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#	**PAGE LIMIT**	**SUBMISSION REQUIREMENT**
B1.1	**2**	**Executive Summary** Provide an Executive Summary that includes: a. An overview of the Offeror's organization, b. The Offeror's relevant experience providing healthcare for the population specified in this Solicitation (not limited to the three reference contracts), and c. A high-level description of the Offeror's proposed unique approach to meet Contract requirements. This submission may be used in whole or part by AHCCCS in public communications following Contract awards. ***The Executive Summary is a non-scored item.***
B1.2	**4**	**Offeror Readiness** Describe the Offeror's process for ensuring internal plan readiness to meet all Contract and member transition requirements prior to October 1, 2027, and address each of the items below. Note: AHCCCS is not looking for a summary of State readiness requirements; the Offeror should instead present plan-specific milestones, priorities and challenges and describe how they will be addressed. a. Key implementation milestones, beginning with Contract award through October 1, 2027, b. What the Offeror has identified as the greatest potential risks to readiness and the actions it plans to take to mitigate the risks. Discuss differences between urban and rural parts of the State, if any. c. The Offeror's structure and process for managing/monitoring internal readiness activities and challenges, and the metrics to be used for measuring progress, and d. Relevant experience with similar implementations, any risks or barriers to implementation that the Offeror encountered and how these were addressed (not limited to the three reference contracts in Contract Citations).

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B1.3	**5**	**Person-Centered Service Planning and Case Management** Describe the Offeror's approach to person centered service planning and case management and address each of the items below, including but not limited to members with complex or co-occurring needs. a. How the Offeror supports members and their families to help the member remain in the most appropriate, least restrictive setting as long as possible, and how the Offeror monitors for and acts swiftly to address potential disruptions to the stability of the living situation, b. How the Offeror trains and monitors case managers to ensure members are supported in developing and achieving personal goals and in creating individually tailored and unique person-centered service plans, c. How the Offeror supports members in engaging, physical and behavioral health providers, specialty providers, caregivers (paid and unpaid), and natural and community supports, in the person-centered planning process, d. How the Offeror engages, communicates and supports the member's individualized goals, cultural preferences, language preferences, adaptive communication needs, and disability accommodations across primary care providers, specialty providers, direct care staff and other agencies serving the member, and e. How the Offeror monitors for and identifies and addresses care gaps between the approved service plan and actual service delivery, caregiver no-shows, missed medical or behavioral health appointments, missed NEMT and other health-related social services.
B1.4	**4**	**Workforce Development** Describe the Offeror's workforce development prioritization, vision, and overall approach and address each of the items below. Highlight any differences in the Offeror's strategy between urban and rural parts of the State. a. How the identification of workforce needs is integrated into and informed by all aspects of program operations and at all levels of the organization (e.g., provider relations, case management, medical management, quality, etc.) including what data/information is used to make decisions regarding workforce needs and investments and how frequently it is reviewed, b. How the Offeror will demonstrate accountability, drive expansion, and support providers in expanding total capacity through recruitment, retention and reducing turnover among direct care workers. Provide specific turnover and capacity improvement targets for the contract period and describe how the Offeror will monitor performance against these targets, and c. Identify the most critical workforce needs to serve ALTCS E/PD members and ensure access to care. Provide both short- and long-term strategies to address these needs. Provide specific access improvement targets and describe how the Offeror will monitor progress against these targets.

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B1.5	**5**	**Network Development and Management** Describe the Offeror's network development and management strategy to ensure accessibility of services and address each of the items below. Highlight any differences in the Offeror's strategy between urban) and rural parts of the State. a. How the Offeror defines network sufficiency and its strategy for monitoring and improving access for each service type below: i. Home-and Community-Based Services (in home) ii. Non-Emergency Transportation Services iii. Durable Medical Equipment b. The Offeror's proposed methods beyond the AHCCCS required provider surveys, to assess provider satisfaction and take systemic action, including how the Offeror will collaborate with other awarded Offerors, to reduce provider abrasion and address issues identified by providers, e.g., streamlining reporting and other processes and adopting uniform audit criteria, c. How the Offeror envisions "integrated care delivery" and its strategy for improving access and promoting its use to meet members' primary care and behavioral health needs, d. Financial and non-financial incentives the Offeror proposes to improve the capacity of Skilled Nursing Facility and Assisted Living providers to meet the needs of members with co-morbidities, including members with behavioral health needs and members with complex medical needs, such as ventilator/respiratory care, bariatric services and bedside dialysis, e. How the Offeror monitors quality of care delivered by the network and how determinations are made regarding what providers enter or remain in the network, and f. How the Offeror will use value-based purchasing strategies to improve service accessibility.

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B1.6	**4**	**Case Study 1** Jenny is a 78-year-old newly enrolled member who lives with her daughter, Carolyn. She also is enrolled in the Offeror's DSNP plan. A retired cook who loved to travel when she was younger, Jenny has mild cognitive impairment, type 1 diabetes, osteoporosis, and high blood pressure. She needs moderate hands-on assistance with dressing and with mobility, particularly navigating around the furniture in the house and down the single step between the hallway and family room. Due to prior injuries and her frailty, Jenny also needs full physical assistance with transfers and bathing. Carolyn divorced a year ago. Her teenage daughter, Emma, lived at home and helped care for her grandmother until she left for college two months ago. Carolyn monitors her mother's blood sugar, administers her insulin injections and provides personal care (as an unpaid caregiver). Carolyn has been working remotely from home but with child support and alimony ending, Carolyn has accepted a full-time, in-office position to support her household. Carolyn starts her new job in three weeks. When Emma was home, she often had friends over who loved to listen to Jenny tell stories about her travels; occasionally they would sit and help Jenny with her jigsaw puzzles. Jenny reports being lonely since Emma left for college. She refuses to go to the adult day center, complaining, "they are all too old there!" Jenny's last PCP visit was three months ago, just before her physician retired. The primary care office has been backlogged and has not scheduled Jenny with a new PCP. Her last eye exam was over a year ago and her most comprehensive lab reports are from six months ago. Carolyn has requested daily in-home supports for her mother and occasional respite care for when she travels out-of-state to visit Emma at college. Carolyn has requested to interview potential staff, as she has concerns about who may be coming into her home. Recently, Carolyn called the plan's nurse advice line with concerns about Jenny's vision, her increased level of confusion and new episodes of urinary incontinence. Jenny increasingly complains she is tired and feels weak. Describe the Offeror's engagement and person-centered planning process for Jenny and Carolyn, and the service options presented for their consideration. Address both immediate and long-term needs.

B1.7	**4**	**Case Study 2** Carlos is a 38-year-old dual-eligible member living outside Yuma, who suffered a traumatic brain injury (TBI) after a motorcycle accident five years ago. As a result of his injuries, Carlos also lost a leg, has difficulty hearing, and has difficulty with auditory processing. Carlos lives alone in a rental mobile home that he and a neighbor refitted with self-made adaptations to assist him in daily living. Carlos' preferred language is Spanish, although he also speaks English. Carlos has traditional Medicare and receives concurrent SSI and SSDI benefits. Carlos has struggled with bipolar disorder and alcohol use since he was a teenager. Carlos has a history of hospitalization for suicidality and of refusing most medications. Carlos reports that being outside and working with his hands helps him stay stable and healthy. He keeps himself busy by fixing appliances and small equipment to sell online. Subsequently, his house and yard are littered with parts, scrap metal and projects in various stages of completion. Carlos has no family in Arizona. He has two dogs he considers his best friends, an old van (not currently running) that he converted to a camper prior to his TBI, and some online friends that he has never met in person. A former teacher occasionally stops by to check in with Carlos. Carlos does not have a regular PCP. If he feels something is wrong, he searches online for his symptoms. When he can get a ride into town, Carlos talks to the pharmacist about over-the-counter pain relievers and vitamin supplements. Carlos frequently reports that his prosthetic is useless as it does not fit well; he claims it is the cause of the phantom pains he often feels. Carlos complains about the cost of groceries and routinely replaces meals with nutritional drinks that he orders online from the cheapest source possible to save money. The pharmacist has had some success in referring Carlos to a free clinic in the next town. Four months ago, the clinic prescribed anti-depressants and a mood stabilizer. However, Carlos took them inconsistently and failed to refill the medications. Recently, Carlos has been adding vodka to his protein shakes. After noticing a slight jaundice and hearing Carlos complain of stomach pain, weight loss and fatigue, the pharmacist suggested that Carlos talk to clinic staff again about medications for depression, his phantom pain, alcohol use and supplements. Carlos requested disenrollment from his previous plan, stating that he got a call from a case manager he didn't know, asking about the medications he never refilled. He reported that the case manager was pushy and nosy. Describe the Offeror's engagement and person-centered planning process for Carlos, and the service options presented for his consideration. Address both immediate and long-term needs.

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B1.8	**4**	**Case Study 3** Enola is an 88-year-old woman who is a member of the Navajo Nation. After a fall resulted in a broken hip, Enola moved to a skilled nursing facility (SNF) for rehabilitation where additional comorbidities were discovered, including chronic kidney disease, hypothyroidism, coronary artery disease and high blood pressure. Enola never regained the strength and mobility to return to the community. She has been enrolled into the Offeror's health plan. Prior to her placement in the SNF, Enola was living in a friend's home with personal care services and a strong support system from her Navajo community. Enola also worked with practitioners in the community who were amenable to combining western medicine and traditional Navajo healing practices. The nursing facility is located several hours from her home community and friends, many of whom have passed away. Enola's son Kai is her guardian and health care decision maker. He lives out-of-state and calls Enola once a month. Kai and his wife are considering returning to Arizona to retire. Enola was recently diagnosed with end-stage-renal disease and has become uninterested in care planning. Kai is in agreement with dialysis treatment, but Enola recently stated she wants to go home to die. Describe the Offeror's engagement and person-centered planning process for Enola, and the service options presented for her consideration. Address both immediate and long-term needs.