BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

REQUEST FOR PROPOSAL – YH24-0001 – ALTCS E/PD

Submitted by:
Health Choice Arizona, Inc.

Part A

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

A1

Offeror's Checklist

EXHIBIT A: OFFEROR'S CHECKLIST

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

OFFEROR'S CHECKLIST ALTCS EPD RFP #YH24-0001		
	SUBMISSION REQUIREMENT	**OFFEROR'S PROPOSAL PAGE NO.**
PART A		
A1	Offeror's Checklist	**4**
A2	Completed and Signed Offeror's Intent to Bid	**6,7**
A3	Completed and Signed Solicitation Offer and Acceptance Offer Page	**9,10**
A4	Completed and Signed Offeror's Bid Choice Form	**12**
A5	Completed and Signed Solicitation Amendment(s)	**14-43**
PART B	**SUBMISSION REQUIREMENTS**	
B1	Executive Summary 2-page limit	**46,47**
B2	Cite Contracts 1-page limit - Utilize Template	**49**
B3	Health Equity Requirement No submission required	
B4	5-page limit	**51-55**
B5	4-page limit	**57-60**
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	**62-67**
B7	4-page limit	**69-72**
B8	4-page limit	**74-77**
B9	4-page limit	**79-82**
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	
B11	D-SNP STAR Rating Utilize Template	**84**
B12	Oral Presentation Information Participant Names, Titles, and Resumes	**86**
PART C	**CAPITATION AGREEMENT/ADMINISTRATIVE AND CASE MANAGEMENT COST COMPONENTS BID**	
C1	Agreement Accepting Capitation Rates	**105**
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C3	Case Management Cost Component Bid	**114**
C4	Actuarial Certification	**116**
PART D		
D1	Intent to Provide Insurance	**141**
D2	Completed Section G: Disclosure of Information Instructions and Attestation	**143**
D3	Boycott of Israel Disclosure	**148**
D4	Moral or Religious Objections	**150**
D5	State Only Pregnancy Terminations Agreement	**152**

A2

Completed and Signed Offeror's Intent to Bid

The Deadline to submit the Intent to Bid form is August 31, 2023, BY 3:00 PM ARIZONA TIME

Each Offeror MUST SUBMIT AN OFFEROR'S INTENT TO BID FORM by the deadline above in order to receive access to the AHCCCS Secure File Share (ASFS). FAILURE TO SUBMIT AN INTENT TO BID form by the due date will DISQUALIFY any potential Offeror FROM SUBMITTING A PROPOSAL FOR THE SOLICITATION. Access to the ASFS is restricted to **TWO INDIVIDUALS PER OFFEROR**. Each individual requesting access shall be an employee of the potential Offeror and not a consultant or independent contractor.

Once received, AHCCCS will request access to ASFS for each individual and each individual will receive a 'Welcome' email from *AHCCCS ISD Customer Support* with instructions for activating an ASFS account. Each individual will be provided access to a folder for upload of its RFP Proposal and download access for download of the RFP Data Supplement file(s). Each individual shall send confirmation of access to RFPYH24-0001@azahcccs.gov.

1	**NAME:**	Jennifer Hynes
2	**TITLE:**	Program Manager
3	**EMAIL ADDRESS:**	jennifer.hynes@azblue.com
4	**PHONE NUMBER:**	602.916.8533
5	**COMPANY NAME:**	BCBSAZ Health Choice
6	**COMPANY ADDRESS:**	8220 N. 23rd Ave., Phoenix, AZ 85021
7	**COMPANY WEBSITE:**	BCBSAZ Health Choice (www.healthchoiceaz.com)

I ATTEST THAT THE FOLLOWING IS TRUE:	INITIALS
My company (listed in box #5 above) has experience providing "Solicitation Services" as described in this RFP.	JH
My company (listed in box #5 above) intends, or is considering its intent, to submit a bid for this RFP.	JH
I understand that submittal of this form does not obligate my company to submit a bid.	JH
I am an employee of my company (listed in box #5 above) and not a consultant or independent contractor.	JH
I understand that it is my responsibility to ensure that the data uploaded to ASFS is shared only with employees of my company (not consultants or independent contractors) who need this information to create a proposal for this RFP, and that it is ONLY used for purposes of this RFP.	JH
I understand that it is my responsibility that all copies of the data retrieved from ASFS shall be destroyed after the award of this RFP.	JH

Signature: Jennifer Hynes **Date**: 08/04/23

If assistance is needed, contact the assigned AHCCCS Procurement Officer listed on the front page of the solicitation at RFPYH24-0001@azahcccs.gov.

The Deadline to submit the Intent to Bid form is August 31, 2023, BY 3:00 PM ARIZONA TIME

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Once received, AHCCCS will request access to ASFS for each individual and each individual will receive a 'Welcome' email from *AHCCCS ISD Customer Support* with instructions for activating an ASFS account. Each individual will be provided access to a folder for upload of its RFP Proposal and download access for download of the RFP Data Supplement file(s). Each individual shall send confirmation of access to RFPYH24-0001@azahcccs.gov.

1	**NAME:**	Amanda Pizzolanti
2	**TITLE:**	Contract Compliance Officer
3	**EMAIL ADDRESS:**	Amanda.pizzolanti@azblue.com
4	**PHONE NUMBER:**	480-760-4539
5	**COMPANY NAME:**	BCBSAZ Health Choice
6	**COMPANY ADDRESS:**	8220 N. 23rd Ave., Phoenix, AZ 85021
7	**COMPANY WEBSITE:**	BCBSAZ Health Choice (www.healthchoiceaz.com)

I ATTEST THAT THE FOLLOWING IS TRUE:	INITIALS
My company (listed in box #5 above) has experience providing "Solicitation Services" as described in this RFP.	AP
My company (listed in box #5 above) intends, or is considering its intent, to submit a bid for this RFP.	AP
I understand that submittal of this form does not obligate my company to submit a bid.	AP
I am an employee of my company (listed in box #5 above) and not a consultant or independent contractor.	AP
I understand that it is my responsibility to ensure that the data uploaded to ASFS is shared only with employees of my company (not consultants or independent contractors) who need this information to create a proposal for this RFP, and that it is ONLY used for purposes of this RFP.	AP
I understand that it is my responsibility that all copies of the data retrieved from ASFS shall be destroyed after the award of this RFP.	AP

Signature: Amanda Pizzolanti **Date**: 08/04/2023

If assistance is needed, contact the assigned AHCCCS Procurement Officer listed on the front page of the solicitation at RFPYH24-0001@azahcccs.gov.

A3

Completed and Signed Offer and Acceptance Offer Page

AHCCCS Arizona Health Care Cost Containment System	**Notice of Request for Proposal**
	SOLICITATION # YH24-0001
	LONG TERM CARE FOR INDIVIDUALS WHO ARE ELDERLY AND/OR HAVE A PHYSICAL DISABLITY (ALTCS EPD)

AHCCCS Procurement Officer:
Meggan LaPorte
Chief Procurement Officer
E-Mail: RFPYH24-0001@azahcccs.gov

Issue Date: August 1, 2023

RFP DESCRIPTION:	**LONG TERM CARE FOR INDIVIDUALS WHO ARE ELDERLY AND/OR HAVE A PHYSICAL DISABILITY (ALTCS EPD)**
PRE-PROPOSAL CONFERENCE:	A Pre-Proposal Conference has **NOT** been scheduled.
QUESTIONS DUE: *Questions shall be submitted to the procurement officer on the Q&A form provided with this RFP. Answers will be posted publicly on the AHCCCS website in the form of a Solicitation Amendment for the benefit of all Potential Offerors.*	**AUGUST 8, 2023** AND **AUGUST 22, 2023** by 5:00 PM Arizona Time
ALL OFFERORS MUST SUBMIT THEIR INTENT TO BID FORM BY: *Refer to RFP Instructions to Offerors for details*	**AUGUST 31, 2023** by 3:00 PM Arizona Time
PROPOSAL DUE DATE: *Proposals shall be submitted in accordance with this RFP's Instructions to Offerors prior to the time and date indicated here, or as may be amended through a Solicitation Amendment.*	**OCTOBER 2, 2023** by 3:00 PM Arizona Time

Late proposals shall not be considered.
OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

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

OFFER AND ACCEPTANCE

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.

Arizona Transaction (Sales) Privilege Tax License No.:

N/A

Federal Employer Identification No.:

62-1796494

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

For clarification of this offer, contact:

Name: Shawn Nau

Title: Chief Executive Officer

Phone: (928) 214-2291

Health Choice Arizona, Inc
Company Name

8220 N 23rd Ave
Address

Phoenix | AZ | 85021
City | State | Zip

Signature of Person Authorized to Sign Offer

Shawn Nau
Printed Name

Chief Executive Officer
Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments, and final proposal revisions (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

The Contractor is cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives purchase order, contact release document or written notice to proceed.

This contract shall henceforth be referred to as

Contract No. _____
Contract Service Start Date: _____
Award Date: _____

_____
MEGGAN LAPORTE, AHCCCS CHIEF PROCUREMENT OFFICER

A4

Completed and Signed Offeror's Bid Choice Form

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EXHIBIT B: OFFEROR'S BID CHOICE FORM

ALTCS EPD RFP YH24-0001 OFEROR'S BID CHOICE FORM

Health Choice Arizona, Inc

OFFEROR NAME

The Offeror named above is bidding on the ALTCS EPD Program for RFP #YH24-0001 in all three Geographic Service Areas (GSAs) [Central, North, and South] as listed in the chart below.

The Offeror shall indicate GSA order of preference for award by indicating (1st choice, 2nd choice, 3rd choice) in the *Order of Preference* column below.

GSA	ORDER OF PREFERENCE
Central: Maricopa, Gila, and Pinal Counties	1
North: Mohave, Coconino, Apache, Navajo, and Yavapai Counties	2
South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties (including zip codes: 85542 85192 8550)	3

Authorized Signature

09/18/2023

Date

Shawn Nau

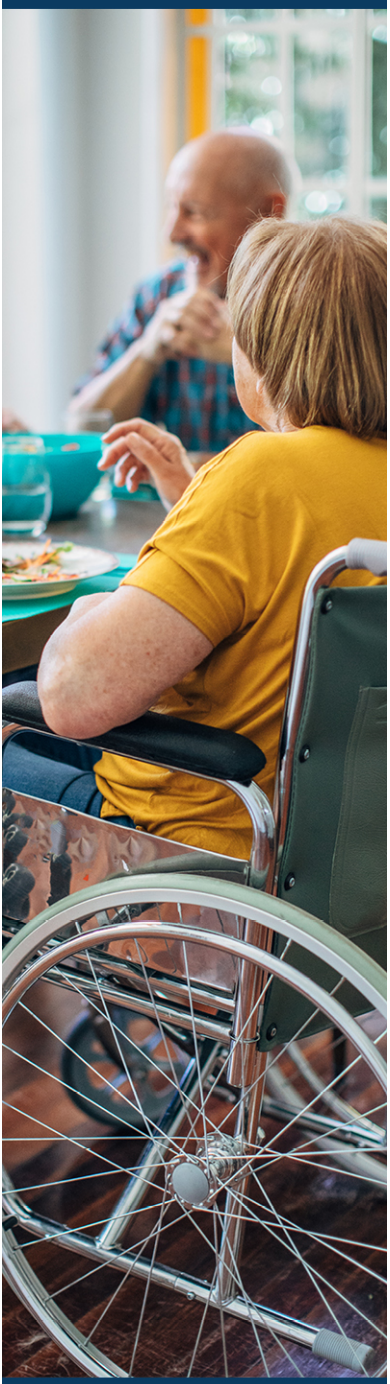
Print Name

CEO

Title

A5

Completed and Signed Solicitation Amendment(s)



BlueCross BlueShield Arizona
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Health Choice

SOLICITATION AMENDMENT #1		
SOLICITATION #: **YH24-0001** **ALTCS E/PD RFP**	**SOLICITATION DUE DATE:** **OCTOBER 2, 2023** **3:00 PM ARIZONA TIME**	**PROCUREMENT OFFICER:** **MEGGAN LAPORTE** **RFPYH24-0001@AZAHCCCS.GOV**

A signed copy of this Amendment shall be submitted with the Offeror's Proposal.

This Amendment will be posted to the Bidders Library: https://azahcccs.gov/PlansProviders/HealthPlans/YH24-0001.html.

This Solicitation is amended as follows:

A. The attached Answers to Questions are incorporated as part of this Amendment.

B. This Solicitation is also amended as follows:

SECTION	YH24-0001 AMENDMENT
SECTION G - DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION	**Revised to correct hyperlink:** 3. Once APEP access is obtained, the Offeror shall upload all appropriate information into APEP. Refer also to the AHCCCS website for MCO instructions regarding the APEP application and its use: ~~https://azahcccs.gov/PlansProviders/APEP/APEPTraining.html~~ https://azahcccs.gov/PlansProviders/APEP/Resources.html

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: CEO	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: 09/18/2023	**DATE:**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1.	UnitedHealthcare Community Plan	August 8, 2023	Section H, Subsection 19	5	14	May graphics, tables and charts contain font sizes smaller than 11-point?	**Graphics, tables, and charts may be in a smaller font.**
2.	Arizona Complete Health	August 8th, 2023	Section H: Instructions to Offerors	1	14	This paragraph lists what PDFS need to be submitted i.e., RFP Part B1, RFP Part B2, RFP Part B4-B10. RFP Part B11 is not included in this listing. Should RFP Part B11 be included in the same PDF as RFP Part B4 – B10 or should RFP Part B11 be in a separate PDF file.	**RFP Part B11 should be included in the same PDF as RFP Part B4. The RFP is revised as follows:** The Offeror shall submit the following electronically via the ASFS in its corresponding health plan folder by the date listed on RFP Section A, Solicitation and Offer Page: a. Capitation Agreement/Administrative Cost Bid Submission: (1) Agreement Accepting Capitation Rates [pdf] (2) Non-Benefit (Administrative and Case Management) Costs Bid Workbook [Excel] (3) Actuarial Certification [pdf], and b. One searchable PDF version of the Offeror's Executive Summary (RFP Part B1), c. One searchable PDF version of the Offeror's Contract citations (RFP Part B2), d. One searchable PDF version of the Offeror's Narrative Submission Requirements and corresponding responses (RFP Part B4-~~B10~~ B11), e. Oral Presentation participant names, titles, and resumes (RFP Part B12), and f. One searchable PDF version of the Offeror's entire Proposal.
3.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	4	68	Community Health Worker/Community Health Representative Services: This section refers to AMPM Policy 310-W. However, AMPM Policy 310-W is not listed on the AHCCCS website. Can AHCCCS provide this referenced policy?	**AMPM Policy 310-W is under development. The RFP is revised as follows:** Certified Community Health Worker/Community Health Representative Services: A certified Community Health Worker/Community Health Representative (CHW/CHR), who obtains certification through the Arizona Department of Health Services (ADHS) as specified in A.A.C. R9-16-802, may provide AHCCCS covered member education and preventive services to eligible members. ~~Refer to AMPM Policy 310-W.~~

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
4.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	3	83	Habilitation: This paragraph states that "This includes habilitation services such as Day Treatment and Training (also known as day program) for persons with disabilities and Supported Employment." Will the following forms of habilitation be considered a covered service for the ALTCS E/PD population 10/1/2024? Habilitation – Supported Employment (T2019), Prevocational Habilitation (T2047 or T2015), Educational Habilitation (T2013), Habilitation Support/IDLA (T2017), Specialized Habilitation/Supported Community Connections	**The RFP is revised as follows:** ***Habilitation***: A service encompassing the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation, and mobility, and behavior intervention. Physical, occupational, or speech therapies may be provided as a part of or in conjunction with other habilitation services. This includes habilitation services such as ~~Day Treatment and Training (also known as day program) for persons with disabilities and~~ Supported Employment.
5.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	3	83	Habilitation: Habilitation is listed as a covered LTSS service. However, AHCCCS AMPM 1240-E states that "Habilitation provider agencies shall be certified by DDD". Is it AHCCCS' intention that a habilitation provider serving only the E/PD population would still need to be certified by DDD?	**AMPM Policy 1240-E revisions are currently in development. Habilitation providers serving the EPD population will not require DDD certification.**

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RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
6.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	21	123	Regarding NCQA Accreditation, for a health plan newly entering the ALTCS program to achieve NCQA LTSS Distinction, even at the Interim level, the plan must be actively serving the population for at least six-months. The Program Requirements state, "*… Must also obtain the NCQA LTSS Distinction by October 1, 2024…*" This would not be possible for new entrants to achieve. Will the state change the requirement to achievement of NCQA LTSS Distinction by October 1, 2025?	**The RFP is revised as follows:** ***National Committee for Quality Assurance Accreditation***: The Contractor shall achieve NCQA First Health Plan Accreditation, inclusive of the NCQA Medicaid Module by October 1, 2023. For successful incumbent E/PD Contractors, the Contractor shall also obtain the NCQA LTSS Distinction by October 1, 2024. For successful incumbent non-E/PD Contractors and non-incumbent Offerors, the Contractor shall also obtain the NCQA LTSS Distinction by October 1, 2025. The Contractor shall also achieve NCQA Health Equity Accreditation by October 1, 2025.
7.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	48	196	Administrative Costs Percentage: There is a typo here, we believe the phrase should be "Total administrative expenses divided by total payments received from AHCCCS **less** Reinsurance less premium tax". Can you please confirm this?	**The RFP is revised as follows:** Total administrative expenses divided by total payments received from AHCCCS less ~~Reinsurance~~ premium tax. All components of the calculation should include annual audit adjustments.
8.	Arizona Complete Health	August 8th, 2023	Exhibit H: Narrative Submission Requirements, B7	N/A	3 of 5	For the term "community-based care" please clarify the service array that may be included in any Nursing Facility expansion activities.	**No additional information will be provided.**
9.	Arizona Complete Health	August 8th, 2023	Non-Benefit Costs Bid Requirements/ Submission	N/A	N/A	Submission Template has several tabs for the Admin Bid for varying membership assumptions. There is no distinction between GSAs on these tabs. Given there are underlying cost differences between the various GSAs, will AHCCCS adjust bid amounts for different GSA combinations that are awarded?	**AHCCCS will distribute the administrative PMPM associated with the membership tier that matches the expected enrollment for each plan across all awarded GSAs. AHCCCS may incorporate underlying cost differences in the populations between GSAs when determining the overall distribution, if such an adjustment is appropriate.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
10.	Arizona Complete Health	August 8th, 2023	Non-Benefit Costs Bid Requirements/ Submission	N/A	N/A	The Non-Benefit Costs Bid Submission Template has one tab for the Case Management Bid with different inputs for each GSA. It does not specify which Contract Year this is for. Should this bid be for CYE 25 only, or the average for the length of the contract?	**This should be for CYE 25 only. The Offeror can provide additional information in its actuarial certification if it expects significant changes over time. For CYE 25, the only anticipated change from the bid is for adjusting member enrollment and mix percentages after awards have been set and final distribution of membership is known, unless there are changes made to AMPM Policy 1630 regarding the maximum caseloads allowed by setting. For contract years beyond CYE 25, the case management component will be modeled based on the underlying assumptions and updated for actual member mix, wage inflation, and any policy changes regarding maximum caseloads allowed for each setting.**
11.	Arizona Complete Health	August 8th, 2023	Section A: Solicitation Page and Offer – Acceptance	N/A	1	*Pre-Proposal Conference: A Pre-Proposal Conference has NOT been scheduled.* Does this mean there will not be a conference, or just that it has NOT been scheduled yet? Does AHCCCS intend to hold a bidder's conference?	**AHCCCS does not intend to hold a pre-proposal bidder's conference for this solicitation.**
12.	Arizona Complete Health	August 8th, 2023	Non-Benefit Costs Bid Requirements/Submission	N/A	N/A	What should each Offeror assume for the Dual/non-Dual mix for each GSA? There is a significant cost difference between these two populations and if each Offeror has a different assumption, it will significantly skew the scoring results.	**AHCCCS suggests using the historical information provided and stating your data, assumptions, and methodologies of the development of your bid in the actuarial certification.**
13.	Arizona Complete Health	August 8th, 2023	Exhibit H: Instructions to Offerors	20	16	Regarding B12 Oral Presentation Information: When does AHCCCS anticipate notifying offerors of oral presentations?	**AHCCCS anticipates notifying Offerors by Thursday, October 5, 2023.**
14.	BCBSAZ Health Choice	8/8/2023	B2			Could AHCCCS please confirm that the contracts listed in B2 include both is active and inactive contracts?	**Yes, the contracts listed for B2 can be active or inactive contracts.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
15.	BCBSAZ Health Choice	8/8/2023	Section G & B2			Based on Section G of the RFP which requires Offerors to submit contract numbers can Offerors utilize experience, or a program associated with that contract number or previous contracts for the same program? (E.g., Health Choice has held an acute contract since the early 1990s. Would we be permitted to discuss experience from both the acute and ACC contracts throughout the narrative responses if we list the contract number for the current ACC in B2?)	**The RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.
16.	BCBSAZ Health Choice	8/8/2023	B2			Could AHCCCS please confirm that the one-page limit is cumulative across all three contracts? (Or is AHCCCS requesting a discrete one-page description for each of the three contracts?	**The one-page limit is cumulative across all three listed contracts. AHCCCS is not requesting a discrete one-page description for each of the three contracts.**
17.	BCBSAZ Health Choice	8/8/2023	B2			Could AHCCCS please confirm that an offeror may discuss best practices and programs (as opposed to contract "experience") from other affiliated organizations and programs even if those contracts were not listed in B2. (E.g., If Health Choice has adopted a best practice from our BCBSAZ Medicare plan.)	**Regarding the example provided ("E.g., If Health Choice has adopted a best practice from our BCBSAZ Medicare plan"), best practices and programs that have been adopted and implemented will be considered as experience and must be from the contracts cited in B2.**
18.	BCBSAZ Health Choice	8/8/2023	B4			Could AHCCCS please confirm that "ALTCS case managers" are the offeror's case managers? (As opposed to provider case managers or AHCCCS' own internal team.)	**In RFP Narrative B4, AHCCCS is not referring to AHCCCS' own internal team.**
19.	BCBSAZ Health Choice	8/8/2023	B7			Would AHCCCS be willing to provide member PCP information and Behavioral Health Home on Member Placement Detail file?	**This information will not be provided at this time. The information may be provided to Successful Offerors during readiness and transition post-award.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
20.	BCBSAZ Health Choice	8/8/2023	Member Placement Detail file			Would AHCCCS be willing to provide race, language preference, and ethnicity data?	**This information will not be provided.**
21.	BCBSAZ Health Choice	8/8/2023	Member Placement Detail file			Would AHCCCS be willing to provide a PRFO utilization data file?	**Assuming PRFO in this question refers to Peer or Family Run Organizations, this information will not be provided at this time. The information may be provided to Successful Offerors during readiness and transition post-award.**
22.	BCBSAZ Health Choice	8/8/2023	B10			Please confirm that an MCO currently serving in the ACC program is considered a "(b) Incumbent non-E/PD Contractor."	**An "incumbent non-E/PD Contractor" includes ACC Contractors and ACC-RBHA Contractors.**
23.	BCBSAZ Health Choice	8/8/2023	B10			Has AHCCCS published the Operational Review Contract Report for the most recently completed OR results that will be used in the bid scoring? If not, would AHCCCS be willing to provide this information?	**AHCCCS will not be providing scoring or weighting details.**
24.	BCBSAZ Health Choice	8/8/2023	B11			Will there be a difference in weight for Arizona DSNP Star Ratings versus non-Arizona DSNP Star Ratings or AZ MA Plans? If so, would AHCCCS be willing to provide the different weights?	**AHCCCS will not be providing scoring or weighting details.**

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RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
25.	BCBSAZ Health Choice	8/8/2023	Solicitation. (Page 8, Section H: Instruction to Offerors		8	We recognize that AHCCCS is requiring that offerors who are owned by the same parent organization must submit a single proposal in response to the Solicitation. (Page 8, Section H: Instruction to Offerors.) Does this mean that the single offeror will be limited to using the experience and performance of the actual legal entity submitting the bid (e.g., Operating Review score under Narrative Submission B10 and contract experience under Narrative Submission B2) or will the offeror be given credit for the higher experience and/or performance of the two organizations?	**AHCCCS will not be providing scoring or weighting details.**
26.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			We noted that the Member Months in the Detail File do not appear to match the Member Count in the Member Placement Detail File. Would AHCCCS be willing to please identify the difference between the two data sets. Which one would AHCCCS prefer bidders to use for PMPM calculations? **CYE 20 / CYE 21 / CYE 22 / CYE 23** Member Months 349,239 321,368 315,085 78,977 Placement Total 349,113 320,560 312,745 78,393 **Difference 126 808 2,340 584**	**AHCCCS suggests bidders use member months for PMPM calculations. The difference between the member months file and the member placement file is the member months will count partial enrollment, while the member placement file provides information on member counts as of a specific point in time.**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
27.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			There are a total of 32,201 members labeled as "Not Placed" in the Member Placement Detail File. How would AHCCCS prefer that we treat these during the rate development process? Should they be classified as HCBS or institutional? Eighty percent HCBS and twenty percent institutional? CYE 20 / CYE 21 / CYE 22 / CYE 23 Not Placed 10,485 9,586 9,644 2,486	**The "Not Placed" members in the Placement Detail File are excluded when calculating the HCBS mix percentage, as described in the rate development documentation. The "Not Placed" members would be included in Member Months which are used to calculate the PMPMs and can be allocated based on the calculated HCBS mix percentage as a proxy for placement.**
28.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			Health Choice has reviewed prior year rate setting documents and have identified the Nursing Facility total dollars provided in the ASFS data look to be substantially lower than the base data in previous rate setting cycles. Would AHCCCS be willing to identify what components are not included in the data book that would account for this difference?	**The question is unclear regarding what exactly is being compared from previous rate setting documents to the ASFS data. All components are included in the data book.**
29.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			Would AHCCCS be willing to provide member data on the use of self-directed care versus non-self-directed care, including county, race, ethnicity, and language data?	**Offerors may refer to the AHCCCS CYE2022 HCBS Annual Report on the AHCCCS website for additional information:** https://www.azahcccs.gov/Resources/Reports/federal.html
30.	Mercy Care	08/08/2023	Section H, 19. Contents of Offeror's Proposal	6	13	Please advise if there is a file size limit for uploads to AHCCCS Secure File Share (ASFS)?	**There is no official document size limit for the ASFS, but excessively large documents may time out when loading. Additionally, the file name has a limit of 32 characters.**
31.	Mercy Care	08/08/2023	Section H, 19. Contents of Offeror's Proposal	5	14	Please advise if Bidders can exclude signed forms, attachments, cover, tables of content, etc. from the sequential numbering requirement?	**Yes, Offerors may exclude these items from the sequential page numbering requirements but please refer to the instructions to determine if these items count toward maximum page limits. Also, see answer to Question #39.**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
32.	Mercy Care	08/08/2023	Section I, Exhibit H, B9	1.c.	4	Considering that a member will be enrolled with Tribal ALTCS if he/she lives on or lived on a reservation prior to admission into an off-reservation facility, please provide clarification regarding "Members residing in tribal communities." Please confirm if these tribal communities are on a reservation and/or off-reservation?	**The RFP Submission Requirement B9 is revised as follows:** Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented. a. Members residing in rural communities, b. ~~Members residing in Tribal communities~~ Tribal members, c. Members in need of community resources, and d. Members in need of Peer and/or Family Support services.
33.	Mercy Care	08/08/2023	Section I, Exhibit H, B2	2	1	Is it expected if a Bidder wants to reference current ALTCS E/PD work, an ALTCS E/PD contract must be cited?	**In response to the Narrative Submission Requirements that ask for the Offeror's experience as well as any other responses where experience is presented, the Offeror shall refer exclusively to the experience from the identified contracts submitted for B2. Additionally, the RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.
34.	Mercy Care	08/08/2023	Section I, Exhibit H, B2	2	1	Please confirm that AHCCCS Complete Care contractors whose contract was expanded to include integrated services for Title XIX/XXI eligible individuals with Serious Mental Illness (SMI) are permitted to respond to the full scope of this contract as a single cited contract.	**The RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
35.	Mercy Care	08/08/2023	Section I, Exhibit H, B2 and B11	1	1 and 5	Non-incumbent bidders will be allowed to select contracts from markets with disparate characteristics from Arizona. How will AHCCCS evaluate "similar healthcare delivery systems to the ALTCS E/PD Program" and ensure equity in the evaluation process of experience and DSNP STAR Rating?	**AHCCCS will not be providing scoring or weighting details.**
36.	Mercy Care	08/08/2023	Section I, Exhibit C, B6	1	3	Considering there are multiple types of data included but not limited to performance metrics and data collected in partnership with members, in lieu of utilization reports are other one-page samples allowable to demonstrate the Offeror's monitoring and analysis process?	**Yes, Offerors may submit other one-page samples, in addition to or in lieu of utilization reports, to demonstrate their monitoring and analysis processes. The RFP Submission Requirement B6 is revised as follows:** The Offeror shall limit its response to the submission requirement to three pages of narrative and should include up to three, one-page sample utilization reports or other sample data to demonstrate the Offeror's monitoring and analysis processes.
37.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Part D, D4	RFP Section D, Moral or Religious Objections	59	The Offeror's Checklist, Part D, Section D4, requires bidders to identify Moral or Religious Objections. If bidders have no religious or moral objections, is a document required? If "yes," should bidders create their own?	**If bidders do not have religious or moral objections to submit for AHCCCS notification, the Offeror is not required to submit a document. The RFP is revised as follows:** **Moral or Religious Objections**: The ~~Contractor~~ Offeror shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The ~~Contractor~~ Offeror may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the ~~Contractor~~ Offeror's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored. If the Offeror does not have a Moral or Religious Objection, the Offeror is not required to submit a document for this submission requirement.

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
38.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Section H: Instructions to Offerors	Section 19. Contents of Offeror's Proposal	14	The instructions indicate that all proposals shall be in Calibri 11-point font or larger with borders no less than ½". Will AHCCCS allow a smaller, readable font size for graphics, callouts, and tables?	**Graphics, tables, and charts may be in a smaller font.**
39.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Section H: Instructions to Offerors	Section 19. Contents of Offeror's Proposal	14	The instructions indicate that all pages of the Offeror's Proposal shall be numbered sequentially, and that numbering of pages shall continue in sequence through each separate section. If we use Section Cover Sheets, are those excluded from the page limit and numbering?	**Yes, Offerors may exclude these items from the sequential page numbering requirements. Section Cover sheets do not count toward page limits. Also, see answer to Question #31.**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
40.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B7	3	With the depth and accuracy required to thoroughly answer question B7, and page limits, would AHCCCS consider adding one page to the page limit?	**The page limit for submission requirement B7 will remain unchanged.**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
41.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B6	3	Given the number of questions and subparts to each question in B6, would AHCCCS consider increasing the page limit for the response to 4 pages of narrative?	**The page limit for submission requirement B6 will remain unchanged.**
42.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B4	2	Question B4 identifies seven objectives. Are Offeror's asked to identify both best practices and Case Management (CM) initiatives related to the seven objectives? Or should these be treated as two separate questions to respond to? Give the number of objectives and subparts to the question, would AHCCCS consider adding an additional one or two pages?	**Offerors shall respond as needed to provide a comprehensive response to the question and meet the requirements of the RFP. The page limit for submission requirement B4 will remain unchanged.**
43.	EMAIL	N/A	N/A	N/A	N/A	Can you share any details about plans for CAHPs surveys in the future? Is there a timeframe when the 2023 ACC CAHPS will be completed?	**AHCCCS is currently in the process of conducting statewide CAHPS surveys for the adult population, child population, and the KidsCare program for 2023. The statewide CAHPS surveys do not include the ALTCS-EPD population; it is AHCCCS' expectation that results will be reported at the statewide level as well as at the ACC and DCS CHP population/line of business level. AHCCCS anticipates the 2023 statewide CAHPS surveys to be completed in March/April 2024.**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
44.	EMAIL	N/A	N/A	N/A	N/A	Can you confirm that AHCCCS did not conduct an Adult CAHPs survey for 2022?	**AHCCCS is confirming that a CAHPS survey was not conducted for the adult population in 2022; however, AHCCCS conducted a 2022 CAHPS survey for the KidsCare program.**

SOLICITATION AMENDMENT #2		
SOLICITATION #: **YH24-0001** **ALTCS E/PD RFP**	**SOLICITATION DUE DATE:** **OCTOBER 2, 2023** **3:00 PM ARIZONA TIME**	**PROCUREMENT OFFICER:** **MEGGAN LAPORTE** **RFPYH24-0001@AZAHCCCS.GOV**

A signed copy of this Amendment shall be submitted with the Offeror's Proposal.

This Amendment will be posted to the Bidders Library: https://azahcccs.gov/PlansProviders/HealthPlans/YH24-0001.html.

This Solicitation is amended as follows:

A. The attached Answers to Questions are incorporated as part of this Amendment.

B. This Solicitation is also amended as follows:

SECTION	YH24-0001 AMENDMENT
Exhibit A: Offeror's Checklist	

PART B	SUBMISSION REQUIREMENTS	
B1	Executive Summary 2-page limit	
B2	Cite Contracts 1-page limit - Utilize Template	
B3	Health Equity Requirement No submission required	
B4	5-page limit	
B5	~~4~~5-page limit	
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	
B7	4-page limit	
B8	4-page limit	
B9	4-page limit	
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	
B11	D-SNP STAR Rating Utilize Template	
B12	Oral Presentation Information Participant Names, Titles, and Resumes	

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTH[illegible]DIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: Chief Executive Officer	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: 9/18/2023	**DATE:**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1.	N/A	August 22, 2023	Exhibit H, B11	N/A	-	What year D-SNP STAR rating should be reported by the Offeror?	**RFP B11 is revised as shown below:** The Offeror shall submit its ~~most recent~~ 2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its ~~most recent~~ 2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State: a. FIDE SNP/DSNP Plan, b. Another type of SNP, or c. Medicare Advantage Plan.
2.	N/A	August 23, 2023	Section H, Part C, Cost Bid	N/A	-	The Capitation Agreement (C1) does not appear to include the accurate Underwriting gain for CYE24. Additionally, the Capitation Agreement (C1) requirements do not stipulate if/how an Offeror should account for moral or religious obligations.	**Section H Instructions to Offerors C1 is revised as follows:** C1 - Agreement to Accept Capitation Rates: The Offeror shall submit an agreement that the Offeror will accept the actuarially sound capitation rates computed prior to October 1, 2024. The agreement shall be signed by the Offeror's Chief Executive Officer. This is a required submission. For the CYE 24 rating period, AHCCCS set the ALTCS-EPD underwriting gain percentage equal to 1.45% of the

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							capitation rates, excluding premium tax. AHCCCS may revise the applicable underwriting gain percentage as part of capitation rate development each year. ~~AHCCCS intends to set the underwriting gain equal to one percent of the capitation rate for each risk group excluding premium tax.~~ Administrative and case management cost components 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 and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides. If any moral or religious objections were submitted as part of the RFP, the Offeror shall include in its Capitation Agreement a statement attesting that the Offeror did not exclude from the administrative and case management bid submission(s) any related administrative and case management costs.

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
3.	UnitedHealthcare Community Plan	August 22, 2023	Section I, Exhibit H	B2	1	Given the current requirement for all incumbent ALTCS Contractors to offer a FIDE-SNP under a SMAC with AHCCCS, please confirm that offerors may write to the companion FIDE-SNP experience and best practices in their response under their current AHCCCS Medicaid contract number and need not separately list their companion FIDE-SNP agreement in response to B2.	**The Offeror must list the FIDE-SNP in B2 if the Offeror writes to experience related to the FIDE-SNP contract.**
4.	UnitedHealthcare Community Plan	August 22, 2023	Section H	B12	19	If an oral presentation participant identified in our response becomes unavailable to attend, may we substitute another individual after our proposal is submitted?	**Yes, if an oral presentation participant becomes unavailable another individual may be substituted; however, the information for the newly added individual must be submitted to AHCCCS (i.e., name, title, and resume) as required by the RFP.**
5.	UnitedHealthcare Community Plan	August 22, 2023	Section H	N/A	N/A	The RFP does not specify whether AHCCCS will accept electronic or digital signatures. Please confirm that AHCCCS will accept a digital or electronically placed signature in place	**Yes, AHCCCS will accept a digital/electronically placed signature in place of a written signature for RFP documents requiring signature.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						of a written signature for all documents requiring signature.	
6.	Arizona Complete Health	8/22/23	Section I: Exhibits Exhibit H	B7	3	Please advise if the action steps and timeline for the first three years of the contract begin on execution of the contract or contract go-live, I.e., Day One of member coverage.	**In reference to B7 submission requirement where it states: "Provide action steps and a timeline for the first three years of the Contract, along with measurable outcomes to be achieved," the action steps should focus on the contract start (execution) date.**
7.	Arizona Complete Health	8/22/23	Section D: Program Requirements	3	83	As a response to the first round of questions, in Amendment 1, AHCCCS made the following revisions: **Habilitation:** A service encompassing the provision of training in independent living skills or special developmental skills, sensory motor development, orientation, and mobility, and behavior intervention. Physical, occupational, or speech therapies may be provided as a part of or in conjunction with other habilitation services. This includes habilitation	**AHCCCS suggests the Offeror refer to AHCCCS policies and other materials as needed.**

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						services such as ~~Day Treatment and Training (also known as day program) for persons with disabilities and~~ Supported Employment. The phrase "such as" implies that Supported Employment is just one example. What other types of habilitation will be included beyond Supported Employment?	
8.	Arizona Complete Health	8/22/23	Section D: Program Requirements	11	60	Does your policy allow for an ALTCS Tribal Member that lives on a reservation to be served by a non-Tribal ALTCS Contractor?	**No, per A.A.C. R9-28-415 Tribal members living on-reservation shall be enrolled with the tribe participating as an ALTCS Tribal program in the member's service area.**
9.	Arizona Complete Health	8/22/23	Non-Benefit Costs Bid Requirements/Submission	N/A	N/A	In response to Amendment 1 Questions and Responses Number 9, AHCCCS stated they "may incorporate underlying cost differences in the populations between GSAs when determining the overall distribution, if such an adjustment is appropriate." What about adjusting the overall total	**AHCCCS does not intend to adjust the overall total administrative cost bid itself as described in this question. If an Offeror believes that their admin costs would be impacted by being awarded a different GSA combo, they are welcome to include additional detail in their actuarial certification of the administrative rates. Offerors should bid based on their projected administrative need, whatever the Offeror determines that to be.**

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						administrative cost bid itself? For example, the PMPM for 100,000 member months is likely to be different for the Central + South GSAs vs the Central + North GSAs. An Offeror would likely bid differently under those two scenarios. How does AHCCCS intend to adjust for this situation?	
10.	Arizona Complete Health	8/22/23	Section I: Exhibits Exhibit H	B2	1	The RFP submission requirement was revised as follows: The Offeror shall identify no more than three contracts in addition to Arizona Medicaid contracts, which represents its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program. Given the one-page length and design of the form submission is it the intent of AHCCCS for bidders to not include AZ information, and only include that of three contracts which represent	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**

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RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						its experience in managing similar healthcare delivery systems, or will AHCCCS provide a new form?	
11.	Mercy Care	08/22/2023	Section I, Exhibit H, B2	B2	1	The current B2 template allows for only three contracts to be cited. Amendment 1 infers that more than three contracts may be cited – Arizona contracts and other state contracts. Please provide clarification if Offerors can list all Arizona contracts and up to three additional non-Arizona contracts. If so, will a new B2 template be provided? If not, please clarify which contracts and how many are to be cited in the B2 template.	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**
12.	Mercy Care	08/22/2023	Section I, Exhibit H, B2	B2	1	Please confirm that, in response to B2, Offerors may cite data and experience of other plans also administered by Offeror's administrator.	**Any experience cited must be related to one of the three contracts listed, or Arizona Medicaid Contracts.**
13.	Mercy Care	08/22/2023	Section I, Exhibit A, Offeror's Checklist and		1 and 3	Please clarify the page limit requirement for narrative submission question B7. Section I,	**The page limit for B7 is 4 pages. The RFP Offeror's Checklist is revised to indicate a 4-page limit for item B7. The Offeror's Checklist will also be reposted to the**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
			Section I, Exhibit H, B7			Exhibit A, Offeror's Checklist indicates 5 pages and Section I, Exhibit H, B7 indicates 4 pages.	**Bidders' Library with the post of this RFP Amendment with this correction included.**
14.	BCBSAZ Health Choice	8/22/2023	B2			Thank you for the response to our questions regarding B2. Based on the revised language of the Narrative Submission Requirement, is an Offeror required to identify and describe their Arizona Medicaid contracts (both active and inactive) *plus* allowed to identify and describe up to three additional non-Arizona Medicaid contracts within the prescribed one-page limit? Or, instead, is the Offeror expected to identify and describe *only* the three additional non-Arizona Medicaid contracts (but the Offeror is allowed to cite and receive credit for their Arizona Medicaid experience in other narratives without	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						identifying and describing them in B2)?	
15.	BCBSAZ Health Choice	8/22/2023	B2			If the answer to the previous question is that Arizona Medicaid contracts must be identified and described, please clarify whether each Medicaid contract number is considered a separate contract, i.e., each individual contract number represents one of the three contract limit (e.g., ACC Contract YH19-0001 and Acute Care Contract YH14-0001 = 2 contracts) or whether continuing contracts are considered as one contract (e.g., ACC Contract YH19-0001 and Acute Care Contract YH14-0001 = 1 contract).	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**
16.	BCBSAZ Health Choice	8/22/2023	B2			Is an incumbent AHCCCS contractor's affiliated DSNP contract considered an "Arizona Medicaid contract" or should the DSNP be identified and described as one of the	**The Offeror must list the affiliated DSNP contract in B2 if the Offeror writes to experience related to the DSNP contract.**

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						three additional non-Arizona Medicaid contracts?	
17.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Part B, B11	Exhibit H, Narrative Submission Requirements, B11	Exhibit H, Page 5, and Page 18 in the Instructions to Offerors	Given that projected STAR ratings for measurement year 2022 have been released, and the final ratings will be released in early October, would AHCCCS consider accepting the 2022 projected STAR ratings for B11, and validate the STAR rating using publicly available information? This would ensure the most current data is utilized.	**RFP B11 is revised as shown below:** The Offeror shall submit its ~~most recent~~ 2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its ~~most recent~~ 2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State: a. FIDE SNP/DSNP Plan, b. Another type of SNP, or c. Medicare Advantage Plan.
18.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Exhibit H: Narrative Submission Requirement	Exhibit H, Narrative Submission Requirements, B6	3	Given the number of questions and size of utilization reports necessary to answer B6, would AHCCCS consider allowing Offerors to submit utilization reports as 3 attachments rather than 3 one-page screen shots of reports, which may be more difficult to read?	**The requirements for submitting sample reports for B6 will remain unchanged.**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
19.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Section H: Instructions to Offerors	Instructions Section 19. Contents of Offeror's Proposal, related to Exhibit H: B7	14	The instructions indicate that the submission be provided in 8 ½" x 11" page size. Would AHCCCS allow an 8 ½" x 11" page in landscape orientation to be used for the action steps and timeline portion of B7?	**Yes.**

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EXHIBIT A: OFFEROR'S CHECKLIST

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

OFFEROR'S CHECKLIST ALTCS EPD RFP #YH24-0001		
	SUBMISSION REQUIREMENT	**OFFEROR'S PROPOSAL PAGE NO.**
PART A		
A1	Offeror's Checklist	
A2	Completed and Signed Offeror's Intent to Bid	
A3	Completed and Signed Solicitation Offer and Acceptance Offer Page	
A4	Completed and Signed Offeror's Bid Choice Form	
A5	Completed and Signed Solicitation Amendment(s)	
PART B	**SUBMISSION REQUIREMENTS**	
B1	Executive Summary 2-page limit	
B2	Cite Contracts 1-page limit - Utilize Template	
B3	Health Equity Requirement No submission required	
B4	5-page limit	
B5	4-page limit	
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	
B7	4-page limit	
B8	4-page limit	
B9	4-page limit	
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	
B11	D-SNP STAR Rating Utilize Template	
B12	Oral Presentation Information Participant Names, Titles, and Resumes	
PART C	**CAPITATION AGREEMENT/ADMINISTRATIVE AND CASE MANAGEMENT COST COMPONENTS BID**	
C1	Agreement Accepting Capitation Rates	
C2	Administrative Cost Component Bid	
C3	Case Management Cost Component Bid	
C4	Actuarial Certification	
PART D		
D1	Intent to Provide Insurance	
D2	Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation	
D3	Boycott of Israel Disclosure	
D4	Moral or Religious Objections	
D5	State Only Pregnancy Terminations Agreement	

SOLICITATION AMENDMENT #3 ISSUED 9/8/2023		
SOLICITATION #: **YH24-0001** **ALTCS E/PD RFP**	**SOLICITATION DUE DATE:** **OCTOBER 2, 2023** **3:00 PM ARIZONA TIME**	**PROCUREMENT OFFICER:** **MEGGAN LAPORTE** **RFPYH24-0001@AZAHCCCS.GOV**

A signed copy of this Amendment shall be submitted with the Offeror's Proposal.

This Amendment will be posted to the Bidders Library:
https://azahcccs.gov/PlansProviders/HealthPlans/YH24-0001.html.

This Solicitation is amended as follows:

SECTION	YH24-0001 AMENDMENT
SECTION H: INSTRUCTIONS TO OFFERORS – DEFINITIONS	• Adding: ***Unsuccessful Offeror***: An Offeror that is not awarded a Contract under this RFP. • Revising: ***Unsuccessful Incumbent Offeror*:** An Incumbent Contractor that is not awarded a Contract for a specific GSA under this RFP where the Incumbent Contractor holds a Contract through September 30, 2023, in one or more of the same counties comprising the specific GSA(s) established for October 1, 2024.
SECTION H: INSTRUCTIONS TO OFFERORS	Correcting all references to Section G "Representations and Certifications of Offeror Instructions and Attestation" to the following: Section G "Disclosure of Information Instructions and Attestation"
SECTION H: INSTRUCTIONS TO OFFERORS – 20. Submission Requirements	**PART D** D1 Intent to Provide Insurance (Refer to information below) D2 ~~Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation~~ Disclosure of Ownership and Control and Disclosure of Information (RFP Section G and RFP Section I, Exhibit I) D3 Boycott of Israel Disclosure (RFP Section I, Exhibit E) D4 Moral or Religious Objections (Refer to information below) D5 State Only Pregnancy Terminations Agreement (RFP Section I, Exhibit F) ~~D6 Disclosure of Information (RFP Section I, Exhibit I)~~

SECTION H: INSTRUCTIONS TO OFFERORS – 20. Submission Requirements (page 20)	***D2 - ~~Representations and Certifications of Offeror and~~ Disclosure of Ownership and Control, and Disclosure of Information Instructions and Attestation:*** The Offeror shall complete requirements outlined in ~~and submit~~ RFP Section G "Disclosure of Information Instructions and Attestation." Please note all submitted documentation shall align with the Offeror's submitted Exhibit D: Offeror's Intent to Bid "Company Name". AHCCCS reserves the right to reject an APEP application should an Offeror's Company Name not match to the information (e.g., Tax ID) used for the APEP application.
EXHIBIT A: OFFEROR'S CHECKLIST	PART D D2 ~~Representations and Certifications of Offeror and~~ Disclosure of Information Instructions and Attestation A revised Exhibit A will be uploaded to the Bidders' Library for use by the Offeror with this Amendment. This revised Exhibit A shall be the version utilized by the Offeror when submitting its RFP Proposal.
SECTION G: DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION	1. Removed reference to *Representations and Certifications of Offeror and Disclosure Information* and replaced with *Disclosure of Ownership and Control*. 2. Added submission requirements for Exhibit I, Disclosure of Information. A revised Section G will be uploaded to the Bidders' Library for use by the Offeror with this Amendment. This revised Section G shall be the version utilized by the Offeror when submitting its RFP Proposal.

INCORPORATED in this Solicitation Amendment:

REVISED SECTION I EXHIBIT A: Offeror's Checklist
REVISED SECTION G: Disclosure of Information Instructions and Attestation

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: Shawn Nau	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: CEO	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: 09/18/2023	**DATE:** **9/8/2023**

Part B

PROGRAM NARRATIVE SUBMISSION

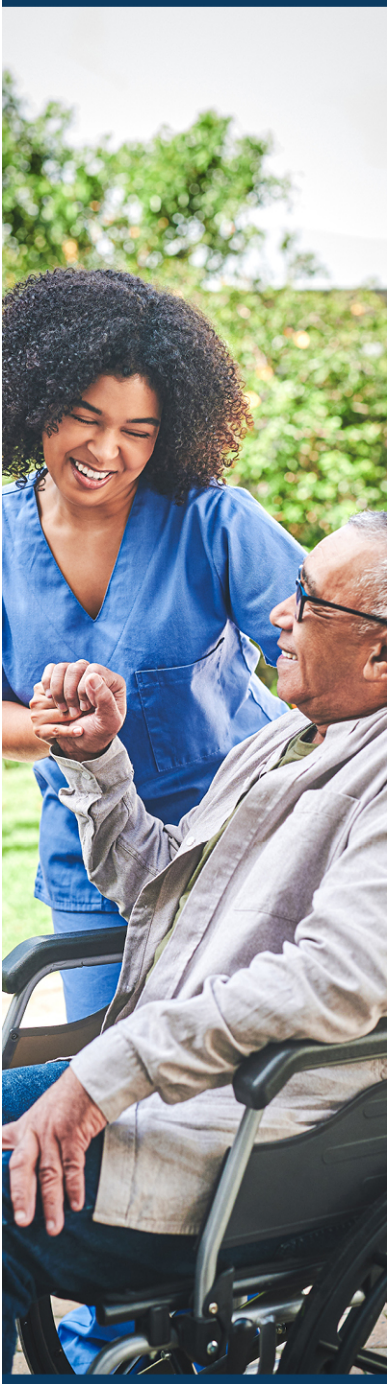
BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

B1

Executive Summary



B1 Executive Summary. Blue Cross® Blue Shield® of Arizona (AZ Blue), through its wholly owned subsidiary, Health Choice Arizona, Inc. (Health Choice) which is solely dedicated to serving Arizona's Medicaid and D-SNP populations, is honored to respond to the Request for Proposal for the Arizona Long Term Care System, Y24-0001.

Organizational Overview. Health Choice has been an active participant in the AHCCCS program for many years, and AZ Blue's acquisition of Health Choice in 2019 has facilitated our ability to innovate on an even larger and faster scale. AZ Blue has served Arizona since 1930 and is the largest health insurer based in Arizona covering approximately two million members. AZ Blue is also Arizona's only nonprofit health insurer, which means that our earnings go back into Arizona communities and financially support hundreds of health-related philanthropic endeavors every year.

AZ Blue is also a part of the national **Blue Cross Blue Shield Association**, which collectively manages more Medicaid-covered lives than any other national system – with 25 Medicaid (including Managed Long-Term Services and Supports and DSNP) plans and covering over 13 million Medicaid members in 2023. These affiliations give Health Choice unmatched access to national and state best practices that drive enhanced person-centered care, adopt innovative and developing technologies, and build workforce capacity to maintain operational excellence to better serve Arizona Long Term Care System ("ALTCS") members, families, caregivers, and providers.

> *"Our number one priority is helping Arizonans get the care and support they need throughout every phase and circumstance of their life – including those in need of long-term care and supports. It would be an honor to serve the unique needs of Arizona ALTCS members."*
> **Pam Kehaly**
> **President and CEO**
> **Blue Cross Blue Shield of Arizona**

Operational Excellence. Health Choice is dedicated to serving AHCCCS and dually aligned Medicare ("DSNP") members. Health Choice remains a discrete company within AZ Blue, with its own management structure and operational teams that have been designed to fully meet both the *letter and spirt* of AHCCCS' contractual requirements and expectations that health plan operations be locally based. Our dedication to serving AHCCCS is exemplified by our becoming the **first AHCCCS health plan** to meet AHCCCS' accreditation requirements by achieving full **National Committee for Quality Assurance** (NCQA) Medicaid accreditation in 2021, Medicare and DSNP accreditation in 2023, and by our efforts toward NCQA Health Equity accreditation in early 2024. If awarded an ALTCS contract, we will apply for Long Term Services and Supports accreditation at the very first opportunity afforded to us by NCQA.

Our dedication to operational excellence extends beyond accreditation status. Health Choice continuously examines our performance across every element of AHCCCS' expectations and develops new approaches whenever an opportunity is identified. Each new approach is then tested, and if necessary revised repeatedly, with the singular goal of achieving the "quintuple aim" of improving health equity, member, and provider satisfaction, reducing administrative and appropriately avoidable medical cost, and continuously driving improvements in the quality of healthcare.

Blue Innovations. The proving ground for many of our innovations has been Health Choice Pathway, our Medicare Advantage DSNP, which serves beneficiaries who have social and health conditions very similar to those of ALTCS members. The success of these innovations is demonstrated by Pathway's quickly becoming Arizona's premier DSNP – achieving a CMS Four STAR rating for the past two performance years – and the only Arizona DSNP with a Five STAR Part D Pharmacy Program. Pathway was also the first Arizona DSNP with both NCQA MA and DSNP accreditation.

Many of the innovations were implemented with the active support of the national **Blue Venture Fund**, as ways to bring our unique person-centered "Blue" programs to ALTCS members. Each of these improvements is focused on promoting quality of life and well-being, and supports personal dignity, independence, choice, individuality, resilience, privacy, and self-determination. Our special needs care model – which recently received top grades from our NCQA reviewers – was rebuilt from the ground up using an ALTCS-based, Case Manager-centric model so that every DSNP member is empowered to choose their own care "pathway" (hence the DSNP's name). Each Case Manager is, in turn, supported by our **Blue Care Team**, which includes social worker, nursing, and general financial and personnel support. The Blue Care Team also includes "health buddies" who essentially serve as a member's personal "concierge." This extends the Case Manager's capacity and improves satisfaction by providing an additional resource to members with helpful information needed to understand the choices, options, and services that members have available to them. In short, we understand and value the role of the Case Manager in the success of the ALTCS program and will apply our learnings from our DSNP and other national Blue Cross resources to create a best-in-class Case Management program.

Health Choice will expand our DSNP's highly successful **BlueCare Anywhere**[SM] multi-service telehealth and **Blue@Home** suite of home-based provider services with ALTCS members in mind. These services include a *choice* of 24/7/365 telehealth providers covering urgent care, primary care, and behavioral health services. These new programs are supplemented by our suite of in-home services to continuously assess members' health status and address resource needs in connection with Contexture's **CommunityCares** closed loop referral system. Existing services are also being expanded to include additional in-home primary care and behavioral health options, substance use, dental, podiatry, and end-stage renal and dialysis care, supplemented with new member engagement tools including AI-enabled

conversational text and chat capabilities which extend the capabilities of our current **Pyx Health** social isolation and **Wellth** social engagement applications.

Developing Networks and Workforce. Health Choice is committed to *significantly* expanding direct care worker capacity by bringing Peer and Family members, parents, friends, relatives, and neighbors into the trained workforce through a variety of initiatives like our **Blue ALTCS Academy** no-cost training program, and a **Blue Caregiver Café** that gives caregivers access to informal 24/7 telephonic, chat, and online portal "help line" services, staffed using trained peers and family members with caregiver experience. Our **Arizona Blue Consumer Direct** initiative is designed to increase appropriate and safe member use of ALTCS' Self-Directed Attendant Care options and expand the pool of caregivers who are available to members, particularly in rural parts of the state and other areas that suffer severe workforce shortages.

Another recent innovation was developed in direct response to ALTCS member and family concerns regarding the lack of sufficient behavioral health resources: Health Choice helped form the **Northern Arizona Behavioral Health Alliance ACO** ("Alliance"), the first behavioral health Medicaid Accountable Care Organization in Arizona, to improve quality performance while expanding behavioral health capacity through the development of regional centers of excellence that will, along with other initiatives, support the growing demand for behavioral health and dementia care services for ALTCS members. The Alliance is already going strong – showing extraordinary quality results in just its first year – and growing too, with **Peer and Family Run Organizations** and supports being added in 2024. We are also committed to using this same model and the supporting technologies we developed to create a similar **ALTCS Alliance partnership** with facilities and providers that serve ALTCS members throughout the state. We will bring network innovations like these and many others to enhance and strengthen Arizona's Home and Community Based Service caregivers and providers to help ensure every member who chooses a home setting will not be limited by the adequacy of the workforce or network.

Exceptional Implementation Expertise. Health Choice is prepared and ready for new plan implementation. We will use our experience as both an accepting and relinquishing contractor to ensure the implementation experience is executed in a near flawless manner and will respond to and fix any issues promptly so that the member and provider have no loss of continuity. As with all previous transitions, we will **honor existing provider-patient relationships**, even if the provider is not in our current network, by extending them in-network status without the need for separate prior authorization **for at least the first year** while we work to bring them into our network. We will use our experienced Transition of Care team to manage the entire process from start to finish.

Modern Healthcare Best Places to Work™ 2023

Bringing in new employees to staff an ALTCS plan will be aided by the fact that AZ Blue is a truly *excellent* place to work. Over 93% of our employees said they were "proud to be Blue" in an independent 2022 survey, and AZ Blue wins "**Best Place to Work**" awards each year – including Modern Healthcare's award for the last three years in a row. We will manage any new employee transitions with the same care and attention as we pay to members and providers, and we will make sure that more than 93% of our new transitioning employees are "proud to be Blue" too.

Improving Health Equity. As an integral part of all our endeavors, Health Choice is implementing programs that address existing health disparities and improve health equity for members. Our **Health Equity Committee,** led by our dedicated **Health Equity Advancement Division,** has developed a comprehensive **Health Equity Improvement Plan** based on the data and detailed findings of the **statewide NAU/ASU Center for Health Equity Research (CHER) study**, which we both funded and supported. Our Health Equity Improvement Plan includes a series of locally specific strategies and operational tactics that we use every day to combat disparities and improve access to culturally appropriate healthcare for all members. These efforts impact every department of our organization and rely heavily on the input and insights of our **Peer and Family members**, **Member Engagement Committee**, statewide provider network, and our mission-driven team of staff members. Our **Tribal Services Team** routinely seeks input and feedback from Tribal members, providers, and governments through our Tribal Summit and consultation programs, which has helped us build trust-based relationships with the Tribal communities that we serve. We also continuously integrate input gained through ongoing community outreach and engagement with organizations throughout Arizona, such as the **Hispanic Chamber of Commerce, NAMI, Community Grand Rounds,** and the **Arizona Town Hall.**

We're all about Arizona. Arizona is our home, and **we love serving Arizona –** and Health Choice is an essential part of how we do that. AZ Blue's origins date back almost 90 years and Health Choice's history spans more than 55 years back to our roots as a small nonprofit dedicated to developing rural community health resources. But we do not rest on past accomplishments. We are dedicated to continuing development of new community resources, service models, and innovative technology-enabled solutions that **improve access to care** for every member regardless of their health condition, personal circumstance, or geographic location. We will continue our long-standing practice of turning challenges into customized care delivery solutions to meet the unique needs of ALTCS members. And above all, we will always be dedicated to "doing the right thing" for every individual, their families, caregivers, providers, home communities, and ultimately for the State of Arizona.

B2

Contract Citations

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
1.	BCBSAZ-Health Choice Pathway CMS Contract No. H5587	Medicare Dual Special Needs Plan	Arizona

Description: Health Choice's Dual Special Needs Plan (DSNP) – "Health Choice Pathway" – is the premier DSNP in Arizona. Health Choice Pathway was the first Arizona DSNP to achieve both NCQA MA and DSNP accreditation (and Health Equity accreditation is on the way). It is one of only two Four STAR DSNPs in Arizona, and it is the only DSNP with a Five STAR Part D Pharmacy Program. Our case manager model of care received high praise from NCQA examiners. Pathway is an **active** Plan with a **17-year history** that continues to grow, with **12,000 members** served during 2023 across the **North and Central GSAs.** The statewide scope of the Pathway provider and assisted living facility network prepares us to serve ALTCS members. Pathway offers **fully integrated** and whole-person health physical, behavioral, and substance use services in coordination with our Health Choice ACC plan.

For 2024, Health Choice Pathway's **person-centered special needs model of care benefit program** includes prescription drug benefits through CMS Value-Based Insurance Design (VBID) waivers, and elimination of cost sharing for low-income individuals and services received through AHCCCS. To further help our members overcome social determinant of health challenges, we ensured that our supplemental benefits include comprehensive Dental, Vision, and Hearing coverage; Over the Counter (OTC) items; Flex-Card allowance for healthy food purchases and delivered meals; remote patient monitoring devices; transportation services; fitness benefits; companionship services; telehealth access; general supports for living such as utilities and rent assistance; and more. Our Pathway members have minimal, if any, out-of-pocket costs for these much-needed services.

The sustained success of the Health Choice Pathway program is powered by the **ALTCS-like intensive Case Management model** that was created by our clinical team to help each individual design their own care "pathway" (hence the plan's name). Health Choice's ALTCS plan will use the same innovative, high-quality standards and approaches to person-centered service planning as our current DSNP members enjoy.

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
2.	BCBSAZ Standard Care CMS Contract No. 53901AZ142	ACA Marketplace Plan (Bronze, Silver, Gold Plans)	Arizona

Description: Blue Cross® Blue Shield® of Arizona (AZ Blue) has maintained an **active** presence in the Affordable Care Act (ACA) federal marketplace in Arizona **since the first days of the ACA in 2013**. AZ Blue continues to offer **multiple ACA plan options** in rural counties where no other insurer will serve. Our ACA plan options are **fully integrated**, and **available in every Arizona county** with a range of affordable options. We currently serve an average of **48,000 Arizonans** with a range of innovative programs, including programs to improve mental health and reduce the impact of diabetes. Starting in 2024, AZ Blue will offer a new plan option in several counties, using the fully integrated Health Choice provider network. The plan is specifically designed to reduce health disparities and ease the transition of members from AHCCCS coverage to a "Medicaid-like" subsidized Silver plan. We also will use this new plan to serve as an innovative way to increase caregiver workforce capacity by creating our **"ACA Care for Caregivers"** solution – a seamless path for caregivers to retain familiar Medicaid-like coverage if they add hours or receive pay increases and thus lose AHCCCS eligibility. The new plan is also designed to help caregivers who lose Medicaid coverage through redetermination.

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
3.	BCBS Minnesota MN DHS Contract No. 218328	Blue Advantage Senior Care Plus	Minnesota

Description: Since **2006,** Blue Advantage Senior Care Plus has served Minnesota Medicaid members (**including fully integrated, long term care services**) along with a coordinated DSNP. Blue Advantage serves more than 386,000 members overall, including **10,000 Senior Plus/LTSS members,** covering all **87 rural and urban Minnesota counties.** BCBS Minnesota's Blue Advantage Plan has significant experience in adapting to constantly changing rural workforce conditions in ways that address provider network and **caregiver sufficiency challenges** through a number of unique and innovative solutions that are available to us through the National BCBS Association. BCBS Minnesota's Blue Advantage Plan has also developed specific Case Management standards, training, and programs, all of which represent best practices that Health Choice will adapt to improve an expand our existing Care Management programs. Blue Advantage has adopted many innovative solutions to address health disparities, enhance availability of social determinant, tribal, and peer and family services, and reducing social isolation.

B4

B4. The ALTCS E/PD member population is complex, and their care often involves a combination of services and providers to effectively meet their needs. Provide a detailed description of how the Offeror will develop and implement best practices of ALTCS Case Managers, and leverage ALTCS Case Management staff to meet the needs of individuals with complex conditions to:

a) Decrease duplication of effort and enhance coordination of care with providers of physical and behavioral health services,

b) Assist members prior to, and throughout transitions,

c) Improve member engagement

d) Coordinate social and community support services,

e) Identify, track, and manage outcomes for members with complex needs,

f) Ensure appropriate identification of members that would benefit from High Needs Case Management and provide Case Management services in alignment with identified needs and reduce burden on members and families in coordinating member care.

Monitor Case Management performance and respond to identified issues, at the individual and system levels.

B4 Case Management Model: Using Best Practices to Meet Individual Needs. ALTCS members have complex medical conditions and functional challenges. Many members are thriving and achieving their individual goals, while others have experienced trauma, struggle with behavioral health challenges, substance use, experience loneliness or isolation, have limited financial resources, or are challenged by issues caused by health disparities. Regardless of circumstance, all members and their families deserve and will receive a compassionate, experienced, inclusive, connected care team. Providing high quality, culturally appropriate, equitable health care and support services to vulnerable Arizonans *is* our mission and **Case Managers are the heart** of everything we do to make it happen.

Our Case Management model will be based on our **Health Choice Pathway DSNP's Special Needs Model of Care** which recently received top scores from our NCQA's DSNP accreditation reviewers and has consistently yielded improved quality outcomes, equitable whole-person care, and high member satisfaction. As a **CMS 4-STAR DSNP** plan, we will build upon our current experience of serving members with complex circumstances, by providing high-touch Case Management and intensive care coordination across systems of care.

> *"This is a health plan I'd be happy to have my family in."*
>
> - Comment from NCQA DSP Surveyor during Health Choice Pathway DSNP's Exit Conference

The Pathway DSNP Special Needs Model of Care was rebuilt in 2020 from the ground up based on NCQA Medicare Advantage and DSNP standards using an ALTCS-like Case Manager model that empowers every member to choose their own care "pathway" (hence the DSNP's name). The Case Manager directs services as the model's "quarterback" with support from our **Blue Care Team** senior level social workers, nurses, and personnel, member safety, finance, and legal resources and includes **Health Buddies** who essentially serve as a member's personal "concierge" to help members when the Case Manager is not immediately available. Together, these additional supports extend the Case Manager's capacity and improve both member and Case Manager satisfaction by providing an additional resource to understand the choices, options, and services that members have available. This team approach is especially helpful in facilitating member transitions such as those involving **Tribal ALTCS providers** and transitions **between residential settings**. The **Blue Care Team** helps the Case Manager to ensure member safety and avoid fraud, waste, or abuse. AHCCCS ALTCS requirements will be the guide our Case Managers will follow to coordinate benefits and provide each Person-Centered Service Plan (PCSP) with all available wrap-around services. Blue AZ will use the **ALTCS Guiding Principles for Case Management** as the foundation to achieving PCSP excellence and the Quintuple Aim including improving health outcomes, member, provider, and caregiver experience, advancing health equity, and managing cost. In short, we understand the key role of the Case Manager in the success of the ALTCS program and will apply our learnings from our DSNP and other resources to create a best-in-class Case Management program.

Developing and implementing equitable best practices. The Case Manager plays the central role in the ALTCS care delivery system's ability to ensure members receive the full benefit from the combination of services, providers, and protections afforded to them. To ensure all members' needs are met, we hire and train knowledgeable, skilled, and passionate people who are called to serve. All Case Management staff live and work in Arizona and will be assigned geographically throughout our service area to ensure proximity and in-person access to our ALTCS members, families, caregivers, facilities, and providers. Our best practice case management model is team-based: nurses, social workers, non-licensed staff, physical and behavioral health medical directors, paraprofessionals, pharmacists, community providers, agencies, families, caregivers, and the members themselves working together.

Blue ALTCS Academy Case Management Track Highlights

AHCCCS ALTCS GUIDING PRINCIPLES	NCQA LTSS ACADEMY FRAMEWORK	AHCCCS ALTCS AND OTHER TRAINING
Consistency of Services Collaboration with Stakeholders	Quality Improvement	AMPM 1600 Series ALTCS
Person Centered Planning Member-Directed Options	Person-Centered Care & Health Equity Considerations	AMPM 540 EVV
Most Integrated Setting	Facilitating Member Transitions including Tribal ALTCS	AMPM 1240 Series Direct Care Services
Accessibility of Network	Managing Integration of Provider Services	AMPM 1300 SDAC
Member-Centered Case Management	Member Engagement	AMPM 1630 Administrative Standards
Collaboration with Stakeholders	Information & Data Exchange	ACOM 407 Workforce Development

In 2022, we formed a new Health Choice division **to provide clinical and compliance/regulatory training** to ensure our Case Managers and care team provide the exceptional level of care and service that we expect. This new division has designed a **Blue ALTCS Academy** Case Management track based on a thorough review of the requirements in the AMPM, member input, HCBS provider network, partnership with expert organizations including AHCCCS staff, national programs like the **NCQA Academy**, the national **MLTSS Association**, **ADvancing States** leadership programs, and thought leadership from over **100 BCBS plans** across the country including extensive assistance from **BCBS Minnesota's** exceptional Case

Management education program. All Case Managers complete the Academy's curriculum upon hire and receive continuing education. The Academy's curriculum will be updated annually and as needed throughout the year to meet new requirements or adapt to the evolving needs of the members we serve.

In addition, each Case Manager will annually complete extensive training on **HIPAA, 42 CFR, Compliance, Privacy**, and courses available through our Learning Management System including **Motivational Interviewing, Diversity, Equity, Inclusion, and Cultural Humility training**, and more as the evolving circumstances of each year warrants. Case managers will also receive ongoing training to improve their skills in preventing, identifying, early intervention, and reporting consistent with AMPM 1620-O related to member abuse, neglect, or exploitation. They will also receive ongoing training in caring for members with behavioral health needs to ensure the effective and efficient identification of individuals who have a Serious Mental Illness (AMPM 320-P) and to ensure those deemed in need of Special Assistance receive the appropriate support consistent with AMPM 320-R.

We have also built organization-wide resources that support and inform Case Manager work with members. Our **Health Equity Committee**, led by our dedicated **Health Equity Advancement clinical team** developed a comprehensive plan to address disparities and guide culturally appropriate care for our members. Our **Tribal services team** routinely seeks input and performance feedback from Tribal members and governments through our Tribal Summit and Tribal consultation programs, and we continuously integrate input gained through ongoing **statewide** community outreach and engagement with organizations throughout Arizona, such as the **Hispanic Chamber of Commerce**, **NAMI**, **Community Grand Rounds**, and the **Arizona Town Hall**.

Decreasing duplication of effort & enhancing coordination of care between physical and behavioral health. ALTCS eligible members are complex – often interacting with multiple providers, agencies, and others within the system of care. Comprehensive care frequently necessitates use of multidisciplinary teams made up of caregivers and subspecialists such as pulmonologists, cardiologists, nutritionists, psychologists, and therapists. As the single point of contact, our Case Managers will reduce the confusion for members and their support teams by navigating those systems of care.

Consistent with AMPM Policy 1620-A, AMPM Policy 580, and AMPM Policy 910, an initial member screening will always be completed by the member's assigned Case Manager. The Case Manager then coordinates and communicates across all involved disciplines including physical, behavioral, ancillary service providers, home and community-based services, dental and family resources effectively, efficiently, and equitably. Case Managers are responsible for initiating and updating the **member driven PCSP** which serves as the evolving care plan through which the member and other contributors communicate their recommendations which are shared across providers and settings to ensure transparency and reduce duplication of services and effort.

Our Case Managers will use a set of **highly integrated, advanced technology and communication tools** to ensure they have real-time access to treatment plans, claims utilization, and pharmacy data through a single, mobile platform. We will use **OLIO Health's** user-friendly software to simplify communication and care coordination so that facilities and providers can quickly access another Case Manager to assist them, even if their assigned Case Manager is not immediately available. All providers will have access to our integrated care provider portal which houses timely, relevant information including claims and pharmacy utilization, as well as the member's PCSP. We incentivize provider use of **Contexture's health information exchange** platform and the **CommunityCares closed loop referral platform** to reduce duplication. Case Managers are accountable to ensure medical records are shared across disciplines such as sharing behavioral health records with the PCP. Case Manager supervisors, **as members of our Network Services Committee**, offer timely, critical information about network gaps, pending changes, member, and caregiver requests to facilitate prompt **network design** and **contracting changes**. Together, these resources significantly mitigate the risk of duplicating effort and dramatically improve integrated care coordination between providers.

Assisting members prior to, and throughout, member transitions. Member transitions represent a critical juncture for members and their families, which means having comprehensive care transition processes in place are imperative. Poorly managed transitions can be extremely detrimental to the well-being of members. Based on our successful Pathway D-SNP Transition of Care model, we have developed a set of policies and procedures, and extensive operational infrastructure for our Case Managers to facilitate effective, efficient member transitions through all circumstances and conditions using a system of templates, connected to a suite of communication tools.

Unplanned transitions are perhaps the most disruptive and present the greatest risk to ALTCS members and families. While we work diligently to prevent them through real-time visits and reviews, unplanned transitions involving hospitalizations and emergency department visits do occur. Our Case Managers vigilantly monitor our real-time notification system for acute utilization encounters so we can rapidly activate a **Transition of Care team response**. The Case Manager works closely with the Transition team to ensure all information is available and provided to the member, family, and each participant on the member's integrated care team to ensure all are aware of each step in the process in agreement with the plan. Transitional support often includes arranging transportation, scheduling appointments, meal delivery, coordinating Peer and Family resources, reconciling medications, and setting up durable medical equipment

installation. If a **Single Case Agreement** is needed with a non-contracted provider, the Case Manager initiates the process and stays in contact with all parties through completion of the process – which, under most circumstances, we routinely complete within 24 hours.

Unplanned transitions occur for other reasons: Members are new to ALTCS, existing ALTCS members transition to our health plan from another health plan or move to or from a new GSA. Some transitions may include a care team change based upon additional benefit designations, provider reassignment, member health status changes or changes to the member support team. Our Case Managers **monitor our enrollment files daily** and review the existing PCSP if applicable and other data, including ETI forms, from the prior health plan. From experience supporting members through transitions, as a best practice we will ensure continuity of care is honored for all members up to one year as needed.

For **planned transitions**, our Transition of Care team and the Case Manager will collaborate with the members, family, providers, LTSS, HCBS, behavioral health, and any current community support services to ensure continuity. Communication is key to ensuring members and families are kept aware of the transition plan and anticipated needs associated with it. Case Managers **preemptively** plan equipment, caregiver support, assistance from Community Health Workers, Community Interveners, Promotores and other direct care workers, transportation, home health services, nutrition, and medication/treatment prior to the member returning home. If skilled, home and community-based setting, palliative care, or hospice services are anticipated, the planned transition process allows time for members to choose the setting or providers with whom they are most comfortable.

Regardless of the transition's circumstance, our Case Managers are trained to use the **CommunityCares** platform to refer members to community agencies for support, food, and special services and monitor the platform to ensure our members receive the services. If the member has pets, we will ensure the **Pet Support Plan** is documented in the PCSP to reduce stress on the member. Our fully integrated behavioral and physical health model is key to supporting person-centered care. Health Choice's over **55 years of experience** supporting **members living with Serious Mental Illness** (SMI) informs our efforts during these members' transitions. We have maintained, and even expanded, our extensive **statewide** network of behavioral health providers who serve members living with SMI. Our **community psychiatrist network** recently provided positive feedback indicating they are "highly confident" in our ability to ensure safe transition for members with SMI, which speaks to our continued deployment of innovations, use of best practices, and overall capacity to coordinate services for members with complex transitional care needs such as SMI.

We are also committed to helping our **transition-age youth** members achieve their best quality of life. Our ALTCS transition-age youth will have our Case Manager's support to navigate a host of changes that accompany adulthood. We will proactively begin the transition process no later than 16 years of age to collaboratively develop a PCSP that addresses anticipated provider changes, education goals, vocational support, preventive care including family planning (as appropriate), peer support programs, and independent living options.

We have developed a set of tools to specifically assist Case Managers with the unique member needs associated with **transitions from ALTCS "acute only"** services (often due to homelessness) to HCBS or institutional settings. Members wishing to transition **from an institutional to HCBS setting** will be evaluated, appropriate levels of support identified, and services coordinated to ensure a safe transition to home in compliance with the Transitional Program Standards in AMPM 1620-H. When appropriate, the Case Manager will assist the member in accessing the Community Transition Service funding as identified in AMPM 1240-C and will help the member coordinate and maximally utilize their Pathway D-SNP's **Value Based Insurance Design (VBID)** supplemental benefits to assist their reintegration into the community. Benefits and services, including those around end-of-life care, are coordinated according to member preference in a **culturally sensitive** manner that addresses LTSS support and HRSN, and will be reflected in the PCSP. As a best practice, the Case Manager will conduct in person visits as often as needed to assess how the member and family are adjusting to the new environment and the discuss the options available to the member for additional services.

Improving member engagement. The Case Manager's initial outreach to ALTCS members of all ages and stages will be in person and meet the standards of AMPM 1620A to honor member and family preferences. The Case Manager will assess member strengths, preferences, and service and support needs with the member and the planning team including paid and non-paid caregivers. We make a concerted effort to assign Case Managers with similar cultural and ethnic backgrounds, including spoken language to each member.

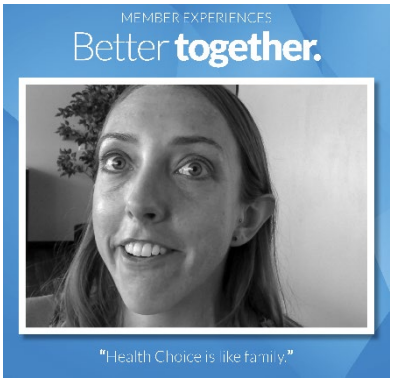
We will not only provide written materials such as health literacy material, but also offer and assist members with using multiple avenues of communication to engage with our Case Managers and other supports including face-to-face, text, chat, email, telephonic, and video conference to meet our members' expectations and improve engagement in the case management process. Our **Case Managers are trained to listen intently** to our members' and families' concerns and address the issues most important to them first – an essential component of building trust. The Case Manager's name, contact information, and hours of availability are shared with the member, family, and caregiver in a **Member Resource Toolkit** as a reminder of who to contact for any issues.

For members who are hard to reach, have specific conditions, or are withdrawing from participating in their care, our Case Managers will work with **Community Health Workers, Community Interveners, Peer and Family Organizations, and HCBS providers** to facilitate member engagement to address barriers. If members appear disengaged, our Case Managers will assess the root cause, which may range from depression, pain, relationship challenges, or even the need to change Case Manager assignments. For members who have difficulty engaging in health and wellness conversations, our Case Managers use motivational interviewing skills to meet the members where they are and gently build rapport.

Like the members in our D-SNP program, we anticipate many ALTCS members who qualify for LTSS services will have functional, sensory, and HRSN needs. Our Case Managers will use our adaptive tools set to bridge gaps in communication and to enhance engagement. Loneliness and depression are common experiences for members with complex conditions, who are homebound, in an institutional setting, or otherwise at high-risk for social isolation. Our partnership with **Wellth** gives access to a social engagement mobile app, and our partnership with **Pyx Health** offers all members a means to engage 24/7 through a mobile app and live customer support center. ALTCS members will also receive social support from **Blue Pets** (an animatronic pet therapy program based on a successful BCBS Minnesota initiative) and virtual neighborhood programs offered through **Wider Circle** as part of our **Blue Connections** program.

Lastly, our research indicates that one of the greatest concerns to Case Managers involves working with caregivers who themselves are under stress. According to Frontiers in Psychology, "[l]oneliness in caregivers is associated with psychological distress and significantly predicts depression and low quality of life." Health Choice has designed an entire suite of **Peer and Family** based services called the **Blue Caregiver Café**, to assist caregivers through the many challenges they face. We will also be the **first MCO to offer** the newly developed **Pyx Caregiver Support program** to family and caregivers -- an exciting, innovative approach to supporting caregiver wellbeing. These initiatives will serve as an extension of the Case Management team during hours when members or caregivers may need to socially connect the most and will broaden our capacity to effectively engage with members.

Coordinating social and community support services. We intentionally and continuously nurture our ongoing partnerships with social and community-based support services to have the widest possible circle of partners to support our members. We use a structured annual process based on the Vitalist Foundation's 12 Elements of a Healthy Community Model to assess barriers to care and community-by-community needs. We then develop strategies and initiatives to address the needs in connection with the statewide NAU/ASU Center for Health Equity Research (CHER) study that we fund and support. Case Managers play a vital role in this process, both by providing feedback and local expertise to identify gaps and barriers, and then once resources are developed, to inform members about local resources that help them achieve greater self-sufficiency using community resources like Peer and Family supports, housing, education, and employment, and volunteer opportunities. To enhance community based clinical services, through Blue Connections we have contracted with providers who offer home and institution-based services including x-ray, lab, dental, vision, wound care, podiatry, nutrition education, telehealth, physical and behavioral health services, and more.



"Health Choice employees literally have kept me above ground. They found me the very best specialists for my multitude of [conditions]."

-- Deborah, Health Choice Pathway DSNP member

Our Case Managers will adhere to the ALTCS Guiding Principles and the goals of the Quintuple Aim – to improve health equity, quality, and member and provider satisfaction, while containing inappropriate or wasteful utilization. We have engaged in an extensive process involving local stakeholders to develop a comprehensive network of *trusted* professional providers, Direct Care Workers, and community agencies, all of which are contained in the Community Resource Guide compiled through the **NAU/ASU CHER study**. Case Managers have access to a rich library of social and community service supports in their **Blue Resource Toolkit** and can use the **CommunityCares** platform to make referrals for members at any time. Case Managers work closely with staff dedicated to **health equity advancement**; our Tribal liaison and service team is active across the state; our Veteran and Member liaisons work closely with members and community agencies; our Justice and Court coordinators and our OIFA and Peer staff collaborate with the clinical teams; and we have teams focused on managing and developing new permanent and transition housing resources across the state.

Identifying, tracking, and managing outcomes for members with complex needs. ***Identify:*** Outcomes demonstrate impact. Our data-driven approach uses a suite of resources to proactively identify, track, monitor, and manage outcomes for our members with complex needs. Our Case Managers are trained on and routinely review High-Cost/High-Need reports, Chronic Condition reports, HEDIS Performance Measure results, and our population health analytics tool (**Johns Hopkins ACG®)** to identify and manage outcomes for our members with complex needs. Our Case Managers will identify needs for complex members through the robust assessment process using the Universal Assessment Tool (UAT) and our evidence based, comprehensive DSNP Health Appraisal which captures a wholistic view of our members' physical, behavioral, functional, HRSN, spiritual, safety, and support system. We continuously monitor environmental and public

health emergencies through resources like **TGEN North** and can deploy our system to immediately identify members with complex needs and provide a range of support services to keep them safe. ***Track:*** Consistent with NCQA expectations that we be a continuous learning and improvement organization, we will track process and outcome measures including **member reported achievements against personal goals**, health related **quality of life** standards, ALTCS, NCQA and HEDIS service **quality** performance, and **member satisfaction** with our Case Management services and their HCBS placement using an independence **CAHPS-based survey** methodology and **National Core Indicator-Aging and Disabilities (NCI-AD™)** indicators when available. These measures will be incorporated into the Case Manager dashboards for continuous visibility and use to improve service levels by Case Managers and their supervisors. As required by EXHIBIT 1620-2, all significant changes will be reported to AHCCCS using the Member Change Report. ***Manage:*** If members are not meeting their goals, the Case Manager will reassess the situation and work with the member, family, and caregivers to determine if the goal is realistic or if additional supports or services would help the member achieve their desired outcome. Managing outcomes is member-directed and Case Manager supported. The Case Manager has access to their supervisors, medical directors, behavioral specialists, and pharmacists, and if necessary, can raise issues directly to the Administrator and Chief Executive Officer to remove barriers that may prevent members from achieving their highest level of independence and outcome goals. Our job is to identify and coordinate the services and benefits that will help members experience the highest quality of life and self-efficacy.

Ensuring appropriate identification of members who would benefit from high needs case management. ALTCS members need stratified levels of intensive Case Management and care coordination. Member data tools developed for our DSNP's Health Appraisal tool will use a **Modified Charlson Comorbidity Index** to identify members who would benefit from high needs case management. We also use the **Johns Hopkins ACG® Predictive Analytics** platform so we can quickly address developing member needs. Risk levels will be identified upon enrollment and monthly thereafter. We use a team-based Case Management model with Registered Nurses, Behavioral health Specialists, and support staff to provide high-needs Case Management and additional coordination when needs are identified. **Staffing levels and supervisory oversight** are constantly monitored and adjusted to meet member needs. Since risk levels change over time, our Case Managers closely monitor Health Appraisal and high-risk indicators to identify new high-risk members.

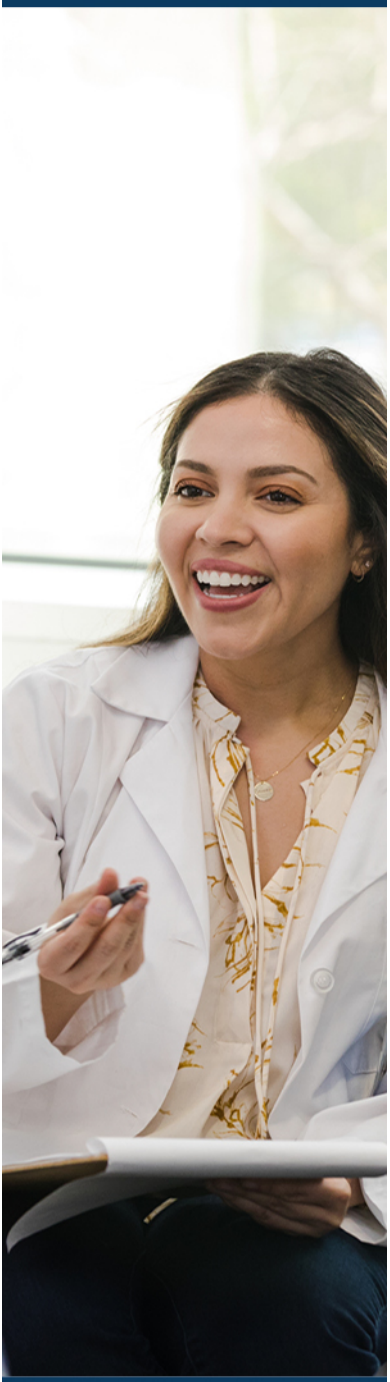
Our Case Managers and support staff will coordinate benefits and services aligned with our members' identified needs that complement our high-touch case management model. Examples include **remote patient monitoring** for chronic conditions, **habilitation, rehabilitation, assisted living support, vocational, childcare options, food and utility assistance programs, dental services, and technology support**. Case Managers will have intentional discussions with the members and caregivers about the most effective way to communicate and types of information they want to receive respecting the person-centered approach. The member, family, caregiver, and care team will receive updates from the Case Manager, as the single point of contact, on the progress of referrals and service coordination so they do have to do so.

Our **24/7 nurse advice line** relays member communication to our Case Managers outside of business hours and is monitored seven days a week with urgent needs routed to receive a **same day response**. Our Pathway D-SNP's **Value Based Insurance Design (VBID)** provides support for rent, utilities, healthy food, nutritional information, and more which we will facilitate for dual ALTCS members to alleviate concern about life basics.

Monitoring Case Manager performance and responding to issues, at the individual level and system level. Our Case Management Department's leadership is and will be accountable for oversight and monitoring of Case Manager performance to ensure that our PCSP process is consistent with the principles of **Person-Centered Thinking, Planning, and Practice**. We recognize not all issues are employee-based. Problems can arise from system-wide factors such as availability of resources, processes, or policies. We have a systematic way to seek out the source of these issues, address, and report them at the system and individual level using performance feedback tools adapted from **Google's OKR performance monitoring tool.** This supports Case Managers (who often have to be the "messenger") so they do not feel like they are being blamed for things beyond their control.

From a Case Management **system level**, we have expanded our Pathway DSNP's set of Case Management performance fidelity reporting tools based on input from **BCBS Minnesota Senior Advantage** MLTSS Plan to cloud-based reporting resources to collect and analyze data in real time from Case Managers who will be visiting members onsite. System level performance monitoring will be adjusted based on feedback from Member Surveys, **Member Advisory Committee** discussion, and input from Case Managers themselves. **Individual** Case Manager performance will be closely monitored by our supervisors using a **Case Manager Scorecard.** This score card is used to discuss member trends and outcomes with the Case Manager on a weekly basis. "Supervisor to Case Manager" ratios will be monitored and adjusted to ensure a high-level of performance. Individual performance monitoring tools will include case file audits, call monitoring, grievance reporting, **Interrater Reliability testing**, member outcome data. This performance data is used by our Case Management supervisory team to inform the **continuous coaching discussions** they have with Case Managers on a **weekly** basis and will also be used by our Blue Care Team to help identify issues that they can emphasize to support Case Manager professional development. Whether the result of an individual or systemic issue, our **ultimate goal** is to improve Case Manager knowledge, skill, and job satisfaction, as a mean to improve the quality of member's lives.

B5



B5. How will the Offeror ensure that person-centered service planning:

a) Includes active engagement with ALTCS members,

b) Includes all aspects of quality of life,

c) Is consistent with the individual's needs and wishes,

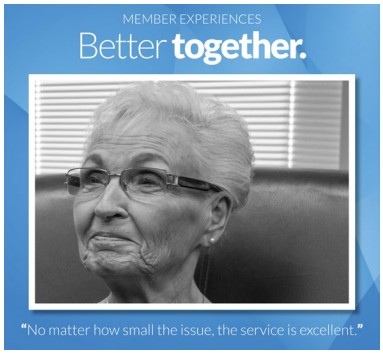
d) Promotes access to services in home and community-based settings, and

e) Results in high quality, equitable, and cost-effective person-centered care.

Additionally, how will the Offeror monitor and evaluate the Case Manager and the member experience and satisfaction to demonstrate the Offeror's person-centered service planning process complies with the values and principles of person-centered thinking, planning, and practice?

B5 Person-Centered Service Planning Process. Starting specifically with the needs of ALTCS members in mind, Health Choice significantly revised our Health Choice Pathway DSNP's Special Needs Model of Care along with its integrated Case Management process. This redesign centered around a **person-centered service planning methodology** that prioritizes individual interests and member needs. We intentionally built this Case Management process around an ALTCS model to work with members and their supports to design person-centered service plans (PCSP) that respectfully address their physical and behavioral health, functional ability, age-related social and life-sustaining resources, and Health Related Social Needs (HRSN). To facilitate the model, we will recruit Case Managers and supporting staff with ALTCS experience who promote values of dignity, independence, individuality, privacy, and choice by embracing diversity, identifying disparities, and promoting innovative and evidence-based programming for our members. We will ensure Case Manager commitment to the PCSP process through careful attention to actively maintaining member engagement, member defined quality of life (QOL), respect for individual needs and wishes, and access to services in home and community-based settings (HCBS) that ultimately improve quality, equitable, and cost-effective person-centered care. As a **CMS 4-STAR rated DSNP,** our Case Managers have developed a best practice approach to assessing member needs, developing integrated care plans, and conducting multidisciplinary care teams – all in compliance with the timeline and content requirements of AMPM Chapter 1600 and other applicable ALTCS and CMS policies and regulations.

Active Engagement with ALTCS Members. The member's **voice and choice** inform the entire PCSP process. *Person-centered thinking* focuses language, values, and actions toward respecting the views of the person and their loved ones and emphasizes quality of life, well-being, and informed choice. *Person-centered planning* is directed by the member with helpers they choose. It is a way to learn about the choices and interests that make up a good life and identify supports (paid and unpaid) needed to achieve it. *Person-centered practices* are present when people have the full benefit of community living and supports that are designed to assist people as they work toward their desired life goals.



"Give these people an 'A' … or whatever you give folk who do a great job! They check in on me all of the time, listen to what I need and get them taken care of."

-- Elizabeth, Health Choice Pathway DSNP member

Absent extenuating circumstances, the member is always encouraged and supported to lead their own PCSP process, and is always informed of their rights regarding disagreement, grievances, appeals, and alternatives at every phase of the process. Interactions with our Case Managers and care team **begin and end** with clarifying and confirming each **member's strengths, interests, needs, and goals.** All PCSPs are collaboratively developed with members, members' Case Managers, identified support person(s), caregivers, designated representative (DR) and/or health care decision maker (HCDM), and all providers including LTSS, physical, and behavioral health. Guided by the member's preferences, a diverse care team is assembled to meet personal, cultural, or spiritual preferences and identify factors impacting their health outcomes. Our assessment process includes use of the **Uniform Assessment Tool** (UAT) along with our Pathway DSNP's customized Health Appraisal tool which includes LTSS-specific questions designed to identify member's unique needs and interests. This enhanced tool ensures we are gathering as much HRSN, social context, health disparity, medical, substance use, and behavioral health information as possible. This data is then fed directly into our **EXL CareRadius™** platform as part of each member's personal profile, for use by the member's extended care team and social resources as directed through the Case Manager. PCSPs are updated with the member at a minimum annually. The member and their DR and/or HCDM are asked to sign the PCSP acknowledging receipt, its accuracy, and agreement.

The success of this complex process is based on the availability of a team of well-trained and highly skilled Case Managers. To support this, we have also redesigned our training and continuing education programs. All Case Managers matriculate through the **NCQA LTSS Academy,** a national best practice format that has guided development of our own **Blue ALTCS Academy.** The Blue ALTCS Academy includes contemporary content from **BCBS Minnesota's Senior Advantage** training and development program on health literacy, cultural competency, cultural humility, and implicit bias training, and ensures a quality member engagement experience. We specifically focus on helping **members who disengage** or may have barriers to engagement. Case Managers are trained to employ strategies to reengage members through motivational interviewing, deployment of **Community Health Workers** and other home-based resources through our **Blue@Home** program, and the help of community-based **Peer and Family support** teams and Community Health Representatives. They also offer members virtual resource tools, such as **Pyx Health's** solution for social isolation and **Wellth's** mobile tool, to facilitate social engagement. Lastly, Case Managers receive training on how to access the **Blue Care Team.** This team was formed to support Case Managers by providing clinical, administrative, and member safety supports from senior level staff whenever the Case Manager needs it.

Building a Trusting Relationship. Member engagement begins with **building a trusting relationship.** Ideally, this first meeting occurs **in person and in the member's preferred environment.** The Case Manager will meet wherever and however the member is most comfortable and include anyone the member chooses. This in-person approach allows Case Managers to learn about the member's preferred method of communication, culture, environmental needs,

individual strengths, fears, concerns, preferences, and often most-importantly, examples of **successes from prior healthcare experiences –** not only from what the member **says,** but from their **body language and** demeanor. The first meeting will include a discussion of the member's preferred providers and facilities. As with all previous transitions, we will **honor existing provider and facility** relationships, extending them in-network status without the need for separate prior authorization for ***at least* the first year** while we work to bring them into our network (which we almost always do).

Incorporating Member Feedback. Case Managers ensure a **continuous feedback loop** between members and their support system (including DR/HCDM and/or family members/caregivers) which strengthens timely and open communications. In addition to information gathered through **in-person member meetings** (which is the primary source of feedback), high level feedback is also collected through surveys (e.g., **QOL Assessment**, CAHPS, HOS, **Pulse surveys,** and satisfaction surveys specifically about Case Manager performance), member and family focus groups, grievance and appeal processes, and guidance from our **Member Advisory Committee.** Focus areas include improvement to service planning, individual rights, community inclusion, choice, care coordination, safety, and relationships. This multi-input feedback process helps Case Managers focus on **both individual and population-level** member needs. Our Case Management leadership team diligently tracks member satisfaction with assigned Case Managers, providers, the PCSP process, self-assessed member progress toward goals, and the member's ability to self-manage healthcare needs – all in real time. If **immediate** issues are identified, member advocacy support is made available through the **Long-Term Care Ombudsman Program,** to investigate and resolve complaints.

Improving Quality of Life. Members *define their own* Quality of Life (QOL) goals. Our Case Managers work with members to develop a PCSP that is **strength-based,** promotes the member's **independence** or ability to self-direct their care, and specifically includes their QOL goals. Our Case Managers use a "QOL Assessment" tool with members to identify the member's own unique definition of what QOL means for them and gives them practical ideas to achieve their specific goals.

Quality of Life Goal Examples from our DSNP Members	
I want to remain in my home, as long as possible	I want to make sure my pets are taken care of when I go to the hospital
I want to ensure my affairs are in order	I want to be able to go to church and to the store
I want to finish school	I want to get a job
I want to be able to feed, bathe, dress myself	I want to reduce my pain
I want to see my grandkids	I want to be able to travel

This is just the start of the QOL process, however. The Case Manager continuously reviews the PCSP with the member. **Person-Centered Thinking, Planning, and Practice** is key to success. Case Managers assist with access to technology, adaptive equipment, remote patient monitoring systems, and telehealth services through our expanding **BlueCare Anywhere**[SM] program. Technology support has become increasingly important to seamless care coordination and timely communication, strengthening quality monitoring to increase member self-sufficiency while preventing abuse and neglect. It is especially critical that our members with **dual sensory loss** of vision and hearing receive the appropriate technological assistance to be able to engage freely and access needed resources, as well as develop and maintain their PCSP. The Case Manager also discusses available transportation benefits, assistance with completing job or school loan applications, and facilitating pro bono resources to draft Wills, Advance Directives, and even find a pet sitter, walker, or other pet care service. (Pets are very important to member well-being!)

Respect for Individual Needs and Wishes. Health Choice Case Managers will always encourage and support members to lead their own PCSP process, absent extenuating circumstances. In doing so, the Case Manager will engage with the member to help them identify their self-recognized strengths, needs, and wishes and **include them in their PSCP.** The Case Manager and care team then works with the member to accurately document the member's individual needs and wishes and identify and select resources to assist members and their caregivers. Our role is to respond to each concern with actions that increase equitable service access, whether in-home or in an institutional or community-based setting. When appropriate, Case Managers will offer education and support to members regarding the use of **Peer and Family supports** and employment of family members, friends, and neighbors as paid caregivers. Members are empowered to self-direct care using ALTCS' Self-Directed Attendant Care (SDAC, Chapter 1300, Policy 1320-A) and Agency with Choice (Chapter 1300, Policy 1310-A) member-direct options, in concert with our **Arizona Blue Consumer Direct** program. In doing so, we will honor special member preferences, such as when members *do not* want family involvement, or *do* want help from Case Managers with specific language skills or need help with pet care services during transitions.

The PCSP will be continuously reviewed and updated in real-time through frequent Case Management check-ins. Check-ins are accomplished consistent with the **member's preference** through in-person, telephonic, and virtual meetings. Where requested, Health Choice provides technology to enable more frequent meetings. Members can request the Case Manager distribute the PCSP to support team persons in print or electronic form. Case Managers have portable printers to facilitate print requests. If a member chooses to **transition** from a **Tribal ALTCS provider** or **another health plan,** our Case Management team reviews the existing PCSP with the member to align with the member's current health status, goals, and desired outcomes. To support continuity of care, we allow the member to stay with non-contracted services and providers for up to one year while we attempt to bring them into our network. We will proactively work with **transition aged ALTCS youth** to collaboratively develop a PCSP that addresses their anticipated provider changes, education goals, IEP development, available Department of Education programs and 504 Plan, vocation support,

preventive care, family planning, peer support, and independent living. We will work with **"acute only" ALTCS members** to collaboratively develop a PCSP that addresses stable housing, so we can support access to broader ALTCS benefits.

Promoting Access to Services in Home and Community-Based Settings. The overall goal of our Person-Centered Case Management model is to engage members and their family/support persons to achieve optimal member functioning in their preferred, most integrated, and least restrictive setting. All HCBS services listed in AMPM Chapter 1200 will be offered and actively promoted through Case Managers. The HCBS Needs Tool (HNT), along with the UAT and Health Appraisal information, inform the PCSP and help identify needed resources. Members also complete the HCBS Needs Assessment to help identify community-based services and resources to aid them with their PCSP goals.

As indicated by our experience with complex DSNP members, it is not enough to simply list resources in a handbook, website, or even in a care plan. Each member and their care team have different levels of knowledge, health literacy, and even investment in the member's well-being. Our Case Managers will receive extensive training through the **Blue ALTCS Academy's Case Management track** on ALTCS benefits and how to access the complete healthcare ecosystem available to members. Our Case Management supervisors will then track and coach Case Manager performance to ensure that all members are being assisted with access to the entire benefit package.

We meet the member where they are. Members may want to remain independent at home but may not want to be a "burden" or stress on their families financially, logistically in terms of space and modifications needed, or in terms of caregiving. The Case Manager will meet with members face-to-face and, using a member's preferred language, help them understand their benefits, carefully explaining each one and how it applies to the member's need and situation.

Often the first hurdle is **safety** and **space.** Health Choice works with **Ability360** to promote programs that empower people with disabilities to take personal responsibility so they can achieve or continue to live independently within their communities, supported by a comprehensive suite of programs from peer support, advocacy, home modifications, nursing home reintegration, employment services, and socialization through recreation programs. These programs are designed to maximize independence, remove barriers, and assist our members to experience optimal integration. We have also developed an extensive **'Food as Medicine'** program, through our Pathway DSNP's VBID supplemental benefits programs, which offers members access to nutritional support and healthy foods. Whether it's education by nutritionists, supplies to aid in meal prep, or the deliveries of pre-made meals, *we have something for every member*.

Sometimes, despite having help and being at home, our members and their families feel lonely or isolated. We currently offer **Pyx Health,** an app that combines live support staff and virtual self-paced activities for our general membership. Based on high member satisfaction and improvements in depression and loneliness scores, we will offer the Pyx program to our ALTCS members. We recognize *caregiver stress* also impacts the member's health status. As a component of our **Blue Caregiver Café** caregiver 24/7 support program, we are the *first MCO to launch the new* **Pyx Health Caregiver** module to address loneliness and isolation among caregivers. This mobile application reduces caregiver stress and isolation, and ensures the caregiver knows there is someone available for them when they need support.

While offering support, resources, and education to make it easier for each member and the care team to access services, we also promote unique, culturally appropriate programs such as our **Tribal Practitioner** and **Sweat Lodge Healing programs,** which offer traditional intertribal coordinated healing services. We continue to expand access to **Peer and Family supports** by adding providers and incentivizing inclusion in our participating ACO network. Our **BlueCare Anywhere** platform offers members a *choice* of multiple telehealth services that provide 24/7 access to technology-based support for members and their caregivers. Similarly, our **Blue@Home** program offers members a *choice* of virtual primary, substance use, and behavioral healthcare for members anywhere – including **Community Paramedicine Programs,** which use networks of EMTs, paramedics, CHWs, **Promotores**, **Community Interveners**, and nurses providing direct care at home or institutional settings. Blue@Home also offers specialty services such as in-home **podiatry, mobile dental,** and supports for end-stage kidney disease through **Monogram Health.** Our Case Managers ensure members who qualify for Attendant Care, Personal Care, or Homemaker services can access services as provided in their PCSP. We have an extended network of provider services and other HCBS community partnerships to support this work and our Case Managers will never use referral agencies to identify placement options for members.

Another set of valuable resources for our Tribal members is our team of **Community Health Representatives,** comprised of paraprofessional **Tribally enrolled community-based trained** staff, who provide HCBS services in regions bordering Tribal lands and within Tribal communities as permitted through Memorandum of Agreement. While workforce adequacy is a significant challenge, our Workforce Development Administrator and expanded Workforce Team has developed education, training, and certification supports through our **Blue ALTCS Academy –** not only for current DCWs and caregivers, but also for candidates who can expand the workforce including new college graduates, family members, friends, neighbors, Peers and Family candidates, and nursing facility staff (particularly in rural areas).

High-Quality, Equitable, and Cost-Effective Person-Centered Care. Health Choice is dedicated to providing high-quality, equitable, and cost-effective person-centered care to every member. We were the **first AHCCCS Medicaid MCO**

accredited by NCQA. In 2023, our pursuit of excellence in high-quality care resulted in **perfect scores** for the MED, MA, and SNP Modules. We have achieved an overall CMS **Four-STAR DSNP** and **Five-STAR Part D Pharmacy Plan** ratings. Guided by the tenets of the **Quintuple Aim,** we use community-based data and feedback to formulate solutions that achieve a high degree of Operational Excellence by implementing strategies that balance improvement in health equity, member and provider satisfaction, and contain unnecessary costs. The Health Choice **Health Equity Plan** was created by our **Health Equality Advancement Division** and overseen by our **Health Equity Committee.** It is based on an extensive statewide study conducted (at our request) by the **NAU/ASU Center for Health Equity** and supplemented with data from local and statewide focus groups and community meetings such as **Community Grand Rounds, NAMI,** and **the Arizona Town Hall.** Our Health Equity Plan describes goals to address identified health disparities on a **community-by-community basis** and population. Recent examples of successful member engagements facilitated through supports we developed include assistance for an Arabic-speaking member who was not engaging in services due to language challenges, and assistance to an African American member who needed a culturally sensitive specialty provider.

We have comprehensive evidence-driven programs in place to make sure the most vulnerable, complex ALTCS members with **multiple comorbidities** get the very best care. Examples of these programs include our pharmacy-led **Performance Improvement Plan to Reduce Polypharmacy** in senior populations and **AZ Blue Action Plans** to address **Diabetes** and **Behavioral Health statewide.** In addition, we have developed collaborative teams trained in culturally responsive practices in mental health care, helping provide special assistance, as outlined in AMPM 320-R, to ALTCS members with **Serious Mental Illnesses** (SMI). Case Managers are trained to activate our **Critical Incident Management System** and use the **Long-Term Care Ombudsman Program** when they identify potential harm or risk to the member or ALTCS provider including abuse, neglect, exploitation. This organization-wide system eliminates immediate threats to members or providers. Allegations are investigated by a dedicated **Quality of Care** team with reports regularly submitted to AHCCCS.

Our research shows that many members want to directly employ their own caregivers. Our **Arizona Blue Consumer Direct** initiative is designed to increase use of ALTCS' Self-Directed Attendant Care [SDAC, Chapter 1300, Policy 1320-A] and Agency with Choice (Chapter 1300, Policy 1310-A) member-direct options. As identified in AHCCCS' 2022 Annual HCBS Report, SDAC has historically been under-utilized, with only 1,705 members using them as of 2022. However, SDAC programs have successfully reduced chronic caregiver workforce shortages in other rural states by giving members the ability to hire people that the member already knows (including family members, friends, and neighbors). SDAC programs can also significantly improve a member's sense of independence since the member is in control. Our research indicates that one of the main barriers to SDAC use is that Case Managers do not feel comfortable recommending the option due to the lack of additional supports that caregiver agencies provide. Our multi-disciplinary **Blue Care Team** will support Case Managers with additional member safety, clinical, caregiver hiring, and budget management assistance (similar to the services that would otherwise be provided by caregiver agencies) so that Case Managers feel comfortable recommending SDAC. We anticipate this program will increase SDAC use by more than 25% over five years.

Commitment to Monitoring and Evaluation of Our PCSP Process. We will use the **ALTCS Guiding Principles for Case Management** as the foundation for tracking, monitoring, and evaluating the performance of the PCSP process, to ensure we not only adhere to but exceed the principles of **Person-Centered thinking, planning, and practice.** We use the National Center on Advancing Person-Centered Practices and Systems *five skill areas* to track and evaluate **competency expectations for Case Managers.** These Key Performance Indicators categories (KPIs) used to evaluate the planning process include **Strengths-Based, Culturally Informed, and Whole-Person Focused; Cultivating Connections Inside the System and Out; Rights, Choice, Control; Partnership, Teamwork, Communication, Facilitation; and Documentation, Implementation, Monitoring.** Case Manager evaluations will include these KPIs. Additionally, we use individual case audits, call monitoring, grievance reporting, Interrater Reliability Testing, Person-Centered Member Experience Surveys, and member quality, cost, and utilization data analysis as part of our firm commitment to assessing the PCSP Process.

We have adopted a best practice accountability oversight and **case management performance fidelity** process from BCBS Minnesota Senior Advantage LTSS Plan. Our Quality Management and Performance Improvement teams will use these tools in connections with an ongoing PDSA process to analyze member participation rates, planned and unplanned transitions, HEDIS measures, as well as External Quality Review Organization feedback on quality, timeliness, and access to PCSP services and continuously make adjustments whenever the circumstance show an opportunity for improvement.

Finally, from an organization performance perspective, our Quality Management, Quality Informatics, Business Intelligence, and Clinical program leaders track and analyze the effectiveness of PCSP program goals, member outcomes, and HEDIS performance measures through an extensive **Monthly Management Report** that dashboards over 350 separate data vectors. This report is discussed with our executive and leadership teams to drive continued improvement. We analyze **adequacy** and **timeliness** of member service delivery through data from our prior authorization process, out-of-network service requests, member grievances, and barriers to providing support services noted by Case Managers, and through Quality-of-Care Reviews, and work with internal departments and community partnerships to support member access to necessary services, **regardless of age, language, ability, transportation, and geographical location.**

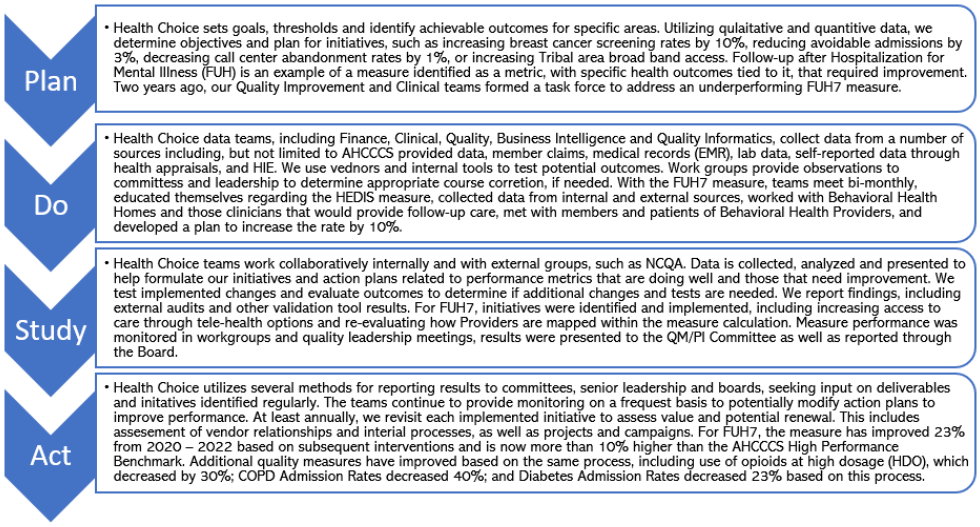
B6

B6. Provide a description of the types of data, including but not limited to performance metrics and data collected in partnership with members (e.g., data from member satisfaction surveys or member focus groups), the Offeror will collect, monitor, and analyze for the purposes of improving member health outcomes and informing program initiatives.

Provide a detailed description of the processes utilized by the Offeror to inform and/or initiate improvement activities, including reporting tools, monitoring technologies, and/or partnerships, as well as processes used for member and population specific data analyses and MCO decision-making processes.

B6 Leveraging Data. BCBSAZ Health Choice (Health Choice) has employed data to drive positive health outcomes within our member populations for years. Maintaining our commitment to a person-centered model of care (MOC) to promote quality of life, overall well-being, and the values of independence, choice, and privacy is rooted in our decision-making process and data analytics. Our strategy for collecting and utilizing data to inform initiatives is based firmly on the **Quintuple Aim** of improving health outcomes, member, and provider experience, reducing costs, and advancing health equity by decreasing disparities. We use a **Population Health** framework that integrates data from a wide variety of sources and partners, including independent third-party surveys of member and provider preferences and satisfaction.

Processes to inform & Initiate Activities. Health Choice has specific processes in place to drive decision-making, impact strategy formulation, and improve organizational performance. Health Choice uses the Institute for Healthcare Improvement (IHI) model of improvement, based on the **Plan-Do-Study-Act (PDSA) rapid cycle intervention** framework, to implement continuous improvement across the organization. We include components of the **Lean Six Sigma Define-Measure-Analyze-Improve-Control** (DMAIC) model to manage projects within a team-based approach. Using a philosophy of continuous improvement, Health Choice improves outcomes and enhances performance. Health Choice has trained and certified staff in specific quality improvement methods to manage processes, formulate strategies and integrate best practices across the organization.



Individual contributors, teams, work groups, and committees evaluate top and bottom performing measures, as well as evaluate improvement initiatives related to underperformance and make recommendations to refine them as necessary. With leadership review and approval, teams Initiate new interventions based on monthly, quarterly, annual data and results, ensuring improvements are sustained over time. Leadership will also allocate administrative resources as needed for improvement plans, based on data. Every problem statement, opportunity for improvement and meeting agenda utilizes a framework around defining the issue and criteria, collecting data from various sources, analyzing the data, acting on the insights, evaluating the outcomes, and managing the data responsibly to protect privacy.

Reporting Tools, Monitoring, and Data Analysis. Health Choice has developed a wide range of internal and external reporting tools, and monitoring, data analysis, and technology **partnerships** that support development metrics and benchmarks. We have invested both funding and staff expertise in the statewide **NAU/ASU Center for Health Equity Research (CHER) study** to develop and routinely update data sets that identify regional differences and local community resource barriers. Additionally, we receive a wide range of member and community inputs through meetings that we sponsor or facilitate, such as **Tribal summits and consultations**, meetings with local **municipalities**, and sponsored statewide and regional gatherings such as the **Hispanic Chamber of Commerce**, **Arizona Town Hall**, **NAMI** meetings, and **Community Grand Rounds**. We collect population statistics provided by our Medical Economics, Business Intelligence and Quality Informatics teams in collaboration with Providers, Health Care Industry groups such as the **Arizona Association of Community Health Centers**, and Accountable Care Organizations (ACO) including the **Northern Arizona Behavioral Health Alliance** and **Equality Health**. Our Network Strategy Committee works with data teams within the organization as well as Provider groups regarding network and workforce reporting. Our Finance team provides member and provider utilization reporting, as well as cost of care trends. Our fraud, waste, and abuse monitoring data is provided by our Compliance team and Special Investigations Unit (SIU), through internally developed monitoring tools as well as partnerships with organizations such

Health Outcomes	Reducing Costs	Member Experience	Provider Experience	Health Equity
Health Appraisals	Polychronic Conditions	Appeals and Grievances	Provider CAHPS	Population Assessment
SDOH Screening – Z-Code	VBP Reporting	Provider Post-Visit Survey	Provider Calls	Z-Code Analysis
Contexture (HIE), ASIIS	DRG Analysis	Electronic Surveys	QM Investigations	Race/Ethnicity reporting
Blindspot, SNAP	Utilization Trending	Member, HUG Calls	Ambulatory Chart Reviews	Language reporting
Vendor Data – Wellth, etc.	Vender data	Call Center statistics	Caregiver Surveys	Rural Access reporting
HEDIS Calculations	Pharmacy data	CAHPS – formal/informal	ACO Feedback reporting	Academic Partnerships
CMS Core Calculations	Medical Expense trends	Disenrollment Surveys	BLS Data	Vendor reporting
Medication Adherence	Aberrant trends	Case Manager data	Pulse Surveys	AHCCCS / CMS statistics
CMS Star Rating Measures	Avoidable Admissions and	Predicative Analytics (DP)	Claims TAT, Accuracy	Community Assessments
National Core Indicators AD	Readmissions	HCBS Survey	EMR data	RHEA

Examples of items related to Health Care Improvement include analysis and implementation of initiatives related to completion of health risk assessments and advanced care planning, quality measure performance, operational metrics, utilization trends, medication adherence, member surveys, and SDOH analysis.

as **Cotiviti** and **Change Healthcare**. As we do now, we will exclusively use **external independent survey organizations** to collect member, provider, and caregiver satisfaction survey data multiple times per year.

Health Choice continuously monitors its members' and providers' performance and quality of care, using the highly integrated data set described above, through detailed **Monthly Management Reports** (MMRs) (the accompanying three exhibits are derived from a recent MMR). Our MMRs include approximately 350 metrics covering the performance of every aspect of the organization including clinical (hospital readmission rates, medication adherence, preventive screening, and other rates that directly impact member outcomes), quality, call center, claims, encounters, grievance and appeals, network, credentialing, compliance, information systems, and cost of care. Each metric shows trends over time, and department directors are required to discuss **PDSA-informed remediation strategies** whenever negative trends or opportunities for improvement have been identified. These reports are reviewed with our entire leadership team to facilitate cross-departmental collaboration and innovation, and then provided to the AZ Blue executive leadership team. MMR results are reviewed quarterly with the **Health Choice Board of Directors**, **Provider CEO Advisory Council**, and our **Governance Committee** and **Medicare Advisory Board** (which both include **Peer and Family** member representation). Additionally, where there is potentially a need for more urgent actions, we have developed more frequent or detailed departmental reports, such as our **Quality Management Report** that covers an additional 202 individual metrics (most of which are identified by county) and our **Call Center** reports **48 metrics, five times daily**. Our data-driven approach allows for targeted interventions, provider education, and process enhancements to ensure the delivery of high-quality care. Health Choice will use the same reporting rigor to ensure the **smoothest possible transitions** for ALTCS members, and that they receive the **highest possible quality services** on an ongoing basis.

Description of Sample Utilization Reports Demonstrating Monitoring and Analysis Processes:

Exhibit 1: Quality. Health Choice uses the **Quintuple Aim** as a guide to deploy **PDSA** processes to constantly analyze and improve our quality improvement performance. We have already built the capability to apply this same discipline to ALTCS performance metrics, including AHCCCS-identified ALTCS Primary and Secondary measures and VBP Benchmarks. Health Choice utilizes work groups dedicated to quality measure performance improvement. These groups plan, collect, and analyze data provided by our **Health Information System** (HIS), **HEDIS** Application (Cotiviti), and multiple provider partners. The work groups examine, analyze data and generate solutions, adhering to NCQA accreditation requirements for Quality Improvement (QI) and Population Health Management (PHM). Using this approach, our Clinical and Quality teams have designed ALTCS specific action plans associated with Controlling High Blood Pressure (CBP), Breast Cancer Screening (BCS), Hemoglobin A1c (HbA1c) Poor Control for Patients with Diabetes: HBA1c Poor Control (HBD), & Cervical Cancer Screening (CCS).

The work groups present their findings and observations to clinical leaders, as well as executive leadership. Feedback is received and utilized to refine projects and initiatives, additional data elements are provided and then reported to the QM/PI Committee for further action. Results associated with interventions are provided to our **Health Equity Committee**, and our community-based **Governance Committee** and **Medicare Advisory Board** – with feedback incorporated back into the process at the work group level. Exhibit 1 provides examples of the data and reporting that is utilized by the work groups and presented to leadership and committees. Exhibit 1 highlights examples of data elements we use to review BCS performance, such as total compliance (Fig.1), compliance by Race and Language (Fig.2), and further analyzed by geography (Fig.3). We look at previous compliance as an indicator of future compliance (Fig.4) and non-compliance by attributed primary care provider group (Fig.5). Identified opportunities for improvement have included locations of mobile mammography units and VBP resource discussions.

Similarly, Exhibit 1 highlights additional reporting the teams utilize for HBD (Fig.6) and CBP (Fig.7) rate improvement. We work with industry leading partners such as **Wellth** on HBD and CBP programs to collect data and improve uncontrolled rates and health outcomes. We monitor rates by race and geography, identifying potential health disparities in Tribal and Rural communities, especially for those members that are **missing tests** and may **not have access to services**. Solutions include Wellth's reinforcement of behavior changes through member rewards for the uncontrolled populations. **Medication adherence** initiatives or access to nutritionists, dieticians, or food as medicine programs have been effective. Health Choice incorporates Z-code data and analysis, **HRSN** and **SDOH** trends in measures based on **Health Risk Assessment** (HRA) data. Our **Polypharmacy self-directed Performance Improvement Project** (PIP) is another example of the PDSA rigor, demonstrating collaboration between internal departments and community-based providers.

It is also worth noting that we have developed an innovative and **interactive model for working with our ACOs and other provider and quality improvement partners**. This model *does not presume* that *our* data is always correct. We provide access to *all* member quality performance data for assigned members to each organization *daily*. This allows our partners to develop their own reports, identify additional data sets that can help providers produce better results, and

critique *our* quality reporting processes. These collaborations have already led to numerous improvements in quality performance and reporting including several measures shown on Exhibit 1.

Exhibit 2: Cost of Care. Health Choice has developed comprehensive processes and tools to collect, analyze and report data trends to stakeholders and leadership for **cost of care initiative identification**. Health Choice holds bi-monthly Clinical/Finance work group meetings to review data and reporting such as those presented in Exhibit 2 concerning historical trends for payments (Fig.1) and utilization (Fig.2). Clinical, Finance, Medical Economics, Business Intelligence and Quality Informatics teams examine trends across broad categories of service, including but not limited to inpatient admissions (Fig.3), outpatient services (Fig.4), readmissions (Fig.5), professional (i.e., physician, caregivers, and other clinician) services, and prescription drugs. From a **prospective** perspective, we use **Johns Hopkins ACG™** reporting, which we helped pioneer a decade ago. Health Choice reporting includes analysis of inpatient, outpatient, and physician billing and member utilization to provide a more granular, patient-focused view of the drivers of spending in our populations, including utilization and pricing variation. Health Choice analyzes all aspects of paid and denied medical and pharmacy claims, including prescription drug claims, manufacturer rebates and other cost considerations. We compare to historical trends, analyze by provider type, compare to "like" practices, search for anomalies in the data and highlight utilization increases and decreases that exceed thresholds for our work groups to analyze and recommend changes to leadership for consideration. If additional, more granular analysis is required, our two **self-service analytics** platforms allow us to "click down" to specific member, provider, provider type, geography, and time span details.

FWA. Fraud, Waste, and Abuse (FWA) analytics are generated by our Verisk™ system and reported as part of our MMR, and utilized by our **Compliance Committee**, executive and leadership teams, and the boards and committees described above. Health Choice has efficient and effective **internal controls** in place to detect, prevent and report false, abusive, or suspicious claims activity. We employ **internal reporting** tools, **external vendor resources and technology** (including use of Cotiviti's fraud-checking platform) to collect and report potential instances of fraud, including but not limited to under and over utilization, out of area utilization, coding trends, threshold comparisons and other nationally recognized techniques. We incorporate AHCCCS and CMS alerts regarding certain identified suspicious activities. Monthly and Annual reporting is highlighted in Exhibit 2, such as cases identified and received by SIU (Fig.6), operational metrics (Fig.7) and OIG referrals (Fig.8) monitored by Compliance and Boards. These resources, coupled with a talented analytics team, enables Health Choice to identify and remediate potential instances of FWA *before* they become problems.

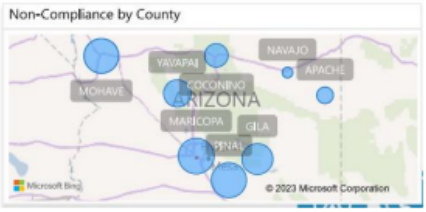
Exhibit 3: Member and Provider Experience. Health Choice gathers feedback from many sources of data related to member and provider experience, such as those items highlighted in Exhibit 3 to drive continuous improvement. Health Choice conducts member and provider satisfaction surveys using an **independent, CMS-approved survey organization** and the **NCQA CAHPS survey tools** (Fig.1). We collect **demographic based** CAHPS survey reporting (Fig.2) and utilize informal surveys conducted throughout the year to indicate periodic performance on initiatives. We utilize Member Advisory Council feedback, Provider Post-Visit Surveys (PPVS), disenrollment surveys, member appeal, grievance and compliance data, among other sources to analyze, monitor and develop initiatives based on identified opportunities. We obtain feedback through quarterly **Provider CEO Advisory Committee** and **Provider CMO meetings**, and a **Provider Forum series** specifically for provider business office staff. Health Choice scrutinizes demographics associated with our member surveys to address the validity of its reporting (Fig.3) and identify **existing or potential health disparities**. Recently our Member Experience Committee identified under-reported populations within our survey data and improvements in collecting surveys with our CAHPS vendor, increasing our rates by 10% in targeted populations (Fig.4).

Additionally, engaging Health Choice providers to improve member health outcomes and **health equity** is crucial to delivering high-quality healthcare. We create a seamless, patient-centered experience that promotes overall member well-being by establishing effective communication and collaboration between our programs and Providers, as reflected in our recent Provider Satisfaction Survey results (Fig.5). Over the last 2 years, based on specific initiatives in place to improve data collection and Provider Satisfaction, Health Choice has witnessed an overall satisfaction increase of 13%.

Conclusion. Our data-driven approach, rooted in PDSA-based processes, improves health outcomes (e.g., our **Four Star Rated DSNP**). We analyze data of vulnerable populations, leverage predictive analytics, monitor performance, address quality, and identify high-risk populations via robust data analytics. Utilizing data, interventions are tailored to individual needs, enhancing the health and well-being of members. **Data integrity** is upheld through various methods, including but not limited to input validation, vigilance towards data processes and critical attributes, removal of duplicate information, access controls, and clear audit trails. We facilitate **data integration and sharing** among various healthcare providers to enhancing health outcomes, typically on a **nightly** basis to ensure they have the most relevant member data possible. We effectively collaborate with multiple provider types, including, but not limited to, hospitals, providers, ACOs, pharmacists, caregivers, and other stakeholders, to facilitate seamless communication and the exchange of information. Through this collaboration, Health Choice ensures that our providers have **access to relevant and real-time member information**, which enables them to make more informed decisions and provide comprehensive, coordinated person-centered care. Our work in this domain will only enhance the quality of care provided to ALTCS members.

Exhibit #1 - Quality Measure Performance/Health Equity Report and Dashboard

ALTCS Primary Measures	Leadership Analysis and Discussion
Breast Cancer Screening (BCS)	1. Analysis regarding correlation with Z-Code use by certain Provider Groups 2. Heat Maps regarding non-compliant population and proximity to facilities 3. Review incentive programs in place and effectiveness
Hemoglobin A1c (HBD) – Poor Control	1. Missing tests and values versus poor control, race and county 2. Supplemental data discussion, collection with VBP Partners
Controlling Blood Pressure (CBP)	1. Missing tests and values versus poor control, race and county 2. Use of DME and RPM vendors as well as in-home assessments



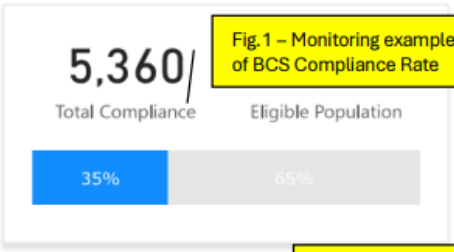


Fig.1 – Monitoring example of BCS Compliance Rate

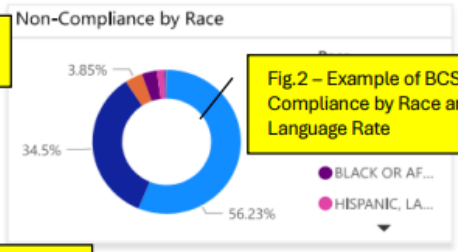
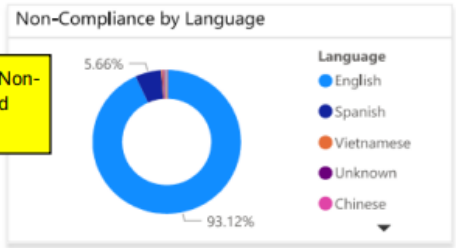


Fig.2 – Example of BCS Non-Compliance by Race and Language Rate



Compliance Rate by Race & County

Fig.3 – BCS Compliance Rate by Race and County

RACE	APACHE				NAVAJO	PINAL	YAVAPAI	Total
ASIAN OR PACIFIC ISLANDER	50.00%	50.00%		40.98%	44.44%		42.86%	41.57%
BLACK OR AFRICAN AMERICAN	25.00%	21.43%		37.11%	28.57%	20.00%	46.39%	25.00%	37.28%
CAUCASIAN	27.92%	29.61%	35.67%	37.11%	36.56%	25.97%	33.99%	30.39%	34.56%
HISPANIC, LATINO OR SPANISH ORIGIN	33.33%	100.00%	50.00%	33.63%	40.00%	50.00%	27.94%	12.50%	34.19%
NATIVE AMERICAN	15.79%	20.89%	40.00%	12.90%	27.27%	7.81%	32.65%	33.33%	19.83%
NOT PROVIDED	22.58%	30.39%	25.53%	40.41%	38.55%	27.75%	41.91%	31.06%	37.20%
OTHER RACE OR ETHNICITY				33.33%			100.00%		36.36%
Total	**25.58%**	**28.29%**	**33.41%**	**37.92%**	**37.05%**	**24.85%**	**37.30%**	**30.59%**	**35.17%**

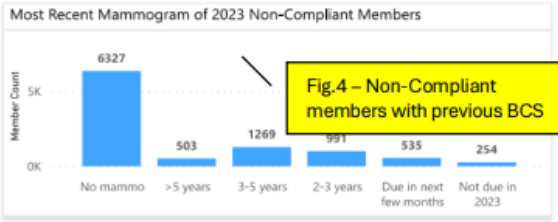


Fig.4 – Non-Compliant members with previous BCS

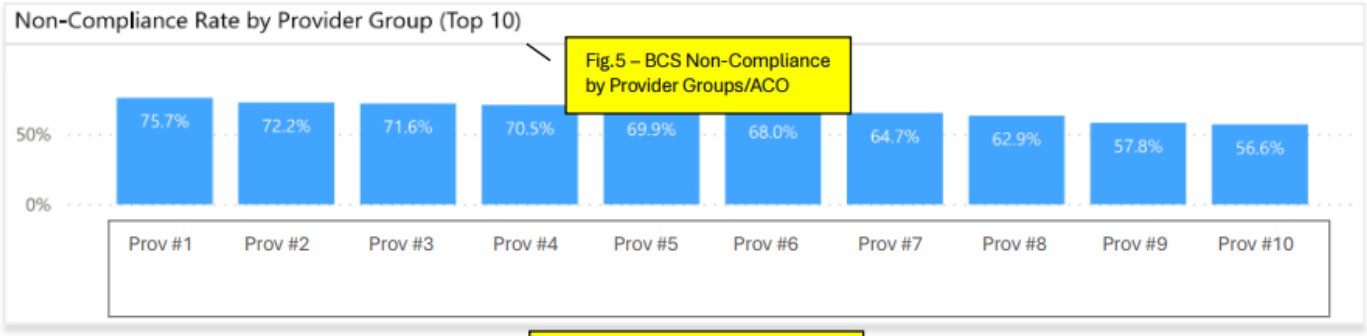


Fig.5 – BCS Non-Compliance by Provider Groups/ACO

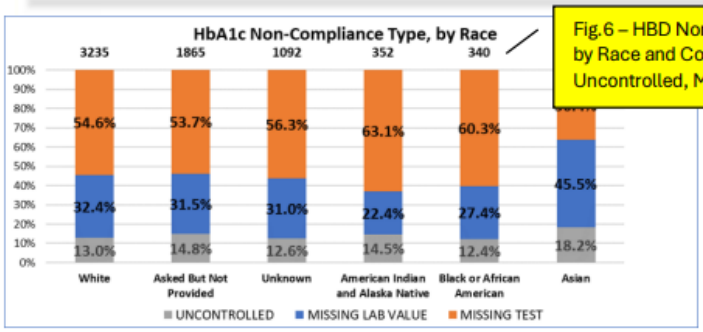
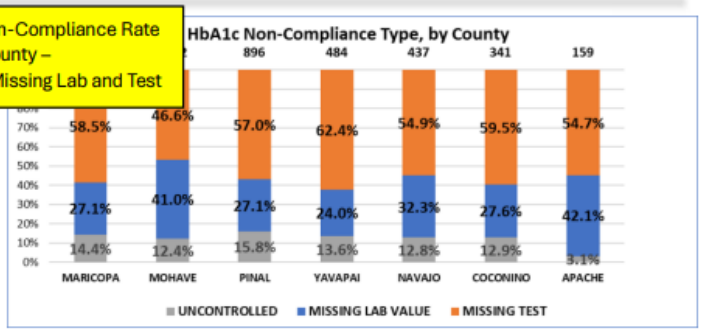


Fig.6 – HBD Non-Compliance Rate by Race and County – Uncontrolled, Missing Lab and Test



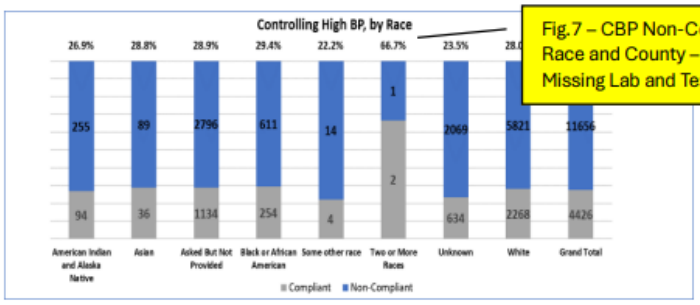
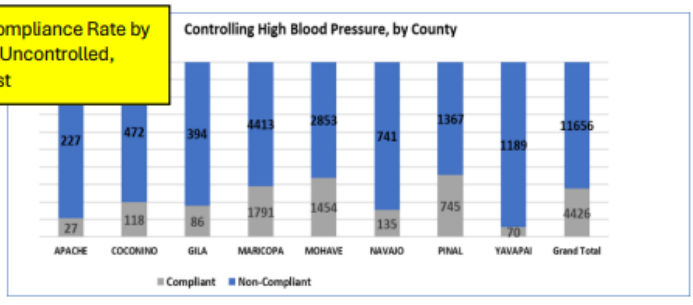


Fig.7 – CBP Non-Compliance Rate by Race and County – Uncontrolled, Missing Lab and Test



Hemoglobin A1c (HBD) – Poor Control	Greatest disparity in missing tests for American Indian/Alaska Native and Yavapai, work with IHS and Blindspot data
Controlling Blood Pressure (CBP)	Review of Non-Compliance rates, efforts to find supplemental sources of race to address unknown and not provided

Exhibit #2 - Member and Provider Utilization Analysis including Fraud, Waste, Abuse Update

Physician and Behavioral Health – Analysis and Reporting
• *Utilization of Outpatient Services had increased since October members receiving serv service. Review and ana by specific provider groups and overall, including Facilities*
• *Analysis and review for Finance and Leadership of top four providers, increases beginning in August of 2020 or later, reviewed AHCCCS Encounters as well as claims data*
• *Many providers have paid amounts significantly higher than the Network average; some Providers have paid amounts over $1M for calendar year compared to "like" Providers and Specialties*

Fig.1 – Example reporting of payment and utilization history and trends

Network	2021	2021 Q4	2021 Q3	2021 Q2	2021 Q1	2020 Q4
Total Paid	$ 6,409,669	$ 2,285,136	$ 1,828,049	$ 1,623,703	$ 672,781	$ 399,299
ts	28,842	7,873	7,961	8,439	4,569	3,230
Days	25,826	7,278	7,478	7,605	3,465	2,135
bers Served per Day	71	79	81	84	38	23
$ Per Member Day	$ 248	$ 314	$ 245	$ 213	$ 190	$ 190
Average $ Per Unit	$ 222	$ 291	$ 231	$ 192	$ 143	$ 124
Units per Member Day	1.1	1.1	1.1	1.1	1.3	1.5

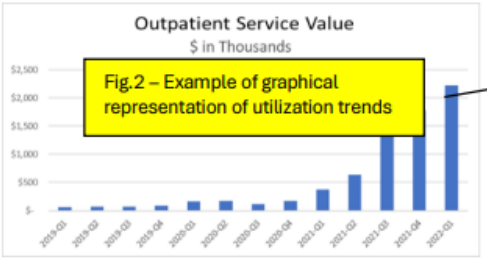
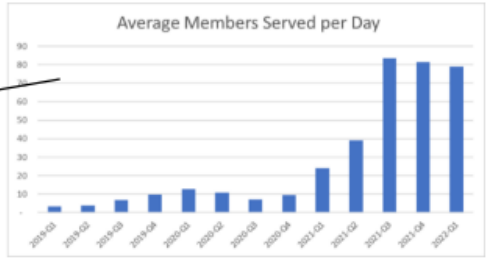
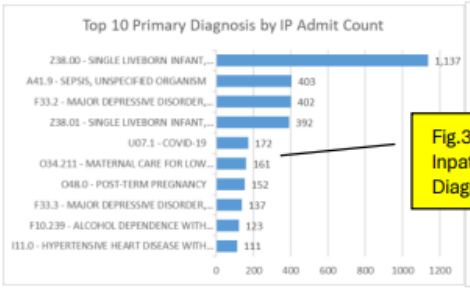


Fig.2 – Example of graphical representation of utilization trends



Utilization by Diagnosis	Provider Groups and ACO specific rates for avoidable admissions, ED / UC frequency and need for case management



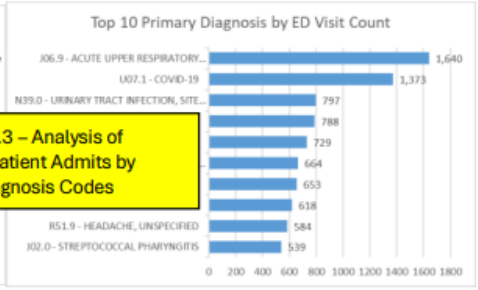


Fig.3 – Analysis of Inpatient Admits by Diagnosis Codes

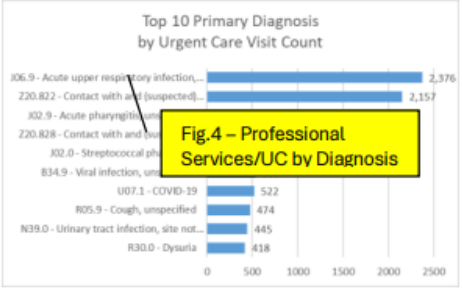


Fig.4 – Professional Services/UC by Diagnosis

Readmissions by ALOS and Age	Identification of aberrant trends in readmit data associated with specific "follow-up" care conducted by Pediatric Groups

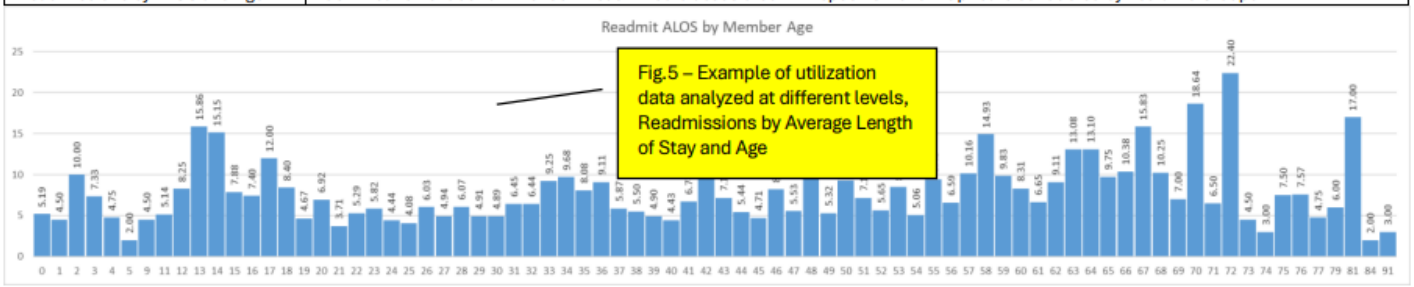
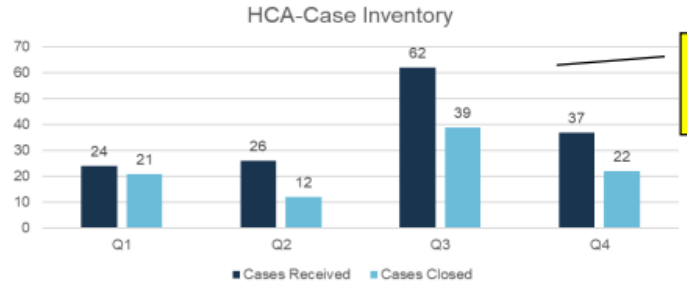


Fig.5 – Example of utilization data analyzed at different levels, Readmissions by Average Length of Stay and Age

Fraud, Waste and Abuse Reporting – Special Investigations Unit Reporting



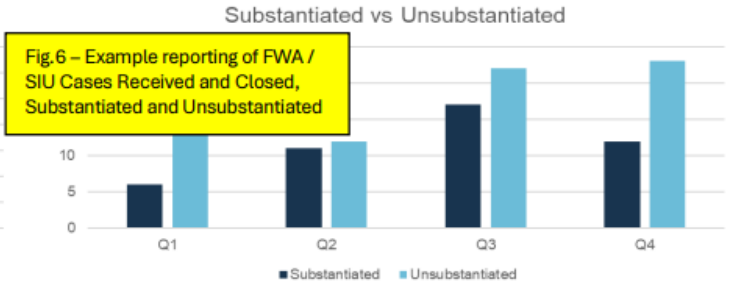


Fig.6 – Example reporting of FWA / SIU Cases Received and Closed, Substantiated and Unsubstantiated

Operational Metrics: SIU – BCBSAZ (ACC) – Avg TA ent; Referrals to OIG
• EAP 224: Recoupment for Incident To (Over year-to-date
• CR 2483: Incident To – provider billing incide er-utilization of modifiers
• CR 2576: Services Not Provided & Unnecessary Services – Provider billing for services not performed/attended
• CR 2579: High Utilization, Balance Billing & Quality of Care – investigation of group after purchase of practice.
• FFP 902: Services Not Provided – "Provider" - Billing a high average number of lab test units per patient
• FFP 903: Incident To: Provider billed 99215 and 99205 however the medical record documentation did not support a high complexity of MDM. Incident to billing was found on records reviewed. Claim and medical record review identified rendering Physician not credentialed and not registered with AHCCCS

Fig.7 – Example of FWA / SIU Operational Metrics, Review and Discussion / Decision Making

OIG Referral Reason	# of Referrals
	2
	2
Unnecessary Services	1
High Utilization	1
Incident To	2
Quality of Care	1

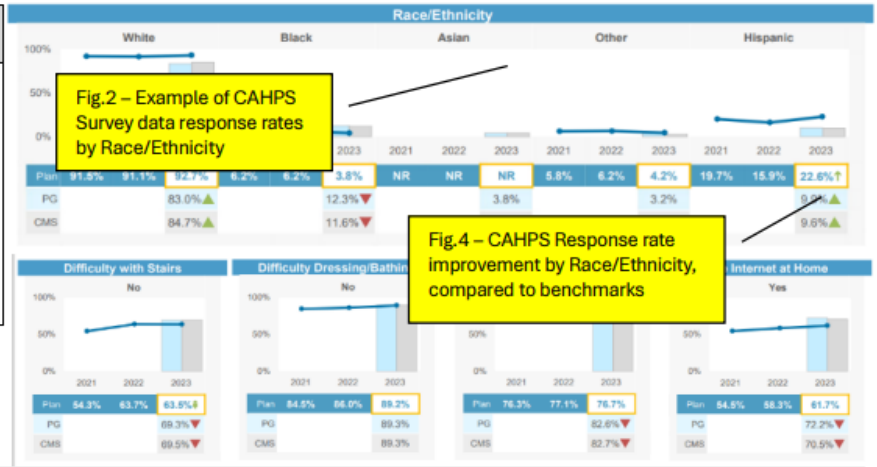
Fig.8 – OIG Referrals

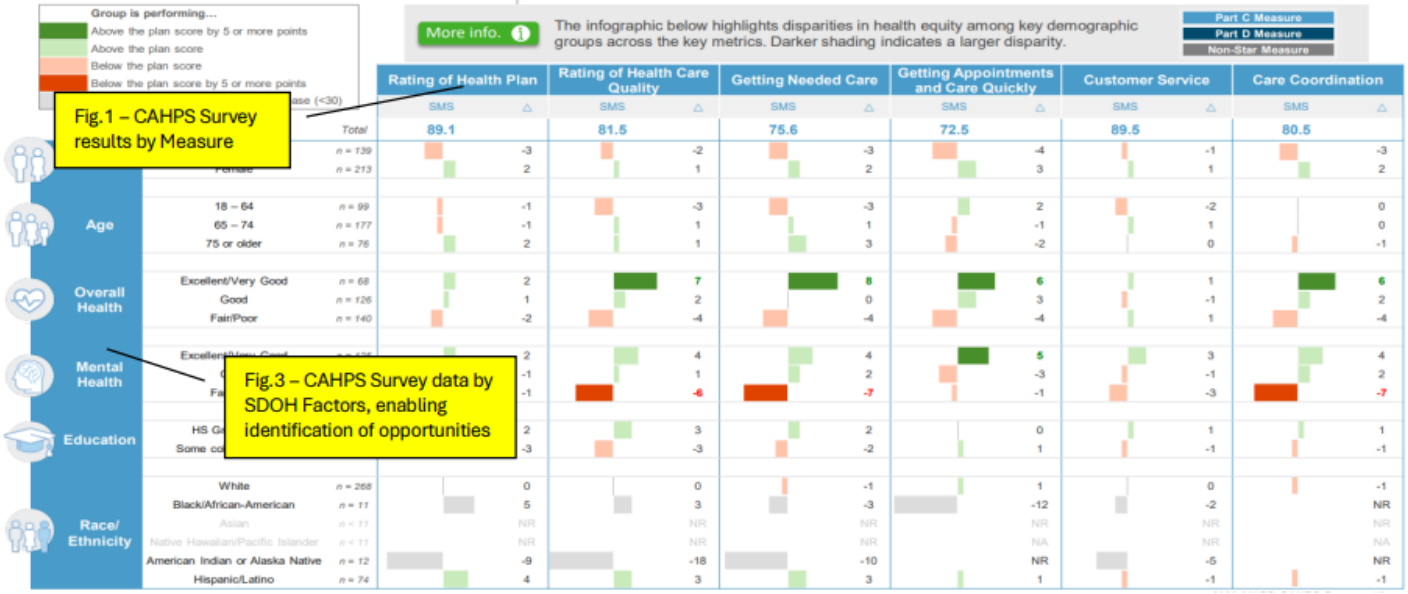
Exhibit #3 – Member, Provider and Caregiver Experience Report and Dashboard

BCBSAZ Health Choice Arizona (ACC and DSNP) – 2022 Member Satisfaction Surveys

Utilization/comparison of AHCCCS performed HSAG member satisfaction surveys and NCQA CAHPS surveys for Adults and Child 2021/22, as well as MCAHPS results for D-SNP populations:

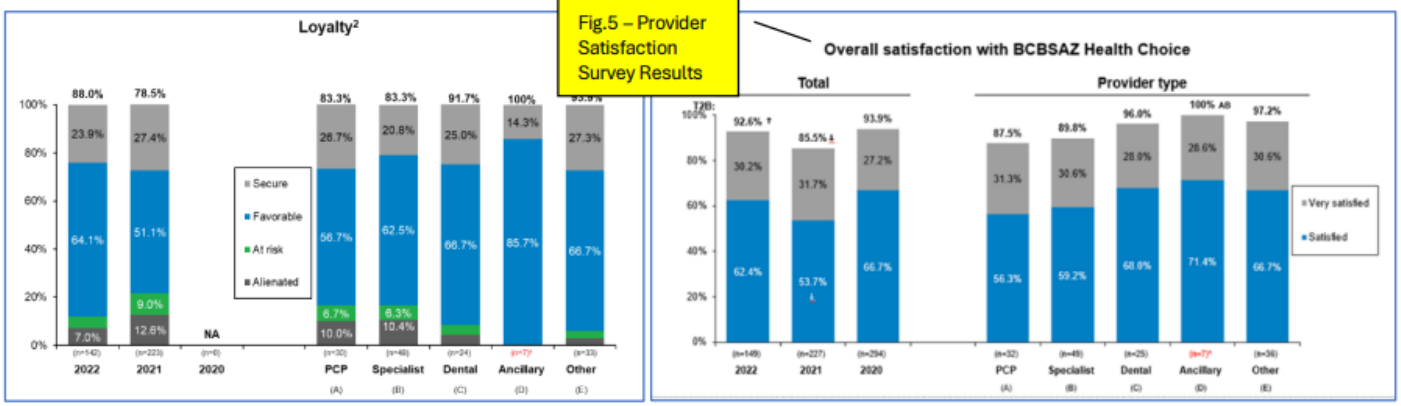
- Review of performance in "provider influenced" and "health plan influenced" measures / questions, separate analysis.
- Alignment with Formal and Informal surveys, Adult/Kids/Medicare comparison and historical trends





BCBSAZ Health Choice Arizona (ACC and D-SNP) – 2022 Provider Satisfaction Survey

- Overall satisfaction and willingness to recommend BCBSAZ Health Choice to other physicians and patients increased from 2021.
  - **93% are very satisfied or satisfied with BCBSAZ Health Choice, overall, which is a significant increase (vs. 86%).**
  - 90% would definitely or probably recommend BCBSAZ Health Choice to their patients, which is a **significant increase** (vs. 84%).
  - 92% would recommend BCBSAZ Health Choice to other physicians, which is a **significant increase** (vs. 81%).
  - 88% of providers are classified as Secure or Favorable, which is a **significant increase** (vs. 79%).
- Measures related to satisfaction with claims processing and prior authorization are the **most important drivers** of overall provider satisfaction. Further improvements to these items have the most potential to increase overall satisfaction.
  - How plan resolves claims issues (68%)
  - Timely resolution of claims issues (70%)
  - Plan's authorization process and timeliness (72%)



B7

B7. Describe the Offeror's network development strategy, including methods to build Home and Community Based Services (HCBS) providers and institutional capacity in rural areas and maximize available resources.

Also discuss specifically how the Offeror will assist rural nursing facilities seeking to expand into community-based care. Provide action steps and a timeline for the first three years of the Contract, along with measurable outcomes to be achieved. The action steps shall illustrate how the Offeror's operational areas will work in an integrated fashion to identify and address network needs.

B7 Network Development Strategy. BCBSAZ Health Choice (Health Choice) and Health Choice Pathway (our Four STAR Dual Special Needs Plan [DSNP]), have an exceptional record in building and maintaining strong, growing, and specialized provider networks focused on high quality member care and outcomes. In January 2022, Health Choice secured full accreditation status by **National Committee for Quality Assurance** (NCQA), making us the **first** AHCCCS MCO to achieve accreditation. We are also the **first** Arizona (AZ) DSNP to offer a **CMS value-based insurance design** (VBID) model program to meet person-centered needs, and we are expanding it in 2024 to align directly with ALTCS initiatives.

Our approach to developing and maintaining a strong provider network is based on gathering and analyzing data as a means to drive development of **person-centered care** and **least restrictive service options**, engage members and caregivers to understand service and support needs, make ongoing investments in workforce training and development, and operationalize strategies through defined action steps and measurable outcomes expanding our current network to ensure HCBS and institutional services are available upon contract go-live and thereafter. As with all previous transitions, we will **honor existing provider and facility** relationships, extending them in-network status without the need for separate prior authorization for ***at least*** **the first year** while we work to bring them into our network. In preparation, we have formed an **ALTCS Network Services Committee (ANSC)**, which developed the Network Development Strategy outlined below. The ANSC is co-led by our Network & Workforce Development Administrators and leadership from every department. All strategies will be monitored and assessed during the 1st 3 yrs. through a Plan-Do-Study-Act (PDSA) cycle.

As outlined in **Figure 1**, our expected outcomes include a **focus on quality** and are established upon the **Quintuple Aim.** Our expected outcomes tie to our strategies and actions. Our primary focus is supporting network providers to address workforce shortages through specific actions, innovative models for addressing network inadequacy in rural and tribal areas, stabilization of providers, & quality of the outcome's individuals experience through identified services & supports.

Quintuple Aim	Figure 1: Health Choice 2024-2027 Network Development Strategy Expected Outcomes
1. Member Experience	a.) 4+ stars ★★★★★ in annual DSNP Rating (includes CAHPs) b.) 4+ stars ★★★★★ in HC annual Member Survey; using NCQA Quality Benchmark c.) Meet 100% of all AHCCCS ACOM 436 and contractual network standards
2. Provider Experience	a.) 71%+ annual 'Overall Satisfaction' on HC annual provider survey using AHCCCS' 2022 survey results b.) Annual increase in Caregiver Satisfaction Survey utilizing 2025 as the baseline c.) Increase the DCW/Nurse workforce in rural GSA's at or below .75 *LQ by 25% by 2027
3. Advance Health Equity	a.) 25% increase in use of housing, food, and other VBID/HRSN benefits by 2027 b.) 10% increase in providers reporting language(s), race, and ethnicity by 2027 c.) 25%+ increase in use of technology by 2027
4. Improve Health Outcomes	a.) 30%+ served 6 mo. or longer report improved quality of life (QOL) since initial assessment b.) 15%+ served 6 mo. or longer show improvement in UCLA loneliness scores since initial assessment c.) 10%+ increase in use of high-value services (PCP, preventative, 30-day drug refills)
5. Reduce Costs	a.) 5% decrease in avoidable ED utilization b.) 5% decrease in avoidable admissions and level of care transitions c.) Less than 20% of members reside in alternative HCBS setting

**Location Quotient (QL) from Bureau of Labor and Statistics (BLS). A LQ <1 means workforce is less concentrated in that area. Base data pulled 8/23.*

2024-2027 HEALTH CHOICE NETWORK DEVELOPMENT STRATEGIES

1. **Build HCBS Provider and Institutional Capacity:** The most in-demand health care jobs in AZ by projected employment growth include Home Health Aides and Nurses, as identified by the Arizona Commerce Authority. Additionally, our analysis of the Bureau of Labor Statistics (BLS) data, indicates AZ's Direct Care Workers (DCW) **must increase at an annual rate of 9%** (22% in our rural areas) to reach min-level staffing expectations by 2026. Based on these needs we will implement programs to build highly skilled HCBS/institutional providers, focusing on rural needs.
2. **Maximize Available Resources:** We will use video, mobile apps, remote monitoring, text-based messaging, and telephonic services and supports, including **Arizona Well-Being Collaborative** programs to expand the capacity of trusted health care providers and supports, in-home services, and virtual technology independent of time or location. We will align our DSNP benefits with ALTCS initiatives and needs to drive connected, coordinated access to care and supports. These actions will improve health outcomes, reduce healthcare disparities, support workforce and member well-being, and reduce healthcare costs by decreasing barriers to care and addressing social risk factors.
3. **Assist Rural Nursing Facilities (NF) Seeking to Expand into Community-Based Care (CBC):** The decrease in demand for NF stays, as well as the increasing availability of HCBS, are just a few of the contributing factors to declining occupancy rates. We will support NF longevity and transformation, while increasing the availability of CBC.
4. **Enhance Data and the Network to Meet Person Centered Needs (PCN):** Building a network that offers a *choice* of high quality, *trusted* providers is *our* job. We use accurate and comprehensive data analysis tools (e.g., Quest) to identify gaps and locate providers in the right service areas for contracting. Members also need accurate provider data, so they have all the information necessary to make important decisions about choosing a provider. We will continue to implement innovative processes and collaborate with providers to enhance both data and the network.

STRATEGY #1: Build HCBS Provider and Institutional Capacity | **FIGURE 1 OUTCOMES:** 1-2, 5

A. Career Ladder Programs: Partner with higher education institutions to fund up to 1,000 scholarships for residents in rural communities who experience economic barriers in entering or pursing promotion in the DCW, community intervener, home health, community health worker, nurse assistant, and nurse practitioner workforce.

B. **BCBSAZ Empowering Diversity Scholarships**: Fund up to 500 scholarships by 2027 to support Arizona minority students in fulfilling their health care educational goals while fostering diversity, equity, and inclusion.		
1A-B. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 5	Target Date (Dt)
a. Network, Workforce, Quality Management (QM), Medical Management (MM), and Business Intelligence (BI) assess membership, population, workforce needs, and higher education institutions by GSA. **TR**: Identify potential participating institutions/providers for job placement.		Q4 2024
b. ALTCS Administrator, Network and Workforce meet w/providers, Arizona Health Care Association (AHCA), rural community colleges and nursing programs. Develop and finalize service area specific programs and certificate tracks. **TR**: Co-create reporting/assessment framework w/educational institutions/providers.		Q1-4 2025
c. Network, Workforce, QM, MM, & BI assess program bi-annually, report to ANSC. **TR**: Up to 1,500 by 2027.		2026-2027
C. **Blue "Care for Caregivers"**: A no-cost BCBS Marketplace product for uninsured low-income Self-Directed Attendant Care (SDAC) and other DCWs who risk losing AHCCCS eligibility due to improved wages or increased hours.		
1C. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 5	Target Dt
a. ANSC works with Provider Advisory committee to plan, design and market program. **TR**: Finalize design.		Q1 2025
b. Network, Case Managers, Workforce communicate program and requirements to DCW agencies, caregivers, and members. **TR**: Program implementation.		Q2 2025-2027
c. Network, Workforce, QM, MM, and BI assess program monthly, report to ANSC quarterly. TR Increase % of full-time DCWs and available Self-Directed Attendant Care (SDAC) caregivers.		Q3 2025-2027
D. **Continuation of AHCA Works**: Collaborate with AHCA and fund a sustainable plan for AHCA WORKS, a workforce development program proven to produce a total of 1,287 students in 15 months.		
1D. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 5	Target Dt
a. ALTCS Administrator, Network and Workforce meet with and develop a collaborative agreement w/AHCA Works beyond ARPA funding. **TR**: Finalize agreement and reporting requirements associated with recruitment, demographic and other data.		Q4 2024
b. ALTCS Administrator, Network, Workforce and AHCA Works identify service area specific programs and certificate tracks to recruit new and talented individuals interested in becoming Certified Nursing Assistants (CNAs) or nurses in skilled nursing facilities and assisted living centers. **TR**: Co-create framework for reporting and assessment.		Q1-2 2025
c. Network, Workforce, QM, MM, and BI assess program bi-annually, report to ANSC. **TR**: 250+ students produced annually to increase network capacity.		Q3 2025 - 2027
E. Implement **Value Based Programs**: For Direct Care Agencies and Institutional Facilities, to include a quality/cost component and requirement that a percentage of funding received flows down to their staff.		
1E. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 5	Target Dt
a. Network, Workforce, ALTCS Administrator BI, MM, and QM analyze membership/provider data. **TR**: Identify viable participating providers.		Q4 2024
b. Network ALTCS Administrator and CEO meet w/identified providers to discuss program. Report outcomes to ANSC for provider assessment and metrics finalization. **TR**: Finalize contracting and implementation.		Q4 2025
c. Network, BI, and QM assess program quarterly, report to ANSC. **TR**: increase in % of staff retained and quality measures.		Q1 2026-2027
F. Promote **Grant Initiatives**: Through the Blue Cross Blue Shield of Arizona Foundation for Community & Health Advancement & other partners to build broad community networks and HCBS capacity to serve members by addressing health inequities, health disparities, structural and health related social needs through grant initiatives.		
1F. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 5	Target Dt
a. SDOH Administrator (SDOH), ALTCS Administrator, QM and MM will work with Foundation, Provider Advisory Group and other partners to identify greatest needs, create grant opportunities, and reporting requirements. **TR**: Create a minimum of 3 grant funded opportunities.		Q2 2025
b. Network and Workforce communicate available grants, application timeline/requirements to ALTCS providers. **TR**: ALTCS providers apply for funding.		Q3 2025
c. Grant awardees announced by Foundation (and other funding partners). **TR**: Providers receive funding.		Q4 2025
d. Foundation, SDOH, Network, QM, and MM assess reporting data w/in 2 weeks of receipt, report to ANSC. **TR**: Increase # of HCBS providers/Institutional Facility capacity. Identify successes for program replication.		2026-2027

STRATEGY #2: Maximize Available Resources	**FIGURE 1 OUTCOMES:** 1-2, 3a & c, 4-5
A. Implement a **Call-to-Action Travel Enhancement Program**: Provider opt-in program for contracted providers who deliver HCBS. These providers will receive referral alerts when a member needs services in an area where there is lack of availability. Providers who opt-in and accept a referral that requires more than a specified number of miles of travel will receive an enhanced rate based on travel time for the associated claim.	
2A. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 3a & c, 4-5	Target Dt

a. Network, Workforce, and ALTCS Administrator collaborate w/providers for implementation/reporting. **TR**: Finalize program requirements.	Q4 2024
b. Network, ALTCS Administrator, and BI assess provider participation, referral acceptance/finalization quarterly, report to Provider Advisory Committee to address needed changes/enhancements. **TR**: 50%+ provider participation target.	2025-2027

B. Offer **"Blue@Home"**: A multi-vendor *choice* of in-home and 24/7 technology-based services to reduce barriers:
- **HCBS virtual** and **in-home care** for *high-risk members* and their *caregivers.*
- **Virtual urgent, primary**, and **behavioral care**, including substance use for *all members anywhere*.
- Telephonic chat and online **Blue Caregiver Café** Helpline Services includes social service referral, patient care ideas, personal support, and available resource guidance in connection with Contexture's closed loop referral system; staffed using trained Peers and Family members and other individuals with lived caregiver experience.
- **Polychronic Care Program** for *members* with conditions that include chronic kidney and end-stage kidney disease.
- **Community Paramedicine Program** for *all members*; utilizes a network of available EMTs, paramedics, and nurses to provide direct care at home and in institutional settings, including examinations, bloodwork, and vaccinations. During the visit S/HRSN data is collected and members are connected to additional resources, when needed.
- **In-Home Dental** for *all members* to avoid complications and maintain or improve quality of life.

C. Offer **Behavioral Health Telepsychiatry Program:** Utilizes a network of Behavioral Health (BH) Homes that provide convenient live video consultations for Institutional Facilities in support of members.

D. Offer **Social Isolation Supports**: We offer a network of social isolation programs and programs available to reduce social isolation, combat loneliness, increase health outcomes, and provide educational support:
- **Blue Pets** animatronic pet therapy for members w/dementia, depression, and cognitive impairment.
- **Pyx Health** member and caregiver mobile app + tech free telephonic. Provides companionship, including skill building with tools and techniques that intentionally meet the participant where they are and help them move forward towards resiliency through positive psychology, while also linking them to community supports, and resources, such as Contexture's **CommunityCares** program, to resolve any underlying structural or health related social needs.
- **Wellth**, our popular **Medication Adherence** social engagement mobile application.
- **Wider Circle**, a peer-based "neighborhood" social connectivity program conducted in-person and remotely. Enabling better health & independence by integrating support/services at the community level, making it easier for neighbors to take care of one another. Member ambassadors lie at the heart of this program and are a go-to, trusted resource for their "neighbors", volunteering their time to lend a hand and share life experiences with others just like them.

E. Offer **VBID and Supplemental Benefits**: Expanded Medicare benefits to address structural and health related needs through a variety of network supports, including home delivered meals, flex care allowance for transitional housing and utilities support, healthy foods purchases, and over the counter items. Comprehensive dental, vision, hearing, housing, and transportation benefits. Fitness benefits including wearables, equipment, and education. Remote patient monitoring to manage acute and chronic conditions, while increasing access and reducing infection risk and Personal Emergency Response Systems (PERS), health and fall monitoring with alert services.

2B-E. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 3a & c, 4-5	Target Dt
a. Training, Marketing, Network, and Workforce create materials and train staff, to use technology/benefits for communication, promotion, and support for members and providers. **TR**: 100% of staff trained/go-live.		Q4 2024
b. Network, BI, QM, MM assess and identify usage/associated member outcomes quarterly, report to ANSC and Provider Advisory Committee. **TR**: Year over year (YoY) increase in technology and program usage.		Q1 2025-2027

STRATEGY #3: Assist Rural NFs Seeking to Expand into CBC | **FIGURE 1 OUTCOMES**: 1-2, 4c-5

A. Implement the **Blue ALTCS Academy (BAA)**: A no-cost, in-person/virtual learning academy. Provides education about community-based service expansion, a toolkit, and resources to support expansion efforts. Will also include training opportunities to improve literacy of ALTCS services, available health technologies/how to use them, cultural competency, DCW services, peer and family engagement, strategies to reduce stress, substance use, professional fulfillment & more for the benefit of providers, caregivers, partners, & stakeholders dependent upon subject matter.

3A. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 4c-5	Target Dt
a. Training, Network, Workforce, ALTCS Administrator, MM, QM plan, design and implement web-based trainings; initial focus to rural NFs CBC expansion. **TR**: Finalize toolkit/training for rural NFs.		Q1 2025
b. Training, Network, Workforce, ALTCS Administrator, MM, and QM collaborate with providers to plan, design, and implement additional web-based trainings and in-person trainings. **TR**: A minimum of 10 new web-based finalized; A minimum of 4 in-person finalized.		Q4 2025
c. Training, Workforce, Network assess end-of class & web-based training traffic & surveys, report to ANSC & provider advisory committee quarterly through 2025, then semi-annually. **TR**: => 50% satisfied w/trainings.		Q1 2025-2027

B. Fund **Community Reinvestment Initiatives**: To support the expansions of rural NFs into community-based care.

3B. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-2, 4c-5	Target Dt
a. Network, ALTCS Administrator, and MM survey rural NFs to identify those seeking to expand and identify barriers to expansion, funding needs, and goals. **TR**: Meet with interested/viable NFs.		Q2 2025
b. Network, ALTCS Administrator, CEO, Finance, BI, and MM identify funding dollars, associated requirements, and definition of success. **TR**: Finalize a min. of 1 contract and provide funding.		Q4 2025
c. Network, ALTCS Administrator, and MM assess reporting data w/in 2 weeks of receipt, report to ANSC. **TR**: Successful expansion.		Q1 2026-2027
C. **Centers of Excellence (COE)**: Offer enhanced rates to rural nursing facilities who 1. expand into community-based services 2. decrease NF days 3. Increase transitions to HCBS settings 4. Participate in Value Based Programs.		
3C. Action Steps, Operational Collaboration and Targeted Results		
a.-c. Action steps, operational collaboration, targeted results, target date and figure 1 outcomes mirror '3B' above.		

STRATEGY #4: Enhance Data and the Network to meet PCN	**FIGURE 1 OUTCOMES**: 1-5	
A. **Actively Recruit**: ALTCS providers that reflect the diversity of members in contracted GSAs.		
4A. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-5	Target Dt
a. Network, Workforce QM, MM, BI review/stratify qualitative and quantitative data, Report findings to ANSC quarterly. **TR**: Identify **needs, recruit, and develop** programs to enhance our network. Increase **Arizona Blue Consumer Direct "ABCD"** (HC SDAC Network) by 5% annually. Meet 100% of AHCCCS ACOM, AMPM, contract network standards. Meet or exceed member, provider, caregiver experience targets.		Q4 2024, monthly thereafter
B. **ALTCS-specific Accountable Care Organization (ACO)**: Using the above data and leveraging our multi-year investment in required technology, improve quality, and support and develop statewide ALTCS provider and facility capacity through an ALTCS ACO. Rural ALTCS providers that we have approached are very excited by this opportunity.		
4B. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-5	Target Dt
a.-c. Action steps, operational collaboration, targeted results, target date and figure 1 outcomes mirror '1f' above.		
C. **Centers of Excellence**: Offer enhanced rates and COE designation to providers who 1. Recruit underrepresented minorities into in-demand LTSS health professions to meet member cultural and linguistic needs. 2. Provide support to retain and 3. Develop. 4. Support collaborative data reporting for enhanced transparency and member support. 5. Participate in VBPs. An example of this process that is already underway is The Guidance Center's **Northern Arizona Dementia Care Center of Excellence** including outpatient and residential services under development in Flagstaff.		
4C. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-5	
a.-c. Action steps, operational collaboration, targeted results, and target date mirror '3B' above.		
D. **Surveys**: **Annual** Health Choice Provider, Caregiver, Member surveys and **Monthly** Pulse surveys to identify areas of satisfaction/opportunities gain immediate feedback for improvement activities.		
4D. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-5	Target Dt
a. Network, ALTCS Administrator, QM, and MM create, conduct, and finalize annual surveys, report to ANSC and implement program or process changes based on identified opportunities for improvement. **TR**: Meet or exceed member, provider, and caregiver experience targets.		Q4 2025, annually thereafter
b. Network, ALTCS Administrator QM, MM create monthly pulse survey questions for use during meetings, via the web, text or other avenues. Report results to ANSC quarterly; implement changes based on identified opportunities for improvement. **TR**: Exceed member, provider, caregiver experience targets.		Q1 2025, ongoing
E. Enhanced **Provider Directory**: Members will benefit from additional information such as provider rating and demographics, also help members identify physicians and practices that are a good fit for their specific needs. We will enhance our data collection efforts and provider directory information to include provider rating, availability of telehealth, whether practices offer LGBTQ-friendly services, provider race and ethnicity.		
4E. Action Steps, Operational Collaboration, Targeted Results	Figure 1 Outcomes: 1-5	Target Dt
a. Network, ALTCS Administrator, and QM collaborate w/Provider Advisory Committee, meet with providers & AHCA to discuss provider directory enhancements. **TR**: Identify targeted strategies for implementation.		Q1 2025

Our Network Strategy demonstrates Health Choice's commitment to **innovation**. One example is our **Blue Care Team** to support case managers and members. This team will help expand the pool of caregivers in our **ABCD** (SDAC Network), by providing member safety, clinical, caregiver hiring and budget management assistance (similar services provided by caregiver agencies) and increase SDAC utilization by more than 25% over five years. Another example, developed based upon ALTCS member and family focus group concerns *regarding the lack of sufficient rural BH* resources, was our creation of the **Northern Arizona BH "Alliance" ACO** in 2022, the **1st** BH Medicaid ACO in AZ. The **Alliance** has already shown great quality improvement results and is continuing to expand, with **Peer and Family Run Organizations** and supports added in 2024. We are also committed to using this same model and supporting technologies to form a similar **ALTCS Alliance ACO partnership** in 2025 incorporating facilities, providers, and Peer and Family supports that serve ALTCS members throughout Arizona.

B8

B8. Describe the Offeror's overall workforce development strategy including the Offeror's workforce development philosophy, the use of data to inform strategies and monitoring activities to determine if strategies are effective, and achievement of desired outcomes. Additionally, the Offeror shall describe how the Offeror will:

a) Assist and incentivize providers to improve workforce monitoring, assessing, planning, and forecasting workforce trends so that the provider can be more strategic in their efforts to recruit, select, train, deploy, and support their staff,

b) Assist providers to improve post-training coaching and supervision to ensure the skills are applied and used effectively to improve member experience and outcomes, and

c) Integrate the operations of the Offeror's workforce development function within the operations of the network, medical management, and quality management departments.

B8 Ensuring an Adequate Workforce. Arizona Long Term Care System (ALTCS) members need a diverse, well-trained, highly skilled direct care workforce capable of providing them with high-quality, person-centered long-term services and supports (LTSS) that align with their unique needs, circumstances, and cultural preferences. **Ensuring an adequate workforce is a core responsibility of all AHCCCS plans.** This is especially true for an ALTCS plan, where both paid and unpaid workers play a critical role in delivering the intensity, scope, and duration of services ALTCS members need and are entitled to help them achieve the goals they set for themselves. BCBSAZ Health Choice (Health Choice) will ensure an adequate workforce is available to members through innovative new programs, covering all professions and disciplines. We do not take this lightly. Based on Bureau of Labor Statistics (BLS) data (the same data used by the **Workforce Arizona Council** for implementing the **Governor's strategic vision** for a robust and effective workforce system) Arizona's direct care workforce **must increase at an annual rate of 9% (and 22% in our nonmetropolitan areas)** to reach minimum-level staffing expectations by 2026. There are many reasons for the shortage of workers, including low wages and worker satisfaction. Our experience during the public health emergency (PHE) has taught us that it is essential to meet workers' needs for well-being, safety, and respect. Because of this, our programs will include a strong focus on developing direct care workers (DCWs), including paid **Peer and Family candidates** and **both paid and unpaid family caregivers**, to ensure they are adequately supported to deliver LTSS in a manner consistent with the **AHCCCS values** of choice, dignity, independence, individuality, privacy, and self-determination, and maximizing ALTCS member experiences and outcomes. We will honor member's and DCW's frequently noted desire for **stability**. We will evaluate, monitor, and support the **capability, capacity, connectivity, culture, and commitment** of our workforce to make certain we can sustain services even in the event of another unexpected sudden and significant decrease in the workforce as occurred during the PHE.

Our workforce development philosophy. Our workforce development and retention philosophies are constructed on the best practice framework of the **Quintuple Aim** (improving health equity, quality outcomes, member, and provider satisfaction, while containing cost) and reflects our dedication to the diverse nature of the people and communities we serve. We want every member of the workforce to derive a deep sense of purpose from their career. Health Choice believes their workplace should reflect and honor their individual identities, preferences, and goals. Our efforts will build on the principles and values identified in the **AHCCCS 2023-2027 Strategic Plan**, **AHCCCS Workforce Strategy**, the **Arizona Olmstead Plan**, and the state's **American Rescue Plan Act Spend Plan**, as well as the excellent foundation established by the **ALTCS Workforce Development Alliance (AWFDA)**. We will strengthen the entire workforce and connect them to communities in need. We will do this by analyzing data and collaborating with members, providers, and other stakeholders to identify the skills needed to create effective training programs by service area. We will also use the data to inform new best practice programs like our **Blue ALTCS Academy** (based on the National Committee for Quality Assurance [NCQA] Academy model) to provide education to all participants in the ALTCS service continuum – both internal and external. We strongly believe that the workforce should reflect the diversity of our membership and communities, including representation from Tribal nations. Our work to assist facilities, provider agencies, and DCWs in achieving their business and career goals is thoughtfully curated to impact members' lives directly and positively.

Our approach to using data to monitor and evaluate workforce development strategy effectiveness. Data analytics is essential to our development, monitoring, and evaluation strategies for both current and future workforce needs. Using the organizational discipline that allowed us to be the first AHCCCS MCO to secure full accreditation status by **NCQA**, our Workforce, Network, Medical Management, and Quality teams work in an integrated fashion to blend information from stakeholders, research, and nationally recognized entities, with internal data to analyze and inform our strategies using the Plan-Do-Study-Act (PDSA) approach. We will analyze direct care workforce-specific and member-specific data before, during, and after implementing the strategies outlined below and partner with academic institutions to perform independent evaluations. Most importantly, we will amplify member and stakeholder voices, captured through processes like our highly successful **Member Advisory** and **Provider Councils**, to help guide design, implement, and evaluate our processes, including ensuring data collection, interpretation, and application that is inclusive of the voices of diverse communities across Arizona. Through the cumulative effect of our approach and processes, Health Choice will **contribute to the State's and to AHCCCS's goals to ensure a robust and effective workforce**. In addition to numerous process measures to help guide our efforts through the years, we will also track and report **outcome measures meaningful to policymakers and to ALTCS members**. To measure our effectiveness in reducing and eliminating workforce shortages, we will directly measure workforce quantity and quality and disseminate reports statewide by collecting, analyzing, trending, and reporting the **BLS Location Quotient (LQ*) benchmark data** to compare local employment to national employment by occupation and we will collaborate with other plans to complete **an annual statewide workforce survey** (e.g., the Paraprofessional Healthcare Institute). To ensure that members have timely access to services, we will measure member experiences with the quality, timeliness, and accessibility of services and supports as the primary outcome that reflects a sufficient and high-quality direct care workforce, including but not limited to timeliness of utilization of services, **Electronic Visit Verification (EVV) data**, and qualitative, anecdotal, and member experience data (both formal and informal **National Core Indicators – Aging and Disabilities (NCI-AD™)**, as well as the **HCBS Consumer Assessment of Healthcare Providers and Systems.**

Our approach to assisting providers, integrating inter-departmental strategies, and driving results. The following table identifies Health Choice's forward-looking efforts in several key workforce development areas. While each of these efforts is important to the whole, we would like to spotlight one of our initiatives: our BCBSAZ Affordable Care Act (ACA) Health Insurance Marketplace plan's **"Care for Caregivers"** program, which offers plan options based on the Health Choice provider network. **BCBSAZ's ACA plan** is the **only AHCCCS MCO-affiliated plan with *coverage options in every Arizona county.*** This is important because the **largest pool of candidates to increase the caregiver workforce** is from **Peer and Family members, parents, friends, and neighbors** – especially in rural areas. Our discussions with statewide caregiver agencies indicate that most of these candidates, and many current workers, are AHCCCS members which leads workers to limit their hours or avoid career advancement for fear of losing AHCCCS coverage. We will ensure these workers have access to an AHCCCS-like, no-cost ACA coverage that maintains access to our Health Choice provider network and promotes continuity for caregivers and their families. **This will *reward* caregivers for increasing their work hours for ALTCS members and help them improve their lives and advance their careers … all at the same time.**

The table below represents an outline of our **Goals, Objectives/Outcomes, Strategy, and Tactics** using the "GOST Model", a best practice, scalable framework for initiative management used by many leading industry participants.

GOAL A: To assist and incentivize providers to improve workforce monitoring, assessing, planning, and forecasting workforce trends so that the provider can be more strategic in their efforts to recruit, select, train, deploy, and support their staff		
Objectives	**Strategies**	**Tactics (Actions)**
1. Biannual training on workforce development	Give providers tools to support workforce development	• Tailored training in conducting workforce development • Skills building in monitoring, assessing, planning, and forecasting • Partner with AWFDA to provide de-identified data to providers related to service utilization in their community
2. Complete six supplemental "pulse surveys" of DCW each year	Provide employers with periodic, targeted insights to quickly identify issues	• In addition to the annual surveys identified above, perform at least six short form "pulse surveys" workforce opinions on targeted "hot-topics" to assist employers in timely identification of workers' needs and motivations to drive support programs
3. Identify and reward "Workforce Centers of Excellence" provider agencies annually	Recognize and reward best practices in monitoring, forecasting, recruiting, hiring, and onboarding	• Establish workforce excellence standards, including clinical quality and member experience metrics • Create contract modifications to support Centers of Excellence (COE) • Pay enhanced rates to those organizations achieving COE designation • Annual recognition at a special event and in various publications
4. Increase the job applications and career training events by 10% annually	Sponsor the **ARIZONA@WORK**, the statewide workforce development network	• Financial sponsorship of the Arizona@Work programs • Promote via news outlets, social media, and other communication channels and schools throughout Arizona • Participate with the **Governor's and local Workforce Boards** • Connect providers with Arizona@Work website resources
5. Certify up to 1,000 new Nurses, Certified Nurse Assistants, and Assisted Living caregivers	Collaborate with AHCA and fund a sustainable plan for **AHCA WORKS**, a workforce development program proven to produce a total of 1,287 students in 15 months	• Develop a collaborative agreement with the Arizona Health Care Association to continue **AHCA WORKS** beyond the ARPA funding using COE enhanced payments and grants • Recruit new and talented individuals interested in becoming Certified Nursing Assistants (CNAs) in skilled nursing facilities, Community Interveners, and Caregivers in assisted living centers • Place interested candidates in training programs, fully funding the education necessary to become certified to serve ALTCS members • Assist in job placement and provide ongoing support to individuals trained through the AHCA Works Program
6. Fund DCW career ladder programs in rural communities	Partner with higher education opportunities	• Support up to 1,000 scholarships to assist residents in rural communities to enter or pursue promotion in the workforce • Establish outreach to encourage minority student participation

7. Matriculate 500 workers yearly in the Blue ALTCS Academy	Implement Arizona Blue ALTCS Academy	• With a focus bringing **Peer and Family candidates, parents, friends, and neighbors into the workforce**, offer no cost training program to develop a skilled DCW workforce and promote career advancement
8. Quarterly training and equipment to increase DCW use of technology	Offer **technology** to enhance capacity of DCWs	• Quarterly training events (virtual and in-person) to improve DCW use of technology-based solutions (e.g., CareConnections closed loop referrals, Pyx, Wellth, BlueCare Anywhere telehealth) • Develop certificate program for career advancement and incentives for provider organizations allowing employee participation
9. Offer healthcare coverage for DCWs who would lose AHCCCS coverage if they increased paid work hours	Implement **Blue Cross ACA "Care for Caregivers"** health insurance supplement coverage to address the "benefits cliff" and reward workers for increased hours of service and career development	• Offer a no-cost BCBS ACA Marketplace health insurance product for uninsured low-income Self-Directed Attendant Care Caregivers and other DCWs who risk losing AHCCCS eligibility due to improved wages or increased hours • Implement appropriate compliance and approval processes • Create contract modifications that support employers' ability to offer access to health insurance options • Support workers with transitions between plans and provide training on healthcare financing literacy • Track employee satisfaction with their health plan options • Through a formal, external validation study, track total hours and employment status for employees through 2027
GOAL B: To assist providers to improve post-training coaching and supervision to ensure the skills are applied and used effectively to improve member experience and outcomes		
10. Coaching and mentoring training for 500 provider supervisors	Improve coaching and mentoring skills to support retention, safety, service	• Implement trainings like: (1) Creating a Culture of Retention: A Coaching Approach to Supervision; (2) The training offered by our affiliate **BCBS Minnesota: Coaching and Mentoring for LTSS supervisors**; and (3) Train on developing ride-along programs to increase supervisor's effectiveness with employees
11. Offer 20 positions each year to high-potential supervisors	Share, free of charge, our **Blue ALTCS Academy** program with providers	• Each year, 20 high-potential provider employees will be given the opportunity to participate in BCBS leadership development programs including best practice **Huron Leadership Development** resources • Monitor participant satisfaction with the program
12. Sponsor 20 organizations to send leaders to wellbeing training	Sponsorship and promotion of the Arizona Wellbeing Collaborative	• Continue the partnership with the NARBHA Institute's **Arizona Wellbeing Collaborative** that empowers health leaders, professionals, and stakeholders to collaborate and transform healthcare workplaces through a culture of wellbeing and equity
13. Offer quarterly diversity, equity and inclusion training to leaders	Offer free advanced training courses to provider supervisors	• Professional development for provider supervisors through training on cultural humility, race, ethnicity and language needs (REaL), sexual orientation and gender identity (SOGI), and health equity to improve their ability to support a diverse workforce
GOAL C: To integrate the operations of our workforce development function within the operations of the network, medical management, and quality management departments		
14. Develop a best-in-class Workforce Development Operations (WFDO) team with full-time employees dedicated to this single objective	Meet and exceed the requirements in ACOM 407 and Section D Program Requirements of the RFP to develop a WFDO team with full-time employees	• Develop the Position Description for a Workforce Development Administrator (WFDA) and up to 9 additional full-time employees • Recruit, onboard, and create professional development plans • The WFDA will co-lead an ALTCS Network Services Committee (NSC) with Network Development Administrator, Quality Improvement/Informatics, and Medical Management, Member and Provider Advisory Councils, AWFDA, and other committees

	dedicated to this single objective	• WFDO team, will plan, implement, coordinate trainings, define metrics, develop benchmarking tools and assessment frameworks

Our approach to supporting the unpaid caregiver workforce. Our decades of experience providing services to Arizona's most vulnerable citizens informs our understanding of the critical role that unpaid family and friend caregivers play in caring for aging members and individuals with disabilities. For example, according to the Alzheimer's Association, Arizona family members of people with dementia provide about 357 million hours of unpaid care every year. In response, Health Choice developed a series of interventions to specifically address the needs of unpaid caregivers. Our **Blue ALTCS Academy** (based on the NCQA Academy concept) will have **CHW/Caregiver, Community Intervener, Promotores, and Peer and Family** tracks to help unpaid workers develop the skills and knowledge they need to successfully navigate various systems of care and advocate for their loved ones. The need for this type of training is especially strong among rural unpaid caregivers, as identified by the statewide study that Health Choice sponsored through the **NAU/ASU Center for Health Equity Research (CHER)**. Our **BlueCare Anywhere** multi-modal telehealth and **Blue@Home** home-based services will help unpaid caregivers by including a *choice* of multiple providers through a single mobile app and offer 24/7/365 virtual and in-home services to continuously assess members and address Health-Related Social Needs (HRSN) resource needs in connection with **Contexture** and **CommunityCares**. Existing services are being expanded to include member engagement tools, including AI-enabled conversational text and chat capabilities, which extend the capabilities of our current **Pyx Health** social isolation and **Wellth** social engagement mobile applications. Our **Blue Caregiver Café** will give both paid and unpaid caregivers access to informal 24/7 telephonic, chat, and online portal "helpline" services, staffed using trained Peers and Family members with caregiver experience, and our **Arizona Blue Consumer Direct** initiative will offer the administrative, clinical, outreach, and financial infrastructure to increase use of member directed paid SDAC caregiver options where it is appropriate to convert an unpaid caregiver to a paid one. Also, through our relationship with the NARBHA Institute, we are supporting the **Dementia Friendly Community (DFC)** initiatives in partnership with the Northern Arizona Alzheimer's and Dementia Alliance (NAZADA). We will also establish the first non-metropolitan **Dementia Friendly America (DFA) community** beginning with a November 2023 kickoff event in Flagstaff and will seek to spread this throughout Arizona. Dementia-friendly communities foster the ability of people living with dementia to remain in the community and engage and thrive in day-to-day living, which simultaneously supports caregivers by lightening the demands for their services.

Our approach to developing other workforce segments, including professional and Graduate Medical Education (GME). Health Choice has for many years supported professional and graduate medical education, and we will expand our efforts to support the needs of ALTCS members, especially those in rural and underserved areas. With our affiliated **BCBS AZ Foundation**, Health Choice will support scholarships for Nurses and other allied Health Professionals at Arizona Universities and Community Colleges. Examples include our support for **Northland Pioneer** and **Coconino Community Colleges** and our partnership with the **NAU School of Nursing** which offers scholarships to 11 students who will one day serve an estimated 26,250 to 27,300 patients. We also support the **Family Medicine and Psychiatry Residencies at North Country Healthcare,** designed to train and retain primary care physicians and psychiatrists with deep knowledge of rural Arizona healthcare and support ongoing professional development through our sponsorship of **ASU's College of Health Solutions Behavioral Health Integration ECHO** and our own **Mountain Project ECHO** capabilities where we will implement a **Project ECHO for Long Term Care** for ALTCS facilities. We will also support initiatives such as the **Coalition to Transform Advanced Care (C-TAC)** that promotes the use of Palliative Care services and empowers members, providers, and caregivers with tools and skills to promote advanced care planning. Our **Blue ALTCS Academy** will also include curriculum to help professionals at all levels of licensure develop the skills they need to navigate various systems of care and advocate for their patients. It will also include training on managing Medicare benefits, including the use of best practices and concepts from other integrated programs such as the **Program of All-Inclusive Care for the Elderly (PACE).**

Our approach to addressing health inequities and promoting equitable member care. Health Choice approaches direct care workforce initiatives through the lenses of diversity, equity, and inclusion. Health Choice is the sole Arizona-based organization participating in the Institute for Healthcare Improvement's **Pursuing Equity Learning Network**. We will use our grant-making resources to re-envision workforce programs, promoting the voice of the worker in program development, **shining a light on racial and ethnic inequities**, and **incentivizing employer practice changes and investing in the systems and structures that increase accountability**. We will use data and measurement in a way that promotes diversity and inclusion. For example, while the AWFDA baseline survey provided valuable insights, we will build on this initial survey to be more inclusive of other perspectives, e.g., non-English languages, non-urban areas (just 3% of the sample was non-urban), under-represented caregiver populations, especially American Indians. Gathering this data will help Health Choice ensure access to person-centered services in rural, frontier, and tribal areas. Finally, our **BCBSAZ Empowering Diversity Scholarships** will help Arizona's historically disadvantaged students fulfill their educational goals. Recipients have attended **post-secondary institutions** across the state of Arizona, **including Arizona State University, University of Arizona, Northern Arizona University, Grand Canyon University, Coconino Community College, Chandler-Gilbert Community College, and Cochise Community College.**

B9

B9. Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented.

a) Members residing in rural communities,

b) Members residing in Tribal members,

c) Members in need of community resources, and

d) Members in need of Peer and/or Family Support services

B9 Addressing Social Risk Factors. Dramatically reducing the harmful member impacts caused by social, economic, and environmental risk factors is, and has long been, a fundamental goal for both AZ Blue and Health Choice. Health Choice's origins date to the 1960s when we started as a social service agency that developed community resources across rural Arizona. This legacy drives our efforts to continuously innovate using the most timely, accurate, and **locally specific** data to develop detailed, outcome-oriented strategies that address each unique member's and Arizona community's needs. These efforts are headlined by our investment and staff involvement in the **statewide NAU/ASU Center for Health Equity Research (CHER) study** that identifies regional differences and local community resource gaps. This data is supplemented with information we receive from a wide range of member and community inputs, including meetings that we sponsor or facilitate, such as Tribal summits and consultations, meetings with local municipalities, and sponsored statewide and regional gatherings such as **Hispanic Chamber of Commerce**, **Arizona Town Hall**, **NAMI**, and **Community Grand Rounds**.

Health Choice uses this data as part of a **four-step approach** to address the unique Health Related Social Needs (HRSNs) that negatively impact people's lives. The **first step** is to identify the barriers that prevent members from accessing the supports and services they need. The **second step** is to identify the best practices and evolving innovations that specifically address these barriers. The **third step** is to make sure that individuals, families, and communities have access to the best practices and innovations. The **last step**, which closes and restarts the "Plan-Do-Study-Act" continuous improvement cycle to dashboard, monitor, and test the results from these best practices and innovations and make pragmatic adjustments as indicated by the data. The entire cycle is managed by our **Health Equity Advancement Director**, who chairs our **Health Equity Committee** with membership from every Health Choice department and is supported by our **Health Equity Advancement Division**, Innovation Office, Office of Family Affairs, and Tribal Services.

How we Identify and Address Barriers. Health Choice uses the **Vitalyst Foundation's 12 Elements of a Healthy Community Model** as an organizing guide for our statewide efforts. We then overlay data from many sources, including member eligibility data, Health Appraisal data, our proprietary Member Demographic Dashboard, county, and local health organization Community Health Needs Assessments (CHNA), and statewide health equity assessment data including **NAU/ASU CHER** data to identify the barriers within each of the 12 elements. We then develop individualized strategies for **each specific Arizona community and population**. The process helps us tailor best practices and innovative solutions to each community's specific unique needs. Ours is *not* a "one-size-fits-all" approach.

Serving rural communities. The challenges facing rural communities are immense but vary widely between communities. Overall, rural communities face many of the same challenges as urban areas, but with unique twists, and often with greater severity. Based on feedback gathered directly from ALTCS members, families, providers, and caregivers over the last two years, the most cited challenges are **access to care** (and in particular, access to qualified caregivers, behavioral health, and the need for a *choice* of telehealth and mobile services), **housing**, **transportation**, **nutritious food options**, and **social isolation**. These challenges are rooted in **geography** (over 90% of Arizona falls under the USDA rural definition), extremely **low population densities** (an average of less than 15 residents per square mile), **economics and poverty** (the nine poorest counties in Arizona are all rural) and known racial and ethnic **disparities** (74% of poor seniors in Arizona are Native American, African American, or Hispanic).

Dramatically improving rural **access to care** through innovation is one of the Health Equity Committee's primary goals, as a means of improving member satisfaction, quality, and addressing rural workforce shortages. For ALTCS members, our overarching solutions involve access to improved Telehealth and In Home services. To this end, we will use and enhance our Pathway DSNP's popular **BlueCare Anywhere** telehealth solution, with an integrated suite of *multiple* telehealth and eHealth services, that gives members, families, and caregivers *a choice* of 24/7 urgent care, nurse hotline, peer and family support, substance use, and behavioral health services ***using a single mobile app***. Additionally, we will use our DSNP's **Blue@Home** program, to give members *a choice* of several in-home service providers that not only cover *primary care, substance use, and peer and family support* but also specialty services ALTCS members have specifically requested, such as *expanded behavioral health, dentistry, podiatry, and renal care/dialysis*. All of these services will be supported by our expanding network of *trusted*, high quality, fully integrated, rural providers, including rural **Community Health Centers**, and **Equality Health's** expanding rural network. Our extensive RBHA behavioral network remains in place and has even expended with over 30 new providers and the newly formed **Northern Arizona Behavioral Health Alliance ACO** ("Alliance ACO"). We will also use our extensive investment in ACO support technology to expand access to care through the creation of an **ALTCS Provider Alliance ACO** and continue support for developing new provider capacities such as the Alliance ACO's **Regional Dementia Care Center of Excellence**.

Member use of these rural resources will be coordinated by our ALTCS case managers, with support from our **Blue Care Team**. This team provides dedicated multidisciplinary staff to assist members and case managers. These resources will receive additional assistance through many resource partnerships, including **CareBridge**, a national leader in round-the-clock care through a technology-enabled, local community health worker-supported model of care and support.

The **Blue Care Team** will also be instrumental in **improving rural access to qualified caregivers** by increasing the use of ALTCS' Self-Directed Attendant Care (SDAC, Chapter 1300, Policy 1320-A) and Agency with Choice (Chapter 1300, Policy

1310-A) member-direct options. As identified in the AHCCCS 2022 Annual HCBS Report, consumer directed programs have historically been under-utilized, with only 1,705 members using them as of 2022. Our research indicates that the main reason for low utilization is that Case Managers do not feel comfortable recommending SDAC due to the absence of member safety supports that the caregiver agencies typically provide. SDAC programs in other largely rural states have overcome this barrier by adding Case Manager support systems. Our Blue Care Team will offer **the same caregiver training, oversight, and member safety support** that would typically be provided by agencies. This will improve Case Manager confidence, enhance member safety, reduce fraud, and help address workforce shortages by giving members the ability to hire from a broader pool that includes people the member knows and trusts (including family members). It will also improve the member's **sense of independence** — since they are in control. We will provide additional support to this expanded pool of caregivers using **Blue Caregiver Café**, our suite of informal 24/7 telephonic, chat, and online portal "helpline" services specifically dedicated to caregivers, staffed with peers and family members who have lived experience as a member or caregiver. Support will include a newly designed **Pyx Health Caregiver module**, assistance to offer social service referral (including the use of Contexture's closed-loop referral system), behavioral consultation (e.g., how to deal with difficult patients or situations), patient care ideas, personal support, and available resource guidance.

Housing, and "*housing transitions"* and "*transitional housing*" specifically, are identified as barriers in rural communities — with members wanting more choice and assistance in selecting home settings. To address the first issue, Health Choice will supplement the allowed financial subsidy in AMPM 1240-C with our Pathway DSNP's supplemental housing benefit and our Foundation's grant funds to expand our existing network of community transition service providers. We will use organizations with capabilities to address the unique needs of rural populations including community and faith-based organizations like **Southwest Catholic Charities** and **Flagstaff Shelter Services**. These services will help members address *housing transitions* (gaps between homes and/or facility stays) and reduce the "acute only" ALTCS population by offering members an ALTCS-eligible housing location. Our work in housing will make more home settings available to keep Alternative HCBS below 19% and ensure ALTCS Acute-only remains at the lowest possible levels. We will, of course, continue our support for existing permanent and *transitional housing* programs such as those offered by the **Alliance ACO** and **Home Matters**, and fall-prevention and housing modification efforts with **Ability 360**.

Rural **transportation** is another regularly expressed concern, and here, Health Choice takes a very different approach from other plans. In addition to using AHCCCS-registered **Non-Emergency Medical Transportation** brokers and leveraging our **Pathway DSNP's VBID and transportation supplemental benefits**, Health Choice highly encourages and *financially incentivizes* **rural provider organizations** to develop and maintain *their own* transportation resources. These incentives include grants to help purchase and maintain vehicles. We also offer enhanced provider rate structures designed to compensate for the greater distances and hiring challenges associated with rural locations. Our experience indicates that members are less likely to miss appointments from, and are generally far more satisfied with, **provider-based transportation** resources. Provider-based transportation resources serve as an essential, timely and local backup when other transportation services have difficulties. Our many conversations with ALTCS providers indicate that they would be excited to see Health Choice extend these same incentives to support the members they serve in rural Arizona.

Our **Blue Connections** program is designed to address rural **nutritious food options** and **social and cultural cohesion** (including social isolation) challenges. This program will offer ALTCS member support through tailored, proven solutions (e.g., Pyx Health; member choice of *multiple* **Food as Medicine** and nutrition education providers, based on our highly successful AZ Blue and Pathway DSNP healthy foods programs). These are supplemented with our Pathway DSNP's **flex card program** through which members can purchase food or have member-preferred and culturally aligned meals delivered. We also will implement a new "pet joy" **animated pet therapy** program based on a successful BCBS Minnesota Senior Advantage program, along with peer-facilitated, local "community neighborhoods" through **Wider Circle** for ALTCS members. These programs leverage unique, developing partnerships with the **Area Agency on Aging** and providers such as **Valleywise Health**, and are designed to help medically vulnerable and marginalized populations across Arizona – *e.g.,* people of color; members of religious minorities; persons identifying as lesbian, gay, bisexual, transgender, and queer (LGBTQI+); refugees; and persons with disabilities - who disproportionately face social cohesion challenges due to marginalization, verbal and physical abuse, denial of services, and other discriminatory practices.

Serving Tribal members. Honor and respect for Tribal sovereignty and diversity are the foundation of Health Choice's longstanding collaboration with Arizona's 22 federally recognized tribes and all Indian Health Service Areas, 638 Tribal health self-governance programs, and Urban Indian Health Organizations. American Indian and Alaska Native (AI/AN) persons in Arizona suffer disproportionately higher rates of mortality and chronic health condition (e.g., cancer, diabetes, obesity, heart disease, and behavioral health illness), requiring a culturally centered model of care, guided by partnerships with Tribal governments, inter-Tribal councils, state agencies, and I/T/U Indian health leadership. Our efforts have produced significant results: Between 2021 and 2022, AI/AN members with diabetes in AZ Blue's ACA plan experienced **41% fewer hospitalizations** than in the preceding two years despite the impacts of COVID-19.

We again used the **Vitalyst Foundation's model** (see graphic below) to analyze the feedback we have received through our long-standing annual **Tribal Summit** series listening sessions. This feedback indicated that, although Tribal

communities experience the same challenges as rural communities, they experience them in different ways and with greater intensity. Thus, **all of the rural community solutions** described above will **also support Tribal communities** (with the Tribe's consent where needed, of course), but **with added, specialized resources**.

Tribal members frequently move between Tribal and AHCCCS ALTCS programs and providers, complicating **access to care**. As a result, we will expand our existing formal care management partnerships with Tribal governments and Tribal ALTCS programs to **ensure seamless case management** and **service planning transitions**. We will also offer our **Blue ALTCS Academy** training curriculum to Tribal programs and providers at no cost. We will offer enhanced care coordination for Tribal members living in HCBS settings through the inclusion of Tribal Community Health Representatives who share language and cultural experiences in the **Blue@Home** program and ensure that culturally appropriate care is available for Tribal members living in HCBS settings. Coordination of pharmacy benefits was also raised as a concern, so we will expand Health Choice's successful **Helping Hands Pharmacy Hugs** program (part of our DSNP's Five STAR Part D program) for Tribal members requiring polypharmacy treatment. Workforce capacity was also raised as a significant barrier. As a result, we will increase our community college scholarship programs and offer incentives to providers who train employees (including Peer and Family members) from the Tribal communities they serve.

The comments we receive continue to indicate that the lack of **heating fuel** and **potable water** often represent a barrier to maintaining stable **housing** in Tribal communities and those that border Tribal lands. As a result, we will expand on our current programs to support providing firewood and equipment to transport potable water to ALTCS members. We will also expand our widely used **Tribal Traditional Practitioner** and **Sweat Lodge Healing Ceremony Programs** which support **social and cultural cohesion** and reduce social isolation for all ALTCS members. These decade-old programs were the first in Arizona to offer ceremonies and healings to individuals and families and have been cited as a national best practice as they are fully aligned with cultural expectations, are easy to use, and help facilitate acceptance of other medical treatments in a culturally aware, wholistic, person-centered approach to care. Currently, our program involves over 80 traditional practitioners from all 22 federally recognized Arizona Tribes. Lastly, we are developing a collaboration with **Contexture** designed to address **social isolation** among **Tribal elders** through enhanced technology training.

Serving members in need of Peer and Family supports. The benefits to members of Peer and Family support are beyond question. Our data show that Health Choice members who regularly access Peer or Family support are approximately 15% more likely to adhere to their individual care plan. In addition to the **Peer and Family programs referenced above**, we will ensure that every ALTCS member receives detailed information regarding the benefit and availability of Peer and Family supports. Since effective member communications always starts with the member's Case Manager, all Case Managers (and support staff) will receive **specific training** through our **Blue ALTCS Academy** (our online training program incorporating best practices from BCBS Minnesota's Senior Advantage program designed to improve literacy and understanding of ALTCS services, readiness for self-directed attendant care [SDAC], and direct caregiver career development) connecting members with appropriate, strength-based Peer and Family supports. Similar training will be required for all **BlueCare Anywhere** and **Blue@Home** provider staff. As a result, all members will receive direct information on the benefits of Peer and Family supports and how to access them, *through every communication channel* in our power. Each issue of our **quarterly member newsletter** will include relevant information and provider profiles; we will provide information through our **AI-enabled conversational text and chat tools**; and we will further expand our recently redesigned **OIFA-specific website** to address the Peer and Family supports for ALTCS members. With assistance from our Peer and Family providers and NAMI, even more projects are already under development for future years.

Health Choice will continue to expand choice options of Peer and Family Support services for ALTCS members through **every level of care** – from crisis to community service agencies – and in **every community we serve**. We have developed our new **Blue Caregiver Café** that will both provide employment opportunities to, and support for, Peer and Family members who work as caregivers. And starting in 2024, we are providing financial **incentives to our ACO partners to incorporate Peer-operated and Family-operated organizations** into their ACOs to improve quality performance through enhanced peer and family engagement. The inclusion of Peer and Family services will help improve quality, help identify recovery goals, lessen isolation, increase practical knowledge and health literacy, and teach coping and self-care skills.

Serving members in need of community services. The value of our process to identify the unique and specific needs of each community is especially evident here. Each community cited very different needs during our community meetings, and the diversity of needs was also supported by the **CHER** study. This both necessitates, and informs, our community-by-community approach to best practices and innovative solutions. Past examples we have developed include **in-canyon behavioral health services** for the **Havasupai Tribe** through The Guidance Center, and later Spectrum Health; expanded **housing** in seven communities; development of the first **Crisis Stabilization** and **Mobile Crisis Units** in Kingman, Prescott,

and Flagstaff; Food Bank expansion in Yuma, **intergenerational community gardens** and **alcohol rehabilitation** in Page; and **chemical dependency residential facilities** in Mohave and Gila counties and for **Tribal members** in Navajo County. Our community meetings have already identified service gaps affecting ALTCS members across Arizona and helped us identify needed projects, including projects advancing social connectedness, food security, ecotherapy, expanded use of **Adult Day Health** services**,** additional **physician residency/health scholarship** opportunities, and independent functioning and basic life skill development. Several of these projects are already underway, including collaborations with **Joy Bus** for meal delivery and **Ability360** supporting transitions from rehabilitation care to independent living for people with neurological disabilities and spinal cord injury, **senior focused muti-service centers** in Apache and Maricopa counties, and a **regional dementia care center of excellence** that will include residential care.

How We Ensure Timely Access to Services & Supports. All of our community meetings identified one absolutely common theme: The need for health plans to better connect people in need to HRSN resources in a timely manner. Our answer was to develop **Blue Connections**, a highly integrated member and community data system that bridges the gap between the **individual** and community resources to make a *real* difference. Timeliness is the key. Most systems rely on claims data, but the lag associated with claims means that people often cannot be located. Instead, Health Choice uses a highly integrated multi-source data system that combines **Contexture's HIE and CommunityCares closed loop referral data**, **pharmacy, and other vendor data**, along with other public record resources, to obtain the latest information for members. These resources are supplemented with **bioinformatics and genomic precision medicine** (e.g., **TGEN North** and **Johns Hopkins ACG™** predictive analytics) and other personal health data gathered through resources including Case Managers and our **Blue Care Team** and information gathered by **Blue@Home** home-based service providers and **HRSN providers** in each community. This "all-hands-on-deck" exercise allows Health Choice to more readily locate people and provide timely **information about HRSN resources to the member and their supports**.

The first and most important resource we use to do this is the Case Manager who "quarterbacks" the entire system. Our **EXL Care Radius™** system gives access to member profiles to communicate with the member directly and through a suite of AI-informed conversational communication tools using **Blue Connections** – all with direct bi-directional feeds into the **CommunityCares** closed loop referral system. These services will link to our **ALTCS Community Service Directory** (developed in connection with the CHER study led by the NARBHA Institute) that maps community resources for ALTCS members based on need and geography.

Anticipated Outcome Goals			
Tribal & Rural Communities (Over 5 years)	**Results**	**Community, Peer & Family Services (Biannual NAU/ASU CHER Survey)**	**Results**
Average % of members living in HCBS setting	>90%	Improved clinical and community service provider ALTCS literacy	>5%
Increase in members using Self Directed Care (SDAC) program	>25%	Improved awareness of the value and availability of Peer and/or Family supports	>10%
Increases in behavioral health service delivery to HCBS settings	>20%	Improved sense of social connectedness across all races and ethnicities to social supports and nutritional services	>5%
Average member adherence rate for updated advance care planning	>95%	Improved awareness of decision-making support for timely member transitions to palliative/hospice care	>5%
Reduction in ED and acute inpatient admissions over five years	>17%	Annual reductions in member transfers to higher levels of care	>3%
Increased number of evaluations through telehealth by registered dieticians for members with diabetes and other chronic conditions	>20%	Improvement in timely identification of and response to programmatic needs for ALTCS members, including those with physical disabilities.	>10%
Improvements in member UCLA loneliness reduction scores	>15%	Increased closed-loop referral system utilization	>75%

The **"last and first" step** in the continuous PDSA cycle uses our systematic approach to **monitoring, dashboarding, and testing results**, developed in conjunction with our Pathway DSNP and **NCQA program improvement standards** to align with **ALTCS performance measures** and facilitate learning and improvement based on data. Our monitoring process collects data on a **community-specific basis** and reports it using a dashboard that includes **unmet demand, output, and outcome/results metrics**. (See above table for a sample of projected ALTCS results measures that we will meet.) The dashboard results are reported monthly to the **Health Equity Advancement Director** and **Health Equity Committee**, which is empowered to make direct changes as they deem necessary. It is also reported to the entire Health Choice leadership team (all supervisors and above) and AZ Blue's executive team as part of our **Monthly Management Report** (which covers over 350 performance metrics). To facilitate community input, the data will also be presented to our **Member Advisory** and **Provider Councils**, our new **Community Services Council for Long-Term Care** comprised of peer and family members, provider, and community representatives, as well as our community-based **Governance Committee** and **Medicare Advisory Board**. Feedback from these groups will be presented back to the Health Equity Committee, with a response required by the following meeting. Lastly, to support continue learning and access to care, we will implement a **Project ECHO for Long Term Care** for ALTCS facilities, providers, and caregivers, leveraging Health Choice's ten-year-old **Mountain ECHO** program (Arizona's first ECHO hub) and the 2023 launch of our **ECHO for Social Determinants of Health** screening program, with special emphasis on palliative care, hospice, and ALTCS member needs and priorities.

B11

D-SNP STAR Rating

D-SNP STAR Rating

	MEDICARE PLAN NAME	MEDICARE CONTRACT NUMBER	CORRESPONDING CONTRACT FROM B2	TYPE OF PLAN (FIDE/DSNP; SNP; MEDICARE ADVANTAGE)	STAR RATING
1.	Health Choice Arizona, Inc	*H5587*	*H5587*	*FIDE/DSNP*	*4.0*

B12

Oral Presentation Information

Oral Presentations

- Shawn Nau - Chief Executive Officer
- Diana Policky - Chief Operating Officer/MSA Administrator
- Ellen Lewis - Staff Vice President, Clinical Operations
- Matthew Ladich - Staff Vice President, Health Plan Operations
- Charlton Wilson – Administrator – ALTCS-EPD
- Brianna Barrios – Manager of Health Equity Advancement

Shawn H. Nau
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Shawn.Nau@live.com

Experience

Chief Executive Officer, Blue Cross Blue Shield Arizona - Health Choice Arizona. 410 N. 44th Street, Suite 900. (February 2013 through present.) Manage business strategy and operations for Northern and Central Arizona AHCCCS and Medicare managed care organization, including community stakeholder collaboration efforts, network service development, cultural competency programs, coordination of tribal services team, communications, public relations, and provider policy development. Initiated and lead team to implement program to manage court ordered evaluations for Coconino and Mohave Counties under intergovernmental agreement with AHCCCS and the Arizona Department of Health Services.

City Manager, Eagar, Arizona. 22 W. 2nd Street, Eagar, Arizona 85925. (June 2012 through February 2013.) Turnaround management project for city facing significant financial and operational challenges. Managed all operations including police, fire, public works, planning and zoning, parks and other municipal functions. Completed financial recovery and stabilization plan within fifteen months.

County Manager, La Plata County. Colorado. 1060 East 2nd Avenue, Durango, Colorado 81301. (March 2008 through August 2011.) Managed $68 million county operations including central county administration. Additionally, served on San Juan Basin Health Board; helped create and served as a founding board member of the La Plata County Economic Development Alliance; and helped create and served as a founding board member of the Southwest Colorado Council of Governments**.**

Director of Heath Care Administration and General Government Services, Maricopa County. Arizona. 301 West Jefferson, Suite 320, Phoenix, Arizona 85003. (January 2000 to March 2008; August 2011 to June 2012.) Managed multi-department agency providing a wide variety of health care, strategic planning, legal, and budget related services with budgetary responsibilities in excess of $325 million. Accomplishments included completion of a public initiative and election process to transition 600-bed County hospital and health plan system to a special health care district; managed $360 million health care litigation portfolio; and introduced improved prior authorization and claims payment systems for public correctional

health services. Managed Arnold v. Sarn litigation and coordination with County RHBA; Assisted with reorganization of several key County departments.

Director, Human Resources Department, Maricopa County, Arizona. 301 West Jefferson, Suite 240, Phoenix, Arizona 85003. (September 1996 to January 2000.) Direct personnel system delivering a broad range of human resources services to approximately 14,000 employees, including recruitment, compensation, payroll, employee records, leave and benefit programs, employee relations, and merit systems. Served as the County ethics officer and ADA coordinator. Responsible for operating budget of over $3 million, and benefits trust budget of over $32 million. Served as a lead consultant on Maricopa County's human resources submission to Governing Magazine's "Rating the Counties" project, which resulted in Maricopa County receiving the highest national designation. Served as member of Arizona Joint Legislative Committee on Employee Compensation.

Lead Counsel, Civil Division, Maricopa County Attorney's Office, Civil Division. 301 West Jefferson, 8th Floor, Phoenix, Arizona 85003. (October 1993 to September 1996.) Managed practice group of five attorneys representing Maricopa County departments in general counsel and litigation matters. Major accomplishments: Participated in negotiation of Bank One Ballpark (now Chase Field) memorandum of under-standing with Arizona Diamondbacks for construction of Bank One Ballpark; litigated cases precedent setting case under the Fair Labor Standards Act; assisted in restructuring of county as part of stabilization program following fiscal crisis in 1994.

Associate Counsel, Tower Byrne Beaugureau & Shaw, P.C. 2111 East Highland Avenue, Suite 255, Phoenix, Arizona 85016. (October 1991 through October 1993). Represented both private and public sector clients in a variety of legal matters, including Title VII employment discrimination and civil rights litigation, and administrative matters before the Equal Employment Opportunity Commission. Chaired firm's technology committee and directed implementation of the firm's first computer system.

Assistant Attorney General, Chief Counsel's Staff, Ohio Attorney General. 30 East Broad Street, 17th Floor, Columbus, Ohio 43266-0410 (August 1986 through October 1991). Responsibilities included representation of the Ohio Governor's Office, Supreme Court, Department of Administrative Services, Ohio State University Hospital, Attorney General's Office and Treasurer's Office in financial, employment, and public disclosure matters; served as general counsel to state public employee's deferred compensation fund. Represented other state departments in matters including cases under the Federal Vocational Rehabilitation Act, Americans with Disabilities Act, as well as racial discrimination, gender discrimination and sexual harassment cases. Conducted seminars on various public employment-related issues. Additionally, served as "Open Government Liaison" coordinating public disclosure of media requests for information from the Attorney General's Office and Division of Personnel.

Adjunct Professor, Ohio State University Law School. 1659 North High Street, Columbus, Ohio 43210. (September 1988 through January 1990). Instructed law students in constitutional law, employment law, and legal research and analysis techniques.

Education

Juris Doctorate, University of Toledo School of Law, Toledo, Ohio 43606. Graduated May, 1986, cum laude. Ranked in top ten percent of graduating class. Awarded Gelereed Memorial Scholarship. Activities included Moot Court, Mugal Society.

Bachelor of Arts, State University of New York at Buffalo, Department of Philosophy, Buffalo, N.Y. 14226. Graduated cum laude (university-wide), magna cum laude (department), B.A., Analytical Philosophy. Activities included honors research program on law and ethics, served as judge-advocate in student-wide judiciary alternative dispute resolution program.

Affiliations

International City County Management Association; National Association of Counties; Association of Colorado County Administrators; Society for Human Resources Management; International Personnel Management Association; Admitted to Ohio State Bar and Ohio Federal District Court Bar, November 1986; Volunteer advocate for United Way, United Cerebral Palsy, Upward Foundation, and Grand Canyon Field Institute.

DIANA POLICKY
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OPERATIONS MANAGEMENT

Healthcare | Insurance | Quality

Confident and knowledgeable Chief Operations Officer with over 25 years of experience in operations, development, , and transformation. Outstanding strategist distinguished for saving over $23m in health care costs by coordinating reviews and tracking discrepancies during settlement and litigation proceedings. Exceptional communicator with strong negotiation, problem resolution and client-needs assessment aptitude.

AREAS OF EXPERTISE

- Budgeting and Forecasting
- Financial & Policy Analysis
- Cost Control
- Healthcare Operations
- Business Development
- Strategic Oversight
- Quality
- Leadership
- Personnel Development

PROFESSIONAL EXPERIENCE

BLUE CROSS BLUE SHIELD HEALTH CHOICE, Phoenix, AZ March 2018-Present
Chief Operating Officer/MSA Administrator

- Facilitate the coordination, integration and execution of Arizona Medicaid and Medicare programs and activities across the Health Plan, including new program initiatives.
- Promote accountability, communication, coordination, and facilitation of cooperative corporate decision-making on management, operational and programmatic cross-cutting issues.
- Track and monitor Health Plan performance and intervene, as appropriate, to ensure key milestones/ deliverables are successfully achieved.
- Provide Executive Leadership to operations, including facilitating interaction and coordination between the Regulator and the Health Plan.
- Oversees planning, implementation and evaluation of operational activities, including enterprise-wide information systems and services, grants, claims, member services, sales, grievance and appeals, plan performance, electronic health standards, housing, and network.
- Strategic marketing and operations planning, setting objectives, and identifying methods to reach goals.
- Develop, participate in and oversee organizational growth initiatives related to regional markets and target customer segments.
- Creation of long-term value for the organization from customers, markets, and relationships.

Vice President of Operations 2017-March 2018
Initially hired as Vice President of Business Operations for the Medicaid line of business and through attrition took over interim responsibilities as the Vice President of Marketing, Community Relations and Training.

- Ensured appropriate regulatory requirements were accounted for and implemented as it related to contract terms.
- Identified, developed and implemented procedural and technological improvements to streamline operations.
- Oversight and direction for all member communication and resources.
- Management of community relations programs across the organization.
- Established training processes, curriculum and training programs to ensure consistency across all lines of business.
- Ensured training materials comported with contractual requirements and deliverables.
- Supported internal/external brand through systematic communications; accounting for regulatory requirements as well as culture and community perception.
- Ensured communication delivery and direction supporting the strategic vision in a consistent manner through programs, events, and media relations management.
- Partnered inter-departmentally to support business development opportunities.

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PHOENIX HEALTH PLAN, Phoenix, AZ 2015-2017
Vice President of Contract/Corporate Compliance, Grievance and Appeals, and Business Development

- Senior level executive and point person for oversight, administration, coordination and monitoring of all compliance, grievance and appeals, and business development functions.
- Developed and maintained the organization's compliance program structure to reasonably ensure adherence to applicable federal and state rules and regulations.
- Served as liaison between MCO and regulatory agencies.
- Conducted internal audits, reviews and monitoring to ensure compliance with regulations including investigations of suspected violations.
- Managed regulatory audits for the Medicaid, Medicare, and the Health Insurance Exchange line of business.
- Initiated periodic compliance self-assessments and provided periodic reports to the Board of Directors on the status of compliance efforts.
- Provided advice and served as a resource for employees, contractors and vendors (as appropriate), agents and any applicable governing Board members on compliance issues.
- Trained employees to recognize and identify fraud or abuse and forward reports to the appropriate department.
- Developed, distributed, implemented, and communicated new and revised compliance policies.
- Implemented, conducted, and monitored annual compliance training and education.
- Participated in the development and implementation of internal controls capable of preventing and detecting significant instances or patterns of illegal, unethical, or improper conduct.
- Key point person and project manager for regulatory initiatives such general mental health integration and justice systems initiatives.
- Developed proposals in response to Requests for Proposals.
- Strategic marketing and operations planning with top executives, setting objectives, and identifying methods to reach goals.
- Developed and participated in organizational growth initiatives related to regional markets and target customer segments.
- Creation of long-term value for the organization from customers, markets, and relationships.
- Oversaw the review, research, investigation, negotiation, and processing of CTMs, Appeals and Grievances for the Medicare, Medicaid, and Health Insurance Exchange Product lines of business for three states.

STATE OF ARIZONA, Phoenix, AZ 2012-2015
Operations Manager, Division of Health Care Management
Accomplished professional charged with monitoring the performance of 11 AHCCCS-contracted managed care organizations (MCOs), funded at $5 billion annually to provide acute, long term care, and behavioral health services to over one million Arizona residents. Responsible for the management and oversight of the Operations unit and staff within the division to ensure AHCCCS-contracted MCOs adhere to and perform the duties under contract in a satisfactory manner.

- Monitored the performance and contract compliance of MCOs delivering acute, long term care, behavioral health and children's rehabilitative services.
- Responsible for evaluating provider network adequacy and availability of services, monitoring claims payment systems for timely and accurate payment, monitoring MCO Member Services function to assure members have timely and accurate access to assistance from the MCO, monitoring the federally required grievance system and monitoring compliance with all other terms of the contract.
- Assured development, completion, and publication of a contract review document in compliance with federal law.
- Coordinated and responded to provider inquiries and complaints regarding MCO performance.
- Lead role in the development of Request for Proposals and the procurement process.
- Annual evaluation for amendments of MCOs delivering acute, long-term care, behavioral health, and children's rehabilitative services.

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- Participated in MCO transition and readiness processes following contract award, including transfer of member data, assessment of MCO readiness (network adequacy, staffing adequacy, policy/procedure development, systems readiness).
- Developed and updated Agency policies in compliance with changing regulatory requirements.
- Monitored the development of federal and state statutes and regulations impacting the MCOs, and providing feedback to Agency administration regarding impacts of changes to laws and regulations.

MARICOPA COUNTY, Phoenix, AZ 1997-2012
Administrative and Health Care Litigation Manager, General Government, 2010 – 2012
Administrative and Health Care Litigation Manager charged with managing administrative functions for General Government, Health Care Programs and Pre-AHCCCS litigation. Managed administrative and operational managerial and supervisory staff, providing considerable input in the development and implementation of departmental strategic goals.

- Directed the development and implementation of policies, procedures, department plans and programs.
- Identify operational problems and develop solutions.
- Participated in high-level meetings with County Management, the Board of Supervisors, and outside agencies. Direct the overall preparation and administration of the department budget and fiscal matters.
- Research, review and resolve claims and lawsuits for complex litigation and other County healthcare programs.
- Develop training materials, train and coach team members.
- Aid internal and external attorneys with research and interpretation of policies, procedures, and statutory guidelines.
- Act as an expert witness during trial.

Legislative Analyst/Budget Supervisor, Maricopa County Office of Management and Budget, 2008 – 2010
Recruited initially to complete legislative analysis, economic forecasting, policy development and health care litigation. Promoted to Acting Budget Supervisor, with expanded duties including coordinating professional staff on financial and policy analysis in conjunction with developing, analyzing and consolidating the annual County budget.

- Coordinated and conducted long- and short-range revenue and expenditure analysis of budgetary/fiscal issues.
- Coordinated the work of independent professionals contracted to perform special studies and analyses.
- Provided managerial assistance in the implementation of new programs, procedures, methods and systems.
- Coordinated with technology staff on budget system implementation and administration issues.
- Served as backup for Deputy Budget Director as needed.
- Continued to manage Pre-AHCCCS litigation, Long-Term Care Residual and Tuberculosis Claim program functions.

Risk Manager, Maricopa County Correctional Health Services and Health Care Programs, 2008
Key member of the Correctional Health Service Executive Team and other adjunct teams as needed.

- Planned, organized, and directed risk management activities, including loss prevention and litigation.
- Evaluated individual cases and communicated with internal and external customers on specific claims.
- Obtained evidence for contested and/or litigated claims to assist internal and external attorneys to defend claims and to prepare for trial; prepare and represent the County at court appearances and other administrative bodies.
- Acted as a consultant to other County departments and developed policies and programs designed to limit the County's exposure to risk.
- Managed the CHS Medical Records Risk department.
- Trained staff and other paraprofessionals.
- Developed and provided periodic statistical, financial, and other performance reports on risk management activities and loss data.
- Compiled and analyzed data on trends to identify high-risk areas and develop action plans accordingly.
- Continued to manage Pre-AHCCCS litigation, Long-Term Care Residual and Tuberculosis Claim program functions.

Operations Manager/Acting Director, Maricopa County Health Care Programs, 2001 – 2008
Operations Manager promoted to act in the Director's absence. Provided County Management with considerable input on the development and implementation of strategic goals and objectives.

- Analyzed department results and implemented process improvements to service delivery.
- Identified operational problems and developed solutions.
- Lead and directed staff, special operational and organizational studies/projects.
- Participated in high-level meetings with County Management, the Board of Supervisors, and outside agencies.
- Directed the preparation and administration of the department budget and fiscal matters.
- Oversaw Pre-AHCCCS litigation, AHCCCS Maricopa Managed Care Run-out Program, Maricopa County Long-Term Care Residual Program, and the Ryan White Grant Funded Programs.
- Oversaw Correctional Health, Juvenile Detention, Long-Term Care and Tuberculosis Claim functions.
- Expert witness in three multi-million-dollar trials.
- Saved millions of dollars in outsourcing costs, while meeting an aggressive six-month timeframe for completion.
- Saved over $23m in claims cost by coordinating reviews, tracking discrepancies, and identifying invalid claims during settlement and litigation proceedings.

EDUCATION & PROFESSIONAL DEVELOPMENT

BACHELOR OF SCIENCE, BUSINESS ADMINISTRATION, UNIVERSITY OF PHOENIX, PHOENIX, AZ (2004)
CERTIFICATION, NURSING ASSISTANT, CITRUS COLLEGE, COVINA, CA (1993 – 1994)
CERTIFICATION, HOME HEALTH AIDE, CITRUS COLLEGE, COVINA, CA (1993 – 1994)
COURSEWORK, TAX ACCOUNTING, CITRUS COLLEGE, COVINA, CA (1993 – 1994)

ELLEN N LEWIS 480 • 694 • 0235 / enlewis@earthlink.net Scottsdale, AZ

PROFESSIONAL CAREER EXPERIENCE

Healthcare Executive, Operational Leader
P&L Accountability, Start-Ups, People Leader

Staff Vice President, Clinical Operations
BCBSAZ Health Choice, Phoenix, AZ *2016 to Present*

- Direct all clinical operations functions in a 220-250K member health plan serving Medicaid and Medicare D-SNP enrollees in Arizona. Operational areas of accountability include Utilization Review, Dental Program, Care Management, Behavioral Health, Maternal and Pediatric services, Prior Authorization, and Medical Claims Review
- Improved KPIs across the spectrum: Average Length of Stay (ALOS) under 4 days; reduced Skilled Nursing ALOS from 22 days to 15 days in one year. Dental Prior Authorization (PA) averaging less than one day, Medical PA less than two days and claims Turn Around Time averaging 7 days. Readmission rate for Medicaid population 8%, Dental program revamp reducing FTEs, improving provider satisfaction.
- Led planning and execution resulting in NCQA accreditation, first for any Medicaid health plan in AZ
- Driving population health model with care management programs for members with opioid use disorder, diabetes, children with highly complex physical health needs, high risk pregnancy
- Developed a medical claims review process that analyzes claims pre-payment for medical necessity, appropriate coding, and DRG documentation. DRG correct coding adjustments have netted several million dollars in savings
- Integrated behavioral health and physical health model for population health management for new Medicaid contract in 2018
- Lead team of 200 remote and onsite professionals and paraprofessionals including certified nurse coders, social workers, and nurses
- Led through multiple transitions including two major acquisitions, integration of two health plans, and delivery model changes
- Launched two new dedicated team models to focus on Accreditation and Training and Health Equity Advancement
- Under previous ownership held prior accountability for Clinical Operations for Medicaid and D-SNP Plan in Utah
- Authored Model of Care for D-SNP application for Utah; accepted by CMS first time with score of 97%
- Implemented all aspects of clinical programs for new Medicare SNP plan in Utah

Senior Director, Clinical Services
Aurora Behavioral Health System, Phoenix, Arizona *2012 - 2016*

- Strategic operational leader in a for-profit, free-standing, psychiatric hospital system, directing day-to-day clinical operations in two geographically separate hospitals, managing, and

developing staff, ensuring high quality care, sound fiscal operations, and compliance with Joint Commission, CMS, and state regulations. 238 acute inpatient beds and outpatient clinics dedicated to adult and adolescent behavioral health and substance abuse treatment. Oversee 24/7 operations including nursing, social services, adjunctive therapy, Health Information Management, and pharmacy.

- Developed processes for joint venture with medical hospital system, providing onsite behavioral health assessments, level of care determinations, and referrals
- Developed and implemented an ECT program; average 85 procedures a month
- Planning and developing program for special needs children with autism
- Right-sized FTE models for multiple departments; created shared staff model between the two hospitals. Reduced salary expense by more than $160K/month at each location
- Changed supply vendor after cost analysis; savings of 30-50%
- Worked closely with payers on value-based metrics including ALOS, readmission reduction, follow-up appointments, and spend
- Ensured survey readiness across the organization: Successful Joint Commission survey less than a year after taking the reins; multiple successful surveys over 4+ years
- Revamped the quality program; instituted new tracer methodology for performance improvement
- Standardized policies, procedures, processes across the two-hospital system. Improved efficiency and success with shared staff model
- Oversaw the facility and clinical aspects of inpatient bed expansion/build-out at both hospitals

Chief Nursing Officer
Valley Hospital, Phoenix, AZ *2010 - 2011*

Directed key functions in a new start-up, for-profit, 122 bed free-standing psychiatric hospital including nursing services, pharmacy operations, supply chain, infection prevention, Employee Health Program, and transportation services. Patient treatment programs included adult, geriatric, women's, chemical dependency, intensive care, and active-duty military.

- Key leader in new hospital start-up operations
- Achieved state licensing, Joint Commission and CMS accreditation in less than 5 months of operation
- Hired and trained all staff; instituted policies, procedures, system processes; all 122 beds open within 6 months

Director, Medical Management
United Health Group, Community Plan, Phoenix, Arizona *2007 - 2010*

Directed statewide medical management activities at a for-profit health plan providing acute and post-acute adult and pediatric inpatient services for 300,000 Medicaid, Medicare SNP, DDD, and CRS members.

- Achieved best year over year medical management metric performance in last 5-year history of health plan

- Reduced bed days/1000 more than 10%; Savings greater than $8M on inpatient costs alone; readmission rate decreased by 20%
- Built cohesive multidisciplinary teams statewide focused on case management, discharge planning, member support and claims review
- Designed and implemented Transition Coach Program to reduce readmissions by 20% in Maricopa County
- Orchestrated streamlined processes in medical claims review; regulatory TAT for all LOBs met daily; increased community provider satisfaction with new claims reconsideration process

Regional Administrator
Arizona Cancer Institute, 21st Century Oncology, Scottsdale, AZ *2003 - 2007*

Operational leader of for-profit oncology and multi-specialty services in several geographic locations in Arizona. Accountable for P&L, human resources, growth, billing, budget, marketing, compliance, licensing, facility, and equipment management

- Planned and executed growth strategy to add 4 new build oncology centers over 1.5 years, one major remodel, and four radiation oncology acquisitions in a highly competitive market
- Orchestrated the addition of multi-specialty providers to the cancer centers: naturopathic, medical oncologists, surgeons
- Implemented the latest treatment technology and modalities: Trilogy and Calypso
- Created marketing, advertising programs; print, radio, and TV; web site development; branding
- Led team of physicists, dosimetrists, nurses, radiation therapists, and physicians in providing high quality oncology care; patient satisfaction surveys consistently 99% 'Excellent' rating

Career Officer in United States Air Force

EDUCATION

MSN	Nursing	Arizona State University, Tempe Arizona
BSN	Nursing	Notre Dame of Maryland University, Baltimore, MD
Diploma	Legal Nurse Consulting	Kaplan College, Boca Raton, FL

MATTHEW C. LADICH

12873 E. Sorrel Lane | Scottsdale, AZ 85259| 775-219-9912

matthewladich@sbcglobal.net | www.linkedin.com/in/matthew-ladich/

Extensive experience in administrative, managerial, and operational capacity within managed care. Collaborative leader of various operational areas of health insurance organization, such as Government Programs, Compliance, Marketing, Information Technology, Claims, Customer Service, Contracting, Risk Adjustment, Process Improvement and Accreditation. Proven experience in creating successful health insurance products and highly rated plans.

PROFESSIONAL EXPERIENCE

Health Choice Arizona (Blue Cross Blue Shield of Arizona), Phoenix, Arizona | 2020-
Current Steward Health Choice Network, Phoenix, Arizona | 2019-2020
Health Choice Administration – Steward Health Care Network and Health Choice Arizona
Staff Vice President of Health Plan Operations (D-SNP)

Reporting to Chief Executive Officer of Health Choice Arizona. Responsible for specific aspects of Medicaid and Medicare lines of business, including Quality programs and initiatives, Member Experience, Medicare (D-SNP) Operations, Medicare Product Development and Sales, Risk Adjustment, Medicare compliance and Star Ratings.

Renown Health, Reno, NV | 2000-2019
Hometown Health Administration – Renown Health
Chief Operating and Government Programs Officer | 2015-2019

Responsible for Planning, Product Development, Customer Service, Reimbursement Services (Claims), Self-Funded marketing and operations, Worker's Compensation, Wellness, and ACO Medicare Shared Savings Board participation. Successful URAC Accreditation and collaboration with other operational areas such as Health Services, Network Services and Finance, including external partners through the Renown Health Integrated Health Delivery System.

Director of Government Programs | 2006-2015

Accountable for successful administration of all Medicare products (Medicare Advantage, Stand-Alone Prescription Drug Plans, and Medicare Supplement) offered by Hometown Health. Oversaw all operational areas of Medicare products, including, but not limited to, compliance, bid submission, administration of plans and benefits, marketing and advertising, enrollment, CMS audit coordination, and CMS relationships. Renown Health leader of the year in 2010.

Senior Care Plus Manager | 2005-2006

Operational accountability for Medicare Advantage-Prescription Drug (MA-PD) Plans. Supervised staff of individuals responsible for enrollment, sales and marketing, risk adjustment, bid submission and overall compliance.

Business Analyst| 2004-2005

Part of the Information Technology team, responsible for providing reporting and analytics as an aid in system wide decision making. Develop and maintain databases utilizing general ledger, medical management system, and Data Warehouse.

Senior Financial Analyst| 2003-2004

Reported directly to Director of Finance responsible for developing financial metrics, analytical reports of insured employer groups and medical providers' practices, analytical reports of operational and performance measures, as well as leadership accountabilities.

Financial Analyst | 2000-2003

As a member of the Decision Support team, responsible for analyzing provider fee schedules, referral and performance patterns, developing databases and query tools, present analysis of underlying trends to senior management for purpose of enhancing understanding of industry changes.

EDUCATION

University of Nevada - Reno, Reno, NV; Master's in Public Administration (MPA) — In Progress
University of the Pacific, Stockton, CA; Master's in Business Administration (MBA) - Graduated
Northern Arizona University, Flagstaff, AZ; Bachelor of Science in Business Administration (BSBA) – Graduated

OTHER TRAINING

America's Health Insurance Plans (AHIP) – Executive Leadership Program, Certified Health Insurance Executive – 2011
Nevada Division of Insurance, Licensed Insurance Producer - Expired

Charlton A. Wilson, MD, FACP, FACHE

Flagstaff, AZ | (480) 419-0402 | charltonawilson@gmail.com | www.linkedin.com/in/charltonawilson/

Physician Executive

Executive-Level Leadership | Healthcare Management | Board-Certified Physician

I am a transformational thought leader and Physician Executive with an extensive track record of success. I am passionate about improving the accessibility, affordability, and quality of healthcare for diverse populations. I draw upon my experiences as a frontline primary care provider, as a senior leader in multi-billion-dollar public agencies and private sector enterprises, and as a policy developer in the halls of Congress to bring wisdom, caring, and critically tested analytical skills to help healthcare organizations thrive and improve the health of communities they serve.

I have built and empowered large-scale healthcare workforces which far exceeded patient, customer, and organizational expectations by creating cultures that promote diversity & inclusion, professional development, and person-centered approaches. I have outstanding writing skills with success in multiple proposals and grants and over 50 peer-reviewed journal articles and book chapters. I am a sought-after speaker, lecturer, and trusted media contact. I have a rich professional network, have built coalitions, and have served as a valued community board member and trusted advisor.

- Population Health
- Practice Transformation
- Strategic Planning & Analysis
- Operations & Budget Management
- Public & Private Sector Programs
- Health Insurance
- Acute, Behavioral, LTSS, I/DD, & Foster Care Benefit Management
- Coalitions & Partnerships
- Program Evaluation & Research
- Emotional Intelligence
- Team Building & Leadership
- Talent Management
- Staff Training & Development
- Employee Engagement

PROFESSIONAL EXPERIENCE

BLUE CROSS BLUE SHIELD OF ARIZONA, HEALTH CHOICE, Phoenix, AZ 2023 –

Medical Director, Long-Term Services and Supports

Delivering member-focused leadership with policy, implementation, and operational knowledge and experience

CHARLTON A WILSON HEALTHCARE CONSULTING LLC, Flagstaff, AZ 2022 –

Owner and managing member

Bringing wisdom, caring, and critically tested analytical skills to help healthcare organizations and government agencies thrive and improve the health of the communities they serve.

- Transformational Fellow at the NARBHA Institute, Flagstaff, AZ

NATIONAL ACADEMY OF MEDICINE, Washington, DC 2021 – 2022

Robert Wood Johnson Foundation Health Policy Fellow

Chosen as one of only six professionals from across the US for the coveted fellowship program, the "***…nation's most prestigious learning experience at the nexus of health, science, and policy in Washington, D.C.***."

- Served as a Congressional Fellow and Staff Assistant for the US House of Representatives, Committee on Energy & Commerce, Subcommittee on Health.
- Researched, analyzed, and influenced key health policies and delivered critical insights for committee hearings and high-priority legislative actions.
  - ➢ Areas of experience included Medicare & Medicaid, health insurance, mental health & substance abuse, Telehealth, biomedical research & development, public health, medical drug & device safety, and more.

MERCY CARE, Phoenix, AZ 2010 – 2021

Chief Medical Officer

Led all clinical operations and established the strategic priorities for the $4B nonprofit health plan to provide best-in- class care for 400K+ members covered under Medicaid, Medicare Advantage, and other related benefit programs. Answered directly to the Mercy Care Board of Directors and national CVS/Aetna Medicaid Administrators. Served as the go-to resource in the organization for leading mission-driven successes in both nonprofit and for-profit business practices.

- Delivered the critical leadership that catapulted the organization through tremendous growth, going from $2B to over $4B in annual revenue while continually earning top healthcare quality ratings in the state.

- ➢ Directed and won seven major procurements, among other leadership efforts vital to making the organization into the largest Medicaid Health Plan in Arizona, one of only two serving every county.
- Spearheaded priority initiatives in Practice Transformation, Data Analytics, Behavioral & Physical Health Integration, Accountable Care Organization Models, Quality Improvement, and more to keep the health plan at the forefront of healthcare innovation and trends.
- Set a high bar for performance and quality of care across all areas while employing fair and transparent processes to handle/resolve member and provider issues and create an exceptional level of trust statewide.
- Instilled a vibrant culture to empower the success of the diverse, 500+ employee workforce and earn the highest employee engagement scores (93%) across the region.
- Worked hand-in-hand with state leaders to champion policies to increase coverage for ACA populations and integrate behavioral, physical, crisis, & substance abuse services and other priority areas.
- Forged strategic partnerships with county, state, & municipal health programs, top regional educational institutions, health advocacy groups, community coalitions, and others.
- Showcased thought leadership in the face of the unprecedented pandemic, quickly pivoting to rollout vaccination access, Telehealth `flexibilities, and other innovative programs to provide mission-critical health services during the public health emergency.

US PUBLIC HEALTH SERVICE (USPHS), INDIAN HEALTH SERVICE (IHS), Multiple Locations 1990 – 2010

Captain – Commissioned Corps

Directed several mission-critical clinical care and other programs over 20 years for the Indian Health Service (IHS), a $4B agency, meeting the needs of 2M+ beneficiaries across the United States.

- Awarded multiple USPHS medals for outstanding clinical care and agency-advancing research efforts as a Primary Care Physician with expertise in HIV, diabetes, and managing chronic diseases.
- Traveled throughout the US as an IHS consultant to play a vital role in improving clinical standards of care, healthcare service delivery, and disease management programs.
- Lauded by organizational peers and leaders for managing Hospital Incident Command and USPHS Deployment Support programs and innovative scientific investigations during the initial new world Hantavirus outbreak.
- Turned around a significant `fiscal crisis as the Interim CEO and COO for one of the largest IHS facilities by addressing the root causes of business performance, maximizing the performance of 1K+ staff, and leading successful reaccreditation processes.
- Delivered exceptional rural healthcare as a Physician and Clinical Director at the Mescalero Indian Hospital in New Mexico.

CURRENT ACADEMIC APPOINTMENTS

Professor of Practice– Arizona State University, College of Health Solutions

Clinical Assistant Professor – Department of Internal Medicine, University of Arizona's College of Medicine, Phoenix

Research & Training Consultant, Centers for American Indian & Alaska Native Health, Colorado School of Public Health, & Arizona State University, College of Health Solutions.

EDUCATION & TRAINING

Internship/Residency, The Johns Hopkins Hospital, Baltimore, MD

M.D., University of Texas Health Science Center, Houston, TX

B.A. in History (Cum Laude), Texas A&M University, College Station, TX

LICENSES & CERTIFICATIONS

Active Licenses in Arizona & New Mexico | Board Certified, American Board of Internal Medicine

Board Certified, Board of Governors, American College of Healthcare Executives

HONORS & AFFILIATIONS

Fellow of the American College of Physicians | Fellow of the American College of Healthcare Executives

BRIANNA BARRIOS

T: 928.856.4296
E: babarrios01@gmail.com

Summary of Qualifications

- Proven success in designing and implementing applied health psychology projects
- A demonstrated ability to collaborate with key stakeholders in the community
- Extensive training, education, and experience in providing crisis management and disaster response services

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Education

Northern Arizona University (NAU), Flagstaff, Arizona — **2016 - 2018**
Master's degree in Psychological Sciences

Northern Arizona University (NAU), Flagstaff, Arizona Bachelor of Arts in Psychological Sciences, with Summa Cum Laude Bachelor of Science in Sociology, with Summa Cum Laude — **2012 - 2016**

Professional Experience

Manager of Health Equity Advancement — **Sept 2022 – Present**
Blue Cross Blue Shield of Arizona Health Choice, Flagstaff, Arizona

- Manage a diverse team of staff who are responsible for programs related to population health and advancing health equity
- Maintain and implement programs aimed at reducing disparities and enhancing care for members in collaboration with key stakeholders
- Ensure compliance with NCQA, AHCCCS, and CMS regulations
- Monitor and analyze integrated healthcare and health equity data

Crisis Services Coordinator | Disaster Response Coordinator — **Feb 2019 – Sept 2022**
Blue Cross Blue Shield of Arizona Health Choice, Flagstaff, Arizona

- Manage the behavioral health crisis system across six Arizona counties
- Manage health plan operations and coordinate crisis support during emergencies across the state, including COVID-19 and wildfires
- Analyze crisis system data and collaborate with key stakeholders, like law enforcement and Tribal partners, to improve the delivery of services
- Recipient of CEO Award of Excellence

Crisis Response Lead Advocate — **May 2018 - Feb 2019**
Victim Witness Services for Coconino County, Flagstaff, Arizona

- Manage the crisis response program, including the coordination of trainings, supervision of crisis responders, and oversight of volunteers
- Provide advocacy to victims of crime and crisis in Coconino County
- Facilitate the children's domestic violence support group

Crisis Responder — **May 2016 - May 2018**
Victim Witness Services for Coconino County, Flagstaff, Arizona

- Provide 24-hour crisis response mobile advocacy for Coconino County
- Collaborate with community partners to address client's immediate needs
- Support volunteer responders by debriefing and offering encouragement

Research Assistant — **June 2017 – Dec 2017**
Center for Health Equity Research, NAU, Flagstaff, Arizona
- Prepare for the research period. By producing literature reviews, developing survey materials, and refining data protocols
- Administer surveys and other test procedures to consenting inmates in the Coconino County Detention Facility
- Facilitate collaboration and act as a liaison between research partners and justice partners

Sexual Assault / Relationship Violence Graduate Assistant — **Aug 2016 - May 2017**
Health Promotion, Campus Health Services, NAU, Flagstaff, Arizona
- Deliver Bystander Intervention training to NAU affiliates
- Implement campus-wide events and initiatives to educate and prevent sexual assault and relationship violence
- Lead the Sexual Assault / Relationship Task Force on campus

Intern — **Jan 2016 - May 2016**
Victim Witness Services for Coconino County, Flagstaff, Arizona
- Assist director in community outreach and promotion of services
- 24-hour crisis response mobile advocacy to survivors of crime
- Complete crisis response mobile advocacy training (40 hours), in addition to other advanced trainings

Certifications and Trainings

• Grief Following Trauma	August 2022
• Suicide Prevention, Intervention, and Postvention	July 2022
• Critical Incident Stress Management: Group and Individual/Peer Support	December 2020
• MGT439: Pediatric Disaster Response and Emergency Preparedness	October 2019
• Psychological First Aid (PFA)	May 2019
• Mental Health First Aid (MHFA)	May 2019
• Association for Training on Trauma and Attachment in Children	October 2018
• Arizona Advanced Academy for Victim Assistance	June 2018
• Sex Trafficking in Coconino County	June 2017
• Forensic Experiential Trauma Interviewing	June 2017
• Victim Witness Services 40-Hour Crisis Response Training	February 2016

Publications

Arazan, C. L., **Barrios, B. A.**, Brown, M. S., & Dmitrieva, N. O. (2019). Measuring Health in Jails: Limitations and Opportunities in Measurement of Health-Related Constructs. *Practicing Anthropology*, *41*(4), 21-25.

Trotter, R., Camplain, R., Eaves, E., Fofanov, V., Dmitrieva, N., Hepp, C., Warren, M., **Barrios, B.,** Pagel, N., Mayer, A., & Baldwin, J. (2018) Health Disparities and Converging Epidemics in Jail Populations: Protocol for a Mixed-Methods Study. *JMIR Research Protocols*, *7(10).*

Part C

CAPITATION AGREEMENT/ ADMINISTRATIVE AND CASE MANAGEMENT COST COMPONENT BID

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

C1

Agreement Accepting Capitation Rates

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

October 2, 2023

Meggan LaPorte, CPPO, MSW
Chief Procurement Officer
801 East Jefferson Road
Phoenix, Arizona 85034

Re: ALTCS EPD RFP NO YH24-0001
Section C1 Agreement Accepting Capitation Rates

Ms. LaPorte:

As require by the ALTCS EPD RFP No YH24-0001, Health Choice Arizona, Inc. will accept the actuarially sound capitation rates prior to October 1, 2024.

The legal entity submitting this bid is Health Choice Arizona, Inc. Consistent with the RFP, it is our understanding and expectation that such rates will be developed by AHCCCS' actuaries according to the applicable provisions of 42 CFR Part 438, applicable Actuarial Standards of Practice, and other generally accepted actuarial principles and practices.

Sincerely,

Health Choice Arizona, Inc.
Company Name

Signature of Person Authorized to Sign Agreement

8220 N 23rd Avenue
Address

Shawn Nau
Printed Name

Phoenix AZ 85021
City State Zip

Chief Executive Officer
Title

C2

Administrative Cost Component Bid

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Admin Bid MMs 0-34,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars
Compensation	$ 89.82	$ 2,750,488	$ 92.51	$ 2,854,412	$ 95.29	$ 2,962,310	$ 98.15	$ 3,074,336	$ 101.09	$ 3,190,649
Occupancy	$ 0.13	$ 284,836	$ 0.13	$ 293,381	$ 0.13	$ 302,183	$ 0.13	$ 311,248	$ 0.13	$ 320,586
Depreciation	$ -	$ 14,520	$ -	$ 14,956	$ -	$ 15,404	$ -	$ 15,866	$ -	$ 16,342
Care Management/Care Coordination	$ 0.06	$ 1,627	$ 0.06	$ 1,676	$ 0.07	$ 1,726	$ 0.07	$ 1,778	$ 0.07	$ 1,831
Professional and Outside Services	$ 12.72	$ 470,764	$ 13.10	$ 484,887	$ 13.50	$ 499,433	$ 13.90	$ 514,416	$ 14.32	$ 529,849
Office Supplies and Equipment	$ 6.92	$ 287,695	$ 5.96	$ 296,326	$ 6.13	$ 305,216	$ 6.32	$ 314,372	$ 6.51	$ 323,803
Travel	$ 0.59	$ 1,299	$ 0.61	$ 1,338	$ 0.62	$ 1,378	$ 0.64	$ 1,420	$ 0.66	$ 1,462
Repair and Maintenance	$ 12.43	$ 449,696	$ 12.80	$ 463,187	$ 13.19	$ 477,083	$ 13.58	$ 491,395	$ 13.99	$ 506,137
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 90,846	$ -	$ 93,572	$ -	$ 96,379	$ -	$ 99,270	$ -	$ 102,248
Marketing	$ 0.16	$ 67,592	$ 0.16	$ 69,620	$ 0.16	$ 71,709	$ 0.16	$ 73,860	$ 0.16	$ 76,076
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.58	$ -	$ 1.63	$ -	$ 1.68	$ -	$ 1.73	$ -	$ 1.78	$ -
Third Party Activities	$ 3.30	$ 10,848	$ 3.40	$ 11,174	$ 3.50	$ 11,509	$ 3.61	$ 11,854	$ 3.71	$ 12,210
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.09	$ 48,193	$ 0.10	$ 49,639	$ 0.10	$ 51,128	$ 0.10	$ 52,662	$ 0.10	$ 54,242
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.32	$ 200	$ 0.32	$ 206	$ 0.32	$ 213	$ 0.32	$ 219	$ 0.32	$ 226
Total Admin Costs	$ 128.60	$ 4,478,607	$ 131.26	$ 4,634,374	$ 135.18	$ 4,795,671	$ 139.22	$ 4,962,698	$ 143.38	$ 5,135,661
Member Months Assumed in Bid		31,200		31,200		31,200		31,200		31,200

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 35,000-69,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 66.59	$ 3,132,446	$ 68.59	$ 3,249,715	$ 70.65	$ 3,371,434	$ 72.77	$ 3,497,774	$ 74.95	$ 3,628,911
Occupancy	$ 0.12	$ 373,528	$ 0.12	$ 384,734	$ 0.12	$ 396,276	$ 0.12	$ 408,164	$ 0.12	$ 420,409
Depreciation	$ -	$ 19,141	$ -	$ 19,716	$ -	$ 20,307	$ -	$ 20,916	$ -	$ 21,544
Care Management/Care Coordination	$ 0.06	$ 2,153	$ 0.06	$ 2,217	$ 0.06	$ 2,284	$ 0.06	$ 2,352	$ 0.06	$ 2,423
Professional and Outside Services	$ 11.66	$ 619,724	$ 12.01	$ 638,316	$ 12.37	$ 657,466	$ 12.74	$ 677,190	$ 13.12	$ 697,505
Office Supplies and Equipment	$ 6.26	$ 377,978	$ 5.44	$ 389,317	$ 5.60	$ 400,997	$ 5.77	$ 413,026	$ 5.94	$ 425,417
Travel	$ 0.53	$ 1,971	$ 0.55	$ 2,030	$ 0.57	$ 2,091	$ 0.58	$ 2,154	$ 0.60	$ 2,218
Repair and Maintenance	$ 11.28	$ 592,228	$ 11.62	$ 609,995	$ 11.97	$ 628,295	$ 12.33	$ 647,144	$ 12.70	$ 666,558
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 122,053	$ -	$ 125,714	$ -	$ 129,486	$ -	$ 133,370	$ -	$ 137,371
Marketing	$ 0.15	$ 89,020	$ 0.15	$ 91,691	$ 0.15	$ 94,441	$ 0.15	$ 97,275	$ 0.15	$ 100,193
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.44	$ -	$ 1.48	$ -	$ 1.53	$ -	$ 1.57	$ -	$ 1.62	$ -
Third Party Activities	$ 3.03	$ 14,225	$ 3.12	$ 14,652	$ 3.21	$ 15,092	$ 3.31	$ 15,544	$ 3.41	$ 16,011
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.08	$ 63,214	$ 0.09	$ 65,110	$ 0.09	$ 67,064	$ 0.09	$ 69,076	$ 0.09	$ 71,148
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.30	$ 263	$ 0.30	$ 271	$ 0.30	$ 279	$ 0.30	$ 287	$ 0.30	$ 296
Total Admin Costs	$ 101.96	$ 5,407,945	$ 103.99	$ 5,593,479	$ 107.09	$ 5,785,510	$ 110.29	$ 5,984,272	$ 113.58	$ 6,190,005
Member Months Assumed in Bid		45,000		45,000		45,000		45,000		45,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 70,000-104,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 42.48	$ 4,057,537	$ 43.76	$ 4,207,139	$ 45.07	$ 4,362,344	$ 46.42	$ 4,523,364	$ 47.82	$ 4,690,421
Occupancy	$ 0.10	$ 587,069	$ 0.10	$ 604,681	$ 0.10	$ 622,821	$ 0.10	$ 641,506	$ 0.10	$ 660,751
Depreciation	$ -	$ 30,315	$ -	$ 31,225	$ -	$ 32,161	$ -	$ 33,126	$ -	$ 34,120
Care Management/Care Coordination	$ 0.05	$ 3,441	$ 0.05	$ 3,544	$ 0.05	$ 3,650	$ 0.05	$ 3,760	$ 0.05	$ 3,873
Professional and Outside Services	$ 10.21	$ 979,753	$ 10.52	$ 1,009,146	$ 10.83	$ 1,039,420	$ 11.16	$ 1,070,603	$ 11.49	$ 1,102,721
Office Supplies and Equipment	$ 5.48	$ 595,849	$ 4.77	$ 613,724	$ 4.92	$ 632,136	$ 5.06	$ 651,100	$ 5.21	$ 670,633
Travel	$ 0.46	$ 3,856	$ 0.47	$ 3,971	$ 0.49	$ 4,090	$ 0.50	$ 4,213	$ 0.52	$ 4,339
Repair and Maintenance	$ 9.73	$ 937,835	$ 10.03	$ 965,970	$ 10.33	$ 994,949	$ 10.64	$ 1,024,797	$ 10.96	$ 1,055,541
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 198,562	$ -	$ 204,518	$ -	$ 210,654	$ -	$ 216,974	$ -	$ 223,483
Marketing	$ 0.13	$ 140,791	$ 0.13	$ 145,015	$ 0.13	$ 149,365	$ 0.13	$ 153,846	$ 0.13	$ 158,461
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.25	$ -	$ 1.28	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.40	$ -
Third Party Activities	$ 2.66	$ 22,356	$ 2.74	$ 23,026	$ 2.82	$ 23,717	$ 2.91	$ 24,429	$ 2.99	$ 25,161
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.07	$ 99,397	$ 0.07	$ 102,378	$ 0.08	$ 105,450	$ 0.08	$ 108,613	$ 0.08	$ 111,872
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.27	$ 414	$ 0.27	$ 426	$ 0.27	$ 439	$ 0.27	$ 452	$ 0.27	$ 466
Total Admin Costs	$ 73.36	$ 7,657,172	$ 74.67	$ 7,914,763	$ 76.90	$ 8,181,196	$ 79.19	$ 8,456,782	$ 81.55	$ 8,741,842

Member Months Assumed in Bid		81,600		81,600		81,600		81,600		81,600

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 105,000-139,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.45	$ 5,129,227	$ 46.82	$ 5,319,232	$ 48.22	$ 5,516,382	$ 49.67	$ 5,720,949	$ 51.16	$ 5,933,216
Occupancy	$ 0.09	$ 698,082	$ 0.09	$ 719,024	$ 0.09	$ 740,595	$ 0.09	$ 762,813	$ 0.09	$ 785,697
Depreciation	$ -	$ 36,225	$ -	$ 37,312	$ -	$ 38,432	$ -	$ 39,584	$ -	$ 40,772
Care Management/Care Coordination	$ 0.05	$ 3,968	$ 0.05	$ 4,088	$ 0.05	$ 4,210	$ 0.05	$ 4,336	$ 0.05	$ 4,467
Professional and Outside Services	$ 9.53	$ 1,166,155	$ 9.82	$ 1,201,140	$ 10.12	$ 1,237,174	$ 10.42	$ 1,274,289	$ 10.73	$ 1,312,518
Office Supplies and Equipment	$ 5.25	$ 708,494	$ 4.50	$ 729,749	$ 4.64	$ 751,641	$ 4.78	$ 774,191	$ 4.92	$ 797,416
Travel	$ 0.44	$ 3,552	$ 0.45	$ 3,658	$ 0.46	$ 3,768	$ 0.48	$ 3,881	$ 0.49	$ 3,998
Repair and Maintenance	$ 9.11	$ 1,105,764	$ 9.39	$ 1,138,937	$ 9.67	$ 1,173,105	$ 9.96	$ 1,208,298	$ 10.26	$ 1,244,547
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 241,151	$ -	$ 248,386	$ -	$ 255,837	$ -	$ 263,513	$ -	$ 271,418
Marketing	$ 0.12	$ 168,058	$ 0.12	$ 173,099	$ 0.12	$ 178,292	$ 0.12	$ 183,641	$ 0.12	$ 189,150
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.15	$ -	$ 1.19	$ -	$ 1.22	$ -	$ 1.26	$ -	$ 1.30	$ -
Third Party Activities	$ 2.48	$ 26,586	$ 2.55	$ 27,384	$ 2.63	$ 28,205	$ 2.71	$ 29,051	$ 2.79	$ 29,923
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.07	$ 118,093	$ 0.07	$ 121,636	$ 0.07	$ 125,285	$ 0.07	$ 129,043	$ 0.08	$ 132,915
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.26	$ 491	$ 0.26	$ 506	$ 0.26	$ 521	$ 0.26	$ 537	$ 0.26	$ 553
Total Admin Costs	$ 74.46	$ 9,405,847	$ 75.78	$ 9,724,150	$ 78.04	$ 10,053,448	$ 80.37	$ 10,394,127	$ 82.76	$ 10,746,590

Member Months Assumed in Bid		105,000		105,000		105,000		105,000		105,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 140,000-174,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 37.89	$ 5,819,229	$ 39.02	$ 6,033,639	$ 40.19	$ 6,256,075	$ 41.40	$ 6,486,840	$ 42.64	$ 6,726,252
Occupancy	$ 0.08	$ 840,389	$ 0.08	$ 865,600	$ 0.08	$ 891,568	$ 0.08	$ 918,315	$ 0.08	$ 945,865
Depreciation	$ -	$ 43,904	$ -	$ 45,221	$ -	$ 46,578	$ -	$ 47,975	$ -	$ 49,415
Care Management/Care Coordination	$ 0.04	$ 4,758	$ 0.04	$ 4,901	$ 0.04	$ 5,048	$ 0.04	$ 5,199	$ 0.05	$ 5,355
Professional and Outside Services	$ 8.70	$ 1,409,377	$ 8.96	$ 1,451,658	$ 9.23	$ 1,495,208	$ 9.51	$ 1,540,064	$ 9.80	$ 1,586,266
Office Supplies and Equipment	$ 4.85	$ 854,382	$ 4.14	$ 880,013	$ 4.26	$ 906,414	$ 4.39	$ 933,606	$ 4.52	$ 961,614
Travel	$ 0.40	$ 4,342	$ 0.41	$ 4,472	$ 0.42	$ 4,606	$ 0.44	$ 4,744	$ 0.45	$ 4,887
Repair and Maintenance	$ 8.26	$ 1,331,930	$ 8.50	$ 1,371,888	$ 8.76	$ 1,413,044	$ 9.02	$ 1,455,436	$ 9.29	$ 1,499,099
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 298,805	$ -	$ 307,769	$ -	$ 317,003	$ -	$ 326,513	$ -	$ 336,308
Marketing	$ 0.11	$ 203,419	$ 0.11	$ 209,521	$ 0.11	$ 215,807	$ 0.11	$ 222,281	$ 0.11	$ 228,949
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.04	$ -	$ 1.07	$ -	$ 1.10	$ -	$ 1.14	$ -	$ 1.17	$ -
Third Party Activities	$ 2.26	$ 32,006	$ 2.33	$ 32,966	$ 2.40	$ 33,955	$ 2.47	$ 34,974	$ 2.55	$ 36,023
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.06	$ 142,149	$ 0.06	$ 146,414	$ 0.07	$ 150,806	$ 0.07	$ 155,331	$ 0.07	$ 159,990
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.24	$ 591	$ 0.24	$ 609	$ 0.24	$ 627	$ 0.24	$ 646	$ 0.24	$ 666
Total Admin Costs	$ 64.39	$ 10,985,282	$ 65.45	$ 11,354,673	$ 67.40	$ 11,736,739	$ 69.41	$ 12,131,925	$ 71.48	$ 12,540,689

Member Months Assumed in Bid		140,000		140,000		140,000		140,000		140,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 175,000+

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 31.85	$ 6,357,797	$ 32.81	$ 6,591,071	$ 33.79	$ 6,833,046	$ 34.81	$ 7,084,050	$ 35.85	$ 7,344,424
Occupancy	$ 0.08	$ 957,549	$ 0.08	$ 986,276	$ 0.08	$ 1,015,864	$ 0.08	$ 1,046,340	$ 0.08	$ 1,077,730
Depreciation	$ -	$ 50,361	$ -	$ 51,872	$ -	$ 53,428	$ -	$ 55,030	$ -	$ 56,681
Care Management/Care Coordination	$ 0.04	$ 5,466	$ 0.04	$ 5,630	$ 0.04	$ 5,799	$ 0.04	$ 5,973	$ 0.04	$ 6,152
Professional and Outside Services	$ 8.01	$ 1,613,446	$ 8.25	$ 1,661,850	$ 8.50	$ 1,711,705	$ 8.76	$ 1,763,057	$ 9.02	$ 1,815,948
Office Supplies and Equipment	$ 4.52	$ 975,677	$ 3.83	$ 1,004,947	$ 3.95	$ 1,035,095	$ 4.07	$ 1,066,148	$ 4.19	$ 1,098,133
Travel	$ 0.36	$ 5,670	$ 0.37	$ 5,840	$ 0.38	$ 6,016	$ 0.40	$ 6,196	$ 0.41	$ 6,382
Repair and Maintenance	$ 7.52	$ 1,524,366	$ 7.74	$ 1,570,096	$ 7.97	$ 1,617,199	$ 8.21	$ 1,665,715	$ 8.46	$ 1,715,687
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 350,216	$ -	$ 360,722	$ -	$ 371,544	$ -	$ 382,690	$ -	$ 394,171
Marketing	$ 0.10	$ 233,049	$ 0.10	$ 240,041	$ 0.10	$ 247,242	$ 0.10	$ 254,659	$ 0.10	$ 262,299
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 0.95	$ -	$ 0.98	$ -	$ 1.01	$ -	$ 1.04	$ -	$ 1.07	$ -
Third Party Activities	$ 2.09	$ 36,466	$ 2.15	$ 37,560	$ 2.21	$ 38,687	$ 2.28	$ 39,848	$ 2.35	$ 41,043
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.06	$ 162,001	$ 0.06	$ 166,861	$ 0.06	$ 171,867	$ 0.06	$ 177,023	$ 0.06	$ 182,333
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.22	$ 674	$ 0.22	$ 695	$ 0.22	$ 715	$ 0.22	$ 737	$ 0.22	$ 759
Total Admin Costs	$ 56.25	$ 12,272,738	$ 57.11	$ 12,683,461	$ 58.81	$ 13,108,208	$ 60.56	$ 13,547,466	$ 62.37	$ 14,001,743

Member Months Assumed in Bid		175,000		175,000		175,000		175,000		175,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

C3

Case Management Cost Component Bid

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

ALTCS-EPD Case Management Component Bid										
	North GSA			Central GSA			South GSA			
Assumptions:	**Non-SMI**	**SMI**	**Total**	**Non-SMI**	**SMI**	**Total**	**Non-SMI**	**SMI**	**Total**	
Number of ALTCS-EPD enrollment: [1]	2,194	171	2,365	5,375	463	5,838	2,856	256	3,113	
Institutional Mix %: [1]	28.8%	26.5%	28.7%	19.6%	33.9%	20.7%	25.6%	38.7%	26.6%	
Acute Care Only Mix %: [1]	2.9%	1.4%	2.8%	3.0%	0.9%	2.8%	1.7%	1.1%	1.6%	
Alternative Home and Community Bases Service (HCBS) Mix %: [1]	23.0%	33.7%	23.7%	29.4%	42.1%	30.4%	21.6%	33.0%	22.6%	
HCBS (own home) Mix %: [1]	45.3%	38.4%	44.8%	48.0%	23.1%	46.1%	51.1%	27.2%	49.2%	
Average Case Management Manager total compensation (includes ERE)	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	
Average Case Management Supervisor total compensation (includes ERE)	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	
Average Case Management Administration Support Staff total compensation (includes ERE)	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	
Maximum Members per Case Manager (Institutional) [2]	94.0	67.1	91.5	94.0	67.1	89.4	94.0	67.1	89.7	
Maximum Members per Case Manager (Acute Care Only) [2]	94.0	94.0	94.0	94.0	94.0	94.0	94.0	94.0	94.0	
Maximum Members per Case Manager (Alternative HCBS) [2]	52.2	49.5	51.9	52.2	49.5	51.9	52.2	49.5	51.9	
Maximum Members per Case Manager (HCBS Own Home) [2]	42.7	31.3	41.8	42.7	31.3	42.1	42.7	31.3	42.0	
Average Travel Expenses per Case Management Manager	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	
Average Case Managers per Supervisor	14.5	14.5	14.5	14.5	14.5	14.5	14.5	14.5	14.5	
Average Administrative Support Staff per Supervisor	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	
Calculations:										
Case Management Manager FTEs required	40.3	4.0	44.3	103.6	9.7	113.3	54.3	5.4	59.7	
Case Management Manager salary and ERE	$4,090,546	$402,412	$4,492,958	$10,512,600	$987,717	$11,500,316	$5,510,488	$552,650	$6,063,138	
Case Management Supervisor FTEs required	2.8	0.3	3.1	7.1	0.7	7.8	3.7	0.4	4.1	
Case Management Supervisor salary and ERE	$394,671	$38,826	$433,498	$1,014,295	$95,299	$1,109,594	$531,673	$53,322	$584,994	
Case Management Administration Support Staff FTEs	0.3	0.0	0.3	0.8	0.1	0.9	0.4	0.0	0.5	
Case Management Administration Support Staff salary and ERE	$19,720	$1,940	$21,660	$50,679	$4,762	$55,441	$26,565	$2,664	$29,229	
Travel Costs	$200,497	$19,724	$220,221	$515,273	$48,413	$563,685	$270,095	$27,088	$297,183	
Total Annual Case Management Cost	$4,705,434	$462,903	$5,168,337	$12,092,847	$1,136,190	$13,229,036	$6,338,821	$635,724	$6,974,545	
Total Case Management PMPM			**$182.12**			**$188.84**			**$186.72**	

Footnotes:

1. AHCCCS prescribed values are based on GSA specific averages of enrollment and placement data between July and December 2022. AHCCCS will adjust the member enrollment and mix percentages once awards have been set and final distribution of membership is known.

2. Refer to AHCCCS Medical Policy Manual (AMPM) 1630 Section D. Caseload Management for maximum case load allowed for each setting.

C4

AHCCCS Long-Term Care for Individuals Who Are Elderly and/or Have a Physical Disability Solicitation #YH24-0001

C4. Actuarial Certification for Non-Benefit Costs Bid Submission

October 1, 2024, Through September 30, 2025

Prepared For:
AHCCCS Procurement Officer and Division of Health Care Management

Prepared By:
Nettie R. Meier, ASA, MAAA

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

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INTRODUCTION

Background & Limitations

The purpose of this letter is to provide documentation and actuarial certification in compliance with 42 CFR § 438 for the non-benefit costs (administrative and case management) bid submission of the Health Choice Arizona, Inc. (HCA) response to the Arizona Health Care Cost Containment System (AHCCCS) Long-Term Care for Individuals Who Are Elderly and/or Have a Physical Disability (ALTCS-EPD) Solicitation #YH24-0001. Included are the data, assumptions and methodology used in the development of the administrative and case management components of the HCA bid for services covered during the period beginning October 1, 2024, through September 30, 2025, known as Contract Year Ending (CYE) 2025.

This certification has been organized following the Centers for Medicare and Medicaid Services (CMS) 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide), which outlines the appropriate documentation and rate development standards needed for Medicaid managed care rate certifications.

This actuarial certification was prepared for the AHCCCS Procurement Officer, Meggan LaPorte, and the AHCCCS Division of Health Care Management Actuarial Team, for review of HCA's actuarially sound non-benefit costs bid submission. This certification may not be appropriate for any other purpose. The actuarial rates contained herein represent projections of future events which will vary from actual results. If this rate certification is made available to third parties, it should be provided and reviewed in its entirety. Any third party reviewing this certification should be familiar with the AHCCCS ALTCS-EPD Program, 42 CFR § 438, the CMS 2024 Guide, Actuarial Standards of Practice (ASOPs), and generally accepted actuarial principles and practices.

Executive Summary

The HCA non-benefit costs covered by this certification for the ALTCS-EPD Solicitation #YH24-0001 bid submission, effective for the twelve-month period October 1, 2024, though September 30, 2025, are summarized below.

Administrative Component Bid

		Membership Tier					
		0-34,999	35,000-69,999	70,000-104,999	105,000-139,999	140,000-174,999	175,000+
Member Months Assumed in Bid:		31,200	45,000	81,600	105,000	140,000	175,000
CYE 25: (10/1/24 - 9/30/25)	Variable Cost **PMPM**	$128.60	$101.96	$73.36	$74.46	$64.39	$56.25
	Fixed Cost Total **Dollars**	$4,478,607	$5,407,945	$7,657,172	$9,405,847	$10,985,282	$12,272,738
CYE 26: (10/1/25 - 9/30/26)	Variable Cost **PMPM**	$131.26	$103.99	$74.67	$75.78	$65.45	$57.11
	Fixed Cost Total **Dollars**	$4,634,374	$5,593,479	$7,914,763	$9,724,150	$11,354,673	$12,683,461
CYE 27: (10/1/26 - 9/30/27)	Variable Cost **PMPM**	$135.18	$107.09	$76.90	$78.04	$67.40	$58.81
	Fixed Cost Total **Dollars**	$4,795,671	$5,785,510	$8,181,196	$10,053,448	$11,736,739	$13,108,208
CYE 28: (10/1/27 - 9/30/28)	Variable Cost **PMPM**	$139.22	$110.29	$79.19	$80.37	$69.41	$60.56
	Fixed Cost Total **Dollars**	$4,962,698	$5,984,272	$8,456,782	$10,394,127	$12,131,925	$13,547,466
CYE 29: (10/1/28 - 9/30/29)	Variable Cost **PMPM**	$143.38	$113.58	$81.55	$82.76	$71.48	$62.37
	Fixed Cost Total **Dollars**	$5,135,661	$6,190,005	$8,741,842	$10,746,590	$12,540,689	$14,001,743

Case Management Component Bid

	North GSA	Central GSA	South GSA
Bid Prescribed Enrollment	2,365	5,838	3,113
Total Case Management **PMPM**	$182.12	$188.84	$186.72

SECTION I – MEDICAID MANAGED CARE RATES

The non-benefit cost development and documentation outlined throughout this certification is consistent with 42 CFR § 438, specifically 42 CFR § 438.4 through 42 CFR § 438.7. The rates discussed are developed in accordance with 42 CFR § 438.4(b), and in observance of the principles CMS uses to apply the regulation standards (as outlined in the 2024 Guide):

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR § 438 and generally accepted actuarial principles and practices.

In addition, the following relevant ASOPs were reviewed:

- ASOP No. 1 – Introductory Actuarial Standard of Practice
- ASOP No. 5 – Incurred Health and Disability Claims
- ASOP No. 12 – Risk Classification (for All Practice Areas)
- ASOP No. 23 – Data Quality
- ASOP No. 25 – Credibility Procedures
- ASOP No. 41 – Actuarial Communications
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development
- ASOP No. 56 – Modeling

The term "actuarially sound" referenced throughout this certification is defined consistent with ASOP 49:

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

1.1. General Information

A. Rate Development Standards

i. Standards and Documentation for Rate Ranges

All standards and documentation outlined in the 2024 Guide apply to the development of both individual capitation rates and capitation rate ranges. However, AHCCCS develops individual capitation rates for the ALTCS-EPD Program, so rate ranges are not applicable for this certification.

ii. Rating Period

The ALTCS-EPD CYE 2025 capitation rates are effective for the twelve-months beginning October 1, 2024, through September 30, 2025.

iii. Required Elements

(a) Letter from the Certifying Actuary

The actuarial certification letter for the HCA CYE 2025 non-benefit costs bid submission is found in Appendix 1. The signing actuary, Nettie R. Meier, meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the standards established by the Actuarial Standards Board. Nettie R. Meier, acting on behalf of HCA, certifies that the CYE 2025 non-benefit costs contained in Appendix 2 are actuarially sound, meet the standards

set forth in 42 CFR § 438, and are reasonable and appropriate for the purpose of the ALTCS-EPD Solicitation #YH24-0001 bid submission.

(b) Final and Certified Capitation Rates

This rate certification is only for the HCA non-benefit, specifically the administrative and case management, costs components of CYE 2025 ALTCS-EPD capitation rates. The benefit costs components for the corresponding rates will be developed by the AHCCCS Actuarial Team. Therefore, this certification does not include the actuarial certification for the final CYE 2025 capitation rates to be provided to CMS; this will be provided by AHCCCS actuaries at a future time. Per the AHCCCS Rate Development Documentation bid document, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management costs components, in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.

(c) Program Information

(i) Summary of the Program

According to the AHCCCS website (azahhhc.gov), ALTCS-EPD is health insurance for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care. Those who qualify do not have to reside in a nursing home, however. Many ALTCS members live in their own homes or an assisted living facility and receive needed services in a home or community-based setting.

The ALTCS-EPD Program delivers comprehensive integrated benefits, including long-term services and supports (LTSS), acute, behavioral health and case management services to eligible members. A full description of covered services is included in the "Program Requirements: Scope of Services" section of the Request For Proposal (RFP) Document, as well as the Service Matrix, both found in the solicitation Bidder's Library. The capitation rates fund prospective and prior period coverage for long-term, acute, behavioral health and case management services, as well as coverage of acute care services only for members that qualify for ALTCS-EPD but decline to receive LTSS care services.

Since the late 1980s, AHCCCS has operated the ALTCS-EPD Program on a statewide basis. As of the last ALTCS-EPD bid solicitation, AHCCCS has contracted with a total of three managed care organizations (MCOs) to provide services. However, the number of contracts has varied by Geographical Service Area (GSA). The following counties make up the three GSAs:

- North – Apache, Coconino, Mohave, Navajo, and Yavapai
- Central – Gila, Maricopa, and Pinal
- South – Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma

For the ALTCS-EPD Solicitation #YH24-0001, AHCCCS intends to make a total of three awards, awarding GSAs based upon the winning bids in each GSA. The maximum number of MCOs by GSA will be two in the North and South, and three in Central. Awards may therefore result in zero, one, or two statewide MCO(s). As requested, this certification includes HCA's non-benefit bid submission for all three GSAs.

(ii) Rating Period Covered

The rating period for the ALTCS-EPD CYE 2025 capitation rates is the twelve-month period beginning October 1, 2024, through September 30, 2025.

(iii) Covered Populations

The populations covered by the ALTCS-EPD Program are Title XIX individuals who are age 65 or older, and/or have a disability, and have been deemed eligible to receive nursing facility level of care services through AHCCCS. A full description of covered populations is included in the "Program Requirements: Purpose, Application and Introduction" section of the RFP Document in the solicitation Bidder's Library. The covered population is segmented into two risk groups for capitation rate development purposes:

- "Duals" – members who are dually eligible for Medicare and Medicaid,
- "Non-Duals" – members who are not eligible for Medicare.

ALTCS-EPD capitation rates vary by risk group, GSA and MCO. For purposes of this rate certification, HCA developed the administrative component of the non-benefit expense at the statewide level, and the case

management component by GSA, as requested for the bid submission. Per the Non-Benefit Costs Bid Requirements document in the RFP, AHCCCS will allocate non-benefit expenses between the dual and non-dual risk groups during the capitation rate development process for each year of the contract, in compliance with the current Managed Care Rate Setting Guidelines. The non-benefit costs will also be adjusted for membership volume after awards have been set and final distribution of membership is known.

(iv) Eligibility or Enrollment Criteria

AHCCCS determines eligibility for ALTCS-EPD members. The "Program Requirements: Eligibility" section of the RFP Document in the solicitation Bidder's Library outlines the following criteria:

- **Financial Eligibility:** Anyone may apply for ALTCS at any of the ALTCS eligibility offices located throughout the State. The applicant shall be an Arizona resident as well as a U.S. citizen or qualified legal immigrant as defined in A.R.S. § 36-2903.03. To qualify financially for the ALTCS Program, applicants shall have countable income and resources below certain thresholds. The AHCCCS Medical Assistance Eligibility Policy Manual provides a detailed discussion of all eligibility criteria. The Manual is available on the AHCCCS website.
- **Medical Eligibility:** In addition to financial eligibility, an individual shall meet the medical and functional eligibility criteria as established by the Preadmission Screening tool (PAS). The PAS is conducted by an AHCCCS Registered Nurse (RN) or Social Worker (SW) with consultation by a physician, if necessary, to evaluate the person's medical status. The PAS is used to determine whether the person is at immediate risk of placement in a Nursing Facility (NF). In most cases, AHCCCS does not re-evaluate the medical status of each ALTCS member annually; however, the MCO is responsible for notifying AHCCCS of significant changes in a member's condition, which may result in a change in eligibility.
- **Serious Emotional Disturbance/Serious Mental Illness (SED/SMI) Eligibility:** The MCO shall ensure the identification and assessment of enrolled members by qualified clinicians to identify those individuals who may meet the SED or SMI eligibility criteria as specified in the AHCCCS Medical Policy Manual (AMPM) Policy 320-P.

AHCCCS has the exclusive authority to enroll and disenroll members. AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment (passive enrollment) is used pursuant to the terms of the 1115 Waiver Special Terms and Conditions [42 CFR § 438.54(d)].

(v) Summary of Special Contract Provisions Related to Payment

Not applicable. This certification does not include special contract provisions.

(vi) Retroactive Capitation Rate Adjustments

Not applicable. This certification does not cover retroactive adjustments for previous capitation rates.

iv. Rate Development Standards and Federal Financial Participation (FFP)

Differences in assumptions, methodologies or factors used to develop the non-benefit costs bid submission are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations and are not based on the rate of FFP for the populations covered under the ALTCS-EPD Program.

v. Rate Cell Cross-subsidization

The final ALTCS-EPD capitation rates are set at the risk group level. Payments for one risk group therefore do not cross-subsidize other risk groups.

vi. Effective Dates of Changes

It is assumed the effective date of any changes will be October 1, 2024, consistent with the assumptions used to develop the CYE 2025 non-benefit costs included in this certification.

vii. Minimum Medical Loss Ratio

The assumed final certified capitation rates from AHCCCS will be developed so each ALTCS-EPD MCO would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 2025.

viii. Conditions for Certifying Capitation Rate Range

Not applicable. AHCCCS does not set a rate range for the ALTCS-EPD Program.

ix. Certifying Actuarially Sound Capitation Rate Range

Not applicable. AHCCCS does not set a rate range for the ALTCS-EPD Program.

x. Generally Accepted Actuarial Principles and Practices

(a) Reasonable, Appropriate and Attainable Costs

In the actuary's judgement, all adjustments to the fixed and variable components of the administrative costs as well as case management costs included in this certification reflect reasonable, appropriate, and attainable costs.

(b) Rate Setting Process

HCA anticipates AHCCCS will make adjustments to the capitation revenue during the rate setting process for the final CYE 2025 ALTCS-EPD rates, including the adjustments referenced above to the non-benefit costs contained in this certification. All other adjustments performed outside of the rate setting process are not considered actuarially sound under 42 CFR § 438.4.

(c) Contracted Rates

The final CYE 2025 contracted rates in each cell for the ALTCS-EPD program will be developed and certified by the AHCCCS Actuarial Team, matching the capitation rates included in their rate certification.

xi. Rates from Previous Rating Periods

The final CYE 2025 capitation rates will be certified for the period effective October 1, 2024 through September 30, 2025 by the AHCCCS Actuarial Team. Typically, this section is not applicable in the AHCCCS certifications as capitation rates from previous rating periods are not usually used in the development of future periods.

xii. COVID-19 Public Health Emergency (PHE) Assumptions, Impacts, and Risk Mitigation

The non-benefit costs included in this certification do not include any explicit adjustments related to the impact of the COVID-19 PHE and subsequent unwinding.

A review of the enrollment information included in the Data Book provided shows a decrease in annual ALTCS-EPD total membership from CYE 2020 to CYE 2021, and then again to CYE 2022. One possible cause could be the unfortunate disproportionate mortality associated with COVID-19 on the elderly and disabled population represented in the ALTCS-EPD Program. ALTCS-EPD was also not as impacted by the maintenance of effort (MOE) requirements as other AHCCCS populations. The MOE allowed members who became eligible for benefits before or during the PHE to remain eligible through the end of the PHE. This caused significant increases in enrollment and now subsequent disenrollments as part of the unwinding for other Medicaid populations. This phenomenon is not expected for the ALTCS-EPD program as the higher allowable income limits and age/medical criteria make it unlikely a member would lose eligibility once determined eligible for ALTCS-EPD. Due to these factors, HCA kept the enrollment assumption flat for the five years requested in the administrative costs bid submission. No other adjustments due to COVID-19 were applicable for the non-benefit costs components.

Risk mitigation strategies will be in place for ALTCS-EPD in CYE 2025 and will apply in the event of adverse impact due to the COVID-19 PHE. These are discussed in Section 1.4., Special Contract Provisions Related to Payment, below.

xiii. Rate Certification Procedures

Not applicable. The AHCCCS Actuarial Team will be certifying the final CYE 2025 capitation rates and any related contract amendments.

B. Appropriate Documentation

i. Capitation Rates or Rate Ranges

AHCCCS will be certifying capitation rates for each risk group described above, not rate ranges.

ii. Elements

This certification includes documentation of all data, assumptions and methodological elements used to develop the HCA CYE 2025 ALTCS-EPD non-benefit costs components.

iii. Capitation Rate Cell Assumptions

All assumptions and adjustments used in the development of the statewide administrative and GSA case management non-benefit costs are included in this certification.

iv. Capitation Rate Range Assumptions

Not applicable. AHCCCS does not set a rate range for the ALTCS-EPD Program.

v. Rate Certification Index

The table of contents, immediately following the cover page, serves as the index for this certification. Sections that are not applicable are noted throughout the narrative.

vi. Assurance Rate Assumptions Do Not Differ by FFP

Not applicable. AHCCCS will be completing the final rate certification for the CYE 2025 ALTCS-EPD Program that will be provided to CMS, including assurance that the assumptions do not differ by FFP.

vii. Differences in Federal Medical Assistance Percentage (FMAP)

Not applicable. AHCCCS will provide assurance that all covered populations under the ALTCS-EPD Program receive regular FMAP.

viii. Comparison to Prior Rates

Not applicable. Given HCA would be a new MCO contractor for the ALTCS-EPD Program, there are no prior non-benefit rates to compare to. However, we have reviewed the previous and current rates for other contractors available on the ACCCHS website and determined the rates included in this submission to be reasonable and appropriate.

ix. Future Rate Amendments

Not applicable. At this time, we are not expecting or considering future rate amendments. In the event of future amendments, we will work with AHCCCS to revise the non-benefit costs as needed during the final rate development process.

x. COVID-19 PHE Impacts

Since the beginning of the COVID-19 PHE, HCA has continued to monitor its impacts on our existing AHCCCS Complete Care (ACC) population, as well as State and industry information related to utilization, enrollment, vaccines, new treatments, etc. As we considered how the impacts of COVID-19 may relate to the ALTCS-EPD population, we determined no adjustments are necessary for the non-benefit costs included in this certification. Specific considerations include:

- **Enrollment:** As discussed above, enrollment is assumed to be flat given historical declines in member volume for this population combined with minimal impact due to the MOE requirements included in the Families First Coronavirus Response Act.
- **Non-Benefit Administrative Costs:** Some overhead expenses theoretically are lower now than historical levels as most staff have continued to work from home or adopt a hybrid working environment. However, because our baseline ACC experience used for the ALTCS-EPD administrative cost development was after the COVID-19 PHE timeframe, it already reflects this change in work environment. No other adjustments were considered necessary.
- **Non-Benefit Case Management Costs:** It is possible members' LTSS service needs have changed as a result of COVID-19, which could result in an impact on the benefit costs component of the rates that AHCCCS develops. While it was not a direct assumption related to the COVID-19 PHE, HCA has assumed a lower case manager weighted average caseload than the maximum prescribed by AHCCCS. This would allow additional capacity for case management staff should their work be more intense as a result of this potential change in LTSS need. The caseload assumption is described in more detail in Section 1.5.B.i. below.
- **Acuity:** Another potential impact is on the acuity of the covered population due to enrollment changes, changes in utilization of services, COVID-19 testing, new treatments and vaccines, deferred care, and/or expanded coverage of telehealth, etc. Impacts for any of these reasons would be reflected in the benefit cost component of the capitation rates. However, AHCCCS described in their CYE 2024 rate certification letter:

  > *"The LTSS and acute care services received by the members in the ALTCS-EPD Program were not affected by the PHE in the same manner as acute care services for traditional populations. Similarly, the ALTCS-EPD Program enrollment was not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs were… which resulted in the evaluation of changes in acuity being negligible… and so while*

the population was evaluated for acuity changes, no adjustments to the rates were made as they were unnecessary."

- **Risk Mitigation:** Strategies will be in place for ALTCS-EPD in CYE 2025 and will apply in the event of adverse impact due to COVID-19 PHE.

1.2. Data

Not Applicable. Given this certification only pertains to the non-benefit costs component of the capitation rates, we are not including a discussion of benefit cost base data, nor our internal projections of final ALTCS-EPD capitation rates. HCA did however review the Data Book information that was provided by AHCCCS as part of the Solicitation #YH24-0001 Bidder's Library for reasonableness, as well as previous rates and financial reports from the current contractors. We have not performed an audit of any of this information, relying on the ongoing review and audit performed by the AHCCCS Actuarial Team. We determined this information is reasonable however for our internal financial projections.

A discussion of non-benefit costs data is included in Section 1.5.

1.3. Projected Benefit Costs and Trends

Not applicable. Given this certification only pertains to the non-benefit costs component of the capitation rates, we are not including a discussion of benefit costs trend. We did however review historical AHCCCS ALTCS-EPD trend projections for reasonableness and inclusion in our internal projections of the final ALTCS-EPD capitation rates.

A discussion of non-benefit costs trend is included in Section 1.5.

1.4. Special Contract Provisions Related to Payment

The following reflects information provided by AHCCCS in the Rate Development Documentation included in the Solicitation #YH24-0001 Bidder's Library, the Solicitation Program Requirements as well as the CYE 2024 Capitation Rate Certification for the ALTCS-EPD Program. In accordance with 42 CFR § 438.6, an MCO may be subject to a withhold arrangement, eligible for incentive payments, participate in delivery system and provider payment initiatives, and/or direct payments to providers. A summary of the provisions determined by AHCCCS for the ALTCS-EPD Program are specified below. The AHCCCS Actuarial Team provides additional documentation of these provisions in the final capitation rate certification.

A. Incentive Arrangements

An incentive arrangement, as defined in 42 CFR § 438.6(a), is any payment mechanism under which a managed care plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract. AHCCS provides for the following incentive arrangements:

- **Alternative Payment Model (APM) Initiative – Withhold and Quality Measure Performance (QMP) Incentive:** The APM Withhold and QMP incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for performance on select performance measures identified in AHCCCS Contractor Operations Manual (ACOM) Policy 306. AHCCCS will make a lump-sum payment after the completion of the contract year and the computation of the performance measures.
- **Alternative Payment Model Initiative – Performance Based Payments (APM-PBP):** The APM-PBP incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care. In accordance with ACOM Policy 307, for those APM arrangements which result in PBP to providers, AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year.

B. Withhold Arrangements

The APM Initiative – Withhold and QMP incorporates a withhold arrangement of 1% of capitation and a portion of, or all of, the withheld amount will be paid for performance on select performance measures identified in ACOM Policy 306. AHCCCS will apply the withhold after the completion of the contract year by recouping the full amount of the annual withhold. Also, after the completion of the contract year and the computation of the performance measures including measure stratifications, AHCCCS will reconcile the Contractor's earned portion of the withhold against the withheld funds and will make a lump-sum payment to the Contractor. The Contractor will not be paid greater than 100% of the withhold.

C. Risk-Sharing Mechanisms

AHCCCS intends to have two risk corridor type arrangements for the ALTCS-EPD Program:

- **Tiered Reconciliation:** A reconciliation of costs to reimbursement.
- **Share of Cost (SOC) Reconciliation:** A reconciliation of actual SOC payments to the assumed SOC offsets in the certified capitation rates for members receiving LTSS services.

The tiered risk corridor will reconcile medical cost expenses to the medical revenue paid to the contractor. More information is found in the ACOM Policy 301. In the first year of the contract, this reconciliation is anticipated to limit the Contractor's profits and losses as shown in the table below. It is the intent of AHCCCS to add a tiered loss segment and expand the tiered profit segment in a future year of the ALTCS-EPD RFP contract.

Profit	Contractor Share	State Share	Max Contractor Profit	Cumulative Contractor Profit
<= 2%	100%	0%	2%	2%
> 2% and <= 6%	50%	50%	2%	4%
> 6%	0%	100%	0%	4%
Loss	**Contractor Share**	**State Share**	**Max Contractor Loss**	**Cumulative Contractor Loss**
<= 2%	100%	0%	2%	2%
> 2%	0%	100%	0%	2%

The SOC risk corridor will reconcile the actual member SOC payments received during each federal fiscal year against the SOC Per Member Per Month (PMPM) amounts assumed in the capitation rates for that year. The SOC payments are reconciled to zero; that is, payments to the Contractor, or recoupments from the Contractor, are the arithmetic difference between the actual and assumed amounts, grossed up by 2% for premium tax.

In addition, AHCCCS provides a reinsurance program to the ALTCS-EPD contractors. For regular reinsurance cases, the deductible amount is not anticipated to differ from the deductible in place for the ALTCS-EPD contracts for CYE 2024. The reinsurance stop loss limit is also anticipated to be the same $1,000,000 that is in place for CYE 2024. All risk groups under ALTCS-EPD are subject to the same deductibles. High-Cost Behavioral Health reinsurance will be discontinued effective October 1, 2024. Medical expenses which have historically qualified for reinsurance under High-Cost Behavioral Health reinsurance may qualify for reinsurance under another reinsurance case type after October 1, 2024.

D. State Directed Payments

42 CFR § 438.6(c) and § 438.6(d) provide the State flexibility to implement delivery system and provider payment initiatives. AHCCCS reserves the right to utilize this flexibility to require Contractor participation in initiatives that may require certain payment levels and/or certain directed payments to providers to support State actions that are critical to ensuring timely access to high-quality care. AHCCCS will obtain written approval from CMS prior to implementation, if applicable, and Contractors will be required to implement, as directed by AHCCCS guidance. AHCCCS anticipates that most initiatives will involve payments to the Contractor outside of the monthly base capitation payments, made as a separate lump sum payment. AHCCCS will compute directed payment amounts and ensure the associated payments and/or capitation rates

meet actuarial soundness requirements, as applicable. The following is a summary of these directed payment arrangements from the AHCCCS CYE 2024 Capitation Rate Certification.

- **Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC):** Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.
- **Differential Adjusted Payments (DAP):** The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.
- **Access to Professional Services Initiative (APSI):** The APSI provides a uniform percentage increase of 75% to otherwise contracted rates for eligible practitioners, critical to professional training and education efforts, who deliver services to AHCCCS members. The uniform percentage increase is applicable only to services covered under the AHCCCS APSI policy. The rate increase is intended to supplement, not supplant, payments to eligible providers.
- **Pediatric Services Initiative (PSI):** The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the State's freestanding children's hospitals with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.
- **Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII):** The HEALTHII delivers a uniform percentage increase to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The HEALTHII uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class's aggregate targeted pay-to-cost ratio for Medicaid Managed care services. The increase is intended to supplement, not supplant, payments to eligible providers.
- **Nursing Facility Supplemental Payments (NF-SP):** The NF-SP delivers a uniform dollar increase across all Contractors' reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund, plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter. The increase is intended to supplement, not supplant, payments to eligible providers.

E. Pass-Through Payments

Not applicable. There are no pass-through payments for the ALTCS-EPD Program.

1.5. Projected Non-Benefit Costs

A. Rate Development Standards

In accordance with 42 CFR § 438.5(e), the development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin and cost of capital. In addition, the non-benefit component must include other operational costs associated with the provision of services under the contract, developed in accordance with generally accepted actuarial principles and practices.

The ALTCS-EPD capitation rates include two non-benefit components that have been developed by HCA for purposes of our HCA bid submission and included under this certification: administration and case management expenses. A description of the data, assumptions and methodology used in the development of the PMPM costs for each of these two components, in accordance with 42 CFR § 438.7(b)(4), is included below. Given HCA is not a current contractor for the ALTCS-EPD Program, there are no changes to the data or other material changes from previous rate certifications. In addition, HCA has no concern with meeting the capitalization requirements of the contract.

B. Appropriate Documentation

i. Description of the Development of Projected Non-Benefit Costs

Administrative Expenses

The Solicitation #YH24-0001 Non-Benefit Costs Bid Submission requires the Offeror to bid administrative expenses within each of six membership tier ranges. HCA has assumed the following member month (MM) projections in our bid submission. In the initial year of the contract, AHCCCS intends to determine the appropriate membership tier for each awarded Contractor based on projected membership after initial member assignment and member choice.

Membership Tier		HCA MMs Assumed
1	0-34,999	31,200
2	35,000-69,999	45,000
3	70,000-104,999	81,600
4	105,000-139,999	105,000
5	140,000-174,999	140,000
6	175,000+	175,000

HCA is currently a contractor for the AHCCCS ACC population and administers a Medicare Dual-Eligible Special Needs Plan (DSNP). Our financial projections for these existing lines of business, for the period January 1, 2023, through December 31, 2023 (CY 2023), serves as the base data used for the ALTCS-EPD projection.

In consultation with the HCA Finance Team, we first segmented the base data costs into compensation versus non-compensation related expenses, as well as fixed versus variable expenses. These four segments were further stratified by individual line items listed in the Administrative Component Bid tabs of the submission file. Next, by detailed line item and segment, we determine an appropriate allocation to apply for each line of business with the addition of the ALTCS-EPD population. The allocation methodology was unique to each category based on the type of work performed by the department or vendor. For instance, it was appropriate to allocate some categories by membership volume where a higher staff/vendor burden is not expected based on the acuity of the population, while others by expected revenue PMPM given the intensity of administrative services varies by population and benefits covered. Line items that only apply to ACC and/or DSNP were allocated 100% to those lines of business and excluded from the ALTCS-EPD expense build-up.

Based on this review, a range of fixed costs currently covered by ACC and DSNP are being allocated to ALTCS-EPD. Total fixed costs for HCA will remain constant, however different membership scenarios will drive a different allocation of the portion of fixed costs charged to ATLCS-EPD currently covered by ACC and DSNP. Future ACC and DSNP non-benefit costs will reflect this change in fixed cost allocation by line of business, based on final ALTCS-EPD award membership volume. Projected variable expenses for ALTCS-EPD increased or decreased from the base data depending on the allocation methodology used for each detailed line item.

Next, each department reviewed the Solicitation #YH24-0001 Program Requirements document to determine where additional staff will be needed to meet the requirements of the ALTCS-EPD contract. We are assuming the following incremental staff for each department will be needed at the various membership tiers. To determine the incremental costs associated with these adds, we utilized the Blue Cross Blue Shield of Arizona CY 2023 wage and employee related expense (ERE) cost structure for similar positions. The resulting approximate total cost addition at each tier level is also reflected below.

Position Department	Tiers: 1, 2 & 3	Tier: 4	Tiers: 5 & 6
Administration	1	1	1
Finance and Marketing	2	2	2
Data Analytics	1	1	1
Clinical Management	3	14	14
Information Technology	5	5	5
Claims and Encounters	5	8	10
Provider Relations and Network Management	4	4	4
Quality	5	5	5
Member Services	8	8	9
Total Adds	34	48	51
Contract Required Staff Costs (CY 2023)	**$2.7 M**	**$3.8 M**	**$4.0 M**

Finally, we trended fixed FTE compensation at a merit increase of 4.0% annually to the mid-point of each of the five contract periods required in Administrative Component Bid tabs. We trended all other categories that are impacted by inflation at an annual trend of 3.0%. Those non-compensation categories not impacted by inflation remain flat for the five contract years.

The HCA administrative expense development also includes an assumption for start-up expenses; however, these costs have not been included in the PMPMs reflected in the bid submission covered by this certification as AHCCCS does not reimburse start-up expenses. These costs are used for internal financial projections only.

According to the Non-Benefit Cost Bid Requirements, AHCCCS will be allocating the administrative expenses between the Dual and Non-Dual risk groups, as well as by GSA, during the final capitation rate development process. AHCCCS will evaluate administrative bids and set administrative cost components of the capitation rates for each year of the contract in compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines and ultimate membership levels. HCA anticipates updating the allocation of fixed administrative expenses for each line of business once the final ALTCS-EPD membership distribution is known.

Case Management Expenses

For the case management component of the non-benefit costs bid submission, AHCCCS provided the member enrollment and mix percentages for each Offeror to use, which are based on an average of the data from July through December 2022. AHCCCS will adjust the member enrollment and mix percentages used in capitation rate development after awards have been set and final distribution of membership is known.

The first assumption used in the case management PMPM cost development is the weighted average for each case manager's caseload. In the current AMPM 1630, AHCCCS requires that each case manager's caseload shall not exceed a weighted value of 96. HCA has assumed a caseload of 94 to ensure adequate capacity as staff vacancies may occur. Using this and the setting placement ratios prescribed in AMPM 1630 Section D, HCA is assuming the following maximum members for each setting and EPD/SMI combination. AHCCCS has indicated that if the weights assigned to members or the maximum members per case manager changes from what is in the AMPM 1630, they will adjust the awarded bids as necessary to comply with any new requirements.

Setting	EPD		SMI	
	Ratio	Max Members	Ratio	Max Members
Institutional	1.00	94.0	1.40	67.1
HCBS – own home	2.20	42.7	3.00	31.3
HCBS – alternative	1.80	52.2	1.90	49.5
Acute Care Only	1.00	94.0	1.00	94.0

Next, the case management staffing model was developed. Based on the ALTCS-EPD Program Requirement:

> *"A case manager shall be an Arizona licensed registered nurse in good standing, social worker, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of case management experience, or individuals with a minimum of two years' experience in providing case management*

services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or with an SMI designation."

Using this definition, HCA clinical management developed a mix of RNs, SWs, and individuals with the specified bachelor's degree and/or years of experience, to determine the average case manager total compensation. In addition to the case managers, we are assuming an average of 14.50 case managers per supervisor, and 0.11 administrative staff per supervisor. For the total average compensation costs used for each level of staff, we utilized the Blue Cross Blue Shield of Arizona CY 2023 wage and ERE cost structure for similar positions, trended to CYE 2025 at 4.0%.

Finally, we included a provision for travel since case managers' work is mainly field based. Our assumption is on average, each case manager will travel 150 miles per week. We performed an analysis of historical IRS mileage rates to project this expenditure for each year of the contract, assuming a reimbursement of $0.663 per mile for the CYE 2025 rate period. This results in an average travel expense per case manager of approximately $4,975.

Per the AHCCCS Non-Benefit Costs Bid Requirements, AHCCCS will evaluate case management bids and set case management cost components of the capitation rates for each year of the contract in compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines. The same case management PMPM will be applied to both Dual and Non-Dual rate cells; however, case management PMPMs can, and likely will, vary by GSA.

ii. Projected Non-Benefit Costs by Category

(a) Administrative Costs

The development of the administrative components of the CYE 2025 ALTCS-EPD capitation rates is described above in Section 1.5.B.i. The resulting administrative variable cost PMPMs, administrative fixed cost total dollar amounts, and case management PMPMs covered by this certification are included in Appendix 2.

(b) Taxes and Other Fees

It is anticipated AHCCCS will include a provision of 2.0% for premium tax in the CYE 25 ALTCS-EPD final capitation rates. The premium tax is applied to the total capitation rate. No other taxes, fees or assessments apply.

(c) Contribution to Reserves, Risk Margin, and Cost of Capital

AHCCCS increased the provision for risk margin (i.e., underwriting gain) in the CYE 2024 rates to 1.45%; however, consistent with the Rate Development Documentation on the Bidder's Library, we are anticipating AHCCCS will include a provision of 1.0% for risk margin in the CYE 25 ALTCS-EPD final capitation rates. As a new contractor for the ALTCS-EPD program, HCA recognizes our actual risk margin may be lower than 1.0% in the first contract year.

(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs are expected in the CYE 25 ALTCS-EPD final capitation rates.

iii. Historical Non-Benefit Cost

HCA has not participated in the ALTCS-EPD Program previously, so historical non-benefit costs are not available. However, AHCCCS posts the audited financial statements for all AHCCCS contractors on their website. This information was used as a comparison for the non-benefit costs assumptions described in section 1.5.B.i. above.

1.6. Risk Adjustment

Not applicable at this time. AHCCCS has indicated in the Rate Development Documentation in the RFP that they will be reviewing different LTSS risk adjustment models for implementation during the RFP contract, with the goal to align risk with revenue to the extent possible given the data available. Some of the options under consideration include risk adjustment using functional assessment data, non-diagnostic-based risk adjustment (i.e., past member utilization repriced at AHCCCS fee schedule rates to determine relative risk of individual members), regional factors (i.e., based on MCO specific mixes across placements (e.g., Nursing Facility, Home and Community Based Services)), or some combination of the above. Risk adjustment for the first year will be based on initial member assignment and subsequent member choice.

1.7. Acuity Adjustments

Not applicable. AHCCCS has not indicated the ALTCS-EPD capitation rates will include acuity adjustments for CYE 2025.

SECTION II – MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

The ALTCS-EPD Program discussed in this memorandum is a managed long-term services and supports (MLTSS) program and subject to the actuarial soundness requirements in 42 CFR § 438.4 and includes LTSS benefits as defined in 42 CFR § 438.2(a); therefore Section II of the 2024 Guide is applicable.

2.1. Managed Long-Term Services and Supports

A. CMS Expectations

The rate development standards and appropriate documentation described in Section 1 of the 2024 Guide are also applicable to the MLTSS rate development process.

B. Rate Development Standards

i. Rate Cell Structure

This section of the 2024 Guide outlines the most common approaches to the structure of MLTSS rate cells.

C. Appropriate Documentation

i. Considerations

AHCCCS uses a "blended" approach to structure the ALTCS-EPD rate cells. For each GSA, AHCCCS completes the rate development process by health care status and long-term care setting, then blends the data to establish a Dual and Non-Dual total blended benefit PMPM.

The ALTCS-EPD rates are payable monthly for each enrolled member. The benefit cost development is described in Section 1.3 above. Section 1.4 above describes the other payment provisions applicable for the ALTCS-EPD Program. ALTCS-EPD has historically operated as a managed care program, therefore no data is available to quantify the effect that the management of LTSS is expected to have.

ii. Projected Non-Benefit Costs

The non-benefit costs components are added to the blended benefit rates. The development of the non-benefit costs is described in Section 1.5.B. of this certification.

iii. Additional Information

No additional information beyond what has been discussed previously in this certification was considered.

SECTION III – NEW ADULT GROUP CAPITATION RATES

The New Adult Group is not a covered population under the AHCCCS ALTCS-EPD Program; therefore Section III of the 2024 Guide is not applicable for this certification.

APPENDIX 1 – ACTUARIAL CERTIFICATION

I, Nettie R. Meier, am an employee of Blue Cross Blue Shield of Arizona, of which Health Choice Arizona, Inc. (HCA) is a fully owned subsidiary. I am a member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA). I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

I am certifying the actuarial soundness of the administrative and case management rates contained in the HCA Non-Benefit Costs Bid Submission file for Solicitation #YH24-0001, also included in Appendix 2 of this memorandum. They are reasonable and appropriate for the population and services covered under the AHCCCS ALTCS-EPD contract for the twelve-month period beginning October 1, 2024, through September 30, 2025.

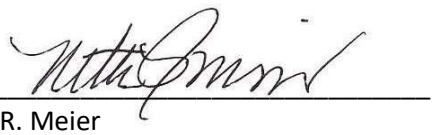
Consistent with the requirements under 42 CFR § 438.4(a), ASOP #49 defines "actuarial soundness" as follows:

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

To develop the rates, I relied on information provided by Arizona Health Care Cost Containment System (AHCCCS) in the Solicitation #YH24-0001 ALTCS-EPD Bidders' Library, the Data Book on the ASFS system, as well as historical rate and financial information on the AHCCCS website. In addition, I relied on the HCA Finance Team for certain internal financial data and assumptions. I have not performed an independent audit of any of the data utilized but determined it to be reasonable for inclusion in actuarial rate development. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete.

The actuarially sound rates covered by this certification are based on a projection of future events. Actual experience will vary from the data and assumptions assumed in the rates. The rates were developed for the AHCCCS Procurement Officer and Division of Health Care Management for the sole purpose of evaluating HCA's bid submission and may not be appropriate for other purposes. Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board.

The rates covered by this certification only reflect the non-benefit components for the ALTCS-EPD Program, specifically the administrative and case management cost components of the capitation rates, in accordance with 42 CFR § 438.7(b)(3). The final ALTCS-EPD capitation rates for the period beginning October 1, 2024, through September 30, 2025, that include all benefit and other non-benefit costs and will ultimately be submitted to the Centers for Medicare and Medicaid Services for approval, will be separately developed and certified by the AHCCCS Actuarial Team.



Nettie R. Meier
Associate, Society of Actuaries
Member, American Academy of Actuaries

9/28/2023
Date

APPENDIX 2 – NON-BENEFIT COSTS BID SUBMISSION

Admin Bid MMs 0-34,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars	Variable Cost PMPM	Fixed Cost Total Dollars
Compensation	$ 89.82	$ 2,750,488	$ 92.51	$ 2,854,412	$ 95.29	$ 2,962,310	$ 98.15	$ 3,074,336	$ 101.09	$ 3,190,649
Occupancy	$ 0.13	$ 284,836	$ 0.13	$ 293,381	$ 0.13	$ 302,183	$ 0.13	$ 311,248	$ 0.13	$ 320,586
Depreciation	$ -	$ 14,520	$ -	$ 14,956	$ -	$ 15,404	$ -	$ 15,866	$ -	$ 16,342
Care Management/Care Coordination	$ 0.06	$ 1,627	$ 0.06	$ 1,676	$ 0.07	$ 1,726	$ 0.07	$ 1,778	$ 0.07	$ 1,831
Professional and Outside Services	$ 12.72	$ 470,764	$ 13.10	$ 484,887	$ 13.50	$ 499,433	$ 13.90	$ 514,416	$ 14.32	$ 529,849
Office Supplies and Equipment	$ 6.92	$ 287,695	$ 5.96	$ 296,326	$ 6.13	$ 305,216	$ 6.32	$ 314,372	$ 6.51	$ 323,803
Travel	$ 0.59	$ 1,299	$ 0.61	$ 1,338	$ 0.62	$ 1,378	$ 0.64	$ 1,420	$ 0.66	$ 1,462
Repair and Maintenance	$ 12.43	$ 449,696	$ 12.80	$ 463,187	$ 13.19	$ 477,083	$ 13.58	$ 491,395	$ 13.99	$ 506,137
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 90,846	$ -	$ 93,572	$ -	$ 96,379	$ -	$ 99,270	$ -	$ 102,248
Marketing	$ 0.16	$ 67,592	$ 0.16	$ 69,620	$ 0.16	$ 71,709	$ 0.16	$ 73,860	$ 0.16	$ 76,076
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.58	$ -	$ 1.63	$ -	$ 1.68	$ -	$ 1.73	$ -	$ 1.78	$ -
Third Party Activities	$ 3.30	$ 10,848	$ 3.40	$ 11,174	$ 3.50	$ 11,509	$ 3.61	$ 11,854	$ 3.71	$ 12,210
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.09	$ 48,193	$ 0.10	$ 49,639	$ 0.10	$ 51,128	$ 0.10	$ 52,662	$ 0.10	$ 54,242
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.32	$ 200	$ 0.32	$ 206	$ 0.32	$ 213	$ 0.32	$ 219	$ 0.32	$ 226
Total Admin Costs	$ 128.60	$ 4,478,607	$ 131.26	$ 4,634,374	$ 135.18	$ 4,795,671	$ 139.22	$ 4,962,698	$ 143.38	$ 5,135,661
Member Months Assumed in Bid		31,200		31,200		31,200		31,200		31,200

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 35,000-69,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 66.59	$ 3,132,446	$ 68.59	$ 3,249,715	$ 70.65	$ 3,371,434	$ 72.77	$ 3,497,774	$ 74.95	$ 3,628,911
Occupancy	$ 0.12	$ 373,528	$ 0.12	$ 384,734	$ 0.12	$ 396,276	$ 0.12	$ 408,164	$ 0.12	$ 420,409
Depreciation	$ -	$ 19,141	$ -	$ 19,716	$ -	$ 20,307	$ -	$ 20,916	$ -	$ 21,544
Care Management/Care Coordination	$ 0.06	$ 2,153	$ 0.06	$ 2,217	$ 0.06	$ 2,284	$ 0.06	$ 2,352	$ 0.06	$ 2,423
Professional and Outside Services	$ 11.66	$ 619,724	$ 12.01	$ 638,316	$ 12.37	$ 657,466	$ 12.74	$ 677,190	$ 13.12	$ 697,505
Office Supplies and Equipment	$ 6.26	$ 377,978	$ 5.44	$ 389,317	$ 5.60	$ 400,997	$ 5.77	$ 413,026	$ 5.94	$ 425,417
Travel	$ 0.53	$ 1,971	$ 0.55	$ 2,030	$ 0.57	$ 2,091	$ 0.58	$ 2,154	$ 0.60	$ 2,218
Repair and Maintenance	$ 11.28	$ 592,228	$ 11.62	$ 609,995	$ 11.97	$ 628,295	$ 12.33	$ 647,144	$ 12.70	$ 666,558
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 122,053	$ -	$ 125,714	$ -	$ 129,486	$ -	$ 133,370	$ -	$ 137,371
Marketing	$ 0.15	$ 89,020	$ 0.15	$ 91,691	$ 0.15	$ 94,441	$ 0.15	$ 97,275	$ 0.15	$ 100,193
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.44	$ -	$ 1.48	$ -	$ 1.53	$ -	$ 1.57	$ -	$ 1.62	$ -
Third Party Activities	$ 3.03	$ 14,225	$ 3.12	$ 14,652	$ 3.21	$ 15,092	$ 3.31	$ 15,544	$ 3.41	$ 16,011
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.08	$ 63,214	$ 0.09	$ 65,110	$ 0.09	$ 67,064	$ 0.09	$ 69,076	$ 0.09	$ 71,148
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.30	$ 263	$ 0.30	$ 271	$ 0.30	$ 279	$ 0.30	$ 287	$ 0.30	$ 296
Total Admin Costs	$ 101.96	$ 5,407,945	$ 103.99	$ 5,593,479	$ 107.09	$ 5,785,510	$ 110.29	$ 5,984,272	$ 113.58	$ 6,190,005

Member Months Assumed in Bid		45,000		45,000		45,000		45,000		45,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 70,000-104,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 42.48	$ 4,057,537	$ 43.76	$ 4,207,139	$ 45.07	$ 4,362,344	$ 46.42	$ 4,523,364	$ 47.82	$ 4,690,421
Occupancy	$ 0.10	$ 587,069	$ 0.10	$ 604,681	$ 0.10	$ 622,821	$ 0.10	$ 641,506	$ 0.10	$ 660,751
Depreciation	$ -	$ 30,315	$ -	$ 31,225	$ -	$ 32,161	$ -	$ 33,126	$ -	$ 34,120
Care Management/Care Coordination	$ 0.05	$ 3,441	$ 0.05	$ 3,544	$ 0.05	$ 3,650	$ 0.05	$ 3,760	$ 0.05	$ 3,873
Professional and Outside Services	$ 10.21	$ 979,753	$ 10.52	$ 1,009,146	$ 10.83	$ 1,039,420	$ 11.16	$ 1,070,603	$ 11.49	$ 1,102,721
Office Supplies and Equipment	$ 5.48	$ 595,849	$ 4.77	$ 613,724	$ 4.92	$ 632,136	$ 5.06	$ 651,100	$ 5.21	$ 670,633
Travel	$ 0.46	$ 3,856	$ 0.47	$ 3,971	$ 0.49	$ 4,090	$ 0.50	$ 4,213	$ 0.52	$ 4,339
Repair and Maintenance	$ 9.73	$ 937,835	$ 10.03	$ 965,970	$ 10.33	$ 994,949	$ 10.64	$ 1,024,797	$ 10.96	$ 1,055,541
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 198,562	$ -	$ 204,518	$ -	$ 210,654	$ -	$ 216,974	$ -	$ 223,483
Marketing	$ 0.13	$ 140,791	$ 0.13	$ 145,015	$ 0.13	$ 149,365	$ 0.13	$ 153,846	$ 0.13	$ 158,461
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.25	$ -	$ 1.28	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.40	$ -
Third Party Activities	$ 2.66	$ 22,356	$ 2.74	$ 23,026	$ 2.82	$ 23,717	$ 2.91	$ 24,429	$ 2.99	$ 25,161
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.07	$ 99,397	$ 0.07	$ 102,378	$ 0.08	$ 105,450	$ 0.08	$ 108,613	$ 0.08	$ 111,872
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.27	$ 414	$ 0.27	$ 426	$ 0.27	$ 439	$ 0.27	$ 452	$ 0.27	$ 466
Total Admin Costs	$ 73.36	$ 7,657,172	$ 74.67	$ 7,914,763	$ 76.90	$ 8,181,196	$ 79.19	$ 8,456,782	$ 81.55	$ 8,741,842

Member Months Assumed in Bid		81,600		81,600		81,600		81,600		81,600

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 105,000-139,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.45	$ 5,129,227	$ 46.82	$ 5,319,232	$ 48.22	$ 5,516,382	$ 49.67	$ 5,720,949	$ 51.16	$ 5,933,216
Occupancy	$ 0.09	$ 698,082	$ 0.09	$ 719,024	$ 0.09	$ 740,595	$ 0.09	$ 762,813	$ 0.09	$ 785,697
Depreciation	$ -	$ 36,225	$ -	$ 37,312	$ -	$ 38,432	$ -	$ 39,584	$ -	$ 40,772
Care Management/Care Coordination	$ 0.05	$ 3,968	$ 0.05	$ 4,088	$ 0.05	$ 4,210	$ 0.05	$ 4,336	$ 0.05	$ 4,467
Professional and Outside Services	$ 9.53	$ 1,166,155	$ 9.82	$ 1,201,140	$ 10.12	$ 1,237,174	$ 10.42	$ 1,274,289	$ 10.73	$ 1,312,518
Office Supplies and Equipment	$ 5.25	$ 708,494	$ 4.50	$ 729,749	$ 4.64	$ 751,641	$ 4.78	$ 774,191	$ 4.92	$ 797,416
Travel	$ 0.44	$ 3,552	$ 0.45	$ 3,658	$ 0.46	$ 3,768	$ 0.48	$ 3,881	$ 0.49	$ 3,998
Repair and Maintenance	$ 9.11	$ 1,105,764	$ 9.39	$ 1,138,937	$ 9.67	$ 1,173,105	$ 9.96	$ 1,208,298	$ 10.26	$ 1,244,547
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 241,151	$ -	$ 248,386	$ -	$ 255,837	$ -	$ 263,513	$ -	$ 271,418
Marketing	$ 0.12	$ 168,058	$ 0.12	$ 173,099	$ 0.12	$ 178,292	$ 0.12	$ 183,641	$ 0.12	$ 189,150
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.15	$ -	$ 1.19	$ -	$ 1.22	$ -	$ 1.26	$ -	$ 1.30	$ -
Third Party Activities	$ 2.48	$ 26,586	$ 2.55	$ 27,384	$ 2.63	$ 28,205	$ 2.71	$ 29,051	$ 2.79	$ 29,923
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.07	$ 118,093	$ 0.07	$ 121,636	$ 0.07	$ 125,285	$ 0.07	$ 129,043	$ 0.08	$ 132,915
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.26	$ 491	$ 0.26	$ 506	$ 0.26	$ 521	$ 0.26	$ 537	$ 0.26	$ 553
Total Admin Costs	$ 74.46	$ 9,405,847	$ 75.78	$ 9,724,150	$ 78.04	$ 10,053,448	$ 80.37	$ 10,394,127	$ 82.76	$ 10,746,590

Member Months Assumed in Bid		105,000		105,000		105,000		105,000		105,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 140,000-174,999

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 37.89	$ 5,819,229	$ 39.02	$ 6,033,639	$ 40.19	$ 6,256,075	$ 41.40	$ 6,486,840	$ 42.64	$ 6,726,252
Occupancy	$ 0.08	$ 840,389	$ 0.08	$ 865,600	$ 0.08	$ 891,568	$ 0.08	$ 918,315	$ 0.08	$ 945,865
Depreciation	$ -	$ 43,904	$ -	$ 45,221	$ -	$ 46,578	$ -	$ 47,975	$ -	$ 49,415
Care Management/Care Coordination	$ 0.04	$ 4,758	$ 0.04	$ 4,901	$ 0.04	$ 5,048	$ 0.04	$ 5,199	$ 0.05	$ 5,355
Professional and Outside Services	$ 8.70	$ 1,409,377	$ 8.96	$ 1,451,658	$ 9.23	$ 1,495,208	$ 9.51	$ 1,540,064	$ 9.80	$ 1,586,266
Office Supplies and Equipment	$ 4.85	$ 854,382	$ 4.14	$ 880,013	$ 4.26	$ 906,414	$ 4.39	$ 933,606	$ 4.52	$ 961,614
Travel	$ 0.40	$ 4,342	$ 0.41	$ 4,472	$ 0.42	$ 4,606	$ 0.44	$ 4,744	$ 0.45	$ 4,887
Repair and Maintenance	$ 8.26	$ 1,331,930	$ 8.50	$ 1,371,888	$ 8.76	$ 1,413,044	$ 9.02	$ 1,455,436	$ 9.29	$ 1,499,099
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 298,805	$ -	$ 307,769	$ -	$ 317,003	$ -	$ 326,513	$ -	$ 336,308
Marketing	$ 0.11	$ 203,419	$ 0.11	$ 209,521	$ 0.11	$ 215,807	$ 0.11	$ 222,281	$ 0.11	$ 228,949
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 1.04	$ -	$ 1.07	$ -	$ 1.10	$ -	$ 1.14	$ -	$ 1.17	$ -
Third Party Activities	$ 2.26	$ 32,006	$ 2.33	$ 32,966	$ 2.40	$ 33,955	$ 2.47	$ 34,974	$ 2.55	$ 36,023
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.06	$ 142,149	$ 0.06	$ 146,414	$ 0.07	$ 150,806	$ 0.07	$ 155,331	$ 0.07	$ 159,990
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.24	$ 591	$ 0.24	$ 609	$ 0.24	$ 627	$ 0.24	$ 646	$ 0.24	$ 666
Total Admin Costs	$ 64.39	$ 10,985,282	$ 65.45	$ 11,354,673	$ 67.40	$ 11,736,739	$ 69.41	$ 12,131,925	$ 71.48	$ 12,540,689

Member Months Assumed in Bid		140,000		140,000		140,000		140,000		140,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Admin Bid MMs 175,000+

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 31.85	$ 6,357,797	$ 32.81	$ 6,591,071	$ 33.79	$ 6,833,046	$ 34.81	$ 7,084,050	$ 35.85	$ 7,344,424
Occupancy	$ 0.08	$ 957,549	$ 0.08	$ 986,276	$ 0.08	$ 1,015,864	$ 0.08	$ 1,046,340	$ 0.08	$ 1,077,730
Depreciation	$ -	$ 50,361	$ -	$ 51,872	$ -	$ 53,428	$ -	$ 55,030	$ -	$ 56,681
Care Management/Care Coordination	$ 0.04	$ 5,466	$ 0.04	$ 5,630	$ 0.04	$ 5,799	$ 0.04	$ 5,973	$ 0.04	$ 6,152
Professional and Outside Services	$ 8.01	$ 1,613,446	$ 8.25	$ 1,661,850	$ 8.50	$ 1,711,705	$ 8.76	$ 1,763,057	$ 9.02	$ 1,815,948
Office Supplies and Equipment	$ 4.52	$ 975,677	$ 3.83	$ 1,004,947	$ 3.95	$ 1,035,095	$ 4.07	$ 1,066,148	$ 4.19	$ 1,098,133
Travel	$ 0.36	$ 5,670	$ 0.37	$ 5,840	$ 0.38	$ 6,016	$ 0.40	$ 6,196	$ 0.41	$ 6,382
Repair and Maintenance	$ 7.52	$ 1,524,366	$ 7.74	$ 1,570,096	$ 7.97	$ 1,617,199	$ 8.21	$ 1,665,715	$ 8.46	$ 1,715,687
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ 350,216	$ -	$ 360,722	$ -	$ 371,544	$ -	$ 382,690	$ -	$ 394,171
Marketing	$ 0.10	$ 233,049	$ 0.10	$ 240,041	$ 0.10	$ 247,242	$ 0.10	$ 254,659	$ 0.10	$ 262,299
Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefit Manager Expenses	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.43	$ -	$ 0.44	$ -
Fraud Reduction Expenses	$ 0.95	$ -	$ 0.98	$ -	$ 1.01	$ -	$ 1.04	$ -	$ 1.07	$ -
Third Party Activities	$ 2.09	$ 36,466	$ 2.15	$ 37,560	$ 2.21	$ 38,687	$ 2.28	$ 39,848	$ 2.35	$ 41,043
Sub Capitation Block Administrative	$ 0.05	$ -	$ 0.05	$ -	$ 0.06	$ -	$ 0.06	$ -	$ 0.06	$ -
Health Care Quality Improvement	$ 0.06	$ 162,001	$ 0.06	$ 166,861	$ 0.06	$ 171,867	$ 0.06	$ 177,023	$ 0.06	$ 182,333
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -	$ 0.02	$ -
Other Administrative Expenses [2]	$ 0.22	$ 674	$ 0.22	$ 695	$ 0.22	$ 715	$ 0.22	$ 737	$ 0.22	$ 759
Total Admin Costs	$ 56.25	$ 12,272,738	$ 57.11	$ 12,683,461	$ 58.81	$ 13,108,208	$ 60.56	$ 13,547,466	$ 62.37	$ 14,001,743

Member Months Assumed in Bid		175,000		175,000		175,000		175,000		175,000

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.

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

Case Management Bid

ALTCS-EPD Case Management Component Bid									
	North GSA			Central GSA			South GSA		
Assumptions:	**Non-SMI**	**SMI**	**Total**	**Non-SMI**	**SMI**	**Total**	**Non-SMI**	**SMI**	**Total**
Number of ALTCS-EPD enrollment: [1]	2,194	171	2,365	5,375	463	5,838	2,856	256	3,113
Institutional Mix %: [1]	28.8%	26.5%	28.7%	19.6%	33.9%	20.7%	25.6%	38.7%	26.6%
Acute Care Only Mix %: [1]	2.9%	1.4%	2.8%	3.0%	0.9%	2.8%	1.7%	1.1%	1.6%
Alternative Home and Community Bases Service (HCBS) Mix %: [1]	23.0%	33.7%	23.7%	29.4%	42.1%	30.4%	21.6%	33.0%	22.6%
HCBS (own home) Mix %: [1]	45.3%	38.4%	44.8%	48.0%	23.1%	46.1%	51.1%	27.2%	49.2%
Average Case Management Manager total compensation (includes ERE)	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500	$ 101,500
Average Case Management Supervisor total compensation (includes ERE)	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000
Average Case Management Administration Support Staff total compensation (includes ERE)	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500	$ 64,500
Maximum Members per Case Manager (Institutional) [2]	94.0	67.1	91.5	94.0	67.1	89.4	94.0	67.1	89.7
Maximum Members per Case Manager (Acute Care Only) [2]	94.0	94.0	94.0	94.0	94.0	94.0	94.0	94.0	94.0
Maximum Members per Case Manager (Alternative HCBS) [2]	52.2	49.5	51.9	52.2	49.5	51.9	52.2	49.5	51.9
Maximum Members per Case Manager (HCBS Own Home) [2]	42.7	31.3	41.8	42.7	31.3	42.1	42.7	31.3	42.0
Average Travel Expenses per Case Management Manager	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00	$ 4,975.00
Average Case Managers per Supervisor	14.5	14.5	14.5	14.5	14.5	14.5	14.5	14.5	14.5
Average Administrative Support Staff per Supervisor	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11	0.11
Calculations:									
Case Management Manager FTEs required	40.3	4.0	44.3	103.6	9.7	113.3	54.3	5.4	59.7
Case Management Manager salary and ERE	$4,090,546	$402,412	$4,492,958	$10,512,600	$987,717	$11,500,316	$5,510,488	$552,650	$6,063,138
Case Management Supervisor FTEs required	2.8	0.3	3.1	7.1	0.7	7.8	3.7	0.4	4.1
Case Management Supervisor salary and ERE	$394,671	$38,826	$433,498	$1,014,295	$95,299	$1,109,594	$531,673	$53,322	$584,994
Case Management Administration Support Staff FTEs	0.3	0.0	0.3	0.8	0.1	0.9	0.4	0.0	0.5
Case Management Administration Support Staff salary and ERE	$19,720	$1,940	$21,660	$50,679	$4,762	$55,441	$26,565	$2,664	$29,229
Travel Costs	$200,497	$19,724	$220,221	$515,273	$48,413	$563,685	$270,095	$27,088	$297,183
Total Annual Case Management Cost	$4,705,434	$462,903	$5,168,337	$12,092,847	$1,136,190	$13,229,036	$6,338,821	$635,724	$6,974,545
Total Case Management PMPM			**$182.12**			**$188.84**			**$186.72**

Footnotes:

1. AHCCCS prescribed values are based on GSA specific averages of enrollment and placement data between July and December 2022. AHCCCS will adjust the member enrollment and mix percentages once awards have been set and final distribution of membership is known.

2. Refer to AHCCCS Medical Policy Manual (AMPM) 1630 Section D. Caseload Management for maximum case load allowed for each setting.

Part D

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

D1

Intent to Provide Insurance

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

October 2, 2023

Meggan LaPorte, CPPO, MSW
Chief Procurement Officer
801 East Jefferson Road
Phoenix, Arizona 85034

Re: ALTCS EPD RFP NO YH24-0001
Section D1 Intent to Provide Insurance

Ms. LaPorte:

As require by the ALTCS EPD RFP No YH24-0001, please accept this notice of Health Choice Arizona, Inc's intent to provide insurance.

If notified of a contract award, Health Choice Arizona, Inc. will submit to AHCCCCS for review and acceptance, the applicable certificate/s of insurance as required within the RFP document within ten (10) business days of such notification.

Sincerely,

Health Choice Arizona, Inc.

Company Name

Signature of Person Authorized to Sign Agreement

8220 N 23rd Avenue

Address

Shawn Nau

Printed Name

Phoenix AZ 85021

City State Zip

Chief Executive Officer

Title

D2

Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

SECTION G - DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION

Pursuant to 42 CFR 455.104, the Offeror shall complete and submit Disclosure of Ownership and Control inclusive of RFP Exhibit I: Disclosure of Information via the AHCCCS Provider Enrollment Portal (APEP) as detailed below.

All submitted documentation shall align with the Offeror's submitted Exhibit D: Offeror's Intent to Bid "Company Name". AHCCCS reserves the right to reject an APEP application should an Offeror's Company Name not match the information (e.g., Tax ID) used for the APEP application.

OFFEROR INSTRUCTIONS

The Offeror shall complete submission of *Disclosure of Ownership and Control including RFP Exhibit I: Disclosure of Information* by September 15, 2023. The Offeror shall:

1. Notify AHCCCS of its intent to submit *Disclosure of Ownership and Control* ***and RFP Exhibit I: Disclosure of Information*** via email to **both** AHCCCS/DMPS dmpsproviderenrollmentunit@azahcccs.gov and AHCCCS Procurement email RFPYH24-0001@azahcccs.
   - The Offeror shall utilize the following email subject line:
     - [Offeror Name] RFP YH24-0001 Section G-Begin Submission Process
   - The Offeror shall utilize the following email message:
     - As required by ALTCS E/PD RFP YH24-0001 Section G, [Offeror Name] is requesting to begin the process for submission of Disclosure of Ownership and Control and RFP Exhibit I: Disclosure of Information. Please confirm receipt and advise on how to access the AHCCCS Provider Enrollment Portal (APEP).
2. Once notification is received, AHCCCS/DMPS will confirm receipt and communicate with the Offeror to ensure the Offeror has access to the APEP.
3. Once APEP access is obtained, the Offeror shall enter all appropriate information into APEP, and email its completed Exhibit I "Disclosure of Information" to AHCCCS/Provider Enrollment Lisa Quihuis at lisa.quihuis@azahcccs.gov. AHCCCS/Provider Enrollment will upload the completed Exhibit I to the Offeror's APEP application on behalf of the Offeror and provide notification to the Offeror when completed. Refer to the AHCCCS website for MCO instructions regarding the APEP application and its use: https://azahcccs.gov/PlansProviders/APEP/APEPTraining.html.

4. Once all the above information has been submitted and entered into APEP and the Offeror has received confirmation that AHCCCS/Provider Enrollment has uploaded its completed RFP Exhibit I, the Offeror shall send confirmation of completion of all APEP information by September 15, 2023, to **both** AHCCCS/DMPS dmpsproviderenrollmentunit@azahcccs.gov and AHCCCS/Procurement Email RFPYH24-0001@azahcccs.gov.

   - The Offeror shall utilize the following email subject line:
     - [Offeror Name] RFP YH24-0001 Section G-Submission Completed
   - The Offeror shall utilize the following email message:
     - As required by ALTCS E/PD RFP YH24-0001 Section G, [Offeror Name] is confirming submission of Disclosure of Ownership and Control and RFP Exhibit I: Disclosure of Information to the AHCCCS Provider Enrollment Portal (APEP).

5. Complete the OFFEROR ATTESTATION (below) and submit with its Proposal by October 2, 2023.

AHCCCS/DMPS will review all information, make its determination, complete the AHCCCS Determination portion of this form, and provide the completed form to RFPYH24-0001@azahcccs.gov. Questions regarding use of APEP shall be submitted to: AHCCCS/DMPS dmpsproviderenrollmentunit@azahcccs.gov.

Should an Offeror's documentation be non-responsive or not meet the requirements of 42 CFR 455.104, AHCCCS will notify the Offeror and AHCCCS reserves the right to reject the Offeror's Proposal.

OFFEROR ATTESTATION

The Offeror shall complete and submit this Attestation with its RFP Proposal by October 2, 2023, 3:00 PM Arizona Time.

The Offeror attests to its submission of DISCLOSURE OF OWNERSHIP AND CONTROL AND RFP EXHIBIT I: DISCLOSURE OF INFORMATION to AHCCCS as specified in RFP Section G Instructions above.

The Offeror attests this information is complete and has been submitted timely.

The Offeror understands that if AHCCCS determines the Offeror's documentation to be non-responsive or not meet the requirements of 42 CFR 455.104, AHCCCS reserves the right to reject the Offeror's Proposal.

OFFEROR

Health Choice Arizona, Inc	09/18/2023
OFFEROR NAME	DATE
Shawn Nau, CEO	
PRINTED NAME AND TITLE OF INDIVIDUAL AUTHORIZED TO SIGN	SIGNATURE OF INDIVIDUAL AUTHORIZED TO SIGN

Phoenix	AZ	85021	shawn.nau@azblue.com	
CITY	STATE	ZIP	EMAIL ADDRESS	PHONE NUMBER

AHCCCS DETERMINATION – FOR AHCCCS USE ONLY

AHCCCS

The Offeror for ALTCS EPD RFP #YH24-0001, [Enter Name of Offeror], completed submission of all Disclosure of Ownership and Control *and Disclosure Information* to AHCCCS via the APEP system. The Offeror completed this on [Enter Month Date, Year]. AHCCCS/DMPS has reviewed this information submitted by the Offeror and provides the below final determination.

The Offeror has submitted its Disclosure of Ownership and Control and Disclosure Information as required by 42 CFR 455.104. AHCCCS/DMPS final determination is indicated by the check box and additional information, if applicable, provided in the explanation below:

☐ **Approved, no occurrences identified**

☐ **Denied, occurrences identified – referred to AHCCCS/Procurement**

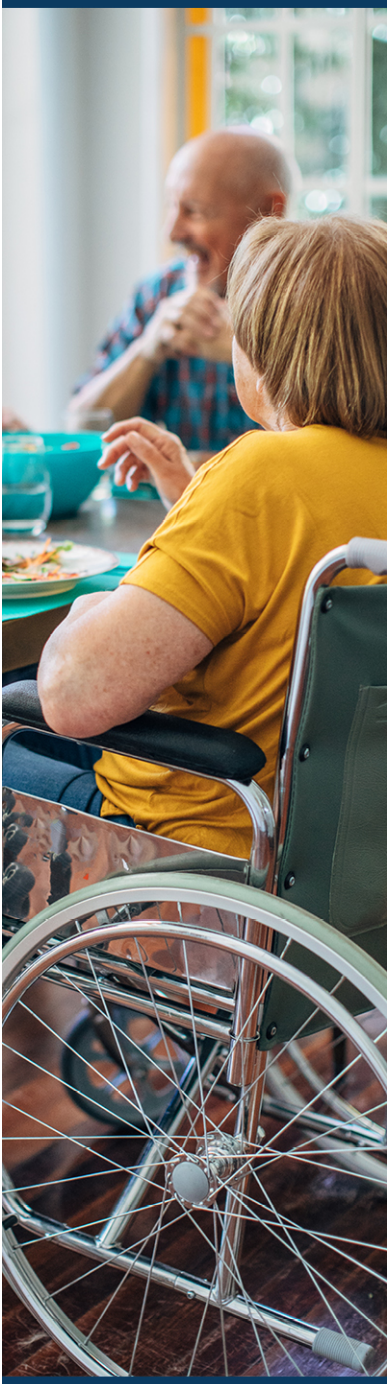
☐ **Denied, non-responsive – referred to AHCCCS/Procurement**

Explanation:

PRINTED NAME OF INDIVIDUAL	DATE
DIVISON AND TITLE OF INDIVDIUAL	SIGNATURE
CITY STATE ZIP	EMAIL ADDRESS PHONE NUMBER

D3

Boycott of Israel Disclosure



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Health Choice

EXHIBIT E: BOYCOTT OF ISRAEL DISCLOSURE

Please note that if any of the following apply to this Solicitation, Contract, or Contractor, then the Offeror shall select the "Exempt Solicitation, Contract, or Contractor" option below:

- The Solicitation or Contract has an estimated value of less than $100,000,
- Contractor is a sole proprietorship,
- Contractor has fewer than ten (10) employees, and/or
- Contractor is a non-profit organization.

Pursuant to A.R.S. § 35-393.01, public entities are prohibited from entering into contracts "unless the contract includes a written certification that the company is not currently engaged in, and agrees for the duration of the contract to not engage in, a boycott of goods or services from Israel.

Under A.R.S. § 35-393:
1. "Boycott" means engaging in a refusal to deal, terminating business activities or performing other actions that are intended to limit commercial relations with entities doing business in Israel or in territories controlled by Israel, if those actions are taken either:
(a) Based in part on the fact that the entity does business in Israel or in territories controlled by Israel.
(b) In a manner that discriminates on the basis of nationality, national origin or religion and that is not based on a valid business reason.
2. "Company" means an organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company or other entity or business association, including a wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate, that engages in for-profit activity and that has ten or more full-time employees.
…
5. "Public entity": (a) Means this State, a political subdivision of this State or an agency, board, commission or department of this State or a political subdivision of this State. (b) Includes the universities under the jurisdiction of the Arizona board of regents and community college districts as defined in section 15-1401.
The certification below does not include boycotts prohibited by 50 United States Code Section 4842 or a regulation issued pursuant to that section. See A.R.S. § 35-393.03.

In compliance with A.R.S. § 35-393 et seq., all offerors must select one of the following:

■ The Company submitting this Offer does not participate in, and agrees not to participate in during the term of the contract, a boycott of Israel in accordance with A.R.S. § 35-393 et seq. I understand that my entire response will become a public record in accordance with A.A.C. R2-7-C317.

☐ The Company submitting this Offer does participate in a boycott of Israel as described in A.R.S. § 35-393 et seq. or

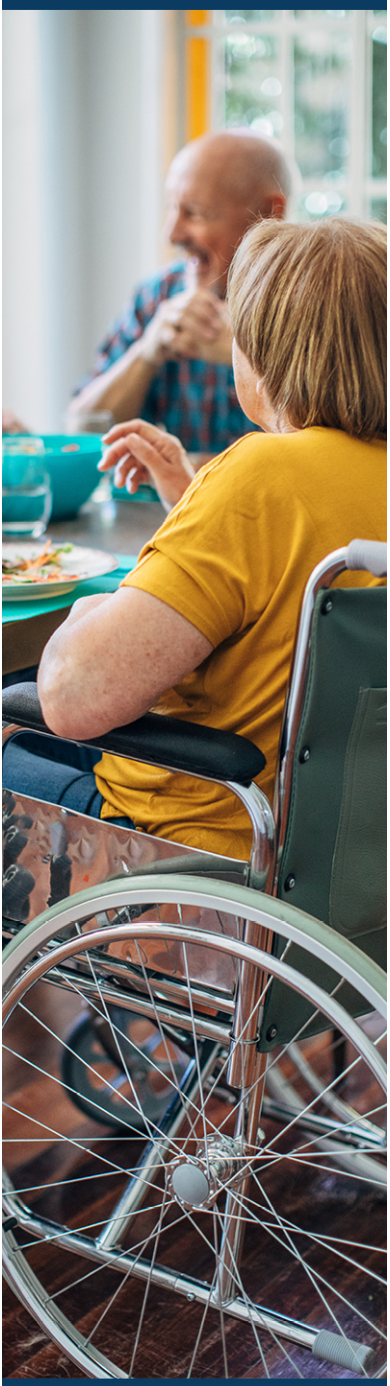
☐ Exempt Solicitation, Contract, or Contractor. Indicate which of the following statements applies to this Contract:

- ☐ Solicitation or Contract has an estimated value of less than $100,000;
- ☐ Contractor is a sole proprietorship;
- ☐ Contractor has fewer than ten (10) employees; and/or
- ☐ Contractor is a non-profit organization.

Signature of Individual Authorized to Sign	Shawn Nau Chief Executive Officer Printed Name and Title
Phoeinx Arizona City State	shawn.nau@azblue.com 480-340-3452 Email Address Phone Number

D4

No Moral or Religious Objections



BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

October 2, 2023

Meggan LaPorte, CPPO, MSW
Chief Procurement Officer
801 East Jefferson Road
Phoenix, Arizona 85034

Re: ALTCS EPD RFP NO YH24-0001
Section D4 No Moral or Religious Objections

Ms. LaPorte:

As require by the ALTCS EPD RFP No YH24-0001, Health Choice Arizona, Inc. hereby acknowledges that it has no moral or religious objections regarding the provision or reimbursement of any covered services [42 CFR 438.102(a)(2)].

Sincerely,

Health Choice Arizona, Inc.	
Company Name	Signature of Person Authorized to Sign Agreement
8220 N 23rd Avenue	Shawn Nau
Address	Printed Name
Phoenix AZ 85021	Chief Executive Officer
City State Zip	Title

D5

State Only Pregnancy Terminations Agreement

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Exhibit F: State Only Pregnancy Termination Agreement

THIS AGREEMENT is entered into by and between the Arizona Health Care Cost Containment System (AHCCCS), located at 801 E. Jefferson, Phoenix, Arizona 85034, and Health Choice Arizona, Inc (Offeror).

WHEREAS, it is the intention of AHCCCS to use the services of the Contractor for medically necessary pregnancy terminations.

WHEREAS, the Contractor represents itself to be qualified for such services in accordance with all applicable laws and regulations governing this profession.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements hereinafter set forth, the parties hereto, and legally intending to be bound thereby, do covenant, and agree for themselves and their respective successors and assigns as follows:

1. The Contractor agrees to provide those services described below:

1.1 Pregnancy terminations which are medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

1.1.1 Creating a serious physical or mental health problem for the pregnant member,

1.1.2 Seriously impairing a bodily function of the pregnant member,

1.1.3 Causing dysfunction of a bodily organ or part of the pregnant member,

1.1.4 Exacerbating a health problem of the pregnant member, or

1.1.5 Preventing the pregnant member from obtaining treatment for a health problem.

1.2 Conditions, Limitations and Exclusions:

1.2.1 The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the *Certificate of Necessity for Pregnancy Termination* and clinical information that supports the medical necessity for the procedure, as referenced in the AHCCCS Medical Policy Manual (AMPM), Chapter 400, Policy 410, *Maternity Care Services*. This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief

Medical Officer or designee for Fee-For-Service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

1.2.2 Pregnancy terminations must be provided in compliance with AMPM Policy 410, *Maternity Care Services*.

2. All outpatient medically necessary covered services related to the pregnancy termination, for dates of service only on the day the pregnancy was terminated, will be considered for reimbursement at 100% of the lesser of the contractors paid amount or the AHCCCS Fee Schedule amount. Adjudicated encounters for these covered services provided to enrolled members will be used to determine reimbursement.

3. Any changes, modifications or revisions to this Agreement shall only be executed through a written amendment, issued, and signed by the authorized AHCCCS procurement officer.

4. Either party to this Agreement may terminate this Agreement without penalty by giving the other party written notice of such termination at least thirty (30) days prior to termination.

5. This agreement shall be governed by the laws of the State of Arizona.

6. The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its service hereunder.

7. The Contractor shall not assign any interest in this Agreement, and shall not transfer any interest, whatsoever, in the same (whether by assignment or novation), without the prior written consent of AHCCCS.

8. The initial term of this Agreement shall be for the term **October 1, 2024** through **September 30, 2031.**

9. Termination – Availability of Funds: If, funds are not presently available to support the continuation of performance under this Contract beyond the current fiscal year, this Contract may be terminated at the end of the period for which funds are available. No legal liability on the part of AHCCCS for any payment may arise under this Contract until funds are made available for performance of this Contract.

   Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

IN WITNESS WHEREOF, the parties have executed this agreement the day and year first written above.

10. Termination For Conflict of Interest: AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting, or creating the contract on behalf of AHCCCS is, or becomes at any time while the Contract or any extension of the Contract is in effect, an employee of, or a consultant to, any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided by A.R.S. § 38-511.

Health Choice Arizona, Inc	
Offeror Name	Signature of Person Authorized to Sign
8220 N. 23rd Ave	Shawn Nau
Address	Printed Name
Phoenix AZ 85021	Chief Executive Officer
City State Zip	Title