health Care Quality Improvement	$ 869,766.45	$ 887,161.78	$ 904,905.01	$ 923,003.11	$ 941,463.17	$ 136,546.80	$ 139,277.74	$ 142,063.29	$ 144,904.56	$ 147,802.65
Information Services / Technology	$ 523,914.95	$ 534,393.24	$ 545,081.11	$ 555,982.73	$ 567,102.39	$ 33,147.91	$ 33,810.86	$ 34,487.08	$ 35,176.82	$ 35,880.36
Interpretive Services	$ 6,799,320.00	$ 6,935,306.40	$ 7,074,012.53	$ 7,215,492.78	$ 7,359,802.63	$ 505,328.56	$ 515,435.13	$ 525,743.83	$ 536,258.71	$ 546,983.88
Member Services	$ 230,553.67	$ 235,164.74	$ 239,868.04	$ 244,665.40	$ 249,558.71	$ 14,587.05	$ 14,878.79	$ 15,176.36	$ 15,479.89	$ 15,789.49
Pharmacy Benefit Manager Expenses [2]	$ 3,306,717.51	$ 3,372,851.86	$ 3,440,308.90	$ 3,509,115.08	$ 3,579,297.38	$ 8,554.43	$ 8,725.52	$ 8,900.03	$ 9,078.03	$ 9,259.59
Pharmacy Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Program Integrity (Fraud, Waste & Abuse)	$ 10,823.54	$ 11,040.01	$ 11,260.81	$ 11,486.03	$ 11,715.75	$ 684.80	$ 698.50	$ 712.47	$ 726.72	$ 741.25
Provider Relations and Network Management	$ 104,409.35	$ 106,497.54	$ 108,627.49	$ 110,800.04	$ 113,016.04	$ 6,605.94	$ 6,738.06	$ 6,872.82	$ 7,010.28	$ 7,150.48
Subcontractors [2]	$ 316,216.81	$ 322,541.15	$ 328,991.97	$ 335,571.81	$ 342,283.25	$ 1,793,537.94	$ 1,829,408.70	$ 1,865,996.87	$ 1,903,316.81	$ 1,941,383.15
Other [1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Professional and Outside Services	$ 15,168,345.69	$ 15,471,712.60	$ 15,781,146.85	$ 16,096,769.79	$ 16,418,705.18	$ 2,689,221.38	$ 2,743,005.81	$ 2,797,865.92	$ 2,853,823.24	$ 2,910,899.71
Non-Compensation	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
Interest Expense	$ 91,788.13	$ 93,623.89	$ 95,496.37	$ 97,406.30	$ 99,354.42	$ 7,239.92	$ 7,384.72	$ 7,532.41	$ 7,683.06	$ 7,836.72
Non-Capital Equipment and Licenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Compensation Health Care Quality Improvement	$ 1,357,063.58	$ 1,384,204.85	$ 1,411,888.95	$ 1,440,126.73	$ 1,468,929.26	$ 107,040.29	$ 109,181.10	$ 111,364.72	$ 113,592.01	$ 115,863.85
Occupancy & Depreciation	$ 144,956.19	$ 147,855.31	$ 150,812.42	$ 153,828.67	$ 156,905.24	$ 11,433.62	$ 11,662.30	$ 11,895.54	$ 12,133.45	$ 12,376.12
Office Supplies, Equipment Repair, Maintenance	$ 248,228.38	$ 253,192.95	$ 258,256.81	$ 263,421.95	$ 268,690.39	$ 19,579.36	$ 19,970.95	$ 20,370.37	$ 20,777.78	$ 21,193.33
Printing, Postage, Fulfillment	$ 1,038,104.48	$ 1,058,866.57	$ 1,080,043.90	$ 1,101,644.78	$ 1,123,677.67	$ 81,881.95	$ 83,519.58	$ 85,189.98	$ 86,893.78	$ 88,631.65
Travel, Marketing, Insurance	$ 1,361,181.99	$ 1,388,405.63	$ 1,416,173.74	$ 1,444,497.22	$ 1,473,387.16	$ 107,365.14	$ 109,512.44	$ 111,702.69	$ 113,936.74	$ 116,215.48
Other [1]	$ 192,048.18	$ 195,889.15	$ 199,806.93	$ 203,803.07	$ 207,879.13	$ 15,148.07	$ 15,451.03	$ 15,760.05	$ 16,075.25	$ 16,396.76
Total Non-Compensation	$ 4,433,370.94	$ 4,522,038.36	$ 4,612,479.12	$ 4,704,728.71	$ 4,798,823.28	$ 349,688.35	$ 356,682.11	$ 363,815.76	$ 371,092.07	$ 378,513.91
Total Admin Dollars	$ 57,982,476.37	$ 59,142,125.90	$ 60,324,968.41	$ 61,531,467.78	$ 62,762,097.14	$ 4,905,073.00	$ 5,003,174.46	$ 5,103,237.95	$ 5,205,302.71	$ 5,309,408.76
Total Management Fees Included Above [3]	$ 28,033,319.64	$ 28,593,986.03	$ 29,165,865.75	$ 29,749,183.07	$ 30,344,166.73	$ 2,371,500.63	$ 2,418,930.64	$ 2,467,309.26	$ 2,516,655.44	$ 2,566,988.55
Management Fee arrangement percentage (contracted)										
Projected Member Months	330,705	337,625	344,950	352,640	360,502	13,625,203	14,154,753	14,701,831	15,270,052	15,860,236

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.

as of 04/29/21

C3. Actuarial Certification

The Offeror shall ensure that an actuary who is a member of the American Academy of Actuaries certifies that the Administrative Cost Bid Submission meets the requirements of 42 CFR 438.5(e) by submitting a signed actuarial certification of all rates submitted with the CCE submission. The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid. Further detail regarding requirements of the bids can be found in the Title XIX/XXI Data Supplement For Capitation Rate Setting in the CCE Library in the Non-Benefit Costs Bid Requirements document in Section F, Rate Development Information.

Molina Healthcare of Arizona, Inc.'s signed certification that our Administrative Cost Bid Submission meets the requirements of 42 CFR 438.5(e) follows this page. Our certification has been signed by an actuary who is a member of the American Academy of Actuaries.

Actuarial Certification of the Administrative Cost Bid for Arizona Health Care Cost Containment System Administration (AHCCCS) Solicitation #YH20-0002
Effective October 1, 2022

The purpose of this document is to provide information related to Molina Healthcare of Arizona, Inc.'s (Molina) actuarial certification of the administrative cost bid for ACHCCCS solicitation #YH20-0002.

Molina Healthcare of Arizona, Inc. is a managed care organization that provides healthcare services for over 44,000 individuals primarily eligible for Medicaid throughout the State of Arizona. Molina Healthcare of Arizona, Inc. is a licensed state health plan managed by its parent corporation, Molina Healthcare, Inc.

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our locally operated health plans in 18 states across the nation, Molina serves more than 4.6 million members. Dr. C. David Molina founded our company in 1980 as a provider organization serving low-income families in Southern California. Today, we continue his mission of providing high quality and cost-effective health care to those who need it most.

200 Oceangate ▪ Suite 100 ▪ Long Beach, CA ▪ 800.526.8196

MolinaHealthcare.com

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ADMINISTRATIVE COST BID **3**

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Administrative Cost Bid

Molina submits the following as the administrative cost bid for the Regional Behavioral Health Agreement (RBHA). Molina's proposal is for the Central geographic service area (GSA).

Population	Administrative Cost	Enrollment	PMPM
SMI	$ 57,982,476.37	330,705	$ 175.33
Crisis	$ 4,905,073.00	13,625,203	$ 0.36

This cost excludes anticipated startup costs and premium taxes. Further detail is included in the submitted Section F – Administrative Cost Bid Submission.

Data, Assumptions, and Methodology

Molina reviewed the following in developing the administrative cost bid:

- Molina anticipated labor, non-labor, and general corporate overhead,
- The administrative cost assumed in the current and prior capitation rates for the central GSA, and
- Administrative expenses for other populations served by Molina

In addition, Molina considered the anticipated enrollment and PMPM revenue for the SMI and Crisis populations.

Molina developed the administrative cost bid by anticipating the labor costs, non-labor costs, and corporate overhead.

Labor costs were determined by projecting the salaries, benefits, and bonuses for the staff required to operate a plan of this size and complexity. In development of the corporate overhead, the total shared service costs attributable to Molina's Medicaid line of business was allocated using established cost accounting practices modeled after the Federal Cost Accounting Standards, which are consistently applied across Molina. The allocation practices rely on projected RBHA enrollment and revenue relative to Molina's total book of business. Non-labor costs were generated using estimated costs for travel, supplies, association dues, interpreting costs, professional services, provider outreach, pharmacy benefit manager services, and other vender services. The table below outlines the expected costs by category.

Category	Administrative Cost
Labor	$ 17,626,520.00
Non-Labor	$ 14,856,209.10
Corporate Overhead	$ 30,404,820.27

The administrative cost was then converted to both a PMPM and a percent of revenue and compared to the current and historical administrative cost built into the capitation rate and the administrative cost observed in Molina's current populations. The resulting administrative costs were determined to be reasonable, appropriate, and attainable.

Total projected administrative costs are expected to increase 2% per year. Administrative costs were allocated to the categories listed in Section F based on a review of Molina's current population covered under the existing ACC contract and a review of the existing expenses for the incumbent RBHA contractor in the Central GSA.

Reliance

In support of this administrative bid development, various data and analyses were provided by other members of Molina's actuarial staff. I have reviewed the data and analyses and found them to be reasonable and consistent.

Actuarial Certification

I, Jack Pierce, as a member in good standing with the American Academy of Actuaries, hereby certify, to the best of my knowledge and judgment, the following:

The administrative cost bid is:

a. Actuarially sound
b. In compliance with all applicable State and Federal Statutes and Regulations, including 42 CFR § 438.5(e) and 42 CFR § 438.7(b)(3)
c. Developed in compliance with the applicable Actuarial Standards of Practice
d. Reasonable in relation to the benefits provided and the population anticipated to be covered
e. Neither excessive nor deficient

Jack Pierce, FSA, MAAA
AVP, Actuarial Services
Molina Healthcare Inc.

October 1, 2021
Date