Banner
University Family Care

Request for Proposal ALTCS E/PD
RFP No. YH24-0001
Banner - University Family Care
October 2, 2023 | 3:00 p.m. Arizona Time

Banner
University Family Care

Part A

Request for Proposal ALTCS E/PD
RFP No. YH24-0001

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	3
A2	Completed and Signed Offeror's Intent to Bid	4-5
A3	Completed and Signed Solicitation Offer and Acceptance Offer Page	6-7
A4	Completed and Signed Offeror's Bid Choice Form	8
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PART B	SUBMISSION REQUIREMENTS	
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B3	Health Equity Requirement No submission required	N/A
B4	5-page limit	43-47
B5	4-page limit	48-51
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	52-57
B7	4-page limit	58-61
B8	4-page limit	62-65
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B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	N/A
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PART C	CAPITATION AGREEMENT/ADMINISTRATIVE AND CASE MANAGEMENT COST COMPONENTS BID	
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PART D		
D1	Intent to Provide Insurance	98
D2	~~Representations and Certifications of Offeror and~~ Completed Section G: Disclosure of Information Instructions and Attestation	99-102
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D5	State Only Pregnancy Terminations Agreement	105-107

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:	Ryan J. Thomsen
2	TITLE:	Sr. Director, Government Programs
3	EMAIL ADDRESS:	ryan.thomsen@bannerhealth.com
4	PHONE NUMBER:	(520) 780-8310
5	COMPANY NAME:	Banner-University Care Advantage dba Banner-University Family Care
6	COMPANY ADDRESS:	5255 E. Williams Circle, Ste. 2050, Tucson, AZ 85711
7	COMPANY WEBSITE:	www.bannerufc.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.	RJT
My company (listed in box #5 above) intends, or is considering its intent, to submit a bid for this RFP.	RJT
I understand that submittal of this form does not obligate my company to submit a bid.	RJT
I am an employee of my company (listed in box #5 above) and not a consultant or independent contractor.	RJT
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.	RJT
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.	RJT

Signature: ______________________ **Date**: _____**8/2/23**________

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:	Vanessa Flores
2	TITLE:	Sr. Manager, Government Programs
3	EMAIL ADDRESS:	Vanessa.Flores2@bannerhealth.com
4	PHONE NUMBER:	(520) 310-2080
5	COMPANY NAME:	Banner-University Care Advantage dba Banner-University Family Care
6	COMPANY ADDRESS:	5255 E. Williams Circle, Ste. 2050, Tucson, AZ 85711
7	COMPANY WEBSITE:	www.bannerufc.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.	VYF
My company (listed in box #5 above) intends, or is considering its intent, to submit a bid for this RFP.	VYF
I understand that submittal of this form does not obligate my company to submit a bid.	VYF
I am an employee of my company (listed in box #5 above) and not a consultant or independent contractor.	VYF
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.	VYF
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.	VYF

Signature: Vanessa Flores (signature) **Date**: **8/4/23**

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

	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.: 46-3757358

E-Mail Address: AHCCCSdeliverables@bannerhealth.com

Banner-University Care Advantage dba Banner-University Family Care
Company Name

5255 E Williams Circle, Ste 2050
Address

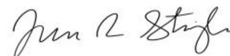
Tucson	AZ	85711
City	State	Zip

For clarification of this offer, contact:

Name: James R. Stringham

Title: VP and CEO

Phone: (602) 568-4179



Signature of Person Authorized to Sign Offer

James R. Stringham
Printed Name

VP and CEO
Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

The Contractor is cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives 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

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

Banner-University Care Advantage dba
Banner-University Family Care
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.

Central: Maricopa, Gila, and Pinal Counties	**1st choice**
North: Mohave, Coconino, Apache, Navajo, and Yavapai Counties	**3rd choice**
South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties (including zip codes: 85542 85192 8550)	**2nd choice**

[signature] September 29, 2023
Authorized Signature **Date**

James R. Stringham VP and CEO
Print Name **Title**

AHCCCS
Arizona Health Care Cost Containment System

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:** SIGNATURE ON FILE
TYPED NAME: James R. Stringham	**TYPED NAME:** MEGGAN LAPORTE, CPPO, MSW
TITLE: VP and CEO, Banner-University Care Advantage dba Banner-University Family Care	**TITLE:** CHIEF PROCUREMENT OFFICER
DATE: September 29, 2023	**DATE:**

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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
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.~~

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RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
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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.**

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.**

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RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
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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.**

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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.

AHCCCS
Arizona Health Care Cost Containment System

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? 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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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? 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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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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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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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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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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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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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.**

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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.

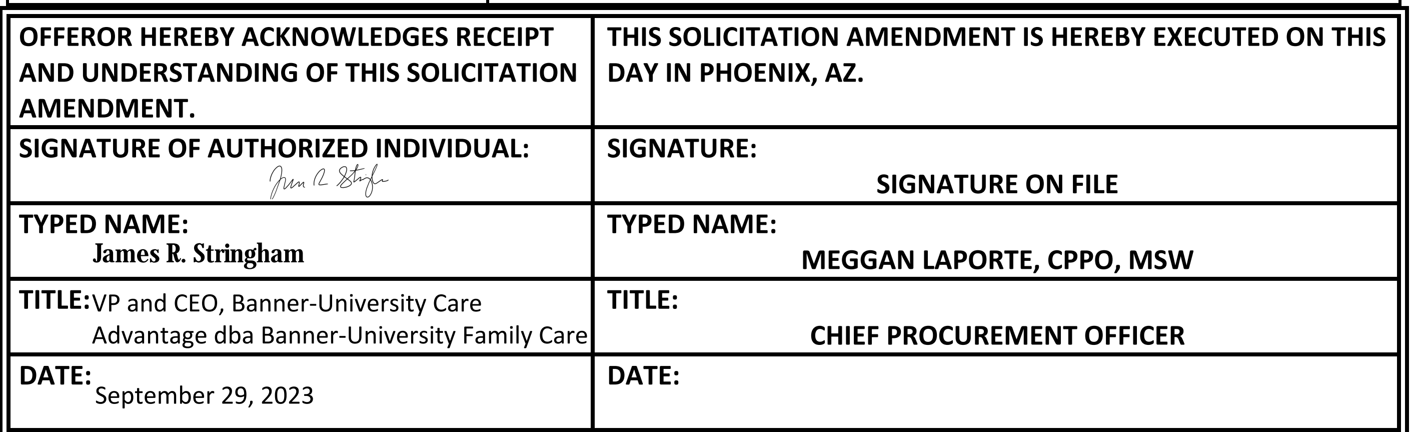
This Solicitation is amended as follows:

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	(see table below)

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 AUTHORIZED INDIVIDUAL: [signature]	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: James R. Stringham	TYPED NAME: MEGGAN LAPORTE, CPPO, MSW
TITLE: VP and CEO, Banner-University Care Advantage dba Banner-University Family Care	TITLE: CHIEF PROCUREMENT OFFICER
DATE: September 29, 2023	DATE:

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#	**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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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.**

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						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/ Su bmission	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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						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**

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			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.**

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						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.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	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.**

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	

AHCCCS
Arizona Health Care Cost Containment System

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.

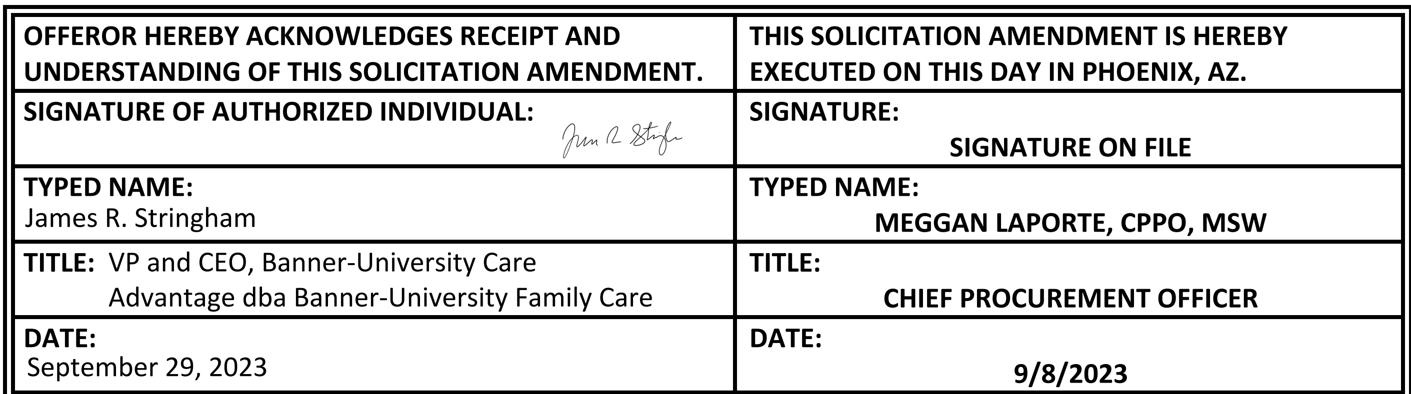
This Solicitation is amended as follows:

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: James R. Stringham	TYPED NAME: MEGGAN LAPORTE, CPPO, MSW
TITLE: VP and CEO, Banner-University Care Advantage dba Banner-University Family Care	TITLE: CHIEF PROCUREMENT OFFICER
DATE: September 29, 2023	DATE: 9/8/2023

Banner
University Family Care

Part B

Request for Proposal ALTCS E/PD
RFP No. YH24-0001

(B.1): Executive Summary

(B.1.a): Overview of the Organization

Banner-University Family Care (BUFC), previously known as the University of Arizona Health Plan, University Family Care Inc., launched as a Medicaid Acute Care Contractor in 1985. Since then, we have experienced significant organizational growth and expansion. In 2015, BUFC was created through a public-private partnership between Banner Health (Banner) and the University of Arizona (UA). We are exceptionally positioned to deliver on AHCCCS priorities due to our relationship with Banner, the state's leading healthcare delivery system, and UA, a leading academic institution. Our connections to Banner and UA give us unique access to the state's leading experts, such as though our partnership with Banner Alzheimer Institute and the UA College of Medicine. We currently serve over 286,000 ALTCS and ACC members and more than 14,000 Banner Medicare Advantage (BMA) Dual members in Central and Southern Arizona. We also manage a top-rated Medicare Shared Savings Program (MSSP) through Banner Health Network (BHN) that is accountable for more than 60,000 Medicare beneficiaries in Arizona, and a Medicare Advantage Prescription Drug Plan (MAPD) through BMA HMO that has seen 428% growth since 2022. As a tenured incumbent, BUFC has been a longstanding and trusted partner that AHCCCS can rely on to collaborate to address cross-system challenges.

We are a committed safety net health plan with a history of innovation, transformation, and strong provider and community relationships. Our Board of Directors includes Banner executives with respected community leaders such as Dr. Shar Najafi-Piper, CEO, COPA Health, Aaron Sinykin, CEO, Devoted Guardians, and Dr. Anne Mathias, Professor, UA. BUFC is ideally positioned to continue to coordinate the delivery of integrated, person-centered care in the southern and central geographic service areas (GSA). In anticipation of a state-wide aware, we are expanding our provider networks in the Northern GSA to ensure network adequacy in advance of June 1, 2024, and to meet the CMS FIDE SNP requirement of January 1, 2025.

BUFC is committed to operationalizing our mission and vision through three strategic pillars: Member-Centered, Community-Committed, and Health Equity-Focused. Aligned with AHCCCS's mission to transform managed care, we aim to provide Arizona's most vulnerable citizens high-quality, integrated health care. Our mission – making health care easier, so life can be better – emphasizes consistent access tailored to meet each member's unique needs in line with their whole-person, person-centered service plan (PCSP). Since inception, BUFC has partnered with AHCCCS, providing leadership to address community challenges like COVID-19 and workforce issues.

(B.1.b): Relevant Experience Providing Healthcare for the Population Specified

As an incumbent and long-standing community partner, we have significant experience serving diverse ALTCS populations across rural and urban communities and settings. Nearly 85% of our ALTCS members experience multiple complex and chronic physical and behavioral health (BH) conditions, often complicated by Health-Related Social Needs (HRSNs). Our whole-person model of care (MOC), informed by our DSNP MOC that received 100% score from CMS, comprehensively addresses members conditions and health needs through evidence-based assessments and PCSPs.

Since becoming an ALTCS plan on October 1, 2017, 68% of our Case Managers (CMs) have remained with us. We launched the program with a focus on retaining the most well-qualified and community connected CMs, prioritizing members, building a comprehensive, high-quality network, and ensuring seamless transitions through meticulous processes and contingency strategies. Banner has invested billions of dollars in Arizona and in partnership with the UA College of Medicine, Public Health, Health Sciences, and Law, Banner supports research and training of Arizona's future workforce. Through our Caregiver Support Program, we take a multifaceted approach to coordinate the efforts and address the needs of formal and informal direct care workers. Banner excels in expanding our organizational capacity and community workforce development. BUFC has invested over $20 million in technology to improve clinical analytics, risk stratification, and customer- and provider-facing tools. Additionally, we hired leading subject matter experts in

claims, encounters, information technology, and network operations to guide our health plan and advance operations. These efforts helped BUFC achieve the highest score among ALTCS plans in our 2023 Operational Review.

As a provider-owned, safety net health plan with academic ties, we are uniquely positioned to address our communities' unmet social needs, Health Equity (HE), and access to care; and take actions to address HE and tailor resources distinct to each county/community. BUFC committees work collaboratively to advance HE, including but not limited to Member Advisory, Enrollee Advisory, Cultural Competency, and Community Reinvestment. In 2022, before required by AHCCCS, we created an executive-level Health Equity Administrator role to advance our capabilities to address health inequities and implement new programs. In addition, the Association for Community Affiliated Plans selected BUFC to participate in its Health Equity Learning Collaborative. In partnership with the Center for Health Care Strategies, we help participating health plans design and implement HE strategies. We also integrated HRSNs categories into our assessments, strengthening our population health approach, and improving health outcomes.

(B.1.c): High-level Description of Proposed Unique Approach to Meet Contract Requirements

BUFC offers a distinct approach that sets us apart from other health plans – we understand and are committed to AHCCCS priorities and continuous quality improvement. Our unique strategies not only meet regulatory requirements, we also introduce innovative programs to optimize outcomes, address HE and disparities, and empower members to make informed decisions. Below are a few examples highlighting our unique approaches to ALTCS principles and goals.

Member-centered and PCSP: BUFC's MOC meets or exceeds RFP, AHCCCS Medical Policy Manual and all ALTCS caseload requirements. BUFC, our CMs, and our local executive team are a part of the communities that we serve. PCSPs are built using member-centric strategies to align outcomes tailored to our members' needs and goals. Our tracking tool monitors progress on quality-of-life goals and HRSNs. Our unique technology-driven approach further enhances member engagement, aligning care with individual preferences. According to our 2023 ALTCS Member Survey, 84% of our members agree their CMs have helped improve their health. They recognize that we go the extra mile.
Member directed options: Our CMs empower members with information, tools, and resources so they can make informed choices to achieve their personal goals. We augment this with digital, member-driven solutions like Rovicare, a digital platform that automates and streamlines access to care and care coordination. This enables members to choose their direct care worker or service providers while engaging all stakeholders in the member's care journey. Rovicare also addresses inefficiencies, improves access to care, member satisfaction, and reduces avoidable readmissions.
Most integrated settings: We aim to provide services in the most integrated, least restrictive way. We offer members a choice of home or community-based settings as a cost-effective alternative to reduce institutionalization, including for members transitioning from other plans. Today, every ALTCS member, or their Health Care Decision Maker, directs their own PCSP Team. CMs act as care navigators, coordinating the PCSP team make-up based on member's needs. Integration is also evident in our systems and technology such as **Innovaccer**, our population health platform, which decreases fragmentation and increases cohesion and coordination of care. Our care management and population health platforms encompass assessments, care planning, and caseload management covering all lines of business and services, including BH, long term care, and more.
Network accessibility and consistency of services: BUFC maintains an extensive clinically integrated and compliant ALTCS network. We are expanding our use of telemedicine, virtual clinics, mobile health partners, and rural health clinics to provide greater access. We employ a high-touch provider relations approach with easy onboarding, streamlined claims processes, education, communication opportunities, and collaborative, value-based programs. As a result, we retain our providers and offer consistent access to value based care in Home and Community Based Settings.
Collaboration with stakeholders: BUFC's longstanding community connections uniquely positions us to address complex, cross-system challenges, promote clinical integration, and add value to serve the best interest of the state. In 2022-23, we invested over $4 million in HE community partners through our community reinvestment programs. We advance our initiatives with the support of community partners such as the eight Arizona Area Agencies on Aging, five Arizona Centers for Independent Living, the Foundation for Senior Living, and our unique Neighborhood Advisory Committees. Our successful Electronic Visit Verification (EVV) implementation highlights BUFC's collaboration with stakeholders to ensure appropriate member care in the face a of a systemwide challenge.

As a well-established incumbent with a proven track record of success, history, a deep understanding of the program, and a trusted community leader, we are ready to continue and expand our ALTCS program.

(B.2): Cite Contracts

	MCO Name and Number of Contract	Name of Program	State
1.	Banner-University Care Advantage dba Banner Medicare Advantage Dual (BMA Dual), Contract # H4931	DSNP	AZ

BMA Dual has been serving Arizona DSNP members for over 15 years, with 13,724 members. BMA Dual has an active contract with CMS in Central and Southern GSA; and an active Medicare Advantage Organization (MAO) Agreement with AHCCCS as a fully integrated dual eligible (FIDE) special needs plan and highly integrated dual eligible (HIDE) special needs plan. BMA Dual populations include Arizonans enrolled in Medicare and receiving assistance under Medicaid, known as Full Benefit Dual Eligible Members. In addition, our populations include over 3,000 living in rural areas, 115 enrolled tribal members, and 226 members with Serious Mental Illness (SMI). 86% of BMA Dual members are aligned with our Arizona Medicaid plans. BMA Dual meets or exceeds all program requirements in Section 2 of the MAO Agreement. BMA Dual is fully integrated, offering whole person care where all members receive integrated Behavioral Health and Physical Health (BH/PH) services including addressing Health-Related Social Needs (HRSN). Our model of care received a 100% CMS score, and all members are assigned a Care Manager (CM). In addition, CMS approved our seamless/default enrollment plan for five years. Our primary health-related supplemental benefits include chiropractic visits, preventative and comprehensive dental, eye exams and eyewear, hearing exams and hearing aids, over-the-counter products, podiatry, and telehealth services. Our non-primary health supplemental benefits addressing HRSN includes meals, transportation, and fitness. We also reward members who complete annual wellness visits, breast cancer, and colorectal screenings. We participate in CMS Value Based Insurance Design (VBID) where members access our Dial into Diabetes program, including exercise physiologist and zero cost sharing on drugs. Under VBID, we obtained full approval on its Health Equity Plan aligning with our health equity initiatives, including hiring a Health Equity Administration. Our CMS predicted STAR rating is 3.5 for projected 2024 rating.

	MCO Name and Number of Contract	Name of Program	State
2.	Banner Health Network (BHN), Contract # A3229	Medicare Shared Savings Program (MSSP)	AZ

BHN has served Arizona Medicare members through an MSSP for over six years and has an active contract with CMS. BHN is Arizona's largest MSSP with over 60,000 Medicare beneficiaries across the metro-Phoenix area. BHN was named a top 10 MSSP across the nation and successfully achieved shared savings for the past five years through implementation of actionable programs for members, PCPs, and care management staff. BHN is a fully integrated accountable care organization, offering whole person care to the Medicare population where all members receive integrated BH/PH services, including addressing HRSN. Key Medicare populations include the frail/elderly and members with chronic conditions such diabetes and chronic kidney disease. We have tailored member-focused programs around the key populations that are the highest risk for disease progression or development and have successfully reduced avoidable healthcare utilization via continuous performance improvement initiatives. Our analytics team facilitates the use of on-demand dashboards for providers, care management staff, and leadership to ensure optimal care for these member cohorts.

	MCO Name and Number of Contract	Name of Program	State
3.	Banner Medicare Advantage (MA) HMO (BMA HMO), Contract # H5843	MA Prescription Drug (MAPD) Plan HMO	AZ

BMA HMO is the fastest growing Arizona MA plan with 10,312 members, with a 428% of growth since 2022. BMA has active contracts with CMS in Maricopa, Pinal, Pima, Santa Cruz, and Yuma counties. BMA HMO is a CMS Coordinated Care Plan that meets and exceeds the provisions referenced in 42 CFR 422, and all members receive integrated BH/PH services, including addressing HRSN. Our primary health related supplemental benefits include chiropractic visits, preventative and comprehensive dental, eye exams and eyewear, hearing exams and hearing aids, over-the-counter products, podiatry, and telehealth services. Our non-primary health supplemental benefit addressing HRSN includes meals, transportation, and fitness. We also reward members completing annual wellness visits, breast cancer, and colorectal screenings. We participate in CMS VBID where members access our Dial into Diabetes program and exercise physiologists. Under VBID, we obtained full approval on its Health Equity Plan aligning with our health equity initiatives including hiring a Health Equity Administration. Our 2024 CMS predicted STAR rating is 3.5.

(B.4) The ALTCS E/PD Member Population Is Complex . . .

Banner-University Family Care (BUFC), an incumbent serving ALTCS members with complex conditions since 2017, applies both nationally and locally recognized best practices to customize our case management program and implements innovative solutions that improve the quality of care and services for our members. In the recent AHCCCS Operational Review, we scored an exemplary 95% overall and 93% in Case Management standards, outperforming all other ALTCS Managed Care Organizations (MCOs) evaluated. As a participant in the NCQA LTSS Best Practices Academy, we collaborate with national experts to develop initiatives that advance utilization of LTSS Best Practices nationwide.

Best Practices: Using a cross-functional approach, clinical and operational leaders identify, develop, and implement best practices to continuously improve our case management processes and workflows. We analyze internal and external data to identify opportunities for improvement; engage key stakeholders such as members, providers, and AHCCCS to ensure goal alignment; and enact modifications to optimize processes. We identify key areas that impact outcomes, define measurements, and establish effective strategies to support goals. We evaluate these practices each year or when any changes occur. Our IT systems capture data to track and report staff compliance with the best practice, and our robust data-driven strategies address systematic factors that impact health outcomes and address drivers of health disparities. BUFC's internal cross-functional management teams implement rapid cycle improvements and collect quarterly metrics, which we review within our Quality Management/Performance Improvement program. We educate Case Managers (CMs) and other employees on these best practices and integrate them into our workflows, desktop tools, and employee performance evaluations. For example, in early 2023 we implemented a best practice to assemble a multi-disciplinary Person-Centered Service Planning (PCSP) Team after the CM meets with a newly enrolled member to develop their initial PCSP. This multi-disciplinary PCSP Team supports members in achieving their goals by leveraging ALTCS staff such as our medical director, RNs, BH Professionals, as well as primary care, and other providers, consistent with the member's needs, wishes, and consent. This process prioritizes members in SNFs and ALFs and has resulted in enhanced collaboration between our medical director and the member PCPs to facilitate quicker community transitions.

Leveraging Case Managers: We consider all ALTCS members to have complex needs, and apply a high-touch, individualized approach to meet those needs. Our member-first approach respects each member's unique goals, medical and social needs, strengths, preferences, risk-factors, culture, language, and beliefs. CMs act as navigators to ensure members with complex conditions remain in the least restrictive, most integrated settings suitable for their complex conditions. Our CMs apply best practices to coordinate care across delivery systems through a comprehensive PCSP process, empowering and engaging members and their families, healthcare decision makers (HCDM), or designated representatives (DR) to make informed decisions. To increase knowledge, inform practices, and advance health equity, we train and evaluate CMs in Cultural Intelligence and Bias, the AHCCCS mission, vision, values, and initiatives, including the Whole Person Care Initiative, the Nine Guiding Principles for Adults and 12 Guiding Principles for Children, 10 Principles of Wraparound services, mental health parity, 42 CFR Part 2, suicide prevention, and mental health stigma. We also train CMs to assess the member's living conditions, e.g., identify the need for home modifications, and assess for Health-Related Social Needs (HRSNs). Our member-centered approach results in strong member relationship and more frequent and timely interactions with the members.

(B.4.a) Decrease Duplication of Effort and Enhance Coordination of Care with Providers

BUFC-ALTCS's PCSP model of care integrates physical health (PH), BH, and community services; minimizes duplication, and maximizes coordination. Our CMs are the crux of this model, advancing meaningful collaborations across the system of care by convening multidisciplinary PCSP Teams and encouraging treating providers' participation. Directed by the member and including their families, caregiver(s), HCDM, and/or DR, as appropriate; PCSP Teams also incorporate participation by BUFC physical, specialty, and BH medical directors; pharmacists; PH and BH professionals; and caregiver, tribal, veterans, housing, employment, and education advocates.

Guided by the member's preferences, goals, and needs, the PCSP Team develops the PCSP and shares it with the member and PCSP Team participants (with member consent). CMs coordinate with the member, their providers, and community organizations to implement the PCSP across the system of care and fully address each member's distinct Health-Related Social Needs (HRSN) as well as medical and BH risk factors. CMs facilitate all communication among PH and BH providers, sharing information such as the AHCCCS Pre-Admission Screening Tool (PAS) and the member's PCSP.

We improve communication and collaboration across PH and BH services using advanced, integrated data-sharing platforms. Our population health platform, **Innovaccer** ingests claims data, including Z-codes and health information exchange (HIE) updates in real-time, enhancing coordination and reducing duplication. In addition, CMs review pharmacy data and work with the member's Primary Care Physician (PCP) to address duplicate orders.

In Q3 of 2023, we adopted Rovicare, digital platform used to streamline care coordination, to automate provider referrals and reduce duplication of effort and administrative burden. Local caregivers contact the member and close the request upon member selection. This system streamlines timely service initiation, enhances member choice, reduces duplication of efforts, and improves coordination.

(B.4.b): Assist Members Prior to and Throughout Transitions

To prevent any delay or disruption of care for ALTCS members who all have complex needs, our CMs and dedicated Transition Coordinator implement our Transition of Care policies and ensure continuity of care between settings, prioritizing member preferences and goals as identified in their PCSP prior to and throughout all transitions. They educate members/families/caregivers/HCDM/DR, on self-management skills to ensure their social, BH, and PH needs are met; support safe member returns to the setting of their choice; and develop back-up plans to reduce preventable readmissions, institutionalizations, and adverse outcomes. CMs oversee transitions in person, when possible, to resolve potential barriers to a successful transition and confirm 90-day continuity of care authorizations and services. If a member with an SED or SMI designation is receiving care from an out-of-network provider, CMs collaborate with our Network and UM Teams to assure care continues and is authorized. We negotiate single case agreements with non-network providers, while working to negotiate a contract, to assure care continues without disruption. We ensure medication reconciliation to minimize medication errors and access Innovaccer data to support successful transition.

Assisting All Members, During All Transitions: Within 30 days of enrollment, we convene a specialized PCSP Team that includes medical directors and other professionals to proactively identify members, particularly those in institutional settings, who can transition to community living settings. In addition to the PCSP Team participants described above, this specialized team also includes a Transition Coordinator, Member Liaison Coordinator, and our newly created Caregiver Advocate role, as appropriate. We leverage the PCSP to ensure a successful transition and consider the member's individual goals and desired outcomes, including their unique HRSN, strengths and medical and behavioral risk factors. CMs work with existing community transition programs and coordinate with aligned and unaligned DSNPs to promote coordinated care and ensure a successful transition.

The following table reflects activities common to all transitions:

Pre-transition PCSP - All Transitions
In advance of the identified potential transition, CMs convene a multi-disciplinary PCSP Team (described above), and – using our member-first approach – work with the member to develop a transition plan that includes logistical arrangements (e.g., follow-up appointments and transportation), coordination among care and service providers (e.g., attendant care), member and caregiver education, pharmaceutical needs (e.g., medications for OUD treatment), DME, and community supports.
Member and Caregiver Engagement Strategies - All Transitions
Throughout the transition process, CMs listen to the member/families/caregivers/HCDM/DR, ensuring the member's specific preferences, goals, and needs guide transition planning activities and enable the member to live in the least restrictive and most integrated setting of their choice. For example, CMs may set up facility tours for a family or link a caregiver/HCDM to culturally appropriate community resources and supports after transition. The DR protects member rights as applicable.
Post-Transition Follow-Up Between Care Settings - All Transitions
Informed by the PCSP and to ensure care continuity, the CM meets the member and their desired PCSP Team on-site within 10 business days after the transition to a new setting. The CM works with the PCSP Team and the member's treating providers to verify required services and supports are in place, the member is satisfied with those services, and there are no barriers to care. The PCSP Team conducts formal reviews of complex cases as needed to ensure a seamless transition. If the transition is not into the least restrictive environment, such as an interim stay in physical rehabilitation facility, our CMs work with the PCSP Team to accomplish this goal.
Information Systems Supporting Transitions - All Transitions
BUFC's case management system integrates data and shares information among providers, members, and CMs. This system ensures coordination of care, tracks services used by members through episodes of care, and streamlines care transitions to ensure positive health outcomes. PCSP Team members also access transition information through the provider portal or by contacting our Call Center. CMs use the comprehensive case management platform to complete PCSPs and document transitions.

Transitions Metrics Collected and Monitored - All Transitions
CM leadership tracks metrics such as initial contact, visit completion, verification of services, and initiation of services, which are key data sources for ensuring successful transitions and evaluating effectiveness of strategies.

Examples of activities conducted by CMs, by specific Transition Type, are depicted in the table below:

Transitions From Home to ALF/SNF	CMs participate in on-site care conferences and collaborate with the ALF/SNF Admissions Contact, and the member/families/caregivers/HCDM/DR. Within 10 days of the transition, the CM shares the PCSP and any assessment information, continuously evaluating and planning for transition back to community if clinically appropriate and aligned with member goals.
Transitions From Non-Acute Care Settings	CMs monitor Minimum Data Set data, which we map to the Universal Assessment Tool to identify discrepancies and/or changes to the level of care and participate in on-site case conferences, conduct assessments, and implement the resulting PCSP. As feasible, the member's assigned CM is on-site during the move.
Transition Activities from Acute Care Settings to ALF, NF, Behavioral Health Residential Facility (BHRF), Correctional Institution, or Home	CMs begin discharge planning at the time of admission, coordinate with the discharging and accepting facilities, and meets with the member, HCDM and other member-identified supports prior to planned discharge to complete the PCSP. For complex cases, we conduct an integrated multi-disciplinary staffing prior to a planned discharge including the discharging facility, accepting facility, transition coordinator, and justice system liaison, as applicable, to support the member's goals. As part of the PCSP, conducted within 10 days of transition, CMs identify strategies to prevent readmission. They arrange additional needed services and supports, which may include support with activities of daily (ADLs), rehabilitation services, BH, telehealth, peer support, and/or transitional housing, as well as medications and therapy for opioid use disorder. Following transition, our CMs meet with the member and HCDM within five days of new placement.
RBHA Transition	CMs screen newly enrolled members with an SMI designation and facilitate timely coordination with the ACC RBHA serving them to determine if the member receives Special Assistance from the AHCCCS Office of Human Rights (OHR). CMs obtain a transfer packet from the SMI service provider, taking administrative responsibility for those on court ordered treatment (COT), and working with the PCSP Team to ensure continuity of PH and BH services.
Youth with Complex Needs Transitioning to Adulthood	Transition Specialists and CMs engage with families as early as age 16 to plan for loss of services for children (e.g., EPSDT) and address potential social needs such as education, housing, and job training. If clinically appropriate, CMs arrange for an SMI evaluation no later than age 17.5 years. As one of our best practices, we train CMs on transition to adulthood and apply the AHCCCS practice toolkit and TIP model.
Transition Activities Between MCOs, Services Area Changes, FFS, and/or other Healthcare Providers and Large Scale Transitions	When BUFC transitions a member to another MCO, CMs create and forward to the receiving MCO an Enrollment Transition Information (ETI) form with records within 10 days of notification of the change to. We coordinate closely with the other MCO to ensure continuity of care, regardless of whether we are relinquishing or receiving MCO. When BUFC is the receiving MCO, CMs identify and contact treating providers, create 30-day authorizations, at minimum, complete new member enrollment assessments and HRSN screenings, and initiate the PCSP. They also provide new members a Member Handbook, Provider Directory, and emergency numbers. BUFC has a proven process for seamless management of large-scale transitions. We work closely with AHCCCS and the relinquishing MCO to ensure timely information exchange and prevent any service disruption. In 2017, we successfully leveraged dually employed CMs with the relinquishing contractor to promote continuity of care and established relationships.

(B.4.c): Improve Member Engagement

Building strong, trust-based relationships is the cornerstone of our member engagement strategy. By actively listening to our members and consistently following through on our commitments, we are better equipped to help them address complex challenges and improve their health. This sense of trust is fostered through the longevity and commitment of our CMs — in fact, 68% of CMs have been with BUFC since 2017. As a best practice, all CMs are trained in motivational interviewing, BH, dementia care, and health equity principles. Members may request a specific CM who meets their unique needs. CMs follow member preferences related to method and frequency of communication – honoring each member's interests, needs, culture, language, belief system, and identified strengths. Members can reach a CM 24/7 to help with any needs. CMs engage, re-engage, and walk alongside assigned members to establish and re-assess person-centered goals, continuously monitor progress toward those goals, and engage members at every opportunity.

In our experience, we improve member engagement by deploying multiple communication methods, and ensuring that there is ongoing communication with the member's chosen identified supports/HCDM consistent with the PCSP. Prior to

each encounter, CMs review **Innovaccer** to consider current data that may impact engagement success. CMs ask how members prefer to communicate, honoring their needs and cultural priorities.

We tailor our member-first engagement strategies to each individual's unique preferences, medical, BH, dental, and HRSN needs, encouraging active participation in the care planning process. We segment our member populations and prioritize matching CMs by geographic location, language and other member preference.

Family engagement takes precedence in our approach, especially when dealing with ALTCS members who have complex needs or are minors. For our younger members, we make sure their guardians serve as the primary points of contact, adhering to the AMPM 1610 guiding principle. We actively support caregivers through our multi-pronged Caregiver Support Program. Recognizing the crucial role they play, we offer a variety of educational topics, including Virtual Dementia Training to simulate the experience of living with dementia. Upon award, we will hire Caregiver Advocates to ensure caregivers have a voice and receive the benefits of this program, including peer support and respite. We will share best practices and innovations via targeted communication for these important individuals via our website.

We incorporate member-centered outcome measures and input and direction from our ALTCS Member Advisory Committee and Governance Committee to inform our engagement strategies. CMs recruit members to participate in our Cultural Competency and Grievance and Appeal Review Committees, and make sure their voices are heard.

BUFC offers interpretation services and materials in multiple languages. We also assist members to access eligibility and benefit information, file a grievance or appeal, request ID cards, update contact information, change PCPs, and check authorization status, as well as advise on actions to take in emergencies or after hours. We have continuously improved our member portal to enable real-time communication and member access to resources and their PCSP. This technology-driven approach further enhances member engagement and satisfaction by offering convenience and choice for members in both language and format. Our website also offers links to BUFC and community-based resources.

To strengthen our ties to the community and member population, we fund and promote staff and member engagement at community events. During the holidays, we deliver handmade cards and collect socks and blankets to personally deliver to members. Over the last year, our CMs planned and attended 25 social events, including Bingo, art activities, and gardening at the facilities and in the communities where our members live. During the Public Health Emergency, our CMs organized COVID-19 vaccine events at SNFs and ALFs to engage BUFC members and others in the community.

(B.4.d): Coordinate Social and Community Support Services

Over the past 6 years serving ALTCS populations, we have strengthened our collaborations with various local community organizations, including the Foundation for Senior Living, Jewish Family and Children's Services, and Interfaith Community. These relationships are central to our approach to whole person care and facilitate member access to essential HRSN support services, such as housing and employment assistance, nutritional support, and transportation. CMs use the Contexture CommunityCares Closed-Loop Referral System (CLRS) and leverage our Community Resource Guide to ensure members have access to services. We made 273 referrals for nutritional support last year alone.

(B.4.e): Identify, Track, and Manage Outcomes . . . and (B.4.f): Appropriate Identification of Members . . .

We consider all ALTCS members to have complex needs, so our approach incorporates continuous monitoring of all members to promptly identify those who would benefit from High Needs Case Management (HN Case Management). Because of this and to avoid repetition, **we have combined our responses to subparts B.4.e and B.4.f**. Our approach to caring for members with complex needs is both data-driven and high touch. We apply reliable data analytics, described below, to promptly identify members with complex needs/those who would benefit from HN Case Management. Our CMs use **Innovaccer** to continuously monitor, track, and manage outcomes for all members, including those with complex needs or those who would benefit from HN Case Management. **Innovaccer** facilitates ongoing monitoring of the member's evolving needs and changing risks, including between assessments, advancing timely identification of members who would benefit from HN Case Management. Using these continuously updated data feeds, CMs, the member's PCSP Team, and treating providers have a 360° view of the member with visibility into risk scores, all historic utilization, overall costs, medications, gaps in care, and the complete PCSP.

Identifying Members Using Predictive Modeling: Our proactive identification process ensures members with complex, high, and/or emerging medical, behavioral, and HRSN needs receive timely, focused support. BUFC ALTCS uses

predictive analytics software to prioritize and guide case management outreach. Our software analyzes data from assessments and screenings, enrollment files for eligibility, assigned benefits, lab results, medical/behavioral data (including Z Codes and aligned DSNP), and publicly available zip code level data, such as air quality and known food deserts. It also reviews pharmacy claims data to generate a list of potential diagnoses and prescribed medications,

attributing to predictive risk scores. This software provides member-level insights into three key areas: social vulnerability index score, member activation, and clinical and behavioral risk factors. This allows us to identify members at risk of admission within 30 days or on a trajectory of developing opioid misuse within 6 months, for example. We are currently enhancing our predictive modeling by incorporating Arizona's HIE data to include members enrolled in another MCO's DSNP plan.

Leveraging CMs to Identify Members with Complex Needs and Those Who Would Benefit from HN Case Management: Our CMs foster deep, long-term connections with members and their supports through their long tenure serving the BUFC ALTCS program. This established trust promotes open communication and timely identification of changes in member needs. Members identified as having high needs receive at least monthly face-to-face CM visits, and more frequent touches as often as necessary, to monitor, asses, and educate. When CMs identify a member undergoing an SMI evaluation, they schedule an initial meeting with the member and treating provider within seven business days. The CM tracks the status and submission to Solari to monitor the SMI determinations and final determinations.

Case Management Aligned with Identified Needs: CMs meet face-to-face with members to conduct interviews and assessments, enabling first-hand observation of and advocacy for the member's status and living environment. In addition to other gathered data, this supports prompt identification of members who would benefit from HN Case Management. The PCSP is informed by the member and the PCSP Team, all of whom have in-depth insight into the member's needs. The PCSP Team is unique to each member and expands and contracts as needed. For example, the PCSP Team convened for a member requiring HN Case Management would include BUFC Medical Directors, RNs, BH clinicians, in addition to the PCP, CM, and other professionals, and would meet at least monthly or more often as needed. The CM coordinates care, ensuring all decisions align with the member's individual preferences and goals.

Reducing Burden on Members and Families: CMs continuously act on opportunities to "make life easier" for members and families. They connect caregivers to our Caregiver Support Advocate who collaborates with CMs to make caregiving easier and reduce burden on members and their family, as well as promote respite co-ops for our member's caregivers. CMs help schedule appointments, arrange transportation, obtain DME, and coordinate with the member's primary insurance, including aligned and unaligned DSNPs. CMs promote health screenings and wellness events at places of residences when services are less accessible and use the CLRS to connect members and caregivers to HRSN resources. CMs also engage members and families to verify satisfaction of services provided. Our PCSP Teams augment CM efforts and provide another layer of support to members and families, advocating for members to live in the least restrictive and most integrated setting, and ensuring timely delivery of services.

(B.4.g): Monitor Case Manager Performance and Respond to Identified Issues . . .

Led by the Medical Director, BUFC implements comprehensive initial staff orientation and training, ongoing education activities, and periodic performance audits. We complete quarterly and annual analysis reflecting overall percentages and trends for each CM, PCSP Team, and the case management department overall. This enables supervisors and trainers to target specific areas. We present audit results at each quarterly department training. We administer annual surveys to members regarding their CMs, and in 2022, 88% of members either "Strongly Agreed" or "Agreed" that they are happy with their CM and 84% of members either "Strongly Agreed" or "Agreed" that their CM has helped them improve their health. We use comments and feedback from the survey to inform CM training priorities.

At the Individual Level: Case Management leaders conduct Inter-Rater Reliability Reviews (IRR) chart audits monthly and quarterly. CMs scoring below 90% in monthly audits receive individual coaching. For quarterly audit scores falling below 90%, we implement a corrective action plan (CAP) with targeted coaching. Underperformance for two consecutive quarters may result in termination. In 2022, 95% of our CMs scored over 90% in chart audits.

At the Departmental/System Level: We monitor aggregated data, such as CM performance metrics, overall member satisfaction, and Grievances and Appeals information to identify opportunities for improvement. If any category in the IRR or other measure falls below a 90% threshold, we implement a departmental CAP. This plan may include ad hoc refresher training, or at scheduled CM staff meeting trainings to address specific areas, or through focused, small group training for specific underperforming CMs. Adherence to our health equity promotion priorities, PCSP process, Whole Person Care addressing HRSNs, and integrated care are all part of quarterly CM chart audits and care plan reviews.

(B.5): How Will the Offeror Ensure that Person-Centered Service Planning . . .

Banner-University Family Care (BUFC) understands that members with complex behavioral health (BH) and/or physical health (PH) conditions require the highest level of support to meet their health and quality-of-life goals. We believe all members have a right and responsibility to make choices about their lives, and that they should have opportunities for success and independence in community living and employment. Members have the right to try, whether they fail or succeed. We emphasize to members that they choose who participates in the PCSP team and have control over the lives they want to live. We provide a personal touch throughout the member journey to ensure a positive, whole-person and person-centered experience. Through our collaborative and inclusive planning process with the member, stakeholder, and their designated, chosen team, Case Managers (CMs) consider individual member's and family's strengths, needs, and cultural preferences as part of their comprehensive member profile, including race, ethnicity, gender identity, sexual orientation, and Health Related Social Needs (HRSNs). CMs facilitate access to medically necessary care and covered and non-covered support services in the most culturally competent, integrated, and cost-effective manner. CMs tailor the PCSP's elements per the specific needs and risk level of each member and use data as they develop a PCSP that addresses health disparities and improves health outcomes. Our Case Management teams are proficient in both state and federal requirements for care and service planning from birth to end-of-life care and for members with complex, high-risk conditions. The assigned CM collaborates with the member, caregivers, or family members, PH and BH providers, peer support as applicable, and local community-based organizations. This multifaceted approach ensures our care planning process, including short- and long-term goals, is compliant and adaptive and empowers our members.

Through the PCSP, CMs help members build a network of support in the communities where they live. CMs have unique, real-time access to Banner's multidisciplinary healthcare experts to support clinically complex members. The CM uses the PCSP to authorize and coordinate services, as well as to monitor the implementation of services and adherence to the PCSP. By holistically integrating these practices, we fulfill our mission to not only meet but exceed standards of care, ultimately enhancing the lives of our members through customized and person-centered approaches.

(B.5.a): Includes Active Engagement with ALTCS Members

If members and/or their caregivers are not fully engaged, they may miss opportunities to choose their PCSP goals and achieve their individualized vision for their future, including living in a community-based, least restrictive setting which maximizes independence. Our goals for member engagement throughout the planning process include: a) identifying and leveraging member strengths and preferences, b) addressing health inequities and disparities, c) removing barriers and addressing risks, d) educating members that their voice is the most important voice in the ongoing process to manage their overall health and service needs, e) educating members about options for services, supports, health and wellness. To engage members effectively, BUFC involves members at the onset of the planning process. We surpass AHCCCS required timeframes and on average make the first contact within 4 days, meet the member on-site and initiate the PCSP within 8 days and begin service provision within 18 days. We collaborate with and educate families, providers, community advocates, and peer supports. As a safety net health plan, we understand the challenges of unmet HRSN, health inequities, and barriers in the diverse communities we serve.

For the most complex members, the assigned CM contacts the member and/or Health Care Decision Maker (HCDM)/Designated Representative (DR) within one day of notification of enrollment and meets the member on-site and initiates the PCSP within seven days. The CM schedules the initial in-person visit based upon the information available from the Pre-Admission Screening Tool, risk stratification and HRSN. The CM includes individuals identified by the member, to the extent possible, to help develop the PCSP and identify the member's PH, BH and HRSN priorities, goals related to independence and quality of life, preferences, culture, customs, and traditions. If a key support person cannot attend the assessment meeting, we ask the member or the HCDM for permission to contact that individual for additional input. After the initial visit, our CMs convene and encourage treating providers to participate in the member's PCSP Team, which expands and contracts according to the member's evolving needs. The PCSP Team includes the member, families, caregivers, HCDM, DR, PH and BH professionals, medical directors, and Caregiver, Tribal, Veterans, Housing, and Employment and Education Advocates, as applicable and allowable by the member/HCDM. CMs also coordinate with the member's aligned and unaligned DSNP. CMs are available to answer questions and address issues 24/7, offering their direct phone numbers to members.

To maximize member engagement, we:

- Leverage case management through our experienced staff ensuring a collaborative process which assesses, plans, implements, monitors, evaluates and communicates with the member/ PCSP Team to help achieve member goals.
- Leverage technology such as our population-health and case management systems prior to each member contact. This improves engagements as it provides CMs the most up-to-date information about the member's care, including recent visits with providers, social vulnerability and HRSNs, allowing them to be more proactive, prepared and supportive, thereby cultivating trust.
- Provide more than one method of communication and ensure there is ongoing communication with the member's chosen identified supports/HCDM consistent with the PCSP.
- Build trust by consistently delivering services and maintaining clear communication as reliable relationship keeps members engaged.
- Hire CMs with long-standing community ties who live and work in the communities they serve and have diverse backgrounds, including those who are bilingual or have physical disabilities themselves.
- Conduct meetings with members in their preferred location, such as homes, shelters, or institutional settings, to address barriers to accessing care and services.
- Make our presentations and member materials accessible and understandable, incorporating input from members, peers, and family organizations.
- Apply motivational interviewing techniques and explain recommendations in ways that consider the member's health literacy, culture, and goals.

44% of our Case Managers are fluent in another language besides English including Spanish, Arabic, Russian, Bosnian, and American Sign Language. In Nogales, 100% of our CMs are fluent in Spanish while the population in the SGSA is 78% Spanish-speaking.

- Apply principles of Age Friendly Health Systems with a focus on what matters most to the member, as appropriate maximizing mentation, mobility, medication and access to dental screening and treatment.
- If supported by member, medications may be reviewed by our ALTCS pharmacist liaison in collaboration with treating providers with a focus on deprescribing when appropriate. This often decreases side effects, drug interaction, improves cognition, engagement, and achievement of PCSP goals, while also reducing costs.
- Hold discussions at convenient times offering video, teleconference, or other accommodation options.
- Use various technology platforms, such as websites, member portals, social platforms, and web and mobile-based applications to provide health-related supports. For example, we use Pyx to reduce loneliness to connect members to family or circles of support and improve care coordination.
- Support and engage caregivers through our multi-pronged Caregiver Support Program for both formal and informal caregivers. Upon award, we will hire Caregiver Advocates to facilitate seamless communication with caregivers.
- Inform members about community involvement opportunities, such as volunteering, elder abuse programs, and other activities to increase involvement outside their place of residence and decrease social isolation.
- Share information from the AHCCCS BH Practice Tools including Family Involvement and Youth Involvement in the Children's BH System which both include content about opportunities for engagement.
- Involve family and peer support services at all levels of member engagement, reinforcing active participation.

Our case management system stores the PCSP, and the CM gives a written copy to the member. We also send it to the PCP by fax, secure email, or mail, and share it with other individuals, as specified in the PCSP. The CM updates the PCSP when a member's circumstances change and, at a minimum, every 90 days for home and community-based members and every 180 days for institutional residents. For members with complex conditions or high needs, we provide more frequent touches, as often as necessary. CMs monitor the attainment of PCSP goals and objectives, identify and remove barriers, and facilitate communication between providers and members. They update and coordinate with the PCSP Team as often as needed. Members can contact their CM at any time with questions or concerns or to request changes to the PCSP. To support active engagement, CMs accommodate members with limited English proficiency using a professional language line for simultaneous interpretation. For members with blindness, illiteracy, or developmental disabilities, we provide Braille, large print documents, and employ simple language. We provide reasonable accommodations (at no cost) for members with speech, language, sensory or mobility limitations, such as augmentative and alternative communication devices, hearing-enhancing devices, and visual aids. Members electronically sign the PCSP to verify their agreement and understanding of the plan.

(B.5.b): Includes All Aspects of Quality of Life

The PCSP focuses on the individual's unique whole person goals and desired outcomes. CMs conduct in-person comprehensive assessments that include the member's living environment, PH and BH needs, developmental and cultural influences, HRSN, linguistic needs and functional abilities. We use measurable goals and processes to track progress and address barriers. CMs identify opportunities for long-term services and supports (LTSS) so members can remain in or move to the least restrictive, most integrated, and safest living environment per the member's wishes. We recognize LTSS supplements, rather than replaces, medical treatment, so health care is more effective.

CMs use community resources to address HRSN. For example, to combat social isolation among members with complex health conditions, we facilitate connection with others through activities such as Art of Our Soul therapy. This program employs teaching artists with personal experience in mental health challenges or addictions and allows members to express through art the emotions that may be too difficult to put into words. Through Audrey's Angels, community workers visit care homes and engage members through an interactive music and craft program to reduce members anxiety and improve mood.

We encourage and incentivize our provider network to use the Contexture CommunityCares Closed-Loop Referral System (CLRS) to refer members to CBOs as applicable and to identify HRSN using Z codes on claims. We also educate providers and staff on our Community Resource Guide to enhance whole person care and coordination of integrated healthcare. Our training programs further enhance the planning process through the following:

- We train 100% of CMs about dementia care through BUFC's training partner, Banner Alzheimer Institute's memory disorder and dementia specialists, and require CMs to take refresher classes periodically.
- We incorporate evidence-based resources from the *U.S. Department of Health and Human Services' Healthy People 2030 Initiative* to improve the quality of life for members with disabilities and/or who are aging.
- We train CMs on Mental Health First Aid, Question Persuade Refer (QPR) suicide prevention, vaccine hesitancy, motivational interviewing, healthy aging, Mental Health Parity ,42 CFR Part 2 and Mental Health Stigma and all staff on Diversity, Equity, and Inclusion.
- CMs educate members about the Home and Community Based Setting (HCBS) rules and their rights, as well as provide and review the member handbook.
- We educate and monitor providers on HCBS rules, including those subjected to heightened scrutiny, to verify compliance and ensure our members have full access to the benefits of community living.

(B.5.c): Is Consistent with the Individual's Needs and Wishes

CMs assess members' daily life and environment to paint a full portrait of who they are and what they desire. The PCSP process begins by asking, "What is important to you?" CMs develop a complete member profile that includes each member's unique interests, hobbies, spiritual needs, cultural and language preferences, current level of independence, whether they are the decision-maker or desire to be one and preferred medical and service providers. BUFC trains CMs on how to facilitate conversations that focus on a member's vision of a "good life." These conversations include assessments in various life domains, such as preferences, strengths, medications, desired living setting, activities of daily living, current and needed supports, risk assessment, action plan, and informed consent. BUFC emphasizes to our staff that members must be treated with respect, dignity, self-determination, and their privacy be safeguarded. CMs use tools such as the Service Options Decision Tree to describe direct care worker options available, enabling members to take the primary role in their service delivery, supervise their own care, and guide PCSP formation.

Innovaccer aids in the fulfillment of members' care and social needs and goals and provides the PCSP Team with real-time access to crucial data, including recent visits, gaps in care, HRSNs, the PCSP, electronic health records, pharmacy/lab data, case management/clinical notes and assessments, and service authorizations. **Innovaccer** aggregates data and information and makes it actionable for CMs and other providers.

(B.5.d): Promotes Access to Services in Home and Community-Based Settings

Through our experience serving ALTCS members, we know supporting members in their homes and communities improves health and social outcomes. During discussions with members and their PCSP Teams, we promote and educate members and their families/caregivers about our broad and accessible network of HCBS providers. We cover topics such as provider skills, service options, frequency of available services, available community-based organizations, provider locations, and an overview of how various professionals can help. CMs review these options at every PCSP meeting for members residing at home and document the process in our case management platform. 97% of our CMs reside in the same or neighboring city as the member, which helps to build a more cohesive and effective health care system.

CMs promote HCBS options at each meeting with members in a nursing facility (NF), as appropriate, and with their PCSP team, every 180 days and within 10 business days of every hospital discharge and change of placement type. When members who reside in a NF enroll or transfer to BUFC, the PCSP Team contacts the member within 30 days to explore transitioning to alternative, less restrictive/most integrated settings. In collaboration with NFs, our CMs proactively identify and facilitate transitions to less restrictive environments, helping us maintain less than 25% of our membership in NFs, ***as demonstrated in the table below***:

Year	# In NF on Enrollment	# Transitioned to HCBS	Percent Transitioned
2022	714	251	35%
2023 *through August	377	127	36%

Effective use of innovative technology also helps members live in the least restrictive, most integrated setting. In 2022, we enhanced communication between BUFC and post-acute providers using Olio, a cloud-based software solution used by most of our contracted NFs. This platform provides a secure, accessible, bi-directional channel to exchange information. CMs also utilize Rovicare, a digital platform used to streamline care coordination, to facilitate member choice and timely access to HCBS caregiver services.

(B.5.e): Results in High Quality, Equitable, and Cost-Effective Person-Centered Care

BUFC coordinates high-quality, cost-effective care and services; educates members; and allocates resources based on each member's individual needs. We achieve high performing results for our diverse membership, including:

- Over 75% of ALTCS medical expenses fall under VBP agreements that align quality, access, and cost metrics. From 2018 to 2023, ALTCS VBP membership grew by 334%. At the same time, BUFC's Cultural Competency Committee ensures services are rendered in a culturally competent manner, in compliance with AHCCCS ACOM Policy 405.
- In 2022, 84.6% of the 565 existing members provided with a new HCBS reported satisfaction with the service, 14.8% felt indifferent, and less than 1% were not satisfied with service.
- Of 1,971 reported hospitalizations in 2022, CMs updated the change-of-condition-specific PCSPs within 5.88 business days post-discharge on average, well within the AHCCCS goal of 10 business days.

The PCSP Team uses **Innovaccer** to identify gaps in care and HRSNs, determine each member's unique Social Vulnerability Index score, and inform the coordination of services and supports in the most cost effective, equitable way. Through this process we develop whole-person, member-centered PCSPs and backup plans that address possible health inequities and related risk factors.

Guided by the PCSP Team and the member's desired services, the CM completes a Cost-Effective Study (CES) before any new service is arranged to make sure they are medically necessary and more cost effective than an institutional stay. Members with low costs are also evaluated by the PCSP team to ensure optimal use of their benefits. The PCSP team continuously reviews members who reach 80% to 100% of costs. BUFC averages 2.94% of members in HCBS setting in the category of 81-100% Cost-Effective Study (CES) category, versus the statewide average of 2.80% in July 2023.

How We Monitor and Evaluate the CM and The Member Experience and Satisfaction . . .

> In 2023, 88% of respondents agreed or strongly agreed that they are happy with BUFC case management, a three-point increase from 85% in 2022.

BUFC embraces, trains, and monitors CMs on the foundational principles of Person-Centered Planning. To improve member experience and satisfaction, Case Management leadership actively monitors, evaluates, and implements changes based on ongoing feedback, as well as through our formal quality improvement process and governance structure. We receive input from members, stakeholders, peer and family organizations, and providers to identify actions needed. We gather information from our Member Advisory Committee, families, providers, advocacy groups, and community stakeholders. We send Member Surveys to 100% of our membership, with particular focus on case management performance. For example, question 5 of the survey says, "I am happy with the help I receive from my BUFC Case Manager." Our Net Promoter Score, representing the industry standard for satisfaction in the Member Survey, has steadily increased over the past five years. ***The table below shows the significant improvement in NPS since 2018:***

Question from the BUFC Member Survey	2023	2018
On a scale of 1-10, with 10 being the highest, how likely are you to recommend BUFC to a family member or friend?	NPS = 74% ↑	NPS = 53%

(B.6): Provide A Description of the Types of Data, Including but Not Limited To . . .

Banner-University Family Care (BUFC) continuously collects, monitors, validates, and analyzes multiple, reliable sources of data and information to advance continuous performance improvement across clinical and operational domains and to support improved population health. As an incumbent health plan with deep roots in our communities, we are local leaders in bringing together member and provider partners to collect and analyze data to develop collaborative initiatives. We use leading technology such as **Innovaccer**, our population health platform, to aggregate data and make it actionable for our staff and providers via easy-to-understand and actionable dashboards and reports.

Our approaches are informed by federal, state, and local health guidance and directives including the AHCCCS Strategic Plan, AHCCCS Quality Strategy, Arizona Health Improvement Plan, and the Arizona State Health Assessment. Consistent with AMPM 970, we gather data to monitor AHCCCS-required Performance Measure (PMs), which include the CMS Core (Child and Adult) and NCQA HEDIS Measure Sets. For measurement year 2022, we also measured our Long-Term Services and Supports (LTSS) assessments and care plans following the NCQA standard. For the LTSS measures, HSAG, the External Quality Review Organization (EQRO), reviewed 60 files and validated our data at 100% compliance with NCQA LTSS care plan and assessment requirements, including the requirement to share the care plan with the PCP. We monitor and measure standardized PMs using administrative data (inclusive of claims, encounters, and enrollment files), medical records, member surveys, and hybrid data, as defined by the measure specifications.

We collaborate with our members, providers, and other partners to collect information to evaluate and improve member satisfaction, quality of life (QOL), and independence; measure health disparities and advance health equity (HE); drive provider performance, provider satisfaction, and health plan operations; and to measure the value and cost-effectiveness of care. Data sources include but not are not limited to the AHCCCS member reference files, enrollment transition information files, blind spot data, DUGless file data, Health Information Exchange (HIE) data and immunization records. We use all available data to compile comprehensive member profiles to identify special health care needs (SCHNs) and Health-Related Social Needs (HRSNs). We also collect significant information about members during the Person-Centered Service Planning (PCSP) process, which is used to identify and monitor member-specific goals.

In partnership with members and other stakeholders, we also collect, monitor, and analyze data from:

- Member, Enrollee, Governance and Neighborhood Advisory Committees
- Grievance and Appeals, Quality of Care, and Customer Service Departments
- Provider forums and community-listening sessions
- The Governor's Abuse & Neglect Prevention Task Force's Member and Family Survey;
- Member Surveys, including: (1) an annual ALTCS Member Satisfaction Survey; (2) Consumer Assessment of Healthcare Provider and Systems (CAHPS) Surveys; and (3) Member experience surveys (post office-visit, and following interaction with our Customer Service Department)
- Caregiver studies conducted by the University of Arizona (UA)

BUFC is a uniquely member- and community-focused health plan. We maintain a formal ALTCS-only Member Advisory Council (MAC), as well as an ACC MAC and an Enrollee Advisory Committee (EAC) for our Banner Medicare Advantage (BMA) Dual members. We don't just go through the motions. These councils and committees offer a meaningful opportunity for ALTCS members, Health Care Decisionmakers (HCDMs), and other stakeholders to inform our program initiatives by leveraging their lived experiences. These councils and committees also select members to participate on our formal Governance Committee, which includes BUFC executive leaders, peers, and family members. The Governance Committee directs strategic planning, process improvement, and informs BUFC decision making.

Processes Utilized to Inform and/or Initiate Improvement Activities and MCO Decision-Making Process

BUFC maintains comprehensive and documented processes that govern how we monitor and analyze data for continuous performance improvement. Chaired by our Chief Medical Officer, the QM/PI Committee is ultimately accountable to the Board of Directors and directs and evaluates all QM/PI activities. It includes broad, leadership-level representation from across the organization, as well as providers and community representatives. The QM/PI Committee receives, evaluates, and approves baseline performance standards, receives reports from subcommittees, workgroups, and departmental leaders, monitors key performance indicators (KPIs) and trends, directs the deployment of strategies, and identifies opportunities for continuous improvement. QM/PI subcommittees and workgroups, such as

the ACC and ALTCS Performance Improvement Committee, Health Equity Committee, Quality of Care Committee, and Medical Management Committee, as well as our Clinical Strategy Committees (CSCs), make recommendations to the QM/PI Department and QM/PI Committee, establish and review KPIs, identify opportunities for improvement, oversee deployment of improvement initiatives, and monitor/report on interventions.

Consistent with AMPM 980, we implement Performance Improvement Projects (PIPs), both AHCCCS mandated and self-selected, which focus on clinical and non-clinical interventions. Our QM/PI Department identifies PIPs to improve outcomes for members with SHCNs and members receiving Long Term Care Services and Supports (LTSS). PIP interventions are informed by various sources, including our CSCs, which leverage multidisciplinary clinical expertise from across Banner Health to identify opportunities to improve quality and value-based care. Our current CSCs focus on Geriatrics, Acute Care, Behavioral Health, Cardiology, Care Management, Diabetes, Ophthalmology, Oncology, Pediatrics, Renal, Women's Health, and Readmissions.

The QM/PI Department supports and leads cross-functional teams to deploy focused interventions using the Plan-Do-Study-Act (PDSA) process. In addition, our rapid-cycle improvement teams, comprised of QM/PI Department experts, operational leaders, and advisory groups such as the CSCs, prioritize high-impact, low-resource interventions for execution and rapid-cycle PIPs. When they identify an opportunity for improvement, they conduct root-cause analysis and use tools such as fishbone diagrams and Pareto mapping to develop interventions and measure the effectiveness of implemented interventions. Our internal workgroups deploy PIPs at the direction of the QM/PI Committee and/or responsible subcommittees and review reported data monthly to confirm progress of PIPs, and the QM/PI Committee assesses progress at least quarterly.

For example, our Renal CSC noted a high prevalence of chronic kidney disease (CKD) in our Medicare Shared Savings Program (MSSP) population, associated with significant morbidity and mortality and high cost. We deployed our QM/PI Department PDSA rapid-cycle structures to identify opportunities to slow disease progression, control costs, and improve QOL for our members. After the CSC and rapid-cycle workgroups gathered and analyzed data, identified root causes for the areas for improvement, and set initial benchmarks, the team planned and deployed multipronged interventions. They developed KPIs and monitored Per Member Per Month CKD levels and length of time of CKD progression and identified those members with advanced levels of CKD who have not yet been referred to a nephrologist for specialized care. The rapid cycle improvement team also partnered with our Pharmacy Department to identify and reduce dispensing of commonly prescribed nephrotoxic medications. Using this process over a one-year period, we identified over 1,000 members that would benefit from this intervention and we observed a 45% reduction in prescribing of harmful medications, and a 68% reduction of NSAID usage in this group. Based on these results, the CSC and workgroup recommended to the QM/PI Committee expanding the scope to our ALTCS members. At the QM/PI Committee's direction, we identified 71 ALTCS members with CKD who are filling nephrotoxic medications and recently deployed the same strategies with positive initial results.

Reporting Tools and Monitoring Technologies

BUFC has made significant investments in innovative tools and technologies to improve member outcomes and experience. Our reporting tools and monitoring technologies include:

Innovaccer: This high-impact technology ingests and aggregates multiple data sources and creates dashboards and reports for BUFC and its providers to utilize to identify and close care gaps, improve health outcomes, and inform program initiatives. Using this tool, QM/PI teams, Case Managers (CMs) and clinical and operational leadership can easily assess opportunities and trends. **Innovaccer** supports our efforts to advance health equity by ingesting and aggregating data such as Z codes, PCSP-identified HRSNs, and geographic socioeconomic data to provide a member-specific Social Vulnerability Index (SVI). The SVI helps BUFC target resources and interventions to address social and environmental factors contributing to health outcomes. **Innovaccer** supports real-time, evidence-based decision making. Following this narrative, are three example **Innovaccer** utilization dashboards/reports:

1. **Utilization Dashboard:** Provides BUFC population health and utilization information such as per member per month (PMPM) utilization of inpatient, outpatient, and professional services, avoidable readmissions, skilled nursing facility (SNF) average length of stay, and other population-level utilization and cost metrics.

2. **Primary Care Quality Dashboard:** Offers BUFC staff and providers real-time access to provider- and group- level performance metrics and gap-in-care data. This dashboard allows BUFC and its providers the opportunity to measure provider performance, advance VBP arrangements, and target outreach and interventions. It includes a Frail and Elderly Dashboard, which allows providers to easily identify their most vulnerable members. It allows PCPs to see their network rank and performance over time across key metrics.
3. **Patient 360:** The Patient 360 allows BUFC, including QM/PI and Case Management teams, as well as other operational and clinical staff, and providers, to see member-specific information related to gaps in care, service utilization, member service history via an easy-to-read visit timeline, and a unique social vulnerability score. This provides actionable data for BUFC and its providers to advance health equity by helping us identify and close gaps related to unmet clinical and social needs.

Additional reporting tools and monitoring technologies include:

Inovalon Quality Spectrum Insight Software: Provides NCQA-certified clinical and quality outcomes measurement and reporting through detailed reports and population-specific dashboards, including subpopulation data such as members with SHCNs, behavioral health category, TXIX/TXXI status, and others.

Lightbeam Risk Stratification Tool: Helps Case Managers identify and engage members with known and unknown rising risks to proactively intervene, provide guidance, and to improve member health outcomes.

Cotiviti: Used by FWA Specialists to analyze claims data using advanced algorithms to flag suspicious claims. The flags are used by the FWA Specialists to review and identify suspicious or incorrect billing patterns, and to identify FWA. We have used this system to generate more than 300 referrals of suspected FWA to AHCCCS OIG since October 1, 2022.

Client Relationship Manager and Medical Management Systems: Used by internal teams to document member interactions with Customer Care, Grievance and Appeals, and Case Management, and to document Quality Management and Medical Management cases, data is aggregated to allow operational leaders to monitor service level trends, and to allow Case Managers to track progress on our members' individually identified and prioritized goals and desired outcomes.

Partnerships Leveraged to Inform and Initiate Improvement Activities

BUFC is a collaborative organization that has developed close relationships with members and providers to improve healthcare quality and advance health equity. Examples of innovative partnerships include:

Foodsmart: BUFC recently partnered with Foodsmart, the nation's largest provider of Registered Dieticians (RDs), to provide telehealth nutrition and food security support services for our entire ACC and ALTCS populations. This partnership followed an evaluation process that began in June 2022, which identified food insecurity across our populations. Foodsmart RDs meet with members by phone or by video to assess identify needs, which may include short-term, medically supportive food assistance, and to develop nutrition self-efficacy on a long-term basis. Members are offered the Foodsmart digital app where they can access meal plans, shop for groceries, compare prices at local stores and develop healthy affordable meal prep. To facilitate member utilization of this service, BUFC launched a targeted outreach campaign to ALTCS members. Since its launch in August 2023, every ALTCS member has been contacted and educated about this service, including 92 tribal members, and more than 50 members have scheduled appointments with a Foodsmart RDs.

American Cancer Society (ACS): BUFC has been a long-term partner of ASC. We have leveraged this partnership to review national and state benchmarks for colorectal cancer (COL), and to identify clinical best practices on engaging members and providers on COL screenings. Through a four-year collaboration with ACS's "FluFit" Campaign, we targeted member outreach and increased COL screenings. Seventy-nine primary care offices participated in the FluFit Campaign, resulting in 1,376 returned FitKits and achieving an 80% return rate for our D-SNP and ALTCS plans combined. Our QM/PI team also uses **Innovaccer** to track COL performance using the Primary Care Quality Dashboard.

As demonstrated by this response, BUFC is a focused on improving the health and wellbeing of our members and communities by a collaborative and data-driven approach to continuous performance improvement. Our approach, is supported by advanced technology, guided and informed by collaboration with our longstanding partnerships, and is focused on improving health equity and addressing HRSNs.

(B.6.1): Utilization Dashboard

Cost Management Summary

Last Updated: 4/25/2021 7:27:52 PM (Version: v2.0.0)

Risk Adjusted PMPM	PMPM	Person Years	Average Risk
$1,823	$1,205	177,164	0.661
PY: $104 (+1654.7%)	PY: $51 (+2257.2%)	PY: 254,255 (-30.3%)	PY: 0.492 (+34.3%)

Summary | Summary Detail | Inpatient | Emergency Department | Skilled Nursing Facility | Imaging | My Patients | Report Info

IP/1000	ED/1000	Readmission %	SNF/1000	Imaging/1000	Rx Utilization
93	1	18.4 %	16	1,302	0.0
PY: 1 (+8862.8%)	PY: 0	PY: 0.0 %	PY: 1 (+1841.9%)	PY: 0 (+1141772.7%)	PY: 0.0

Year: 2019
Month: All
Line of Business: All
Payer: All
Plan: All
Organization: All
Practice: All
PCP: All

Synopsis

PMPM for the current selected period is $1,205 and the change in PMPM YoY is 2257.2 %.
Acute Inpatient has the highest PMPM at $1,019 and shifted by 2,123 % compared to previous year(PY).

Cost Center Comparison

Cost Center Type	PMPM	PMPM PY	PMPM YOY %	Utilization/ 1000	Utilization/ 1000 PY	Utilization/ 1000 YOY %
Inpatient	$1,041	$49	2,013 %	118	3	3768 %
Professional	$86	$0	254,453 %	9,847	2	604654 %
Outpatient	$69	$2	3,814 %	1,182	9	13331 %
Others	$9	$0	27,468 %	518	4	11705 %

PMPM (Trailing 12 Months)

Inpatient, Outpatient, Professional
$2,000; $1,500; $1,000; $500; $0
Jan 2019, Feb 2019, Mar 2019, Apr 2019, May 2019, Jun 2019, Jul 2019, Aug 2019, Sep 2019, Oct 2019, Nov 2019, Dec 2019

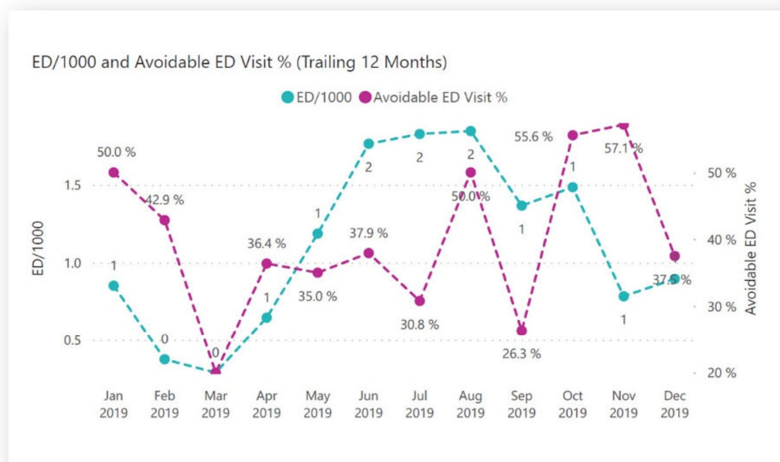
Avoidable ED % & Frequent ED Flyer % by Assigned PCP

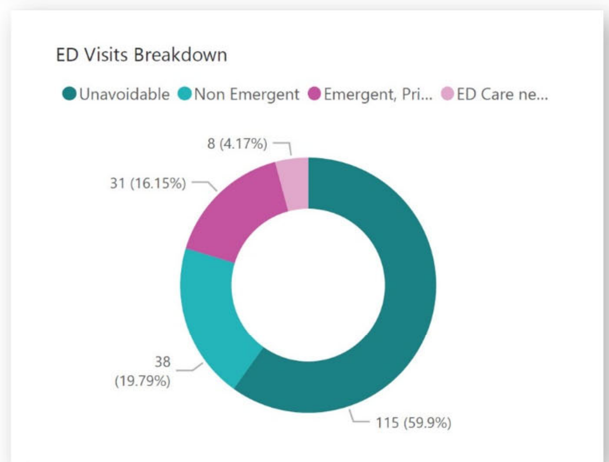
Assigned PCP	#Attributed Lives	Avoidable ED Cost %	ED Flyers %	#Avoidable ED Visits
Not Assigned	109725	37.6 %	0.0 %	149
Lucas D5 Durant 9528	797	0.0 %	0.0 %	1
Jackie H5 Cole 0767	702	0.0 %	0.1 %	2
Ayla O1 Meechum 1443	604	66.7 %	0.0 %	3
Remy N7 Gallagher 3392	599	100.0 %	0.0 %	1
Zoe O9 Russo 1885	574	0.0 %	0.0 %	2
Ayla A1 Cole 4715	536	50.0 %	0.0 %	2
Victor M9 Barnes 8318	529	100.0 %	0.0 %	1
Cathy N8 Barnes 1385	499	0.0 %	0.0 %	1
Christina L1 Durant 7169	499	100.0 %	0.0 %	3

Readmission % by DRG (Top 10)

Only DRGs with at least 10 admits

DRG	Readmission % by DRG
Chemotherapy without acute leukemia as secondary diagn...	73.1 %
Postoperative or post-traumatic infections with O.R. proce...	55.6 %
Pleural effusion with CC	52.4 %
Disorders of liver except malignancy, cirrhosis or alcoholic ...	50.0 %
Tracheostomy with MV >96 hours or PDX except face, mou...	47.8 %
Cirrhosis and alcoholic hepatitis with CC	47.1 %
Postoperative and post-traumatic infections with MCC	47.1 %
Postoperative and post-traumatic infections without MCC	46.7 %
Aftercare without CC/MCC	45.5 %
Lymphoma and non-acute leukemia with MCC	45.5 %





Skilled Nursing Facility

Last Updated: 4/25/2021 7:27:52 PM (Version: v2.0.0)

Summary | Summary Detail | Inpatient | Emergency Department | Skilled Nursing Facility | Imaging

SNF PMPM	Risk Adjusted SNF PMPM	SNF Admits/1000	Readmits to IP %	Average Length of Stay
$15	$22	16	18.4 %	25.7
PY: 1 (+1308.8%)	PY: $2 (+948.7%)	PY: 1 (+1841.9%)	PY: 25.6 % (-28.3%)	PY: 37.8 (-32.1%)

(B.6.2): Primary Care Quality Dashboard

Quality Management

Last Updated 2023-09-07 01:00:37 | Version: 2.0.2

Attributed Lives	Measures Meeting Target	Quality Performance	AWV Score
7,003	28%(26/92)	21.5%	0.0%
YoY Change: 1.6%	YoY Change: 3.2%	YoY Change: -47.9%	YoY Change: 0.0%

Quality Performance | Quality Distribution (Process Measures) | Payer Data | My Patients

Quality Performance for Process Measures

Code	Measure Name	Performance	Goal	Eligible	Gaps Closed	Gaps Open	Open Gaps to Goal
CBPI	Controlling Blood Pressure (CBP)	44.0%	80.0%	1,089	479	610	393
HBD9	HbA1c Control <= 9%	41.0%	83.0%	1,172	480	692	493
BCS	Breast Cancer Screening	32.7%	77.0%	1,015	332	683	450
COL	Colorectal Cancer Screening	27.3%	79.0%	2,463	672	1,791	1,274
EED	Eye Exam for Patients With Diabetes	50.5%	79.0%	1,123	567	556	321
SPCA	Statin Therapy for Patients With Cardiovascular Disease: Statin Therapy	62.2%	89.0%	156	97	59	42
AMR	Asthma Medication Ratio	88.9%	84.3%	9	8	1	Measure Met
CCS	Cervical Cancer Screening	20.1%	77.4%	691	139	552	396
WCV12_17	Child and Adolescent Well-Care Visits : 12 to 17 years	23.9%	60.8%	46	11	35	17
WCV3_11	Child and Adolescent Well-Care Visits : 3 to 11 years	28.6%	60.8%	42	12	30	14

Quality Score by Organization/Practice/Provider

Organization	Quality Performance	Attributed Lives
[illegible]	23.3%	434
[illegible]	21.6%	400
[illegible]	24.3%	388
Banner Primary Care Physicians Arizona LLC	22.1%	343
Banner - University Medical Group	25.4%	320
[illegible]	20.5%	307
[illegible]	17.9%	281
[illegible]	22.1%	259
[illegible]	22.2%	186
[illegible]	23.7%	178
[illegible]	26.0%	114
[illegible]	15.9%	113
[illegible]	20.6%	112
[illegible]	25.0%	101
[illegible]	16.6%	98
[illegible]	19.9%	95
[illegible]	19.8%	87
[illegible]	22.2%	86
[illegible]	17.6%	82
[illegible]	17.4%	82
Banner - University Medical Center Tucson	23.4%	80
Total	**21.6%**	**7,003**

Provider Name

Facility: [illegible]

Last Update: 12/2/2020 6:01:28 PM

Physician: [illegible] | Month Year: Dec-2019 | Payer: All

PCP Scorecard | Panel | Quality | Cost | Risk | Opportunities | Adjust Weights | Report Info

Overall Rank	Panel Size	Quality Score	Risk Adjusted PMPM	Risk Recapture Rate	30 Day Readmissions	ED Visits per 1,000
112 / 416	817	4.0%	$309.28	78.5%	100.0%	1
		Network Avg: 28.6%	Network Avg: $5.26	Network Avg: 85.8%	Network Avg: 12.5%	
↑ 18 from Nov	↓ 1 from Nov	↑ 4.0% from Nov	↑ $309.28 from Nov	↑ 78.5% from Nov	↑ 100.0% from prior year	↑ 1 from prior year

Synopsis

[illegible] overall rank increase was driven by ED Visits Per 1000 rank (↓3) and 30 Day Readmission Percent rank (↓6).

Strategic Focus

Target a ↑0.62% increase in Quality Score next month to increase Overall Rank by 1 point (all else equal).

ED Visits Per 1000 Rank — Details

0 100 200 | 31 76 132 144 155 177 156 187 187 189 189 197 | Jan 2019 Mar 2019 May 2019 Jul 2019 Sep 2019 Nov 2019

30 Day Readmission Percent Rank — Details

0 100 | 0 0 39 65 71 84 87 83 89 89 101 107 | Jan 2019 Mar 2019 May 2019 Jul 2019 Sep 2019 Nov 2019

Quality Score — Details

4% 3% 2% 1% 0% | 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 4.0% | Jan 2019 Apr 2019 Jul 2019 Oct 2019

Frail & Elderly Dashboard

Members were flagged as Frail & Elderly as of: 08/31/2023

Click to View Summary Data

Last Updated: 09/17/2023 11:01 PM

Line of Business: All | Payer / Plan: BUHP AZ Medicaid - ALTCS | New Patient: All | EMPI & Member Name: All | Total Paid in Last 6 Mos: ($1,165) – $569,445 | PCP Visit in Last 6 Mos?: Select all, Yes, No

PCP NPI & Name: All | Practice TIN & Name: All | Organization: All | # of ED Visits in Last 6 Mos: 1 – 57 | # of IP Visits in Last 6 Mos: 1 – 8

EMPI	First Name	Last Name	Birth Date	Gender	Last AW Visit	Last PCP Ofc Visit	ED Visits in Last 6 Mos	IP Admits in Last 6 Mos	Total Paid in Last 6 Mos	Newly Flagged	Payer	Plan	PCP NPI	PCP
[illegible]	[illegible]	[illegible]	[illegible]	F		[illegible]	1		$25,471	N	BUHP AZ Medicaid - ALTCS	ALTCS	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	M	6/3/2021	[illegible]			$10,700	N	BUHP AZ Medicaid - ALTCS	ALTCS	[illegible]	[illegible]

(B.6.3): Patient 360

Female

EMPI	SVI	Plans	PCP	Phone	Email	Pulse Score
	HIGH	Dual Non-FIDE			-	-

New

- Clinical Data
- Care Management
  - Timeline
  - Care Protocols
  - Assessments
  - Tasks
  - Goals
  - Care Plans
  - Med. Reconciliation
  - Community Resources
- Risk
- Claims
- Profile
- Documents

Summary Search — Export PDF — Download CCDA

Payer Name	Plan Name	Plan status	Latest Attribution Date	Patient ID	Attribution Start Date	Attribution End Date	Latest Plan Date
BUHP AZ Medicare Ad...	Dual Non-FIDE	Active	09/01/2023		01/01/2023		09/01/2023

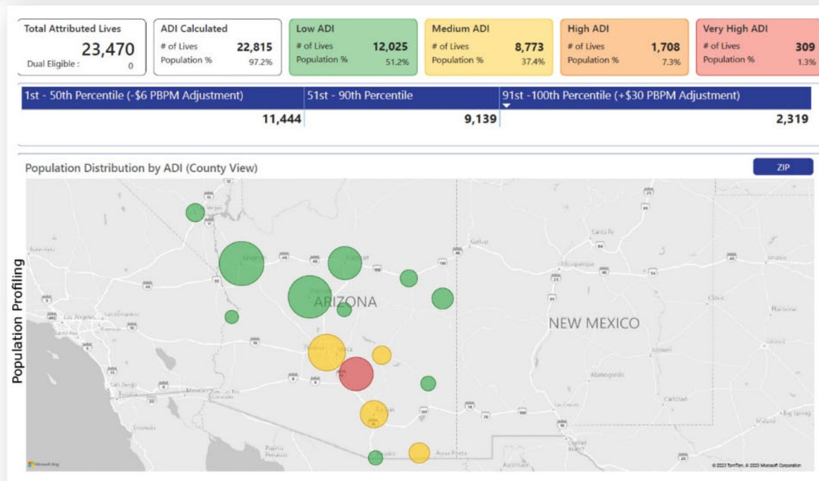
Measures and Care Gaps — last refreshed in 14 days

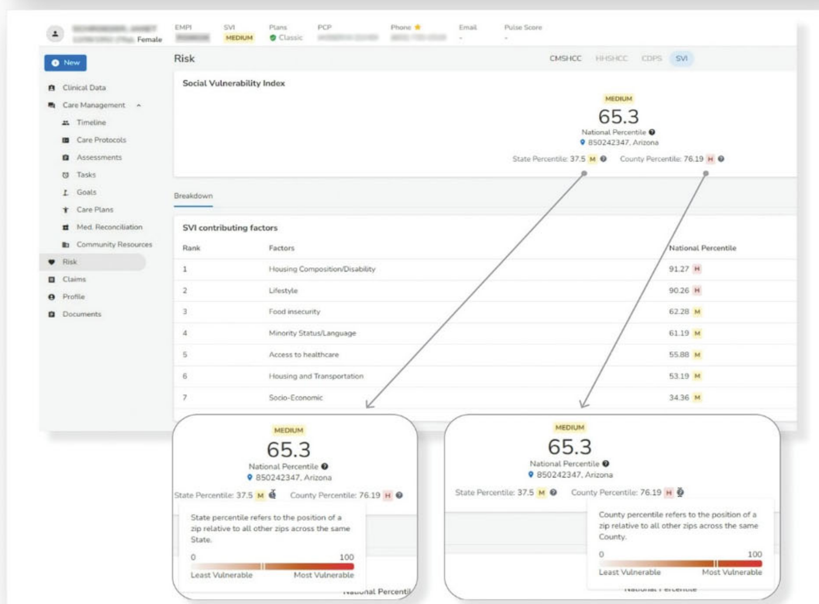
9 Open — 12 Closed

Care Gaps	Status	Last checked on	Payer Name	Plan Name	LOB Name
2023 (9)					
Breast Cancer Screening	OPEN	08/31/2023	BUHP AZ	Dual Non-FIDE	
Annual Wellness Visit-Physical	OPEN	08/31/2023	BUHP AZ	Dual Non-FIDE	
Care for Older Adults : Medication Review	OPEN	08/31/2023	BUHP AZ	Dual Non-FIDE	
Hospitalization for Potentially Preventable Complicatio...	OPEN	08/31/2023	BUHP AZ	Dual Non-FIDE	
Hospitalization for Potentially Preventable Complicatio...	OPEN	08/31/2023	BUHP AZ	Dual Non-FIDE	
Hospitalization for Potentially Preventable Complicatio...	OPEN	08/31/2023	BUHP AZ	Dual Non-FIDE	

Recent Visits — last refreshed 21 minutes ago

Start Date	End Date	Facility Name	Location Type	Encounter Type	Provider	Provider Specialty	Provider Number	Source	Visit ID
07/07/2023	07/07/2023		Office					Claims	
05/09/2023	05/09/2023		Office					Claims	





(B.7.a) Describe the Offeror's Network Development Strategy . . .

As an incumbent, Banner-University Family Care's (BUFC's) network development strategy aligns with AHCCCS goals and is informed by the ALTCS contract requirements, our role as an integrated provider-led health plan, our affiliation with Banner Health (Banner), and the community-based partners who comprise 70% of our network. Our strategy ensures timely, equitable access to high-quality care that gives members a choice of providers and settings. It is grounded in understanding the dynamic needs of our ALTCS members and uses a multi-faceted approach that relies on our three decades of experience serving Arizona communities. We use data-driven insights and longstanding community relationships to recruit and retain high-quality providers who deliver whole-person care. We have and will continuously improve and expand BUFC's network to meet our members' needs, ***as described in the following table.***

1. Data-Driven Approach for Network Optimization	
We continuously monitor to identify and address gaps, disparities, and health inequities. With proactive and retrospective efforts we address access gaps, consider each community's unique needs, and determine the most beneficial and feasible home and community-based services (HCBS) and providers to address needs. These data sources offer macro- and micro-level insights into trends and challenges, timely and equitable access, and address health-related social needs (HRSN) that inform network development activities.	
Proactive optimization data sources	**Retrospective optimization data sources**
• Bimonthly geo-reporting • Health Risk Assessments (HRA) data • Person-Centered Service Plan (PCSP) data • Case and Care Manager (CM) input • Provider and member feedback (e.g., councils and surveys) • Rovicare customized HCBS Capacity Tracker • Provider appreciation events	• Appointment availability monitoring • Utilization/Quality Management (UM/QM) processes • Member-level population health data • Member engagement and coordination of care statistics • Provider and member feedback (e.g., councils and appeals) • Network inquiry and issues reporting • Single case agreement reporting

2. Strategic Relationships to Promote Integrated and Innovative Care that Advances Health Equity (HE)	
Partnership	**Purpose**
Integrated Health Care Summit	Unites Banner leaders to promote "One Banner" philosophy; optimizes integrated whole-person care and HE through collaboration, innovation and sharing best practices.
University of Arizona (UA)	Supports research and training for Arizona's future clinical workforce through 30-year affiliation.
Banner Alzheimer's Institute (BAI)	Brings specialized care and HRSN services to patients diagnosed with dementia across Arizona, including caregiver support that is vital to the ALTCS population.
Integral Health Network of Southern Arizona (IHNSA)	Integrates physical health (PH) and behavioral health (BH) care, specialty, crisis and HRSN service providers to collectively meet members' needs.
Community partnerships	Builds unique relationships and programs such as American Heart Association and Foodsmart. Foodsmart provides virtual nutrition care and food security support services.
Clinical strategy committees	Identifies and promotes development of condition-specific best practices for complex conditions.

3. Intentional Recruitment and Retention to Advance Quality Care and Equitable Access	
BUFC partners with providers to deliver high-quality, equitable access to care. We prioritize provider satisfaction to attract and retain providers and conduct ongoing, data-driven analysis to strategically recruit providers in areas with gaps or potential gaps.	
Provider support	We deliver satisfaction through high-touch relations to quickly address questions/concerns and prioritize face-to-face relationships with dedicated Provider Relations representatives based on provider type and GSA, allowing us to offer tailored support. See B.7.b for additional initiatives.
Ongoing education	We drive education and awareness through training initiatives, continued education opportunities and by promoting available resources such as onboarding materials, provider manuals, provider forums, lunch & learns and the Banner website. In the last two years, we trained thousands of providers and key community support roles through 76 training programs, including 5 Virtual Dementia Tour® sessions to increase awareness when caring for members.
Provider Incentives	Our Value-Based Purchasing (VBP) program consistently meets payment thresholds and we grew our VBP total membership by 334% since 2018, with over 75% of ALTCS medical spend in VBP. We will launch closed-loop referrals using Z-codes and expand partnerships to include Z-codes to identify HRSN and improve health and quality within two years. Our Centers of Excellence (COE) designation promotes best practices with 14 COEs that enjoy priority referrals, partnership opportunities and heightened engagement. BAI will earn our Dementia COE status by December 25, 2023.

As a locally owned plan, we prioritize community participation and governance. To that end, we expanded our Board of Directors to include local executives and physicians from organizations such as COPA Health, Devoted Guardians and UA. These board members offer a provider perspective and insight into HE and the unique needs within their communities. We leverage this input to inform our network strategy and address gaps not evident in reporting.

BUFC and our DSNP plan exceed AHCCCS and CMS network adequacy requirements. BUFC complies with ACOM policies and HCBS rules in South and Central GSAs for ALTCS members. We will meet network adequacy requirements for North GSA by February 2024, we have alignment across Medicaid and Medicare networks. We prioritize growth in HCBS and institutional settings, enabling timely access to care and member-led decision-making. This commitment is evidenced by our 2023 ALTCS member survey with 88% of members reporting high-quality care.

(B.7.b): HCBS and Institutional Capacity Building (HCBS-ICB) in Rural Counties and Maximizing Resources

BUFC builds capacity and maximizes available resources within two broad categories: 1) increasing the ability to serve more members, and 2) increasing knowledge and skills to deliver more specialized, high-quality care.

1. Methods to Increase the Ability to Serve More Members

We are committed to a North GSA expansion with a network that meets adequacy requirements for dual-eligible members. Building on existing contracts, we have added over 50 new contracts or Letters of Interest to achieve Medicaid adequacy prior to June 1, 2024. Due to assisted living facilities (ALF) shortages in the North, we are working to expand ALFs here and in contiguous states. We are enhancing contracts with ALFs in Central and South GSAs to further address shortages in the North. To overcome geographic barriers and improve timely access to at-home care, we will offer HCBS in rural areas statewide. Family and community supports are encouraged to be paid direct care workers.

Both HCBS and institutional capacity benefit from workforce development (WFD) initiatives. We will leverage Banner's accredited Graduate Medical Education (GME) program to expand the workforce by contracting with graduating residents and establishing apprenticeships that provide on-the-job training and experience. We will publish a WFD Toolkit for providers to promote career planning and empower our network to navigate meaningful career paths.

BUFC invests in underserved communities to achieve optimal population health, as demonstrated by our Community Reinvestment (CR) focus and approach. We prioritized HE/HRSN in years prior to the recent contract requirement. For the 2022-2023 program cycle, we allocated 51% of the $1.24M fund to rural areas with nearly 20% going to ALTCS-specific programs supporting nutrition, medication, transportation and housing needs for ALTCS members. One beneficiary alone, Foundation for Senior Living (FSL), served 41,337 meals (congregate and home-delivered) and 10,407 snacks in Q1-Q2 of the CY2022-2023 program cycle through this funding.

The chart below reflects our ongoing efforts with regards to continuously address network challenges:

Additional HCBS Efforts to Serve More Members by Building HCBS Providers	
Partnership approach • Partner with rural health clinics (RHCs) to train employees to provide HCBS care. • Outreach to ALFs in partnership with AHCA to gauge interest in expanding into other services (e.g., adult day health) and provide technical assistance for those interested. • Develop a VBP incentivizing whole-person care that encourages collaboration and engagement between Nursing Facilities (NFs) providing HCBS and the member's support team through the Olio communication platform, structured around Olio's tracking and scoring of timely engagement and responsiveness by both NFs and BUFC.	**Technology** • Streamline referrals and support providers in managing staffing needs using Rovicare's cloud-based referral system. • Monitor real-time workforce availability to evaluate adequacy and capability through our HCBS Capacity Tracker; identify opportunities based on availability, needs and trends in referrals for HCBS to deliver care in the least restrictive setting and enhance HCBS in rural areas. • Expand IHNSA ACO to include HCBS programs and ALTCS providers with VBP arrangement for HCBS and HRSN. • Integrate **Innovaccer's** population health data into InNote to give providers real-time insights to make informed decisions.
Additional Efforts to Serve More Members by Building Institutional Capacity	
Partnership approach • Partner with rural Federally Qualified Health Centers (FQHC) and integrated clinics (IC) to broaden services. • Contract with institutions in bordering states to ensure access to care and facilitate delivery closest to the member. • Increase mobile health clinics in all rural counties.	**Technology** • Expand telehealth capability to all Banner Urgent Care (BUC) facilities to offer virtual and field clinics, coordinating with nurses and caregivers (in-home, in ALFs, and at SNFs). • Offer virtual clinics via telehealth rooms at our Peer/Family-Run sites, facilitating peer support and partner participation.

• Launch mobile mammography through our Pink Bus program in Q1 2025 (up to 28 exams per day). • Expand Wellness Events to facilitate convenient service and increase Star HEDIS compliance to rural areas by Q2 2024. • Partner with BH orgs to locate and offer care at skilled nursing facilities (SNFs) and assisted living programs.	• Offer 24/7 access to PH, BH, and HRSN care and support through a mobile app or prepaid cellular-enabled tablet. The service is in collaboration with CareBridge, a new partner, and includes offering red button immediate access to clinical support.

2. Methods to Increase Knowledge and Skills Across Our Network

BUFC employs engagement, support, and educational techniques to build HCBS providers and institutional capacity in rural areas. We promote awareness of self-directed care by engaging providers and community partners and by educating CMs. CM leadership attends our annual Integrated Summit (described in B.7.a above) to develop network relations and receive health care and network updates. We also hold ALTCS Member Advisory Committee sessions to get input on decisions that affect health plan coverage; member questions or concerns are addressed at the next Prospective Contract Review Committee. Our Cultural Competency Program Committee (CCPC) ensures services are delivered in a culturally competent manner according to ACOM Policy 405, including examining Z-codes and HE trends. We leveraged this work during the COVID-19 pandemic to understand communities and pinpoint vaccination outreach strategies. ***The following chart depicts our focus to build knowledge and skills across our network:***

Additional efforts to increase knowledge and skills (HCBS and institutional capacity)	
Support	**Training and education**
• 24/7 CM Hotline (833-318-4146) for on-call member support. • Launch Caregiver Support program in October 2024 to engage caregivers using gamification and incentivizing activities (e.g., on-time arrival); place a Caregiver Advocate in each GSA to ensure caregivers have a voice and receive all program benefits to develop skills and increase retention. • Facilitate home modifications to support greater independence and ease the burden on caregivers. • Develop a caregiver respite co-op to establish a network of caregivers within GSAs to offer support (e.g., transportation and grocery pick-up) via formal and informal caregivers. • Offer content to identify burnout at the member and provider level through our technology partner Pyx. • Offer dedicated support relevant to providers in FQHC, RHC and IC settings during quarterly meetings (e.g., requirements adherence reminders, process training and key initiatives). • Support State's efforts in seeking approval to institutionalize parents as paid caregivers to enhance HCBS capacity.	• Training on members' rights, available programs and services in Member Advisory Committees and in member materials. • Increase skills necessary to support the diverse needs of ALTCS members and enhance access to care with topics like ALTCS 101, Cultural Competency, Dementia (via BAI, Virtual Dementia Tours®, and 18 different training modules in Relias), Housing 101, Mental Health First Aid, Peer & Family Support, Reducing Mental Illness Stigma, and AZ 9-12 principles. • Partner with BH organizations to deliver training to SNFs. • Provide comprehensive training upon onboarding new hires. Topics include but are not limited regulatory requirements, processes and topics related to supporting ALTCS members like choice of setting through member engagement, Relias dementia modules and Reducing Mental Illness Stigma. • Increase knowledge to manage the challenges of the health care workforce and prevent burnout with topics like Compassion Fatigue and Managing Stress & Burnout.

(B.7.c): Assisting Rural Nursing Facilities Seeking to Expand into Community-Based Care

BUFC supports creative opportunities to expand HCBS. Kaiser Family Foundation cited HCBS workforce shortages as a key variable impacting care during this unprecedented time. Furthermore, the increase in the federal medical assistance percentage (FMAP) to promote HCBS, as outlined in the American Rescue Plan Act (ARPA), pointed to a national movement to support, and develop enhanced HCBS strategies, especially in rural communities.

To that end, we are a willing partner in assisting NFs to expand into HCBS, such as assisted living, adult day health, companion care, attendant care, respite opportunities and home-delivered meal support. We support NFs' autonomy in defining their capabilities and services. Upon agreement to expand into community-based care, we are committed to oversight aligned with Arizona's Systemic Assessment and Transition Plan and to providing technical assistance. Assistance will be determined by the services each NF is interested in expanding into and includes, but is not limited to, help in improving gaps in care, recruiting qualified staff to provide HCBS, and identifying barriers and solutions.

BUFC works with the Arizona Health Care Association (AHCA) to identify individual NFs within our network interested in expanding services. Through this outreach, we already identified interest from Oasis Pavilion in Casa Grande in expanding into HCBS – companion care. We will continue to identify and support similar expansion across our network such as co-locating habilitation/nursing support in group home settings.

(B.7.d): Action Steps and Timeline for the first three years of the Contract . . .

Strategic Operational Focus Areas	
1. Network Manage-ment	**Needs identified:** CM input, adequacy table, HCBS Capacity Tracker in Rovicare, provider feedback forums, grievances and appeals and UM processes. **Needs addressed:** Network Mgmt. coordinates with the appropriate departments to fulfill any and all network needs, including reporting, compliance, outreach, contracting, and VBP partnership efforts (e.g., BH, Complete Care, ISOC, Medical Mgmt. [MM], Provider Relations, Vendor Oversight, Claims Data).
2. HCBS-ICB	**Needs identified:** HCBS Capacity Tracker in Rovicare, CM input, MM data and member and community feedback. **Needs addressed:** CM receives report on capacity and assesses whether additional providers, CR planning, training, or engagement are needed, and coordinates HCBS-ICB-related activities (e.g., home visits, mobile facilities) with Network Mgmt., UM and BH).
3. HE and HRSN	**Needs identified:** CM input, HRSN screening and referral tools, z-codes and Tribal Coordinator. **Needs addresse**d: HE program receives and continuously monitors data to prioritize populations with health disparities from inputs and collaboration with MM, Population Health, Quality, BH, ISOC, Network Mgmt., and WFD to address needs (e.g., training, referrals, HRSN partnerships and expanding programs/services).

#	Action Step	Measurable Outcome	Focus
* Indicates ongoing annual activities- These take place in each contract year after initial launch through contract end as identified by Action Step and Measurable Outcome.			
Year 0: CYE2024 (prior to go-live)			
1.	Evaluate network and member needs*	Recommendations delivered to the network strategy committee to enhance our network program offerings	1, 2, 3
2.	Offer on-demand services*	Use Carebridge to provide 24/7 medical services through tablet technology	1 2, 3
3.	Develop a new Dementia COE with BAI	Verified current program meets COE requirements; execute COE agreement; conduct education/market BAI as COE	1
4.	North GSA expansion	North GSA compliant with ACOM 436 requirements by May 1, 2024	1
5.	Partner with NF for VBP Olio pilot*	Contracted with 2 NFs by go-live and 1 additional NF every year thereafter	1
6.	Expand Wellness Events (WEs)*	Hold regionally based WEs in awarded counties quarterly, including at least 2 in rural counties per year	1, 3
7.	Launch Caregiver Support program	Hire/train caregiver advocate for each awarded GSA; develop incentives/metrics; educate all caregivers on program	1, 2
8.	FQHC, RHC, and IC provider meetings*	Continue holding quarterly provider forums with FQHC, RHC and ICs	1, 3
9.	Educate providers on Z-Codes*	Promote, educate, and trend 100% of the network on the importance of HRSN screenings and Z-Codes	1, 3
10.	Expand PCP expertise*	Provide PCP training on geriatric/ALTCS dementia basics, psychiatric medications, and psycho-social interventions	1, 3
Year 1: CYE2025			
11.	Complete D-SNP integration	100% compliant with CMS requirements for FIDE members by January 1	1
12.	Train RHC employees on HCBS*	We will offer bi-annual HCBS trainings in partnership with RHCs	1, 2
13.	ALFs and NFs expansion*	Outreached to rural ALFs & NFs regarding HCBS expansion and offer bi-annual technical assistance forums to expand	1, 2
14.	Launch z-codes referrals and VBP	Include Z-codes in VBP arrangement for all VBP partners and monitor through claims and closed-loop referrals	1, 2, 3
15.	Launch mobile clinics*	Offer comprehensive mobile healthcare clinics, including mammography, other screenings, and health/wellness education, in awarded counties quarterly, including 2 in rural counties per year	1, 3
16.	Expand Telehealth in BUCs	Telehealth launched in BUCs to increase capacity in all rural counties, inc. support for NFs, ALFs and HCBS providers	1 2, 3
17.	Increase SNF BH education/capacity*	Partner with BH/integrated care organizations to train and co-locate BH for at least 1 SNFs and/or ALF	1, 3
Year 2: CYE2026			
18.	Launch respite co-op	Respite co-op for caregivers developed and launched in each GSA; caregivers received engagement regarding co-op	2, 3
19.	Expand IHNSA to ALTCS members	VBP arrangement expanded to include HCBS and HRSN specific incentives related ALTCS members with BH needs	1, 2, 3
20.	Launch InNote for providers	**Innovaccer** data populated into InNote; providers engaged and trained on using InNote	1, 3
21.	Co-locate Habilitation/Nursing Services	Partner with Copa to co-locate habilitation/nursing services in group home settings.	1, 2
Year 3: CYE2027			
22.	Ongoing Network Activities	Utilizing data and trends to continue ongoing activities as indicated above (*)	1, 2, 3

(B.8): Workforce Development

BUFC's Workforce Development (WFD) Strategy

Banner-University Family Care's (BUFC's) WFD Operation strategy aligns with our organizational values and goals while addressing the evolving needs of the ALTCS program to improve the capacity, capability, and connectivity of our provider workforce. Our WFD Administrator is empowered with the personnel (our WFD Team), authority and resources to develop and implement a comprehensive WFD Operation and Network Plans. The WFD team contributes to the WFD Alliance's Annual Collaborative Assessment and Forecast of WFD priorities, and participates in WFD meetings with the AHCCCS Administrator of Healthcare WFD and the Arizona Association of Health Plans (AzAHP), WFD Alliance (Alliance), and coordinates technical assistance to providers on WFD processes as needed. Our WFD Administrator leads the Healthcare Network Employee Questionnaire (HNEQ) project and Provider WFD Plan (P-WFDP) Data Report analysis and co-led AZ Healthcare Workforce Goals and Metrics Assessment (AHWGMA) data analysis.

Our goals are to build a more cohesive and effective healthcare system through WFD activities. We strive to reduce fragmentation in the health system by collaborating with other MCOs, AHCCCS, the AzAHP, and community stakeholders in the AZ Workforce Development Advisory Council for ALTCS (AWFDAC), the Alliance and the AZ Workforce Development Coalition (Coalition). BUFC works to reduce fragmentation through our clinically integrated network and our care and coverage approach. We will tie incentives to provider WFD through our Caregiver Support Program, an innovative approach described more fully below. We leverage healthcare IT to expand networks and training opportunities to our workforce. We also work with private sector partners like Rovicare to tap into data sources to improve the workforce while serving members.

Philosophy of Our Workforce Development Operation

Our WFD philosophy is core to our beliefs: investing in workforce is investing in members, communities, and the overall success of the ALTCS program. As the Alliance transitioned into a more autonomous, integrated, and competency-based system, we took the lead and established competency-based job descriptions for our employees. As the largest health system in Arizona, we know firsthand the challenges with maintaining a well-trained workforce, which were exacerbated during the COVID-19 pandemic. Informed by this unique position and consistent with AHCCCS goals to provide quality healthcare to those in need across the state, while preparing for the needs of tomorrow – BUFC continually analyzes workforce capacity and trends in collaboration with providers, government entities, education systems, community organizations, and workers to prepare for future WFD needs. We collaborate with private sector partners like Rovicare (described below) to drive innovation, while working with AzAHP to foster coordination between MCOs.

Banner leads efforts to address complex workforce challenges with innovative WFD approaches. As Arizona's largest employer and a community-based plan, a thriving workforce is integral to our success. Relationships like our 30-year partnership with the University of Arizona (UA) serve as an operational foundation. We support provider initiatives like the Pipeline Arizona Healthcare Hub and develop innovative programming of our own, such as through new Caregiver Support Program. WFD education helps earn worker commitment, align cultures, establish connectivity, improve worker capability, and strengthen capacity. As such we drive initiatives in collaboration with community: Arizona Healthcare Workforce Summit, Pipeline Arizona Healthcare Hub, Arizona State University (ASU) Community Health Worker Training Program, Yuma Pathways and Apprenticeships Job Corps Partnerships, PeerWORKS, and ProjectFUTRE partnership with UA. We also support AHCCCS initiatives promoting higher education, including Graduate Medical Education Programs. Our CMO is a Clinical Assistant Professor at the UA College of Medicine. She trains residents and students by including them in administrative medicine rotations. In addition, we have included students and residents in initiatives such as community wellness events.

BUFC collects and analyzes workforce data to identify existing strengths and opportunities in the workforce, forecasts network needs and gaps, increases workforce capacity and capability through technical assistance and education, and drives initiatives to draw in healthcare workers. Our WFD Operation ensures ALTCS members receive services from a qualified, competent, and sufficiently staffed workforce. We support making Relias the required learning management system for a more cohesive ALTCS WFD system. This would facilitate WFD activities across all lines of business, provide a single point of access for most providers trainings, and simplify monitoring of provider and workforce training. With Relias, workers can move seamlessly between different providers without losing their training credits.

Addressing Health Inequities through Workforce Development

Our WFD philosophy not only ensures access to quality care but also aims to reduce disparities and improve equity. We are deeply rooted in our communities and understand unique challenges regarding unmet social needs, health equity (HE), and access. We align our WFD plan with the National CLAS Standards to support our most vulnerable populations, and we have invested over $4 million in CBO programs to address Health-Related Social Needs (HRSNs) and support HE initiatives. We leverage the capabilities of Rovicare, a digital platform that facilitates referrals, transitions of care, and care coordination including identification of health inequities. We track Rovicare metrics such as timeliness, access to care, and culturally competent care to identify and isolate health inequities. We analyze data and address findings through our Quality Management (QM) and Network Development committees, and we develop new and existing support resources with providers, their employees, and caregivers based on identified trends.

BUFC invests in training for Community Health Worker (CHWs) and Promotores de Salud ("promotores" – Spanish term for CHWs) to enhance local access to care. We collaborate with ASU on a CHW program and with UA on a peer/family support placement system. As part of a grant, participants receive $7,500 for completing the program and another $7,500 when they are placed as CHWs. BUFC will assist by finding CHW apprenticeship placements in tribal areas and among Spanish-speaking populations experiencing significant health inequities. In conjunction with the Alliance, we host monthly provider forums in rural service areas to brainstorm ways to improve cultural competency in minority populations. Some of these providers represent both ALTCS and ACC programs.

BUFC recognizes that delivering on health equity for our ALTCS members will require ensuring the HRSNs of our workforce and especially Direct Care Workers (DCWs) are met. The COVID-19 pandemic highlighted how the HRSN of members and DCWs are intertwined. That is why we developed our Caregiver Support Program, described more fully below, and have committed to new training and education programs for DCWs. This approach is informed by data and studies as described below.

Use of Data to Inform Strategies

BUFC works independently, and with AHCCCS and other MCOs to collect data, and to monitor, assess, forecast, plan, and provide technical assistance to providers. The data is integral to our WFD analysis, planning, and trending. Internal information includes network monitoring, call center trends, provider satisfaction surveys, and grievances and appeals (G&A) trends. We collect data from external sources including providers, Rovicare, the Alliance, the Coalition, and the AZ Healthcare Workforce Goals and Metrics Assessment. We use the data collected to inform our strategies and initiatives. For example, learning of caregiver services gaps led to implementation of a HCBS Capacity tracker with Rovicare; data from caregiver surveys that showed DCWs perceive a lack of advancement opportunities led to the creation of the Healthcare Hub on available career pathways; and discussions within the Neighborhood Advisory Councils (NACs) led to creation of sub-committees focused on WFD issues, and ultimately the inclusion of our WFD team within various groups.

In addition, our strategies are informed by survey data collected by the Abuse and Neglect Prevention Task Force's Member and Family Survey, as well as research conducted by UA College of Law Professors Sklar and Milczarek-Desai focused on the experience of DCWs. The Member and Family Survey showed that most members trusted their DCWs and other providers to keep them safe, but that there were opportunities for improvement. The UA study, which focused on the experiences of DCWs, demonstrated that DCWs wanted and needed additional job-related skills training. Based on these studies, BUFC has committed to a 3-year partnership with UA to ensure the voices of DCWs are heard and to provide them with additional occupational training, including training on abuse and neglect prevention best practices, to improve quality of care and to identify and reduce abuse, neglect, and exploitation.

Data Collection and Analysis Activities

Rovicare is particularly valuable to collect and analyze data to prepare workforce assessment reports, forecasts, and plans. We leverage the data (e.g., referral response and timeliness of service initiation, employee retention rates, placement delay or denial reasons) to produce WFD plans, including our Network WFD Plan, developed in collaboration with our Network Development, QM, and Medical/Utilization Management departments. Earlier this year BUFC implemented an HCBS Capacity Tracker within Rovicare to continuously monitor, assess the capacity and support HCBS. We forecast and plan strategies to address future workforce needs, drawing on data from Rovicare, network adequacy metrics and member G&A. Through reviewing length of stay trends and over/under utilization data, we identified a gap

in home health and expanded our Olio partnership to help decrease length of stay in inappropriate levels of care. Olio's platform improves the quality of care while decreasing readmission rates and length of stay by making the engagement between health systems, payers, and post-acute providers more efficient.

Data Activities on the Alliance and Coalition Level

Our WFD team monitors alliance and coalition level data collected from HNEQ, AHWGMA, and P-WFDPs.

- AHWGMA: The Alliance uses this survey for a uniform approach to forecast workforce needs across the state, including turnover rates, ratios of licensed/unlicensed beds, average length of employment, and education level.
- The HNEQ: This questionnaire focuses on what employees need to perform their healthcare job as opposed to what happens at the provider/network-level. We use the results to assess the need for extra education, training, and strategies for managing stress, burnout, and barriers to effectiveness.
- Provider Workforce Development Plan Data Report: At the Alliance level, WFD Administrators from all MCOs review submission of required ACC P-WFDPs and compile trends from the raw data.

Monitoring Activities to Determine if WFD Strategies are Effective & Desired Outcomes are Achieved

Since data collection and analysis in WFD initiatives are in early phases, we are collecting referral patterns, service utilization including referral to start of service, timely access, and G&A data to monitor our initiatives' effectiveness. We collect WFD data for ALTCS providers/caregivers, and we are refining data collection activities. Data sources help evaluate effectiveness and impacts to member outcomes. In addition, the WFD Administrator is applying best practices from all lines of business to streamline efforts, data analysis, and outcome measurements for WFD initiatives. As further iterations are implemented, we will have comparable data, actionable goals, and measurable outcomes. We also monitor effectiveness through forums like Neighborhood Advisory Councils, established during the COVID-19 pandemic to support provider collaboration and overcome challenges.

(B.8.a): Assist and Incentivize Providers to Improve Workforce Monitoring, Assessing, Planning . . .

BUFC assists providers by ensuring they have access to and comply with all workforce training and competency requirements. We also provide access to all resources necessary to meet WFD requirements specified by AHCCCS.

P-WFDPs for ALTCS: The Alliance and BUFC require ACC providers to submit P-WFDPs. WFDPs helps providers to better assess their workforce, and plan, recruit, select, train, deploy, and support staff. The P-WFDP encourages organizations to plan workforce improvements by developing annual WFD goals. It connects the WFD plans to their onboarding processes, competency assessments and member outcomes. Recognizing current WF shortages, our long-term goal includes increasing participation in and expanding the P-WFDP submission process to ALTCS providers. Although not required for ALTCS at this time, BUFC encourages and is developing incentives for providers to complete a P-WFDP. BUFC will also give bonuses to providers who meet competency continuum goals in the P-WFDP. To increase adoption among ALTCS providers, we will also deploy a marketing campaign, offer monthly workshops when the new P-WFDP template is posted in October, and offer one-on-one sessions for technical assistance.

Caregiver Support Program: We support and engage caregivers through comprehensive programs for formal agency staff and informal caregivers, like family and friends. These programs offer resources like respite care co-operatives, peer support, assistive technology, collaborative care planning, personalized skill development, burnout, and stress reduction and community integration initiatives. In addition, BUFC has partnered with Devoted Guardians to use motivational incentives and data collection to measure and incentivize high-performing caregivers and promote retention. We will expand this incentive program to additional providers based on the outcomes of this partnership.

Centers of Excellence (COE): We currently have 14 COEs and will expand to include a Dementia COE by 12/25/23. We designate providers who have earned recognition as a COE on our website, provider services tracker, annual provider newsletter, and on social media twice per year. COEs receive priority referrals and consideration for partnership opportunities, as well as robust engagement and visibility across the network and in their local communities.

(B.8.b): Assist Providers to Improve Post-Training Coaching and Supervision to Ensure Skills . . .

How BUFC Assists Providers to Improve Post-Training Coaching

BUFC will expand our WFD strategy to provide tailored engagement and additional technical assistance to providers. Upon award, as part of our Caregiver Support Program, we will place a Caregiver Advocate in every GSA to ensure caregivers receive a wide array of support services. We will share best practices, ideas, and innovations across our membership via our website, meetings, and committees and adapt the ACC WFD Toolkit to create an enhanced, custom

ALTCS WFD Toolkit to support providers with post-training coaching. The toolkit will include resources such as templates for career advancement and training guides. It will also feature outlines on how to put WFD plans into SMART goal formats — Specific, Measurable, Achievable, Relevant and Time-Bound. Additionally, a competency tracker template will ensure providers can access and comply with all AHCCCS-required WF training programs and competency practices.

BUFC partners with JTED (Joint Technical Education District) for apprenticeships in Pima and Yuma counties. These apprenticeships support providers to sustain coaching for their workforce beyond initial training for jobs such as Certified Nurse Assistant, Certified Medical Assistant, Licensed Practical Nurse, BH Technicians, CHWs, and Medical Billers and Coders.

We offer modules for managing stress and burnout in our Clinician Experience Project on our website. We encourage providers and caregivers to supplement training with the tools to preserve their workforce. Currently, both employees and providers in the Banner system can access this content. We will expand access to providers contracted with BUFC, as well as to caregivers. We offer modules for providers and caregivers to develop competency in treating individuals with ASD, dementia, traumatic brain injury, persistent aggressive behavior, and who are pregnant or post-partum.

How BUFC Assists Providers to Improve Supervision

BUFC reviews supervision recommendations in ongoing provider meetings and as part of our P-WFDP activities at the Alliance level. We assist providers with their supervision activities by collaborating on topics through pre-hire competency assessment process, onboarding best practices, and post-hire check-in frequency. We review their formal competency criteria and advise on strategies to align with industry best practices. We discuss the need for comprehensive resources, the availability of peer support, and competency checks. We suggest 30/60/90-day post-hire discussions to gauge competency, identify needed resources, and suggest tools to assess satisfaction.

How These Activities Improve Member Experience and Outcomes

As a result of these provider trainings, we aim to improve health equity and outcomes in areas such as preventable in-home injuries, preventable bacterial/viral infection, member and caregiver loneliness/depression/isolation, abuse and neglect, and stress/burnout. We monitor member satisfaction related to appointment availability and provider quality and cultural competency. These outcomes drive our initiatives and highlight opportunities for improvements by developing a strong WF in collaboration with our providers. For example, our Rovicare data showed a trend in incomplete/slow referral fulfillment. We isolated the root cause as a lack of caregiver training on Hoyer lifts. In response, we targeted training on the skill, resolved the gap, and improved service delivery timeliness. In addition, we commit to developing reward and recognition programs with DCW agencies to improve job satisfaction and increase retention while reducing workforce stress and burnout.

(B.8.c): Integrate the Operations of Workforce Development Function Within the Operations . . .

Cross-departmental communication and processes between the WFD, network, medical management (MM), and QM departments ensure a coordinated approach to address emerging trends. We train BUFC employees on WFD, share project updates, and educate employees on we can collaborate across departments to improve outcomes. In 2021, we moved the WFD team under BUFC Network Operations department to facilitate seamless coordination and collaboration. Our QM team monitors and analyzes timely access to care as it relates to WFD. Our MM and QM teams help identify when a workforce shortage creates an access to care issue, and our WFD team helps close those gaps. The QM team also collaborates with WFD to develop provider training.

The WFD Administrator is an integral member of these committees and shares data with QM, MM, and BUFC leadership. Our Senior Director of Network Management reports WFD data directly to the COO and CEO, as well as the QM/Performance Improvement (PI) Committee twice annually. Our WFD team contributes to the Network Development Management Plan and develops the Network WFD Plan. Our company culture encourages collaborative conversations. We discuss common goals, identify barriers to success, and utilize process improvement tools to identify solutions to support WFD goals and objectives.

Finally, we collaborate internally to use the major reports from the Alliance and the Coalition. Our WFD Administrator and Senior Director of Network Management distribute the reports to our committees, executive leadership, and the Board of Directors. We use them as data sources to target and support new WFD initiatives and overall health plan strategy.

(B.9): Social Risk Factors and Special Populations

Banner-University Family Care (BUFC) recognizes that social, economic, and environmental conditions impact health outcomes. Those factors are magnified in the ALTCS population and were exacerbated by COVID-19. We enhanced our programs to address social factors and developed new strategies as a result of emerging trends following the pandemic. BUFC continues to collect and utilize data to improve timely access for members with health disparities who traditionally experience greater obstacles based on their geographic location, age, race, ethnicity, language, sexual orientation, gender identity, mental health, and/or Health Related Social Needs (HRSNs). We identify barriers through several mechanisms including member grievance and appeals, appointment availability, neighborhood advisory committees, **Innovaccer** (our population health platform), and community partnerships, such as ours with the University of Arizona's (UA's) Department of Rural Health.

Timely Access to Services and Supports and Monitoring of Outcomes for All Populations

BUFC historically and continually employs targeted strategies to provide timely access to services and supports and monitor health outcomes across diverse member populations, including members in rural areas, tribal communities, and members who require community resources or Peer and Family (P/F) support services.

Our Person-Centered Service Plan (PCSP) process proactively addresses members' complex needs and access to services and supports: We leverage member's individualized Social Vulnerability Index/social risk level via **Innovaccer** and deploy a multi-disciplinary team to review the PCSP within 30 days of enrollment and ensure timely access to needed services. As part of the state's Whole Person Care Initiative, we incorporated questions related to HRSN into our assessment process to identify and address social risk factors. Starting in October 2022, BUFC also added additional HRSN categories to our PCSP process, allowing us to pinpoint specific member needs and quickly match them with appropriate community supports and services. Following the PCSP, a comprehensive HRSN screening is completed on every member within 30 days of initial enrollment, during reassessments, and transitions of care. By capturing this information, we tailor interventions and referrals to address each member's complex health needs. For CYE2022, our analysis shows members achieved 88.78% of identified goals, and 90.15% of community social goals. This streamlined approach honors AHCCCS's vision of privacy, dignity, and respect while ensuring timely access to tailored HRSN services that address the underlying social, economic, and environmental challenges that impact health and well-being.

Identification of gaps, including gaps in HRSNs, improves member access to services and supports: Our Case Managers (CMs) receive care gap notifications via **Innovaccer**. Alerts trigger CMs to work with members to remove barriers, such as transportation, limited access to senior centers, or insufficient food resources. We also monitor CM response to alerts with open and closed gap reports. Additionally, beginning in 2025 all dually enrolled ALTCS members will be aligned with our DSNP plan, further enabling CMs to identify and remediate gaps in care and align Medicare and Medicaid services. Members enrolled in our D-SNP, Banner Medicare Advantage Dual, have access to supplemental benefits to address HRSNs. We understand that Medicaid funding is limited and as such, look for ways to augment funding for necessary, non-covered services, such as through the Banner Health Foundation.

Provider network: BUFC provides timely access to services and supports by building and sustaining a network that is accessible and culturally and linguistically appropriate. We continually monitor network adequacy and appointment availability within our network, maintaining adequacy and accessibility for all members.

Improved timely access to caregivers: Rovicare, our cloud-based digital referral platform used to streamline care coordination, allows for prompt member referrals to home health care workers, enhances choice of providers, and improves health outcomes. Rovicare enables whole-person care through referral automation, an extensive provider directory, workforce development, and provider performance matrix. This allows CMs to focus on meaningful member interactions instead of managing faxes and phone calls. Additionally, Rovicare works beyond normal time and distance standards to identify community-based gaps, address workforce challenges, and improve access. Since implementation in Q2 2023, agencies have accepted referrals within 2.7 days and caregiver services have started within 0.6 days on average. Members are offered a choice of over 20 agencies per referral and the amount of time to start services improved by 36%.

(B.9.a): Members Residing in Rural Communities

Approach to Providing Timely Access for Rural Communities and Monitoring Outcomes

In addition to all the strategies above, we employ and monitor the following for members who live in rural communities.

Timely access to Rural Health Clinics (RHC): BUFC provides timely access to care and member choice of providers

through contracted RHCs at 67 locations throughout rural Arizona. Augmented by telehealth, our providers meet or exceed all appointment availability standards required by ACOM 417. During Q4 of CYE2022, appointment availability standards were close to 100% for all medical, behavioral, and maternity care providers.

Innovative service delivery mechanisms: We leverage a broad network of telehealth providers, including our 47 Banner Urgent Care (BUCs) that offer telehealth and 3 rural sites via BUCs. We also promote virtual/field clinics in rural areas. Select BUCs function as virtual/field clinics by coordination between BUCs and rural on-site nurses/caregivers providing immediate assessment and treatment in the member's home, ALFs, and SNFs. In addition, our newly launched Carebridge Program provides on-demand access to covered services via no-cost technology.

Additional Strategies for Addressing Potential Barriers to Care and Best Practices for Rural Members

Home-Based Primary Care (HBPC) Barriers: The HBPC program is tailored for rural members with multiple chronic conditions and functional impairments. Through our HBPC pilot program, PCPs and nurse practitioners provide comprehensive care in the member's home. Delivering care by multidisciplinary providers in a member's home in remote rural areas overcomes geographic barriers and enhances timely access to care. The HBPC pilot improved health outcomes and cost effectiveness. In the eight-month study period, the pilot results showed an 80% reduction in outpatient clinical charges, an 88% reduction in hospitalization charges, and zero emergency department visits. Based on these results, we have extended this program in 2023, with a goal of over 100 visits in CYE2023.

Geographic distance to providers: In addition to ensuring timely non-emergency medical transportation, we promote broad access to primary and specialty care telehealth services and other innovative service delivery mechanisms. Upon award, we will support Digital Health Navigators to work directly with patients and facilitate engagement with technology to increase access to care. We will continue to leverage Community Reinvestment funding to support providers with the infrastructure to develop telehealth programs, such as through our partnership with a local Peer/Family-Run Organizations (P/FRO) to create telehealth rooms in rural, underserved areas. Conveniently located within the P/FRO, the rooms allow peer support partners to assist members in telehealth sessions when needed. This specific initiative led to a 47% increase in telehealth utilization from CYE2023 Q1 to Q2.

Training for PCPs: Providing psychiatric and dementia training to non-psychiatrists increases timely access to Behavioral Health (BH) services for members with low to moderate mental health needs. BUFC offers the training to in and out of network providers to improve provider capacity to identify BH diagnoses and potential onset of dementia and/or medication and therapy needs. Enhancing the expertise of PCPs to provide early assessment and treatment allows for members to access more comprehensive care during their PCP regular office visits, thereby improving timely access to care and outcomes.

Increased access to BH Services through use of technology: SilverCloud is an app-based intervention that uses best practices informed by the Substance Abuse and Mental Health Services Administration (SAMHSA) best practice in Cognitive Behavioral Therapy to treat depression and anxiety. The app increases access to care and improves health outcomes, as demonstrated by a recent Banner Health pilot program that showed a 14% decrease in the severity of mental health episodes. In addition, we address loneliness with the Pyx App by creating easily accessible linkages to services and community supports, including live social interactions.

Increased access to dental providers in rural areas: To improve access to tele-dentistry, in March 2023, we implemented 24/7 tele-dentistry to assess emergent member issues and when needed prescribe antibiotics and pain medication, with referral to a dentist for continued treatment. A recent study by the National Library of Medicine shows that access to tele-dentistry increases access to care and improves health outcomes.

(B.9.b): Tribal Members

Approach to Providing Timely Access for Tribal Members and Monitoring Outcomes

BUFC cultivates trust with Arizona's 22 federally recognized tribes through a collaborative approach that respects tribal sovereignty and autonomy. There are several ALTCS programs to serve tribal members. Today, we serve 92 ALTCS enrolled tribal members through the following best practices.

Blind spot data: Recognizing that tribal members often receive services at Indian Health Services (IHS) and 638 facilities, we use the "blind spot" file from AHCCCS, which provides claims data for members receiving services at the facilities. The data flows into Innovaccer, which provides our CMs a more complete view of services received at tribal facilities for effective care coordination and reduction in duplication of services.

Bridging cultural barriers: Tribal members experience a lower life expectancy, poorer quality of life, and higher prevalence of chronic conditions. Culturally tailored approaches help reduce risk factors and chronic disease. As such, our Tribal Liaison participates in inpatient rounds to connect these members to tribal services. For example, she recently helped a member who desired traditional healing services to secure treatment with the Tucson Indian Health Center, thus promoting member values of choice, dignity, and self-determination. If awarded a contract in the North, BUFC commits to hiring an additional Tribal Liaison residing in that area to overcome cultural barriers and enhance tribal leadership relationships within each tribe.

Substance Use Disorder (SUD)/Opioid Use Disorder (OUD)/Suicide prevention: Nearly 1 in 5 American Indian and Alaska Native adults has a SUD, according to the 2018 National Survey on Drug Use and Health (NSDUH). To strengthen approaches to address SUD/OUD, we participate in the Tribal Opioid and Substance use initiatives to help build resources, including for naloxone, to address this growing concern. Nationally, suicide rates among tribal members increased nearly 20% from 2015 to 2020. To address both growing concerns, our Tribal Liaison assists our CM teams by outreaching to tribal members with known suicide attempts or gestures, and those with a known SUD and depression. Through outreach and the OUD Service Locator, our Liaison ensures members understand the services available both on and off tribal lands. The Liaison helps secure traditional healing practice services when a member expresses an interest.

Additional Strategies for Addressing Potential Barriers to Care and Best Practices for Tribal Members

Addressing food insecurity and poor nutrition: Recognizing the prevalence of diabetes and/or obesity among tribal members, we identified the need and partnered with Foodsmart, the nation's largest network of Registered Dieticians (RDs). Through telehealth and video, RDs meet with members to assess challenges to food access, affordability, and nutritional quality. Members may use the Foodsmart digital app to meal plan, grocery shop, and compare prices at local stores. In 2023, BUFC launched a targeted outreach campaign to address food insecurity and nutrition to improve 92 Tribal members' (and other BUFC ALTCS populations) health outcomes.

Tribal leadership meetings: Our Tribal Liaison meets with tribal leaders/elders to discuss challenges and opportunities for us to support, educate, and improve timely access to care on and off tribal land. In CYE2023, tribal communities and IHS facilities identified a need for education around point of contact at the health plan, benefits available, and internal processes to obtain services and supports available for tribal members. Phoenix Indian Medical Center was the first IHS facility trained in these areas. It was well received, and other IHS facilities were scheduled to receive the same training.

Cultural training for BUFC staff and providers: Cultural sensitivity training for both BUFC staff and network providers is crucial to fostering an environment of understanding and respect. We offer training focused on specific cultural practices and beliefs that considers historical trauma, which may impact healthcare decisions. Both our internal staff and larger delivery system benefit from this essential training. We know from experience that tribal members are more likely to follow through with timely access to care from providers who are culturally sensitive and trained in trauma informed care, reinforcing our belief that this training leads to better health outcomes.

Transitioning and continuity of care: With member consent, our Tribal Liaison is actively involved and serves as part of the member's PCSP Team. She meets with members to ensure their cultural needs are addressed and incorporated into the delivery of covered services. The Liaison advocates for traditional healing services such as sweat lodges and medicine men, if a member so desires. The Liaison also meets with and provides support to members who are transitioning from a facility or between facilities to ensure timely access to continuity of care.

(B.9.c): Members in Need of Community Resources

Approach to Providing Timely Access to Community Resources and Monitoring Outcomes

Contexture CommunityCares: Our CMs actively use this closed loop referral system (CLRS) tool to identify community resources that address members' HRSNs. The CLRS leverages data to identify and address health disparities across members with different demographic profiles. In addition, CMs leverage a variety of sources including the BUFC Community Resource Guide, 2-1-1, FindHelp, and other online platforms. Our CMs average 295 HRSN referrals to Community Based Organizations (CBOs) each month. We have implemented the CLRS in one county. After only one month, 36% of referrals successfully connected a member to a CBO. Our Provider Relations (PR) team launched a provider education campaign to encourage use of the CLRS to refer members to CBOs that address identified HRSNs. We partner with Contexture to encourage CBOs to participate in the CLRS.

Community resource guide: Our publicly available Community Resource Guide provides information on local resources available to address members' HRSN. The guide is specific to the unique needs of the ALTCS population and updated at a minimum quarterly to ensure continuous accuracy and relevance.

Promotion of Z Code use: Through our CMS-approved Health Equity (HE) plan, we promote awareness on the use of Z codes in documenting member information across delivery systems. We provide summarized Z code data to CMs for use in assessments and system alerts for new or updated Z codes. We monitor Z code utilization, encourage provider adoption through training and incentives, and track Z code year-over-year to identify progress and opportunities.

Additional Strategies for Addressing Potential Barriers to Care and Best Practices . . .

Unaddressed HRSN: Many members have unaddressed social, economic, and environmental needs and often are unaware of community resources available to help. BUFC addresses this gap with the following strategies/best practices.
CMs embedded in the communities they serve: Our CMs have a deep understanding of the unmet needs, unique challenges, and resources in each community. These community ties result in trusting relationships and personalized assistance that enhances member access to social services, economic support, and environmental resources.
Impactful community reinvestment: As part of our commitment to address barriers to care, BUFC launched a proactive community reinvestment strategy to increase the number and strength of community organizations meeting ALTCS members' HRSN. In 2022-2023, we invested over $4 million to support our community partners and increase access to HRSN services. For example, BUFC funded a local FQHC in a rural southern county that lacked public transportation. Our community reinvestment allowed the FQHC to purchase a van to transport members receiving Medication for Opioid Use Disorder (MOUD) services to attend appointments and improve access to care.

(B.9.d): Members in Need of Peer and/or Family Support Services

Timely Access to Peer and/or Family Support Services and Monitoring of Services

Our commitment to fostering a member-centered and family-focused approach to service delivery is reflected in our commitment to ensure members and their families have timely access to peer and family support services. We recognize the vital role Peer/Recovery Support Specialists and Family Support partners play in enhancing member outcomes. Our Office of Individual and Family Affairs (OIFA) partners with P/FROs and regularly extends comprehensive training and technical assistance to potential new and established P/FROs. Our CMs are trained and knowledgeable about Peer and Family Support Services, and our PCSP has a section devoted to assessing the need for these services. BUFC OIFA conducts regular training with case/care management teams on the value and accessibility of community and clinic-based P/FRO support services. P/FROs present their programming and referral processes to case/care management teams. The training provides valuable information to CMs, ensuring they understand available resources and how to help members access timely services. BUFC successfully addressed AHCCCS's desire for Managed Care Organizations (MCOs) to increase access to P/FRO services. In CYE2021, 359 members across all lines of business received P/FRO support services. In CYE2022, this number increased to almost 6,900 members served — an 1,800% increase in only one year. Our goal for CYE2023 is a 10% increase in the number of members served. We offer continued training to our CMs on the benefits of P/FRO services to effectively assess member needs and match them with an appropriate P/FRO.

Additional Strategies for Addressing Barriers to Care and Best Practices for Peer/Family Support Services . . .

Access to P/FRO providers to serve members: BUFC addresses this barrier with active recruitment of P/FRO providers. We are contracted with 9 of 10 Community Service Agencies designated as peer-run organizations (PRO). We work closely with them and provide technical assistance, resulting in the addition of two new PROs to our network in CYE2021-2022. This included the first BH/SUD focused PRO, as well as a second with an innovative focus on recovery-oriented, community-based exercise programming. We are currently contracted with 5 of the 6 FROs. Our goal is to continuously expand the number of P/FROs within our network.
Comprehensive assessment of member needs: Through the quarterly Targeted Outcomes Workgroup, co-facilitated by our BUFC OIFA Administrator, the daily living activities-20 (DLA-20) assessment tool was identified as a best practice and implemented across all P/FROs. The DLA-20 is the National Council of Mental Well-being's evidence-based practice that enables clinicians and PRSSs to measure the daily aspects of life impacted by mental illness or disability and, in turn, provide this data to the caregivers to better address member needs. Member and family engagement is a determining factor in every member's treatment plan. Research shows an early focus on engaging and empowering members and families in their own treatment is effective at changing health behavior across populations. Our focus on supporting and expanding the use of the DLA-20 tool promotes the inclusion of member voices at the point of care. This helps service providers target services to best meet member needs and improve overall health.

These strategies have been informed by our role as an incumbent and through our deep commitment to serving the complex ALTCS population during the greatest public health emergency in the last century.

Making health care easier, so life can be better.

(B.11): 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.	Banner-University Care Advantage dba Banner Medicare Advantage Dual	H4931	Banner-University Care Advantage dba Banner Medicare Advantage Dual	FIDE/DSNP	3.0

(B.12): Oral Presentation Information: Participant Names, Titles, and Resumes

The following Banner-University Family Care (BUFC) employees will participate in the ALTCS Oral Presentation:

James R. Stringham, MA
Chief Executive Officer

Sarah Spiekermeier, MBA
Chief Operations Officer

Sandra J. Stein, MD
Chief Medical Officer
Expertise: Quality Management, Medical Management

Myrna Chaydez, MS
Senior Director, Medicare Administrator

Dan Koesser
Director of ALTCS Case Management
Expertise: Case Management

Emily Hanna, RN
Associate Director of RN Case Management
Expertise: Case Management, Medical Management

James R Stringham, MA

602.568.4179 | james.stringham2@bannerhealth.com

www.linkedin.com/in/james-stringham-8385152a

Education

MA in Community Counseling, 2001
University of Phoenix
Phoenix, AZ

BS, 1996
Northern Arizona University
Flagstaff, AZ

Professional Affiliations

American Heart Association of Arizona, 2023-present
- Co-Chair of 2024 Heart Walk, Executives with Heart, and Executive Leadership Team in Tucson

Board Chair, 2020 and 2023
Board Member, 2018-present
Arizona Association of Health Plans

Board Member, 2015-present
Chandler Compadres,
Men's Civic Organization

Board Member, 2021-present
Home Matter to Arizona

Board Member, 2020-present
Home Matter Fund Committee

Board Member, 2017-2019
Arizona Chamber of Commerce

General Member, 2017-present
Association of Community Affiliated Plans

Volunteer
Boys & Girls Club and ICAN Positive Programs for Youth

Coach
Gilbert National Little League

Booster Club Member
Campo Verde High School Golf and Baseball Teams

Professional Summary

Results-oriented chief executive officer with over 25 years of leadership experience in Medicaid and Medicare Managed Care Organizations including direct oversight experience of LTSS plans in four states. This includes accountability for the financial integrity of the Health Plan, network and resource oversight, strategic vision and implementation, board advisement, fostering community partnerships, and operational excellence. Accomplished in business development, merger and acquisition initiatives including proposal development and implementation. Committed to addressing health disparities and improving health outcomes for all members.

Work Experience

***Chief Executive Officer*, Banner – University Family Care and Banner Medicare**
December 2019 – Present | Banner Health, Tucson, AZ
- Oversees programs and services for nearly 350,000 members across the AHCCCS Complete Care (ACC), Arizona Long Term Care System (ALTCS) and Dual Eligible Special Needs Plan (DSNP) plans, as well as Banner Medicare plans including HMO, PPO, and PDP.
- Accountable to AHCCCS and CMS for program performance and compliance.
- Fosters strong relationships with the state and federal regulators, providers and community partners and is accountable for the financial and operational success of the programs.
- Profit and loss responsibility for the health plan including plan growth and MLR targets.
- Provides strategic direction and oversight to senior leadership team including setting targets, goals, and expectations for performance measures.
- Lead the rigorous implementation and readiness efforts to successfully launch new Medicaid program on time and without deficiencies.

Chief Executive Officer
January 2018 – December 2019 | Magellan Complete Care of Arizona
- Oversight of Medicaid and Medicare health plan operation including all operational, financial, regulatory, and contractual elements.
- Led full business development effort to successfully enter the Arizona Medicaid market including business strategy, government relations, stakeholder engagement and RFP writing and strategy.
- Launched rigorous implementation and readiness efforts to successfully launch new Medicaid program on time and without deficiencies.

Senior Vice President and Chief Operations Officer
July 2014 – January 2018 | Magellan, Public Markets
- Successfully evolved Magellan core BH capabilities into a fully integrated health plan offering across multiple states.
- Provided operational oversight and direction of public market contracts including fully integrated Medicaid and Medicare health plans and carved out specialty health plan across the nation.
- Accountable for the fiscal and operational performance of plans including improvement of member outcomes, development of strategic provider partnerships and meeting financial targets.

Notable Accomplishments

2023 NCQA Certifications

- Long-Term Services and Support Distinction
- Health Plan Accredited

Additional Experience

Program Development, 2 years
Provider Management, 2 years
Training and Development, 3 years
Justice System, 2 years
Clinical Case Coordination, 2 years

National Vice President of Strategic Growth & Account Management

April 2013 – July 2015 I Magellan, Public Markets

- Provided strategic oversight for all aspects of the CMC operations including utilization management, customer services, quality assurance, community outreach and stakeholder relations, all geared to assisting members in achieving recovery outcomes.
- Developed an account management oversight structure to proactively address contractual performance and proactively community to customers.
- Assisted with key growth initiatives by serving as the business lead to leverage best practices and operational efficiencies across accounts.

National Vice President of Public Sector Operations

2009 – 2013 | Magellan, Public Markets

- Accountable for the operational strategy and direction of all Public Sector Care Management Centers including sites located in Arizona, Nebraska, Iowa, Pennsylvania, and Florida.
- Achieved key financial targets while meeting contractual performance expectations.
- Identified innovative initiatives that will improve operational efficiencies while meeting and exceeding customer expectations.
- Implemented a provider and program accountability process including program dashboards designed to improve quality of care for members while reducing unnecessary cost.

Chief Operations Officer

2007 – 2009 | Magellan Health Services of Arizona

- Responsible for directly overseeing the fiscal and administrative operations for Magellan of Arizona, including the areas of customer service, claims payment and billing, utilization management, information technology, staff development and reporting.
- Directly oversaw the management of the service center, including development of policy and procedure, management of the community service delivery system and coordination of relationships with diverse provider network.
- Successfully managed a budget while keeping administrative expenses within target.
- Developed unique provider contracts to serve complex membership while meeting the contract performance requirements.
- Partnered with members, families, and stakeholder as part of a governance board structure to identify and design improvements for the delivery system.

SARAH SPIEKERMEIER, MBA

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Education

Master in Business Administration, 2015
Ashford University-Forbes School of Business
Tucson, AZ

BS in Business Administration, 2009
University of Phoenix
Phoenix, AZ

Certifications

Certified Public Manager (CPM), 2010
Arizona State University
Phoenix, AZ

Professional Affiliations

American Heart Association of Arizona, 2023-present

- Co-Chair of 2024 Heart Walk, Executives with Heart, and Executive Leadership Team in Tucson

Board Member, Sickle Cell Foundation **of Arizona**, 2020-present

Member, ACAP, 2015-present

- 2020 Leadership Academy Class

Member, Military and Veterans Community Network of Southern Arizona, 2016-2021

Member, Coronado Area Council Special Olympics of Arizona Leadership Council, 2019-2021

Professional Summary

Results-driven managed care leader with a proven track record in driving operational excellence, leading safe and seamless care transitions for members to a new health plan, and ensuring adherence to regulations and compliance standards. Comprehensive knowledge of the ever-changing healthcare environment. Keen ability to empower all members in their health care journey and improve access to care with equity and compassion.

Work Experience

Chief Operations Officer, Banner – University Family Care and Banner Medicare
November 2020 – Present | Banner Health, Tucson, AZ

- Directs the operations of two Medicaid and four Medicare plans including marketing, government programs, member retention, network and VBP administration, quality, and medical management administration departments.
- Responsible for ensuring cross-organizational collaboration of operational teams within Banner Plans & Networks, while ensuring organization goals and objectives are met within budget.
- Health plan executive with direct interface with the Arizona Medicaid Agency (AHCCCS), Centers for Medicare and Medicaid Services (CMS), Association for Community Affiliated Plans (ACAP), and the Arizona Association of Health Plans (AzAHP).

Administrative Operations Sr. Director, Banner – University Family Care and Banner Medicare
October 2018 – November 2020 | Banner Health, Tucson, AZ

- Led the development and implementation of company-wide infrastructure to support the Medicaid and Medicare Programs, including the administration of all Medicare and Medicaid Bids and program implementation.
- Department senior leader for Medicaid Administration, Medicare Administration, Enrollment, Vendor Oversight, Member Retention, and Marketing.
- Oversaw and directed the development and implementation of marketing, social media, and member retention strategies for the Health Plan, including partnering with system teams to ensure state and federal regulatory compliance and consistency with and support of the organization's branding, public relations strategies, and goals.
- Developed and managed the department's budget in conjunction with corporate goals and objectives.

Medicaid Administrative Director, Banner – University Family Care
January 2017 – October 2018 | Banner Health, Tucson, AZ

- Health Plan's Contract Compliance Officer responsible for plan's Medicaid contracts, including management of plan deliverables, regulatory policy implementation, and direct communication with AHCCCS.
- Managed Medicaid Operational Reviews and contract bid and implementation efforts in conjunction with health plan senior leaders.

Notable Accomplishments

Non-Renewal Project Lead
80,000 AHCCCS lives successfully transitioned from Maricopa Health Plan to United Healthcare, recognized as a Best Practice by AHCCCS

Procurement & Implementation Lead
CY 2018 Arizona Long Term Care System and CY 2019 AHCCCS Complete Care Proposals, resulting in the successful award of two contracts in ten Arizona counties

Presenter at ACAP

- 2016 Quality and Medicare/MLTC Meeting on care coordination pilot for the justice-involved population
- 2018 Medicaid Managed Care Congress on improvements in care coordination for the justice-involved population
- 2020 and 2022 Chiefs Conference on Member Engagement Strategies, Community Reinvestments, and Health Plan Operations
- 2023 CEO Membership Council on Medicaid Redetermination

Presenter at the Arizona Coalitions of Military Families

- 2017 and 2023 Symposium Family Matters breakout session

Presenter at the 2023 RISE AEP Readiness Summit
Medicare Advantage and Technology Solutions Case Study

Valley Leadership Ready Together, 2020-2021

- Mentorship program with a focus on combating the COVID-19 pandemic

Breakout Session Leader and Presenter
2019 Medicaid Managed Care Congress on behavioral health integration.

- Established development and implementation of programs to support the success of Medicaid, short and long-range goals and objectives, and determined the optimal progression to obtain these goals.
- Lead writer for Banner – University Family Care executive summary for AHCCCS Complete Care (ACC) Request for Proposal.
- Developed and managed the department's budget in conjunction with corporate goals and objectives.

Program Implementation Manager, Banner – University Family Care
July 2015 – January 2017 | Banner Health, Tucson, AZ

- Responsible for managing all large-scale operational implementations for the health plan.
- Successfully implemented a new and complex operational infrastructure established to provide General Mental Health/Substance Abuse (GMH/SA) services to over 11,000 Dual Special Needs Plan eligible AHCCCS members.
- Created Health Plan's five-year strategic plan for Payment Reform, including Value-Based Purchasing.
- Launched the Health Plans' first annual Emerging Leader program and served as a mentor for the 2016 Emerging Leader class.
- Supervised direct reports, monitoring performance measures, attendance, training, and special projects.
- Expert in all health plan operational areas such as Customer Service Call Center, Claims, Network Development, and Grievance and Appeals.

Customer Care Supervisor, Banner – University Family Care
August 2013 – July 2015 | Banner Health, Tucson, AZ

- Supported a high-volume medical inbound call center while analyzing and auditing statistical data to ensure the call center is meeting AHCCCS and CMS guidelines.
- Responsible for managing and auditing member ID card vendor account for all health plan ID cards and carrier letters.
- Led the development of appointment availability surveys and set standard for Managed Care Organizations.

Lead Financial Counselor
June 2012 – August 2013 | Arizona Oncology, Tucson, AZ

- Lead specialist in revenue cycle management, which included account collections, insurance verification and authorization, billing and coding, and patient assistance.
- Assessed patient financial abilities and provided education to patients on assistance programs.
- Project manager on new patient assistance tracking database for all Arizona Oncology locations.
- Site Safety Coordinator for all administrative staff and areas, OSHA and Hazard Communication Awareness training and certification.

Senior Investigator III/Program and Project Specialist II
January 2005 – March 2010 | State of Arizona, Phoenix, Arizona

- Investigate complaints, conduct interviews, organize and conduct Enforcement Advisor Committee meetings for regulatory agencies' disability-related cases.

SANDRA J STEIN, MD

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Education

Doctor of Medicine, 1992
Albany Medical College
Albany, NY

Psychiatry Internship, 1992-1997
Residency and Child Psychiatry Fellowship
University Medical Center
Tucson, AZ

BA in Psychology, 1988
Emory University
Atlanta, GA

Training

American College of Physician Executives
Physicians in Management Seminar I and II, 2010

National Council of Behavioral Health
National Psychiatric Leadership Training Program, 2015

Certifications

American Board Of Psychiatry and Neurology

- Certification In General Psychiatry #45411
- Certification in Child and Adolescent Psychiatry #4795

Professional Affiliations

American Academy of Child and Adolescent Psychiatry

Professional Summary

Executive level medical professional with over 20 years of experience, including clinical and administrative responsibility at the Regional Behavioral Health Authority, State of Arizona Department of Child Safety, integrated provider level, ACC, ALTCS, and Medicare MCOs. Leadership roles in quality management and performance improvement, utilization management and review, care management, integrated care with a focus on HRSNs and health disparities, implementation of evidence-based practices, trauma-informed care, care transformation and innovations, collaboration with members, families, key stakeholders, state agencies, and an experienced and engaging national presenter. Innovations in developing programming to meet the needs of members with complex comorbidity, resulting in reduced hospitalization and crisis utilization, increased engagement in outpatient behavioral health services with primary care. Lead in integrated care demonstration projects for youth with autism spectrum disorder. Clinical Assistant Professor, University of Arizona College of Medicine.

Work Experience

Chief Medical Officer, Banner – University Family Care and Banner Medicare
November 2020 – Present | Banner Health, Tucson, AZ

- Oversight of all medical/clinical areas including quality management, utilization management/review, value-based care, integrated care, care management, technological and clinical innovations, credentialing, community councils and NCQA accreditation for ACC, ALTCS and D-SNP.

Medical Director of Care Integration, Banner – University Family Care
October 2017 – November 2020 | Banner Health, Tucson, AZ

- Medical Director for Behavioral Health Services and Complete Care.

Chief Medical Officer
October 2015 – September 2017 | Intermountain Centers, Tucson, AZ

- Chief Medical Officer including psychiatric oversight of all psychiatric services, outpatient and therapeutic out-of-home services including home care training to home care client, behavioral health residential facilities and specialized programming for members with substance use disorders, autism spectrum disorders and complex needs.

Behavioral Medical Director, Comprehensive Medical Dental Program
March 2015 – September 2015 | Arizona Department of Child Safety, Tucson, AZ

- Medical director for psychiatric and behavioral health services with a focus on statewide implementation of trauma informed care and collaboration with RBHAs, state and community agencies.

Children's Medical Director/Associate Medical Director/Medical Director, Project Match (SAMHSA Grant)
July 1997 – March 2015 | Community Partnership of Southern Arizona/Regional Behavioral Health Authority, Tucson, AZ

- Included all responsibilities of medical director for psychiatric services with a focus on implementation of EBPS, collaboration with state agencies and key community stakeholders, and direct provision of services through Project Match to complex needs multi-state agency involved youth.

Myrna Chaydez, MS

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Education

MS, Leadership, 2018
Grand Canyon University
Glendale, AZ

BS in Business Management, 2012
University of Phoenix
Phoenix, Arizona

Certifications

Six Sigma Lean Black Belt Certified
Healthcare and HIPAA Certified Professional, Management Strategy Institute

Professional Affiliations

Member
Association for Community Affiliated Plans

Notable Accomplishments

Health Equity Plan Approval for the Centers for Medicare Medicaid

Value-Based Insurance Design for Banner Medicare plans

Professional Summary

Healthcare visionary and a driver of excellence with over 18 years in the industry, transforming operational realities into a culture of continuous improvement. Developed and led high performing healthcare teams by applying key principles of leadership to foster a cohesive and collaborative working culture that promotes health equity, reduces health disparities, and improves health outcomes for our members.

Work Experience

Senior Director Medicare Administrator, Banner Medicare
December 2021 – Present | Banner Health, Phoenix, AZ

- Provide leadership and guidance for achievement of financial and operational performance objectives and expectations including product development, expansion, membership growth, revenue growth and operational margin targets.
- Ensure the timely creation and submission of Banner Medicare annual bids, including year over year operational implementation.
- Function as an integral part of BMA's operational leadership teams, serving as a Medicare subject matter expert.
- Serve as the point of contact for the Centers for Medicare and Medicaid Services (CMS) regulator and state Medicaid D-SNP Operations Compliance Officer for Medicare.

President, Managing Partner
November 2014 – September 2021 | 32nd Note Consulting, LLC., Phoenix, AZ

- Provided consulting services to the healthcare industry with expertise in Medicare and Medicaid managed care products. Consulting services offered include five key areas:
  - Health Plan Operations: provider network, credentialing, member, and provider contact center, enrollment, claims, marketing, and sales, appeals and grievances, and clinical operations.
  - Compliance and Auditing: compliance program, delegation oversight, risk assessments, internal audit, CMS Program audits, corrective action plan, and readiness review.
  - Quality Program: program implementation, Stars and HEDIS strategies, and monitoring.
  - Medicare and Medicaid Procurements and Applications: provided managed care organization with strategy, proposal writing, reviews, oral preparation, application submissions, contract implementation, and operational readiness.
  - Leadership: interim leadership roles, leadership training, mentoring, coaching, and succession planning.
- Client portfolio includes Magellan Complete Care of Arizona, Blue Cross Blue Shield of Arizona, HCSC of Illinois, Loma Linda University Shared Services Hospital, and Memorial Hermann Health Plan.

Compliance Officer

September 2011 – November 2014 | Advantage Health Care Management Company, Phoenix, AZ

- Achieved 100% compliance on Arizona compliance program audit.
- Directed CMS application process four years in a row, including 2014 Health Exchange application.
- Led organization through Medicare business expansion in other counties and states.
- Achieved a grand mean in the 97th Percentile on Gallup's Q12 Engagement Score.
- Ranked #1 in departmental leadership scores three years in a row.
- Led a team of direct reports in the areas of internal auditing, fraud, waste, and abuse, regulatory reporting, and compliance program.
- Oversaw compliance implementation for two Medicaid, three Medicare and one commercial plan in Arizona, Michigan, and Texas.
- Chairman for Policy, Compliance, Oversight Subcontractor, and FWA Committees.
- Served as point of contact for state Medicaid regulators, CMS, Medicaid Office of Inspector General, State Attorney General, Office of Civil Rights and state department of insurance regulators.

Director of Marketing and Sales

August 2007 – August 2011 | Advantage Health Care Management Company, Phoenix, AZ

- Oversaw development and execution of Medicaid/Medicare marketing and outreach initiatives, including researching market trends and performing competitive analysis.
- Designed plan benefit packages for Medicare plans.
- Created and led comprehensive retention strategies to minimize voluntary Medicare and Medicaid disenrollment.
- Developed and oversaw annual targeted marketing and sales plans, sales forecasts, key performance indicators to support corporate strategies and objectives.

Daniel Koesser

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Education

Certified Public Manager, 2005
Arizona State University
Tempe, AZ

Associate of Arts in Respiratory Therapy, 1995
Apollo College Phoenix INC

Notable Accomplishments

2023 NCQA Certifications

- Long-Term Services and Support Distinction
- Health Plan Accredited

Community Involvement

Case Management Events

- St Mary's Food Bank Knight and Del Webb
- Vecino's Block Party
- Maricopa Sponsorship Event AZHCA Quality Forum
- Payson 22nd Women's Wellness Forum
- Cochise-Sierra Vista Mall Health and Business Expo
- Banner Health Fairs
- Maricopa-Pebble Creek of Goodyear Health Expo
- Yuma Socks for Seniors
- Park Senior Villas Golden Ticket Bingo
- Back to School Supply Drive
- Jim Click Run N Roll
- Tucson and Phoenix Alzheimer's Walk

Professional Summary

Leader in case management with over 22 years of experience recommending best resources and courses of action to benefit members to help them achieve an optimal quality of life. Develop and implement case management initiatives to foster creative and out-of-the-box thinking combined with solid goal-oriented care planning. Perceptive ability to navigate change and quickly identify trends to strategically plan desired outcomes. Strong knowledge of Arizona Long Term Care Systems (ALTCS) and regulatory requirements of the program.

Work Experience

Director of ALTCS Case Management, Banner – University Family Care
April 2022 – Present | Banner Health, Tucson, AZ

- Monitor program quality to help maintain members in their least restrictive environment.
- Providing direct and indirect leadership to 130 staff to ensure program contractual and regulatory requirements are met.
- Served as project lead for Banner Health Plans requirement for Medicaid Electronic Visit Verification.

Associate Director of ALTCS Case Management, Banner – University Family Care
October 2017 – April 2022 | Banner Health, Tucson, AZ

- Developed required monitoring tools to meet contractual requirements of ALTCS program.
- Provided ALTCS program-related education and mentorship to other departmental requirements of the program.

ALTCS Case Management Supervisor
August 2010 – September 2017 | Bridgeway/ Centene, Phoenix, AZ

- Led, identified, and provided case management team with tools to successfully guide member care plans and provide health care guidance for the elderly and physically disabled residents of Arizona.
- Provided direct supervision to 6 supervisors and helped to oversee 55 case managers.

ALTCS Case Management Supervisor
January 2003 – September 2010 | Pinal Gila Long Term Care, Florence, AZ

- Built monitoring tools, including performance measure tools to help close care gaps.
- Support AHCCCS with Ventilator Dependent Program, helping members to successfully transition from hospital settings to nursing home settings to home.
- Helped to build an Integrated Care Team model which introduced RN Case Management and Behavioral Health Professionals into the Case Management Teams.

ALTCS Case Manager
September 2001 – January 2003 | Pinal Gila Long Term Care, Florence, AZ

- Provided services and support to individuals with physical disabilities in Pinal and Gila counties.

Emily Hanna, RN

480.544.7595| emily.hanna@bannerhealth.com

www.linkedin.com/in/emily-hanna-8772ab110

Education

BS in Nursing, 2003
University of Wisconsin
Oshkosh, WI

Licensures

Registered Nurse, 2004
Arizona License # RN130856

Notable Accomplishments

2023 NCQA Certifications

- Long-Term Services and Support Distinction
- Health Plan Accredited

2023 Mental Health First Aid Certification

Skills

- Quality Care Advocate
- Utilization Management
- Case Management
- Resource Coordination
- Member-Centric
- Palliative Care Awareness
- Acute Care Expertise
- Experienced Healthcare Leader

Professional Summary

Accomplished, detail-oriented Registered Nurse (RN) case management associate director with over 19 years of experience in leading high-performance nursing teams to deliver empathetic and compassionate care to patients. Experience in coordinating hospital operations and clinical workflows to ensure quality service. Maintains a depth and breadth of clinical competency to assess outcomes related to delivery of ALTCS Registered Nurse Case Management. Prioritize making health care easier, so life can be better for ALTCS members.

Work Experience

Associate Director of RN Case Management, Banner – University Family Care
April 2023 – Present | Banner Health, Phoenix, AZ

- Ensures qualified ALTCS Registered Nurses provide clinically competent consultations and collaborative processes to ALTCS case managers to develop care plans and preserve placements.
- Promotes interdisciplinary patient care planning and supports Care Model.
- Participates in the development of the department budget in conjunction with established goals and objectives.

Senior Manager of RN Case Management, Banner – University Family Care
March 2022 – April 2023 | Banner Health, Phoenix, AZ

- Served as a change agent in development, implementation, and evaluation of department goals, objectives, and process improvement activities.
- Analyzed data and healthcare trends to gain efficiencies and improve or implement initiatives focused on enhancing member outcomes.

RN
January 2020 – March 2022 | Banner Home Care, Gilbert, AZ

- Assessed, coordinated, and directed patient care based on individual needs.
- Performed home and clinical assessments, intervened and supported patients and caregivers.
- Preceptor for new hires and was nominated for an excellence in home health care award for Banner Home Care.

RN, Neurology
September 2018 – January 2020 | Banner Baywood Medical Center, Mesa, AZ

- Functioned as charge nurse and stroke responder.
- Delegated and supervised assistive personnel.
- Collaborated with doctors, case managers and other departments on a daily basis to improve delivery of care to patients and facilitate patient plan of care.

RN Senior Manager, Banner Utilization Review Department
January 2016 – September 2018 | Banner Health, Phoenix, AZ

- Hired, trained, conducted performance evaluations, and directed workflow of staff.
- Completed performance audits, rounding monthly, involvement with department and system process teams.

RN Utilization Reviewer
March 2015 – January 2016 | Banner Health, Phoenix, AZ

- Performed admission reviews maintaining above minimum accuracy and productivity.
- Preceptor for new hires, Queue Captain, Pre-surgical Review team member involvement in system teams and projects.

RN Case Manager
October 2011 – February 2015 | Banner Baywood Medical Center, Mesa, AZ

- Managed patient care with attention to appropriateness of care plan, level of care, length of stay, resources available, insurance, and discharge planning.
- Functioned as direct admissions reviewer for Banner Baywood Medical Center and Banner Heart Hospital as a pilot program from August 2014 to February 2015.

RN, Medical Surgery and Neurology Unit
November 2006 – October 2011 | Banner Baywood Medical Center, Mesa, AZ

- Provided clinical support to patients and staff on a neuro unit.
- Supervised employees and participated selection, orientation, counseling, and evaluation of staff.
- Served as RN Clinical Manager from June 2007 to June 2008 and January 2010 to January 2011.

RN, Orthopedics
October 2004 – November 2006 | Scottsdale Healthcare Shea, Scottsdale, AZ

- Functioned as charge nurse in role.
- Delegated and supervised assistive personnel.
- Provided clinical support to patients and staff on orthopedic unit.

Banner
University Family Care

Part C

Request for Proposal ALTCS E/PD
RFP No. YH24-0001

(C.1): Agreement Accepting Capitation Rates

Banner-University Care Advantage dba Banner-University Family Care ("BUFC") agrees to accept the actuarially sound capitation rates computed by AHCCCS prior to October 1, 2024. BUFC understands that AHCCCS' actuaries will develop components of the capitation rates including the medical services component, share of cost offset, reinsurance offset, underwriting gain, and premium tax. BUFC agrees to accept actuarially sound rates, which are defined according to the applicable provisions of 42 CFR Part 438 and Actuarial Standards of Practice, and which follow Generally Accepted Actuarial Principles and Methodologies.

Banner-University Care Advantage dba
Banner-University Family Care
Company Name

Signature

5255 E. Williams Circle, Ste 2050
Address

James R. Stringham
Authorized Signatory Print Name

Tucson AZ 85711
City State Zip

VP and CEO
Title

AHCCCS

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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	$ 70.87	$ 1,649,493	$ 71.78	$ 2,087,402	$ 72.63	$ 2,436,370	$ 73.46	$ 2,718,355	$ 74.27	$ 2,949,293
Occupancy	$ -	$ 44,198	$ -	$ 55,931	$ -	$ 65,280	$ -	$ 72,835	$ -	$ 79,022
Depreciation	$ -	$ 43,007	$ -	$ 54,425	$ -	$ 63,523	$ -	$ 70,876	$ -	$ 76,897
Care Management/Care Coordination	$ 0.18	$ 4,518	$ 0.19	$ 5,733	$ 0.19	$ 6,701	$ 0.19	$ 7,484	$ 0.19	$ 8,125
Professional and Outside Services	$ 31.89	$ -	$ 32.30	$ -	$ 32.69	$ -	$ 33.06	$ -	$ 33.42	$ -
Office Supplies and Equipment	$ 0.56	$ -	$ 0.57	$ -	$ 0.57	$ -	$ 0.58	$ -	$ 0.59	$ -
Travel	$ 0.99	$ -	$ 1.00	$ -	$ 1.01	$ -	$ 1.02	$ -	$ 1.03	$ -
Repair and Maintenance	$ 3.91	$ 576,399	$ 3.96	$ 729,410	$ 4.01	$ 851,343	$ 4.05	$ 949,871	$ 4.10	$ 1,030,563
Bank Service Charge	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -
Insurance	$ 1.15	$ -	$ 1.16	$ -	$ 1.18	$ -	$ 1.19	$ -	$ 1.20	$ -
Marketing	$ 2.44	$ -	$ 2.47	$ -	$ 2.50	$ -	$ 2.53	$ -	$ 2.56	$ -
Interest Expense	$ 4.16	$ -	$ 4.22	$ -	$ 4.27	$ -	$ 4.32	$ -	$ 4.36	$ -
Pharmacy Benefit Manager Expenses	$ 2.13	$ -	$ 2.18	$ -	$ 2.22	$ -	$ 2.25	$ -	$ 2.28	$ -
Fraud Reduction Expenses	$ 0.59	$ 14,514	$ 0.60	$ 18,370	$ 0.61	$ 21,442	$ 0.61	$ 23,925	$ 0.62	$ 25,959
Third Party Activities	$ 0.39	$ -	$ 0.39	$ -	$ 0.40	$ -	$ 0.41	$ -	$ 0.41	$ -
Sub Capitation Block Administrative	$ 2.90	$ -	$ 2.94	$ -	$ 2.97	$ -	$ 3.01	$ -	$ 3.04	$ -
Health Care Quality Improvement	$ 0.38	$ -	$ 0.39	$ -	$ 0.39	$ -	$ 0.39	$ -	$ 0.40	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.79	$ -	$ 0.80	$ -	$ 0.81	$ -	$ 0.82	$ -	$ 0.83	$ -
Interpretation/Translation Services	$ 0.42	$ -	$ 0.43	$ -	$ 0.43	$ -	$ 0.44	$ -	$ 0.44	$ -
Other Administrative Expenses [2]	$ 3.46	$ -	$ 3.50	$ -	$ 3.54	$ -	$ 3.58	$ -	$ 3.62	$ -
Total Admin Costs	$ 127.23	$ 2,332,130	$ 128.88	$ 2,951,269	$ 130.42	$ 3,444,659	$ 131.91	$ 3,843,346	$ 133.38	$ 4,169,858
Member Months Assumed in Bid		33,543		43,522		51,519		57,974		63,227

Input fields	
Formula driven fields	

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.

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Input fields
Formula driven fields

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	$ 60.07	$ 1,807,487	$ 61.82	$ 2,245,910	$ 63.12	$ 2,595,612	$ 64.20	$ 2,878,415	$ 65.16	$ 3,110,192
Occupancy	$ -	$ 47,468	$ -	$ 59,120	$ -	$ 68,413	$ -	$ 75,927	$ -	$ 82,084
Depreciation	$ -	$ 52,187	$ -	$ 64,110	$ -	$ 73,626	$ -	$ 81,326	$ -	$ 87,640
Care Management/Care Coordination	$ 1.68	$ 53,448	$ 1.52	$ 59,377	$ 1.44	$ 64,166	$ 1.39	$ 68,081	$ 1.37	$ 71,320
Professional and Outside Services	$ 29.49	$ -	$ 30.02	$ -	$ 30.46	$ -	$ 30.87	$ -	$ 31.26	$ -
Office Supplies and Equipment	$ 0.51	$ -	$ 0.52	$ -	$ 0.53	$ -	$ 0.54	$ -	$ 0.55	$ -
Travel	$ 0.76	$ -	$ 0.80	$ -	$ 0.82	$ -	$ 0.84	$ -	$ 0.85	$ -
Repair and Maintenance	$ 3.67	$ 699,457	$ 3.73	$ 859,235	$ 3.78	$ 986,761	$ 3.83	$ 1,089,945	$ 3.87	$ 1,174,554
Bank Service Charge	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -
Insurance	$ 1.08	$ -	$ 1.10	$ -	$ 1.11	$ -	$ 1.12	$ -	$ 1.14	$ -
Marketing	$ 2.35	$ -	$ 2.38	$ -	$ 2.41	$ -	$ 2.44	$ -	$ 2.47	$ -
Interest Expense	$ 3.90	$ -	$ 3.97	$ -	$ 4.02	$ -	$ 4.07	$ -	$ 4.12	$ -
Pharmacy Benefit Manager Expenses	$ 1.90	$ -	$ 1.96	$ -	$ 2.01	$ -	$ 2.05	$ -	$ 2.08	$ -
Fraud Reduction Expenses	$ 0.90	$ 28,768	$ 0.88	$ 33,878	$ 0.86	$ 37,970	$ 0.86	$ 41,289	$ 0.86	$ 44,018
Third Party Activities	$ 0.31	$ -	$ 0.32	$ -	$ 0.33	$ -	$ 0.34	$ -	$ 0.35	$ -
Sub Capitation Block Administrative	$ 2.72	$ -	$ 2.76	$ -	$ 2.80	$ -	$ 2.84	$ -	$ 2.87	$ -
Health Care Quality Improvement	$ 2.77	$ -	$ 2.52	$ -	$ 2.39	$ -	$ 2.32	$ -	$ 2.28	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.74	$ -	$ 0.75	$ -	$ 0.76	$ -	$ 0.77	$ -	$ 0.78	$ -
Interpretation/Translation Services	$ 0.38	$ -	$ 0.39	$ -	$ 0.40	$ -	$ 0.40	$ -	$ 0.41	$ -
Other Administrative Expenses [2]	$ 2.97	$ -	$ 3.05	$ -	$ 3.11	$ -	$ 3.16	$ -	$ 3.20	$ -
Total Admin Costs	$ 116.21	$ 2,688,814	$ 118.49	$ 3,321,629	$ 120.36	$ 3,826,547	$ 122.04	$ 4,234,982	$ 123.62	$ 4,569,808
Member Months Assumed in Bid		44,031		55,079		63,928		71,064		76,866

Footnotes:

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

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ALTCS-EPD Administrative Component Bid										
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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	$ 70.58	$ 3,758,059	$ 71.88	$ 4,459,588	$ 73.06	$ 4,950,958	$ 74.21	$ 5,276,923	$ 75.36	$ 5,469,991
Occupancy	$ -	$ 100,827	$ -	$ 119,634	$ -	$ 132,803	$ -	$ 141,535	$ -	$ 146,702
Depreciation	$ -	$ 97,852	$ -	$ 116,125	$ -	$ 128,926	$ -	$ 137,421	$ -	$ 142,457
Care Management/Care Coordination	$ 0.14	$ 8,037	$ 0.15	$ 9,702	$ 0.15	$ 10,917	$ 0.16	$ 11,783	$ 0.16	$ 12,371
Professional and Outside Services	$ 31.74	$ -	$ 32.33	$ -	$ 32.86	$ -	$ 33.38	$ -	$ 33.89	$ -
Office Supplies and Equipment	$ 0.56	$ -	$ 0.57	$ -	$ 0.58	$ -	$ 0.59	$ -	$ 0.60	$ -
Travel	$ 0.99	$ -	$ 1.01	$ -	$ 1.02	$ -	$ 1.04	$ -	$ 1.05	$ -
Repair and Maintenance	$ 3.89	$ 1,313,040	$ 3.96	$ 1,558,102	$ 4.03	$ 1,729,745	$ 4.09	$ 1,843,605	$ 4.16	$ 1,911,041
Bank Service Charge	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -
Insurance	$ 1.14	$ -	$ 1.16	$ -	$ 1.18	$ -	$ 1.20	$ -	$ 1.22	$ -
Marketing	$ 2.42	$ -	$ 2.47	$ -	$ 2.51	$ -	$ 2.55	$ -	$ 2.59	$ -
Interest Expense	$ 4.20	$ -	$ 4.28	$ -	$ 4.35	$ -	$ 4.41	$ -	$ 4.48	$ -
Pharmacy Benefit Manager Expenses	$ 1.83	$ -	$ 1.91	$ -	$ 1.97	$ -	$ 2.03	$ -	$ 2.09	$ -
Fraud Reduction Expenses	$ 0.58	$ 32,558	$ 0.59	$ 38,668	$ 0.60	$ 42,958	$ 0.61	$ 45,816	$ 0.62	$ 47,525
Third Party Activities	$ 0.30	$ -	$ 0.32	$ -	$ 0.33	$ -	$ 0.34	$ -	$ 0.35	$ -
Sub Capitation Block Administrative	$ 2.91	$ -	$ 2.96	$ -	$ 3.00	$ -	$ 3.05	$ -	$ 3.10	$ -
Health Care Quality Improvement	$ 0.32	$ -	$ 0.33	$ -	$ 0.34	$ -	$ 0.35	$ -	$ 0.36	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.79	$ -	$ 0.80	$ -	$ 0.82	$ -	$ 0.83	$ -	$ 0.84	$ -
Interpretation/Translation Services	$ 0.42	$ -	$ 0.43	$ -	$ 0.44	$ -	$ 0.44	$ -	$ 0.45	$ -
Other Administrative Expenses [2]	$ 3.62	$ -	$ 3.67	$ -	$ 3.72	$ -	$ 3.77	$ -	$ 3.82	$ -
Total Admin Costs	$ 126.46	$ 5,310,374	$ 128.82	$ 6,301,819	$ 130.97	$ 6,996,307	$ 133.05	$ 7,457,082	$ 135.14	$ 7,730,086

Member Months Assumed in Bid		80,170		96,192		107,225		114,272		118,114

Legend
Input fields
Formula driven fields

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As of 05/30/2023

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ALTCS-EPD Administrative Component Bid										
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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	$ 72.73	$ 5,564,763	$ 73.35	$ 5,858,336	$ 74.11	$ 6,039,455	$ 74.97	$ 6,129,264	$ 75.92	$ 6,143,140
Occupancy	$ -	$ 149,225	$ -	$ 157,101	$ -	$ 161,958	$ -	$ 164,363	$ -	$ 164,729
Depreciation	$ -	$ 144,966	$ -	$ 152,603	$ -	$ 157,315	$ -	$ 159,653	$ -	$ 160,016
Care Management/Care Coordination	$ 0.16	$ 13,156	$ 0.16	$ 13,705	$ 0.16	$ 14,070	$ 0.17	$ 14,284	$ 0.17	$ 14,374
Professional and Outside Services	$ 32.72	$ -	$ 32.99	$ -	$ 33.33	$ -	$ 33.72	$ -	$ 34.15	$ -
Office Supplies and Equipment	$ 0.58	$ -	$ 0.58	$ -	$ 0.59	$ -	$ 0.59	$ -	$ 0.60	$ -
Travel	$ 1.02	$ -	$ 1.02	$ -	$ 1.04	$ -	$ 1.05	$ -	$ 1.06	$ -
Repair and Maintenance	$ 4.01	$ 1,944,334	$ 4.05	$ 2,046,852	$ 4.09	$ 2,110,090	$ 4.14	$ 2,141,435	$ 4.19	$ 2,146,259
Bank Service Charge	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -
Insurance	$ 1.18	$ -	$ 1.19	$ -	$ 1.20	$ -	$ 1.21	$ -	$ 1.23	$ -
Marketing	$ 2.50	$ -	$ 2.52	$ -	$ 2.55	$ -	$ 2.58	$ -	$ 2.61	$ -
Interest Expense	$ 4.31	$ -	$ 4.35	$ -	$ 4.40	$ -	$ 4.45	$ -	$ 4.51	$ -
Pharmacy Benefit Manager Expenses	$ 2.01	$ -	$ 2.03	$ -	$ 2.06	$ -	$ 2.09	$ -	$ 2.13	$ -
Fraud Reduction Expenses	$ 0.60	$ 48,490	$ 0.61	$ 51,012	$ 0.61	$ 52,572	$ 0.62	$ 53,352	$ 0.63	$ 53,483
Third Party Activities	$ 0.35	$ -	$ 0.35	$ -	$ 0.35	$ -	$ 0.35	$ -	$ 0.36	$ -
Sub Capitation Block Administrative	$ 2.99	$ -	$ 3.01	$ -	$ 3.04	$ -	$ 3.08	$ -	$ 3.12	$ -
Health Care Quality Improvement	$ 0.35	$ -	$ 0.35	$ -	$ 0.36	$ -	$ 0.36	$ -	$ 0.36	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.81	$ -	$ 0.82	$ -	$ 0.83	$ -	$ 0.84	$ -	$ 0.85	$ -
Interpretation/Translation Services	$ 0.43	$ -	$ 0.44	$ -	$ 0.44	$ -	$ 0.45	$ -	$ 0.45	$ -
Other Administrative Expenses [2]	$ 3.66	$ -	$ 3.70	$ -	$ 3.74	$ -	$ 3.79	$ -	$ 3.83	$ -
Total Admin Costs	$ 130.42	$ 7,864,934	$ 131.53	$ 8,279,609	$ 132.90	$ 8,535,459	$ 134.46	$ 8,662,350	$ 136.17	$ 8,682,001
Member Months Assumed in Bid		121,308		128,280		132,253		133,794		133,341

Legend
Input fields
Formula driven fields

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

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Input fields
Formula driven fields

ALTCS-EPD Administrative Component Bid

Detail Admin Break Out [1]	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)	
	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	$ 70.80	$ 6,405,456	$ 71.14	$ 6,546,706	$ 71.64	$ 6,611,272	$ 72.26	$ 6,612,865	$ 72.96	$ 6,561,018
Occupancy	$ -	$ 170,793	$ -	$ 174,495	$ -	$ 176,153	$ -	$ 176,133	$ -	$ 174,687
Depreciation	$ -	$ 171,887	$ -	$ 176,039	$ -	$ 178,106	$ -	$ 178,465	$ -	$ 177,382
Care Management/Care Coordination	$ 0.66	$ 63,441	$ 0.71	$ 68,236	$ 0.75	$ 72,056	$ 0.79	$ 75,119	$ 0.84	$ 77,588
Professional and Outside Services	$ 32.66	$ -	$ 32.88	$ -	$ 33.17	$ -	$ 33.52	$ -	$ 33.90	$ -
Office Supplies and Equipment	$ 0.57	$ -	$ 0.58	$ -	$ 0.58	$ -	$ 0.59	$ -	$ 0.59	$ -
Travel	$ 0.96	$ -	$ 0.97	$ -	$ 0.97	$ -	$ 0.98	$ -	$ 0.99	$ -
Repair and Maintenance	$ 4.02	$ 2,305,089	$ 4.05	$ 2,360,887	$ 4.09	$ 2,388,668	$ 4.13	$ 2,393,504	$ 4.18	$ 2,378,941
Bank Service Charge	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -
Insurance	$ 1.18	$ -	$ 1.19	$ -	$ 1.20	$ -	$ 1.21	$ -	$ 1.23	$ -
Marketing	$ 2.53	$ -	$ 2.55	$ -	$ 2.57	$ -	$ 2.60	$ -	$ 2.63	$ -
Interest Expense	$ 4.31	$ -	$ 4.35	$ -	$ 4.39	$ -	$ 4.44	$ -	$ 4.49	$ -
Pharmacy Benefit Manager Expenses	$ 2.02	$ -	$ 2.03	$ -	$ 2.05	$ -	$ 2.08	$ -	$ 2.11	$ -
Fraud Reduction Expenses	$ 0.72	$ 68,610	$ 0.73	$ 71,028	$ 0.75	$ 72,563	$ 0.76	$ 73,386	$ 0.78	$ 73,618
Third Party Activities	$ 0.34	$ -	$ 0.34	$ -	$ 0.34	$ -	$ 0.34	$ -	$ 0.34	$ -
Sub Capitation Block Administrative	$ 2.99	$ -	$ 3.01	$ -	$ 3.04	$ -	$ 3.07	$ -	$ 3.11	$ -
Health Care Quality Improvement	$ 1.15	$ -	$ 1.22	$ -	$ 1.29	$ -	$ 1.36	$ -	$ 1.43	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.81	$ -	$ 0.82	$ -	$ 0.83	$ -	$ 0.84	$ -	$ 0.85	$ -
Interpretation/Translation Services	$ 0.43	$ -	$ 0.43	$ -	$ 0.44	$ -	$ 0.44	$ -	$ 0.45	$ -
Other Administrative Expenses [2]	$ 3.56	$ -	$ 3.59	$ -	$ 3.62	$ -	$ 3.65	$ -	$ 3.68	$ -
Total Admin Costs	$ 129.73	$ 9,185,276	$ 130.59	$ 9,397,391	$ 131.72	$ 9,498,818	$ 133.07	$ 9,509,473	$ 134.57	$ 9,443,234

Member Months Assumed in Bid		149,901		153,959		155,677		155,476		153,681

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.

AHCCCS

AHCCCS ALTCS-EPD RFP YH24-0001
Section F - Rate Development Information
Document - Non-Benefit Cost Bid Submission

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	$ 67.05	$ 6,826,218	$ 67.65	$ 6,684,853	$ 68.29	$ 6,598,248	$ 68.98	$ 6,555,137	$ 69.70	$ 6,546,619
Occupancy	$ -	$ 180,422	$ -	$ 176,601	$ -	$ 174,248	$ -	$ 173,061	$ -	$ 172,802
Depreciation	$ -	$ 191,547	$ -	$ 188,002	$ -	$ 185,885	$ -	$ 184,902	$ -	$ 184,820
Care Management/Care Coordination	$ 1.37	$ 147,778	$ 1.43	$ 148,790	$ 1.48	$ 149,936	$ 1.52	$ 151,192	$ 1.55	$ 152,535
Professional and Outside Services	$ 32.13	$ -	$ 32.49	$ -	$ 32.86	$ -	$ 33.23	$ -	$ 33.61	$ -
Office Supplies and Equipment	$ 0.56	$ -	$ 0.57	$ -	$ 0.57	$ -	$ 0.58	$ -	$ 0.59	$ -
Travel	$ 0.88	$ -	$ 0.88	$ -	$ 0.89	$ -	$ 0.90	$ -	$ 0.91	$ -
Repair and Maintenance	$ 3.98	$ 2,568,746	$ 4.03	$ 2,521,197	$ 4.08	$ 2,492,790	$ 4.12	$ 2,479,588	$ 4.17	$ 2,478,480
Bank Service Charge	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -	$ 0.01	$ -
Insurance	$ 1.17	$ -	$ 1.18	$ -	$ 1.20	$ -	$ 1.21	$ -	$ 1.22	$ -
Marketing	$ 2.53	$ -	$ 2.56	$ -	$ 2.59	$ -	$ 2.62	$ -	$ 2.66	$ -
Interest Expense	$ 4.27	$ -	$ 4.32	$ -	$ 4.37	$ -	$ 4.42	$ -	$ 4.47	$ -
Pharmacy Benefit Manager Expenses	$ 1.96	$ -	$ 1.99	$ -	$ 2.02	$ -	$ 2.05	$ -	$ 2.08	$ -
Fraud Reduction Expenses	$ 0.88	$ 94,385	$ 0.90	$ 93,507	$ 0.91	$ 93,107	$ 0.93	$ 93,088	$ 0.95	$ 93,372
Third Party Activities	$ 0.31	$ -	$ 0.31	$ -	$ 0.32	$ -	$ 0.32	$ -	$ 0.32	$ -
Sub Capitation Block Administrative	$ 2.96	$ -	$ 2.99	$ -	$ 3.03	$ -	$ 3.06	$ -	$ 3.10	$ -
Health Care Quality Improvement	$ 2.29	$ -	$ 2.38	$ -	$ 2.46	$ -	$ 2.53	$ -	$ 2.58	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.80	$ -	$ 0.81	$ -	$ 0.82	$ -	$ 0.83	$ -	$ 0.84	$ -
Interpretation/Translation Services	$ 0.42	$ -	$ 0.42	$ -	$ 0.43	$ -	$ 0.43	$ -	$ 0.44	$ -
Other Administrative Expenses [2]	$ 3.39	$ -	$ 3.42	$ -	$ 3.46	$ -	$ 3.49	$ -	$ 3.53	$ -
Total Admin Costs	$ 126.97	$ 10,009,096	$ 128.35	$ 9,812,950	$ 129.78	$ 9,694,215	$ 131.24	$ 9,636,968	$ 132.73	$ 9,628,628
Member Months Assumed in Bid		175,745		171,382		168,483		166,735		165,892

Input fields
Formula driven fields

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.

AHCCCS ALTCS-EPD RFP YH24-0001
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Input fields
Formula driven fields
AHCCCS Prescribed Values

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)	$ 78,080	$ 78,080	$ 78,080	$ 81,648	$ 81,648	$ 81,648	$ 78,012	$ 78,012	$ 78,012
Average Case Management Supervisor total compensation (includes ERE)	$ 116,765	$ 116,765	$ 116,765	$ 116,163	$ 116,163	$ 116,163	$ 117,151	$ 117,151	$ 117,151
Average Case Management Administration Support Staff total compensation (includes ERE)	$ 100,121	$ 100,121	$ 100,121	$ 100,616	$ 100,616	$ 100,616	$ 99,798	$ 99,798	$ 99,798
Maximum Members per Case Manager (Institutional) [2]	96.0	68.0	93.4	96.0	68.0	91.1	96.0	68.0	91.5
Maximum Members per Case Manager (Acute Care Only) [2]	96.0	96.0	96.0	96.0	96.0	96.0	96.0	96.0	96.0
Maximum Members per Case Manager (Alternative HCBS) [2]	53.0	50.0	52.7	53.0	50.0	52.7	53.0	50.0	52.6
Maximum Members per Case Manager (HCBS Own Home) [2]	43.0	32.0	42.1	43.0	32.0	42.4	43.0	32.0	42.3
Average Travel Expenses per Case Management Manager	$ 4,845.50	$ 3,864.33	$ 4,774.49	$ 2,809.78	$ 2,585.51	$ 2,792.01	$ 2,513.87	$ 2,260.81	$ 2,493.03
Average Case Managers per Supervisor	11.25	11.25	11.25	11.25	11.25	11.25	11.25	11.25	11.25
Average Administrative Support Staff per Supervisor	2	2	2	2	2	2	2	2	2
Calculations:									
Case Management Manager FTEs required	39.9	3.9	43.8	102.5	9.6	112.1	53.7	5.4	59.1
Case Management Manager salary and ERE	$3,112,097	$304,486	$3,416,583	$8,366,976	$782,861	$9,149,836	$4,191,409	$418,237	$4,609,646
Case Management Supervisor FTEs required	3.5	0.3	3.9	9.1	0.9	10.0	4.8	0.5	5.3
Case Management Supervisor salary and ERE	$413,685	$40,475	$454,160	$1,058,131	$99,005	$1,157,136	$559,487	$55,828	$615,315
Case Management Administration Support Staff FTEs	7.1	0.7	7.8	18.2	1.7	19.9	9.6	1.0	10.5
Case Management Administration Support Staff salary and ERE	$709,439	$69,411	$778,851	$1,833,021	$171,508	$2,004,529	$953,226	$95,117	$1,048,343
Travel Costs	$193,130	$15,069	$208,918	$287,937	$24,791	$312,885	$135,064	$12,121	$147,310
Total Annual Case Management Cost	$4,428,352	$429,441	$4,858,511	$11,546,065	$1,078,163	$12,624,386	$5,839,186	$581,302	$6,420,614
Total Case Management PMPM			**$171.21**			**$180.21**			**$171.89**

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.

CYE2025 ALTCS E/PD

Administrative and Case Management Actuarial Certification

September 29, 2023

Making health care easier, so life can be better.

Section 1
Introduction

Banner-University Care Advantage dba Banner-University Family Care (hereafter referred to as BUFC) has developed actuarially sound administrative and case management components for the 12-month period from October 1, 2024 through September 30, 2025 (CYE2025).

Per 42 CFR §438.7(b)(3), the Centers for Medicare & Medicaid Services (CMS) requires that a rate certification and supporting documentation describing the development of non-benefit costs be submitted and must meet several criteria for approval, including the following:

- Have been developed in accordance with generally accepted actuarial principles and practices.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and Actuarial Standards Board.

The following report provides an overview of the analyses and methodologies used to develop the CYE2025 administrative and case management components for purposes of Arizona Long Term Care System Elderly/Physical Disability (ALTCS E/PD) RFP YH24-0001. The report follows the currently available outline of the CMS July 2023 through June 2024 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning on or after July 1, 2023. The final administrative and case management bid components are included in a separate attachment.

This document is the result of requirements for the AHCCCS ALTCS RFP as outlined in Section F of the provided data supplement. It should be read in its entirety and has been prepared under the direction of Zach Aters, ASA, MAAA who is a member of the American Academy of Actuaries and meets its US Qualification Standard for issuing statements of actuarial opinion herein.

To the best of BUFC's knowledge, there are no conflicts of interest in performing this work. BUFC expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Section 2
Data

The most recent three years of experience available at the time of non-benefit cost development were CYE2021, CYE2022, and CYE2023 (partial year). In reviewing the data, BUFC determined that the CYE2022 data was appropriate to use as the basis for the CYE2025 administrative cost component and CYE2023 annualized for the case management component.

The data utilized was BUFC administrative and case management costs. BUFC assessed the quality and completeness of the data per Actuarial Standards of Practice 23 (Data Quality) to deem the data sufficient to support non-benefit cost development. Validation efforts included reviews of the data for changes year-over-year, errors in reporting including missing or duplicated data, and overall reasonableness and consistency of the data to ensure it was reasonable to develop the non-benefit costs.

Along with describing the underlying experience, adjustments applied to this data are described in this section.

Base Data Source: As stated above, the CYE2022 and CYE2023 time periods serves as the basis for CYE2025 non-benefit cost development. BUFC validated and reviewed the data to ensure it was appropriate for the populations and services covered in the ALTCS program. This review included comparisons of the data to the previous years' experience. After reviewing the data, BUFC identified adjustments within the administrative cost data and the impact across the ALTCS program are as follows:

- Inclusion of costs allocated for sub capitation block administration of approximately $460,000.
- Inclusion of Program Integrity Fraud, Waste and Abuse Prevention Expenses of approximately $125,000.
- Certain costs had been allocated to the Other Administrative component of the overall administration costs. For CYE2022, BUFC had reported a negative amount due to re-allocation to other categories. As it is not expected to continue at a negative rate, BUFC made an adjustment to reflect this category at approximately $500,000 based on historical experience.

Section 3

Administrative Cost Development

After the base data was reviewed and adjusted as described in Section 2, BUFC applied several assumptions in the development of the projected CYE2025 administrative cost component for the ALTCS bid. These assumptions are described in detail in this section.

Fixed and Variable Cost Assumptions

Fixed and variable costs were identified using historical (CYE2022) experience at the General Ledger (GL) Account level and were aggregated into the AHCCCS Account categories seen in the administrative cost template (provided in the Data Supplement, Section F). These fixed and variable costs were projected separately by Geographic Service Area (GSA) and population group. Splitting fixed and variable costs prior to projection allowed BUFC to better reflect the economies of scale that could be realized in the administrative cost bid. Adjustments were applied to the aggregate administrative expense to reflect these economies of scale achieved for fixed costs stemming from enrollment growth.

Once projected, the individual categories outlined in the administrative cost template were reviewed to ensure that an appropriate assumption of fixed and variable costs had been applied. The overall fixed administrative cost percentage is projected to be approximately 30%.

Projected Admin Trend

As part of the CYE2025 administrative cost development, BUFC reviewed historical administrative data to apply trend to major admin categories. These assumptions do not vary by GSA or population. The final trend factors were applied from the mid-point of the base period (April 1, 2022) to the mid-point of the CYE2025 period (April 1, 2025). This reflects 36 months of movement for trend application. The aggregate adjustment for trend is represented as an annualized value and is summarized in the table below:

Category	Assumption
Compensation	2%
Case Management/Coordination	2%
Fraud Reduction/HCQI	2%
Depreciation/Bank Service/Subcap Block/FWA	0%
Interest Expense	-37%
All Other Categories	1%
Total	**-0.8%**

Note, the total annualized trend applied is negative due to the large interest expense incurred in CYE2022. Throughout 2022 and into 2023, BUFC has increased the number of claims processed through auto adjudication. This has substantially decreased the volume of aged, pended claims and reduced the interest expense in emerging 2023 experience. This is expected to continue as BUFC continues to increase utilization of the auto-adjudication process.

Re-allocation Assumptions

As noted in Section 2, BUFC's administrative claims data reflects a mid-year change to Banner Health's overall administrative cost allocation methodology. Banner Health strives to continuously improve processes and as such, periodically reviews and updates the methodology used to allocate administrative costs across multiple lines of business. As part of the due diligence in response to this ALTCS E/PD RFP, BUFC (and Banner Health) reviewed the allocation methodology, staffing models, and enrollment growth modeling to determine a current best estimate of administrative allocation to the ALTCS E/PD line of business.

BUFC reviewed each category provided in the administrative bid template in detail utilizing more recent data and trends to determine an appropriate adjustment by category. The resulting aggregate impact to the ALTCS program is expected to be a reduction of approximately 30%.

Community/Institutional Mix

After all other adjustments described above were applied, BUFC developed an assumption for the projected CYE2025 community/institutional mix. The purpose of this assumption is that overall administrative costs are impacted by the number of members residing in the community or institutional setting. Since more case management is needed when members reside in the community, administrative costs may increase for these members, whereas the costs may

decrease due to limited case management needed in an institutional setting. The overall CYE2025 mix assumptions vary by GSA and dual status and are displayed in the table below:

GSA/Population	Assumption
Central Dual	76%
Central Non-Dual	63%
South Dual	73%
South Non-Dual	69%
North Dual	69%
North Non-Dual	69%

Final Projected Administrative Cost

After all adjustments described above have been applied, BUFC calculated the final projected administrative cost for each of the six membership tiers as outlined in the Section F of the ALTCS-EPD RFP YH24-0001 document.

BUFC developed various membership scenarios based on potential GSA awards to provide AHCCCS with the administrative bid amount by tier as requested. The scenarios selected for completing the template were those that BUFC felt were most likely to occur. The table below assumes the following CYE2025 membership scenarios for each of the six tiers in the bid template:

MM Scenario Tier	GSAs Awarded	Assumed MMs	Community Mix %	Dual Mix %
0-34,999 MMs	Central	33,543	73.1%	80.9%
35,000-69,999	Central, North	44,031	72.1%	81.9%
70,000-104,999	Central, South[1]	80,170	72.8%	82.4%
105,000-139,999	Central, South[2]	121,308	72.8%	81.7%
140,000-174,999	Central, South, North[3]	149,901	72.6%	81.7%
175,000+	Central, South, North[4]	175,745	72.2%	82.2%

[1] Central: All incumbents retain contracts, South: All incumbents retain contracts.
[2] Central: Banner and one new entrant, South: All incumbents retain contracts.
[3] Central: Banner and two new entrants, South: All incumbents retain contracts, North: All incumbents retain contracts.
[4] Central: Banner and two new entrants, South: One new entrant, North: Banner only.
The bid amounts for each tier are included in a separate attachment.

Section 4
Case Management Cost Development

The case management cost assumption was developed utilizing the data supplement provided by AHCCCS. BUFC relied upon the AHCCCS prescribed values and calculations as outlined in Section F of ALTCS-E/PD RFP YH24-0001. BUFC did not audit or alter the assumptions or calculations provided in the template. In our opinion, it is appropriate for the intended case management development. However, if the data and information are incomplete/inaccurate, the values shown in the case management bid template may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to the report.

For the values that BUFC input to the template (compensation, members per case manager, travel expenses, case managers/support staff per supervisor), details are provided in the remainder of this section.

Assumptions

Average Compensation

BUFC reviewed more recent salary data by GSA (from CYE2023) for case managers, supervisory roles, and support staff as a basis to estimate the average compensation requested in the case management bid template. North GSA average compensation rates were estimated by analyzing BUFC's statewide compensation in CYE2023. A trend rate of 2.5% was applied to project the costs to CYE2025.

Average Travel Cost

BUFC reviewed more recent travel costs by GSA from CYE2023 through August 2023 for traveling case managers. These incurred costs were annualized and allocated to the GSAs in which the case managers work. North GSA travel costs were estimated by analyzing the CYE2023 costs for case managers who primarily work in the South GSA outside of Pima. A trend rate of 2.5% was applied to project the costs to CYE2025.

Maximum Case Managers

The assumptions for the maximum case managers by setting is based on the prescribed values in the AHCCCS Medical Policy Manual 1630 Section D. BUFC did not vary from these prescribed values for purposes of the bid development.

Case Managers and Administrative Support Staff per Supervisor

The assumption for the case managers per supervisor meets the standard set forth in the current approved case management plan submitted to AHCCCS annually.

BUFC estimated the administrative support staff per supervisor based on the observed CYE2022 and CYE2023 averages. The assumption is sufficient to support the supervisors and ALTCS population and is not expected to vary significantly in the CYE2025 projected period.

Section 5
Other Considerations

Financial Viability

BUFC has no concern meeting the financial viability standards as defined in ACOM Policy 505 and as outlined in Section D.48 of RFP No. YH24-0001. This includes:

- Maintaining a Current Ratio of at least 1.00
- Equity per member value of at least $3,000 (for CYE2025), $3,500 for CYE2026, and $4,000 for CYE2027 and thereafter
- An administrative cost percentage no greater than 8%
- Equity per member of at least $350 for the AHCCCS-certified Dual Special Needs Plan, Banner Medicare Advantage Dual

Section 6
Certification of Final Costs

This certification assumes items in the bid documentation will not be altered and are final. In preparing the administrative and case management rates, BUFC used and relied upon our own enrollment, eligibility, and non-benefit cost information from our data systems. We have reviewed it for validity, completeness, and consistency and reasonableness for the intended bid documentation purposes.

Because modeling all aspects of a scenario is not possible or practical, BUFC may use summary information, estimates, or simplifications of calculations to facilitate modeling of future events in an efficient and cost-effective manner. BUFC may also exclude factors or data that are immaterial in our judgement. Use of such simplifying techniques does not, in our judgement, affect the reasonableness, appropriateness, or attainability of the results for the ALTCS program. Actuarial assumptions may also be changed in subsequent certifications because of changes in mandated requirements, program experience, changes in expectations about the future, and other factors. A change in assumptions is not an indication that the assumptions outlined in the report were unreasonable, inappropriate, or unattainable when they were made.

BUFC certifies that the administrative and case management rates shown in the bid templates were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the ALTCS covered populations and services under the AHCCCS contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of the administrative and case management rates. To the best of BUFC's knowledge, there are no conflicts of interest in performing this work.

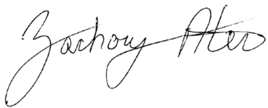
These costs developed by BUFC are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any party or for any other purpose than for which it was issued

by BUFC. BUFC is not responsible for the consequences of any unauthorized use. Actual costs will differ from these projections. BUFC has developed these cost estimates to demonstrate compliance with the CMS requirements under 42 CFR §438.7(b)(3) and accordance with applicable law and regulations. Use of these estimates for any purpose beyond stated may not be appropriate. BUFC disclaims any responsibility for use of these estimates by any other contractor for any purpose.

This report assumes the reader is familiar with the AHCCCS ALTCS program, Medicaid eligibility rules, and actuarial rating techniques. It has been prepared exclusively for AHCCCS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professional competent in the areas of actuarial projections to understand the technical nature of these estimates. BUFC is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

This report is deemed final and acceptable. If there are any questions regarding this report, please contact Zach Aters at Zachary.Aters@bannerhealth.com.

Sincerely,



Zach Aters, ASA, MAAA
Chief Actuary, Banner Health

CC: Mike Brady, Senior Director, Banner Health
Blake Marx, Associate Director, ASA, MAAA, Banner Health
Omni Williams, Director, ASA, MAAA, Banner Health

Banner
University Family Care

Part D

Request for Proposal ALTCS E/PD
RFP No. YH24-0001

(D.1): Intent to Provide Insurance

If notified of contract award, Banner-University Care Advantage dba Banner-University Family Care will submit to AHCCCS for review and acceptance, the applicable certificate/s of insurance as required by RFP YH24-0001, within ten (10) business days of such notification.

SECTION G - DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION

Pursuant to 42 CFR 455.104, the Offeror shall complete and submit ~~Representations and Certifications~~Disclosure of Ownership and Control ~~and~~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* ~~*Representations and Certifications of Offeror and*~~ *including RFP Exhibit I: Disclosure of Information* by ~~Thursday, August 31, 2023 3:00 PM Arizona Time.~~ September 15, 2023. The Offeror shall:

1. ~~The Offeror shall n~~Notify AHCCCS of its intent to submit *Disclosure of Ownership and Control* ~~*Representations and Certifications of Offeror*~~ ***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 ~~Representations and Certifications of Offeror~~ 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 ~~AHCCCS Provider Enrollment Portal (APEP)~~APEP.

3. Once APEP access is obtained, the Offeror shall ~~upload~~ 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 ~~also~~ 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, ~~Once all information has been submitted, the Offeror shall send confirmation of completion of submittal (due no later than August 31, 2023 3:00 PM Arizona Time)~~ 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 ~~Representations and Certifications of Offeror~~ 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 ~~REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR~~ 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	
Banner-University Care Advantage dba Banner-University Family Care	September 29, 2023
OFFEROR NAME	**DATE**
JAMES R. STRINGHAM, VP AND CEO	[signature]
PRINTED NAME AND TITLE OF INDIVIDUAL AUTHORIZED TO SIGN	**SIGNATURE OF INDIVIDUAL AUTHORIZED TO SIGN**
TUCSON AZ 85711	**James.Stringham2@bannerhealth.com 602-568-4179**
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 ~~*Representations and Certifications of Offeror*~~ *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 ~~Representations and Certifications of Offeror~~ 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

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.

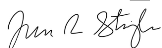
In compliance with A.R.S. § 35-393 et seq., all offerors must select one of the following:

☐ 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		James R. Stringham, VP and CEO Printed Name and Title	
Tucson	AZ	James.stringham2@bannerhealth.com	(602) 568-4179
City	State	Email Address	Phone Number

(D.4): Moral or Religious Objections

Banner-University Family Care Plan does not have any moral or religious objections that would affect its provision of, or reimbursement for, a covered service.

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 Banner-University Care Advantage dba Banner-University Family Care (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.

Banner-University Care Advantage dba Banner-University Family Care	[signature]
Offeror Name	Signature of Person Authorized to Sign
5255 E Williams Circle, Ste 2050	James R. Stringham
Address	Printed Name
Tucson Arizona 85711	VP and CEO
City State Zip	Title