

SECTION I: EXHIBITS

EXHIBIT A: OFFEROR'S CHECKLIST

CCE NO. YH20-0002

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

OFFEROR'S CHECKLIST		
	SUBMISSION REQUIREMENT	OFFEROR'S PROPOSAL PAGE NUMBER(S)
PART A		
A1	Offeror's Checklist	1
A2	Offeror's Completed, Signed Solicitation, and Offer Page	2-3
A3	Offeror Submission Form	4
A4	Offeror's Signed Signature Page(s) for each Solicitation Amendment, if applicable	5-9
PART B		
PROGRAMMATIC - NARRATIVE SUBMISSION		
B1	2-page limit	10-12
B2	2-page limit	13-15
B3	3-page limit	16-19
B4	4-page limit	20-24
B5.a (North GSA)	2-page limit	NA
B5.b. (South GSA)	2-page limit	25-27
B5.c. (Central GSA)	2-page limit	NA
B6	1-page limit for each of a through g	28-41
B7	5-page limit	42-47
B8	3-page limit	48-51
B9	3-page limit	52-55
B10	2-page limit	56-58
B11	2-page limit	59-61
B12	2-page limit	62-64
PART C		
CAPITATION AGREEMENT/ADMINISTRATIVE COST BID SUBMISSION		
C1	Agreement accepting capitation rates	65
C2	Administrative Cost Bid Submission Workbook	66
C3	Actuarial Certification (The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid)	67-68

	NOTICE OF COMPETITIVE CONTRACT EXPANSION
	SOLICITATION # YH20-0002
	EXPANSION OF AHCCCS COMPLETE CARE CONTRACT YH19-0001

SECTION A: SOLICITATION AND OFFER PAGE

Chief Procurement Officer

Meggan LaPorte, CPPO, MSW
 Chief Procurement Officer
 701 E. Jefferson, MD5700
 Phoenix, AZ 85034

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

LOCATION: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (AHCCCS)

DESCRIPTION: EXPANSION OF AHCCCS COMPLETE CARE CONTRACT YH19-0001

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

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

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

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

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

Late Proposals shall not be considered.

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

	NOTICE OF COMPETITIVE CONTRACT EXPANSION
	SOLICITATION # YH20-0002
	EXPANSION OF AHCCCS COMPLETE CARE CONTRACT YH19-0001

OFFER

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

Arizona Transaction (Sales) Privilege Tax License No.:
07639733

Federal Employer Identification No.:
46-3766901

E-Mail Address: James.Stringham2@bannerhealth.com

Banner – University Family Care
 Company Name
2701 E. Elvira Road
 Address
Tucson AZ 85756
 City State Zip

For clarification of this Offer, contact:
 Name: James Stringham

Title: VP and Chief Executive Officer

Phone: 602-568-4179


 Signature of Person Authorized to Sign Offer
James Stringham
 Printed Name
VP and Chief Executive Officer
 Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

This Contract shall henceforth be referred to as Contract No. _____
 Award Date: _____

MEGGAN LAPORTE, AHCCCS Chief Procurement Officer

CCE EXHIBIT B: OFFEROR SUBMISSION FORM

**COMPETITIVE CONTRACT EXPANSION (CCE)
OFFEROR SUBMISSION FORM**

1. ACC Contractors owned by the same parent organization shall not submit separate Proposals in response to the CCE Solicitation; only one Proposal is permitted on behalf of all ACC Contractors owned by the same parent organization.
2. The ACC Contractor or its parent organization may only submit one Offeror Submission Form. ACC Contractors or its parent organization may only submit an Offeror Submission Form for the GSAs in which it currently operates as an ACC Contractor. Only those ACC Contractors serving all counties in the South GSA will be eligible to compete for the expanded services in that GSA.
3. The ACC Contractor or its parent organization shall complete the table below to include the Offeror's name, the GSA(s) requested, and priority choice of each GSA. Priority preferences for award shall be indicated by entering (1st choice, 2nd choice, 3rd choice) in the priority choice column below. Additionally, for a parent organization submitting a single Proposal as noted in #1, identify the ACC Contractor by GSA in the table below.

OFFEROR NAME is submitting the CCE Submission Form for the expansion of services in the GSA(s) indicated below:		
	GSA	Priority Choice
<input type="checkbox"/>	North: Mohave, Coconino, Apache, Navajo, and Yavapai Counties ACC Contractor:	
<input checked="" type="checkbox"/>	South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties (Including zip codes 85542, 85192, and 85550) ACC Contractor: Banner – University Family Care	1 st Choice
<input type="checkbox"/>	Central: Maricopa, Gila, and Pinal Counties (Excluding zip codes 85542, 85192, and 85550) ACC Contractor:	

James R. Stringham

Authorized Signature

9/23/21

Date

James Stringham

Print Name

VP and Chief Executive Officer

Title

SOLICITATION AMENDMENT #1		
YH20-0002 Competitive Contract Expansion	Solicitation Due Date October 4, 2021 3:00 pm Arizona Time	Chief Procurement Officer Meggan LaPorte CCE-YH20-0002 Questions@azahcccs.gov

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

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

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

**COMPETITIVE CONTRACT EXPANSION SOLICITATION #YH20-0002
AMENDMENT #1 – QUESTIONS AND RESPONSES**

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL: 	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: James Stringham	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: VP and Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 9-23-21	DATE: August 26, 2021

SOLICITATION AMENDMENT #2		
YH20-0002 Competitive Contract Expansion	Solicitation Due Date October 4, 2021 3:00 pm Arizona Time	Chief Procurement Officer Meggan LaPorte CCE-YH20-0002_Questions@azahcccs.gov

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

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

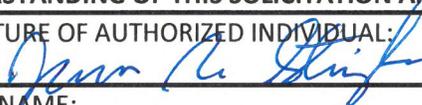
SECTION	YH20-0002 AMENDMENT
Section D, Paragraph 15, Staffing Requirements	<p>Revised as follows:</p> <p>Quality Management Manager who is located in Arizona, and an Arizona-licensed registered nurse, physician or physician's assistant in good standing or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or CHCQM by the American Board of Quality Assurance and Utilization Review Providers. The QM Manager shall have experience in quality management and clinical investigations. Quality Management shall have sufficient local staffing who are licensed clinical or behavioral health professionals to meet the requirements of the quality management program. <u>The Quality Management Manager shall not hold any other position other than the Quality Management Manager position.</u> Staff shall report directly to the Quality Management Manager.</p> <p>The primary functions of the Quality Management Manager position are:</p> <ul style="list-style-type: none"> a. Ensure individual and systemic quality of care, b. Conduct comprehensive quality-of-care investigations, c. Conduct onsite quality management visits/reviews, d. Conduct Care Needed Today/Immediate Jeopardy investigations, e. Integrate quality throughout the organization, f. Implement quality improvement, and g. Resolve, track, and trend quality of care grievances.
Section D, Paragraph 15, Staffing Requirements	<p>Revised as follows:</p> <p>Performance/Quality Improvement Manager who is located in Arizona and:</p> <ul style="list-style-type: none"> a. Is a CPHQ by the National Association for Health Care Quality (NAHQ), b. Is a CHCQM by the American Board of Quality Assurance and Utilization Review Physicians, or c. Has comparable education and experience in health plan data and outcomes measurement. <p>The Performance/Quality Improvement Manager is responsible for quality improvement activities as well as staff conducting quality improvement work as specified in Contract and policy. Staff reporting to this position shall be located in Arizona, have knowledge of both physical and behavioral health service delivery, and appropriately qualified (education/certification/professional experience) to meet the AHCCCS quality improvement contractual and policy requirements. <u>The Performance/Quality Improvement Manager shall not hold any other position other than the Performance/Quality Improvement Manager position.</u> The primary functions of the Performance/Quality Improvement Manager are:</p> <ul style="list-style-type: none"> a. Focus organizational efforts on improving quality performance measures, b. Develop and implement performance improvement projects, c. Utilize data to develop interventions/strategies to improve quality outcomes and member satisfaction, and d. Report quality improvement/performance outcomes.

SECTION	YH20-0002 AMENDMENT
Section D, Paragraph 36, Subcontracts	<p>Revised as follows:</p> <p><i>Pharmacy Benefit Manager Subcontracts Pass-Through Pharmacy Benefit Manager Pricing Model and Discrete Administrative Fee:</i> The Contractor shall amend the subcontract between the Contractor and its Pharmacy Benefit Manager (PBM) to reflect a pass-through pricing model, defined as a PBM subcontract in which:</p> <ol style="list-style-type: none"> 1. The Contractor reimburses the PBM the exact amount of the actual payments made to pharmacies inclusive of the ingredient costs and the dispensing fees for prescription claims. 2. The Contractor and PBM shall ensure that no additional direct or indirect remuneration fees, any membership fees or the like may be imposed on a pharmacy as a condition of claims payment or network inclusion. No additional retrospective remuneration or recoupment models including, but not limited to, Generic Effective Rates (GERs) or Brand Effective Rates (BERs) shall be permitted. However, nothing shall preclude the reprocessing of claims due to claims adjudication error of the Contractor or its agent, or claim related pharmacy audit adjustments for incorrectly billed pharmacy claims. <u>Effective January 1, 2022, the Contractor shall ensure that encounters submitted to AHCCCS are payments issued by the MCO's PBM and/or the MCO PBM's contractors or subcontractors and are representative of the amounts allowed under the reimbursement methodology delineated in the contract between the MCO PBM or Pharmacy Services Administrative Organization (PSAO) and the pharmacy.</u> 3. All revenues including direct and indirect payments and credits received by the PBM related to services provided for the Contractor are passed through to the Contractor, including but not limited to: pricing discounts/credited paid to the PBM, inflationary payments, clawbacks, fees, credits, grants, chargebacks, reimbursements, all rebates, administrative fees paid by manufacturers or other related entities, and any other payments received by the PBM on behalf of or related to the Contractor, 4. The Contractor pays the PBM an all-inclusive administrative fee, on a fixed and/or per script basis, for all services provided under the PBM subcontract. The administrative fee shall not be funded directly or indirectly with revenues associated with credits, rebates, or other payments made to the PBM, 5. For all Contractors, including those contracting with a PBM that subcontracts with another PBM, the submitted encounter by the Contractor shall be the actual payment to the pharmacy. The contracts, between the Contractor and the PBM or the PBM and its subcontracted PBM or any other identified subcontracts associated with the delivery or administration of the pharmacy benefit, shall be submitted to AHCCCS upon request, and 6. For Contractors whose PBMs subcontract with a Pharmacy Services Administrative Organization (PSAO), the submitted pharmacy encounter to AHCCCS shall include the actual payment to the pharmacy that provided the service, including the paid ingredient cost and dispensing fee.
Section D, Paragraph 9, Scope of Services, Crisis Services	<p>Revised to include the following:</p> <p><u>There are specific modifier(s) which shall be included on claims to identify that the service is being provided as part of a crisis episode. The Contractor and providers shall work together to ensure the modifier(s) are being included. The Contractor shall educate its providers about the crisis modifier(s) in order to ensure all appropriate costs are included in the capitation rates for the correct risk group.</u></p>
CCE Library Title XIX/XXI Data Supplement For Capitation Rate Setting, Section F	<p>Revised and reposted to the CCE Library and SFTP, as applicable, to allow for GSA Combination bids:</p> <p>Section F. Rate Development Information</p> <ul style="list-style-type: none"> ○ Administrative Cost Bid Requirements ○ Administrative Cost Bid Submission (SFTP)



Douglas A. Ducey, Governor
 Jami Snyder, Director

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

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 Stringham	TYPED NAME: Meggan Laporte, CPPO, MSW
TITLE: VP and Chief Executive Officer	TITLE: Chief Procurement Officer
DATE: 9-23-21	DATE: September 14, 2021

B1. Transitioning a contract to a new health plan has the potential to slow the critical processes of the delivery system while the new Contractor broadens its understanding for providing services to the population. Describe the efforts the Offeror will undertake to minimize delays and disruption to both members and providers, and to ensure advances that have been made in recent years continue in the transfer of responsibility. This submission will not be scored.

B1. Banner-University Family Care (BUFC) is a Managed Care Organization (MCO) and a division of Banner Health (Banner). BUFC's ACC plan, ALTCS plan and affiliated Dual Special Needs Plan (DSNP) serve nearly 300,000 urban and rural members across central and southern Arizona. With a mission to make health care easier so that life can be better, we are the only local organization that couples ***care and coverage*** through our member-centric culture. Every employee strives to honor the individuals we are privileged to serve through a company-wide campaign focused on the needs of "Ana" (the persona of a member we know), wherein we embrace and consider every interaction. Our commitment to serving Arizona's most vulnerable citizens is demonstrated throughout our 30+ years of experience and vast Medicaid MCO expertise, including numerous contract awards with successful member transitions. As a non-profit organization rooted in the communities we serve, we understand and will comply with the ACC-RBHA requirements outlined in the Competitive Contract Expansion (CCE). As the largest employer and Medicaid provider, Banner has invested five billion dollars in the State over the past five years and has a 30-year affiliation with the University of Arizona. Banner supports research and training of Arizona's future workforce. We give all individuals VIP access to the best integrated health care solutions, whether they come through BUFC, Banner's delivery system, or our community provider network. ***We stand ready to expand our safety-net and cost-effective services to individuals with SMI and others served under the ACC-RBHA contract.***

BANNER'S EXTENSIVE EXPERIENCE PROVIDING SEAMLESS TRANSITIONS FOR MEMBERS, PROVIDERS, AND AHCCCS:

BUFC has a long history of successfully transitioning incoming or outgoing members, with minimal member or provider disruption. In 2015, as part of the greater Arizona transition and the GMH/SU Dual carve-in, we transitioned 11,000 GMH/SU Duals and co-managed 1,000 SMI DSNP members with the RBHA. In 2016, our seamless transition of 80,000 members to UnitedHealthcare was so successful that several of our best practices, such as the plan-to-plan bi-directional communication and the expanded Data Elements File (DEF) and non-DEF file process, are still used today. In 2017, we effectively accepted 6,100 ALTCS members, including individuals with SMI, and onboarded more than 200 new employees. Many of these employees came from prior plans and were provided a flexible dual employment experience during the transition timeline, reducing member abrasion. As a part of the ACC transition, we simultaneously welcomed more than 47,000 members and transitioned 12,000 members to other plans, providing a seamless experience to all. ***BUFC provides the experience, resources, and support necessary for a successful transition.***

CUSTOMER-OBSSESSED AND RELENTLESS IMPROVEMENT APPROACH TO TRANSFER OF RESPONSIBILITY:

BUFC is relentless in its approach to improving member and provider experiences, as evidenced by our exceptional member and provider satisfaction survey scores. We continuously track, analyze, and assess for opportunities to enhance our strategies and processes. With a phased approach to project management for all transitions, we began aggressive planning for this transition more than a year ago with countless stakeholder meetings, including advocacy groups, to understand what is working and what is not. With a governance structure for quality assurance, our detailed and agile plan is ready to launch and includes a dedicated phase for go-live and monitoring. Our plan is composed of key components, such as 24/7 availability of key staff and executive leaders; detailed contingency plans with SWAT teams that have participated in member scenarios and claims system acceptance testing prior to go-live; routine go-live huddles; and monitoring of key operational metrics, such as call center, member ID cards, prior authorization and claims. Utilizing various communication platforms, BUFC communicates and engages with all stakeholders. ***Transparency and follow-through on our commitments to all stakeholders is foundational to providing superior member care.***

Based upon our prior experience, BUFC has identified and implemented a variety of best practices to support seamless transitions for our members, including **(1)** review of transitioning member information from the DEF and non-DEF files to identify members requiring focused transition coordination; **(2)** direct hand-offs between plan care managers (CM), which is critical to transitioning members with any degree of special needs or conditions, and to expediting the development of rapport and trust with new CMs on behalf of the accepting health plan to foster effective ongoing care management and coordination; and **(3)** proactive monitoring of point-of-sale pharmacy rejections, enabling BUFC to resolve issues prior to member impact, thus ensuring an optimal member and provider experience. In addition, we offer a broad pharmacy network that encompasses all major players, as well as a new dedicated behavioral health pharmacist.

As a provider-based plan, BUFC understands the needs of providers and the impact of transitions on them. Our best practices support providers during transitions, including **(1)** ongoing operational-focused provider webinars; **(2)** routine CEO-to-CEO and CMO-to-CMO meetings; **(3)** information-sharing through provider forums, newsletters, website, social media and in-person provider orientations; and **(4)** onboarding of new providers through in-person or virtual orientations that include valuable education on all operational areas and our various programs to enhance optimal provider and member support. Finally, we understand that transitions do not cease at go-live— ***our high touch member and provider-focused approach will continue so services and support will not only remain but will be enhanced.***

DISCIPLINED AND FOCUSED IMPLEMENTATION APPROACH TO MINIMIZE DELAYS AND DISRUPTION: Banner's executive leadership recognizes the importance of supporting BUFC in maintaining a disciplined and focused approach to implementation. With more than 300 collective years of experience working with the SMI population, our team understands the criticality of minimizing disruption. Our transition will be spearheaded by BUFC's Chief Operating Officer, Sarah Spiekermeier, a seasoned transition executive leader, coupled with full support of resources across Banner. As a veteran plan with in-depth knowledge of the readiness review process, we employ rigorous member transition policies and procedures to comply with AHCCCS requirements. Our plan follows AHCCCS' readiness assessment tool, which includes a detailed staffing plan that contains **(1)** working with relinquishing plans to actively interview, hire, and onboard skilled staff through coordinated job fairs to keep workforce within the system; **(2)** advancing the hiring of staff and higher staffing ratios for key areas, such as the call center, for 90 days during the transition; and **(3)** hiring staff who reside in the communities we serve.

Through our prior Arizona transition experience, we know that maintaining consistency in the delivery system is critical to providing a seamless transition. Our strategies for member and provider continuity (developed through past transition lessons learned) are documented in our plan. For example, we will provide timely transportation of all members by utilizing the DEF and non-DEF file data and holding multiple daily huddles with all stakeholders to monitor transportation activities for transitioning members. We will also use additional vendors to support blanket and rural transportation. As an experienced MCO, our comprehensive and robust physical and behavioral health network meets and exceeds ACOM Policy 436 requirements and supports individuals with SMI. In addition to our strong connection to community-based organizations, our network includes an Accountable Care Organization (ACO) support model, such as Banner Health Network (BHN), Banner Network Southern Arizona (BNSA) and the newly formed Integral Health Network of Southern Arizona (IHNSA), coupled with our portfolio of Banner Technology Enabled Care (BTEC). We will utilize the top 100 data provided by AHCCCS to complete a network comparison and close all gaps prior to 10/1/22. To further support continuity of service delivery, BUFC will offer multiple forums and trainings to current and new providers, hold standing weekly provider calls and utilize peer and family transition navigators from our community partners. We will also educate and train critical administrative services subcontractors, such as dental, pharmacy, and transportation providers.

In addition to transition activities outlined in the CCE, including collaborative selection of a statewide crisis line, we will achieve continuity and coordination of care with minimal disruptions by **(1)** collaborating closely with the relinquishing plan for all CM activities, including identifying care gaps, with a focus on special populations, such as high needs/high cost, dialysis, tribal and justice-involved members; **(2)** approving out-of-network providers for 90 days and pursuing letters of agreement; **(3)** continuing prescriptions, medical equipment, supplies, and medically necessary transportation ordered for transitioning members by the relinquishing contractor; **(4)** advancing the loading of prior authorizations and extending authorizations for 90 days; **(5)** assigning a primary point-of-contact for each member-facing team for our call center to utilize to expedite resolution of issues and warm hand-offs; **(6)** contacting identified members prior to 10/1/22 to welcome them to BUFC, verifying their PCP/health home, walking them through available resources and addressing any urgent issues; and **(7)** leveraging our established Member Advisory Councils to quickly engage individuals with SMI and to create a sub-committee focused on transitions that include members, providers and key community stakeholders. In addition, we commit to hosting member welcome sessions facilitated within the community, leveraging our relationships with Indian Health Services (IHS) and 638 Tribal facilities to coordinate services and continue the warm line for tribal members.

ENSURING ADVANCES IN DELIVERY SYSTEM THROUGH INNOVATION AND FOSTERING ACCOUNTABILITY: BUFC is prepared to exceed the ACC-RBHA contract requirements. We are present, we listen, we effectively implement, and we coordinate with stakeholders and hold providers accountable. We are well-positioned to expand our services to individuals with SMI and become a system quarterback by building upon our foundation and readiness that embodies all requirements. Through identified best practices, past lessons learned, and the transition requirements outlined in the CCE, we will minimize delays that can occur during member transitions and create a truly integrated system of care. BUFC recognizes the importance of a seamless transition and preservation of existing relationships between providers and members; members that transition to BUFC will continue to receive services from their existing providers through contracting or single case agreements. We have walked alongside AHCCCS' integration journey as an active partner in various initiatives, such as the Targeted Investment Program, whole health, health disparities, justice system and Social Determinants of Health (SDOH). We will continue to partner with the State to implement strong initiatives to reduce stigma and fragmentation, drive positive outcomes, and promote the future sustainability of the State's SMI program and the members it serves. ***AHCCCS can be comfortable and confident that we will execute and deliver on what the system needs, and the community has been asking for: a better and more cost-effective way of doing business in the South-GSA.***

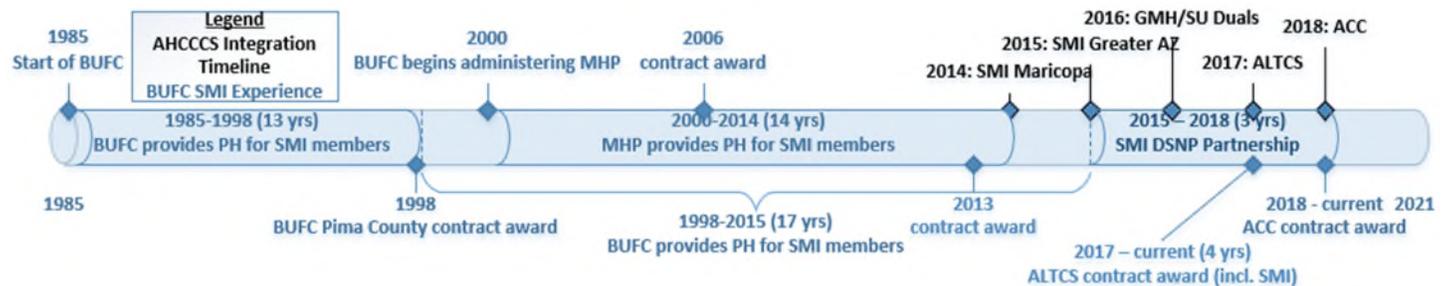
B2. The delivery of comprehensive and effective integrated services (physical health, behavioral health, social service referrals, and support) to individuals with an SMI designation and efficient administration of Non-Title XIX/XXI funding, including federal grants, require significant expertise and experience. Describe the Offeror's experience with:

- a. Service delivery to individuals with an SMI designation (Title XIX/XXI and Non-Title XIX/XXI),
and**
- b. Service delivery using Non-Title XIX/XXI funding sources including federal grants.**
- c. Administration of Non-Title XIX/XXI funding sources including federal grants.**

The description shall include, but is not limited to, geographic coverage, population served, enrollment, efforts to advance health care integration, years serving individuals with an SMI designation, and years administering Non-Title XIX/XXI funding, including federal grants.

B2. Banner-University Family Care (BUFC), a division of Banner Health (Banner), is leading the care innovation revolution to advance the delivery of comprehensive, effective, integrated services for vulnerable individuals with complex health needs. This includes ALTCS members designated SMI and ACC members with complex co-morbid and co-occurring GMH/SU conditions. ***Our in-depth experience as a health plan, delivery system and leadership team uniquely positions BUFC to serve individuals with an SMI designation.*** Collectively, we possess 300 years of experience working in RBHAs and crisis/SMI delivery systems across all three regions of Arizona, including Vice President/CEO, Jim Stringham, an experienced RBHA executive and system trailblazer. He is leading the charge on Banner’s commitment to alleviate the health disparities experienced by individuals with SMI on health and wellness, life expectancy and mortality, in alignment with the Quadruple Aim. Inspired by our connection to our members, BUFC embraces the concept of integration, as demonstrated by our annual Integrated Health Care Summit, led by CMO, Dr Sandra Stein, who is a licensed psychiatrist, University of Arizona College of Medicine clinical assistant professor and a seasoned RBHA/SMI delivery system executive in the South GSA (S-GSA). These summits bring providers and health plan leaders together to strengthen the overall collaboration necessary to achieve innovation through ***care and coverage*** focused on physical health (PH), behavioral health (BH) and Social Determinants of Health (SDOH). Our 2021 summit reviewed the impact of COVID-19 and outlined integration innovations in primary care, service delivery and the use of technology to address key issues facing those facing challenges with BH/substance use disorder (SUD), PH, SDOH, loneliness and social isolation. ***The summit’s strategic plan will serve as BUFC’s foundation in the transformation of integrated care for individuals with SMI.***

A. VALUED AND EXPERIENCED PARTNER IN SERVICE DELIVERY FOR MEMBERS WITH AN SMI DESIGNATION: As part of the largest delivery system in Arizona, and the oldest Medicaid health plan in the State, our experience serving individuals with SMI began **more than 30 years ago** with the formation of BUFC as a health plan. Since its inception, BUFC has actively partnered with AHCCCS on its integration journey, as depicted in **Figure B.2.1: BUFC SMI Experience and AHCCCS Integration Journey.**



Since 1985, BUFC has provided PH coverage to individuals with SMI (primarily in the S-GSA); Banner’s delivery system has provided PH and BH care to this population for as long as it has offered services. In addition, Banner held a 25 percent membership-partnership and two Board of Director seats for the Community Partnership of Southern Arizona (CPSA), providing direct involvement with the approximately **10,000** RBHA members in Southern Arizona between 1995 and 2015. BUFC’s growth included expansion of its PH services for members, including those designated as SMI, through the administration of Maricopa Health Plan (MHP) and several successful AHCCCS procurements that facilitated our expansion into southern Arizona. During this period, we also operationalized a Dual Special Needs Plan (DSNP) in the S-GSA, which coordinates PH and BH Medicaid and Medicare services to provide targeted care and enrollment for individuals with special health care needs, including members designated as SMI. In 2014, we transitioned PH services for individuals with SMI to the Maricopa County RBHA, and continued PH coverage and coordination with the RBHA in the remaining nine counties until 2015, when we transitioned these services to the Southern Arizona RBHA. This experience cemented our commitment to partner with BH entities for individuals with SMI to improve the overall health of our members, while our service delivery system created the BH services and facilities necessary to support the development of comprehensive BH provider networks. From 2015 to 2018, we partnered with the Southern Arizona RBHA to leverage our DSNP for dual-eligible SMI members. We served approximately **1,000 members designated as SMI**, leading the DSNP implementation through providing Identification cards; developing member experience workflows; educating RBHA staff on Medicare supplemental benefits; coordinating care for pharmacy services; paying DSNP claims; overseeing the model of care; and processing grievances and appeals. Also, to promote integration of Medicare and Medicaid services for DSNP members, we maintained bi-directional access to one another’s care management system. In 2017, AHCCCS awarded to BUFC a five-year ALTCS contract in the south and central GSA, which included **~500 ALTCS members designated as SMI**. By 2018, BUFC was awarded the ACC contract in those same GSAs; to-date, we are the largest ACC plan in the S-GSA. As a fully integrated health plan, we provide PH and BH services for all members through a robust provider network that includes SMI services,

such as Medication Assisted Treatment (MAT); psychiatric medication management; evidence-based BH and SUD treatment; peer support; employment; housing; rehabilitative support services; and crisis services/programs.

Banner contracts with all AHCCCS health plans and RBHAs, serving as the safety net for the State's most vulnerable citizens, including Title XIX/XXI (TXIX/XXI) and Non-Title XIX/XXI (Non-TXIX/XXI) members who are designated SMI. We provide critical services for these members through our hospitals, clinics and urgent care centers, making us one of the largest SMI providers in the State. For example, Banner University Medical Group (BUMG) and the Whole Health Clinic (WHC), a fully integrated health home for members with complex medical and co-occurring conditions, includes a full complement of cost-effective BH specialty and support services. Since developed as a BUFC bid commitment in 2018, BUMG has provided Phoenix-based PCP and specialty medical services to **~3,288** individuals with SMI annually, and who are assigned to a RBHA or an ALTCS plan. In Southern Arizona, BUMG and our WHC have provided services to **~813** individuals designated SMI who are enrolled in the RBHA or an ALTCS plan. In addition, Banner operates five distinct BH facilities across the State. Since 2015, these facilities have admitted for treatment over **14,000** individuals enrolled in a RBHA or ALTCS health plan and designated TXIX/XXI and Non-TXIX/XXI SMI. Our experience also extends to providing support, treatment and community education during public health emergencies, such as the opioid use epidemic and COVID-19 pandemic. ***Leveraging this experience, BUFC is fully qualified to successfully provide comprehensive and truly integrated care through this Competitive Contract Extension (CCE).***

B. COLLABORATIVE PARTNER IN SERVICE DELIVERY USING NON-TXIX/XXI FUNDING: As a health plan with more than 20 years of experience in identifying and referring eligible members to the RBHAs assigned to administer Non-TXIX/XXI funds in Southern Arizona, we adhere to the goals of AMPM 320-T1 and 320-T2. Through our Arizona-based integrated care management and member services activities, we identify and refer to the RBHA, individuals potentially eligible to receive Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) Federal Block Grant funds, discretionary grant funds and other funds, which are used for services and populations not covered by TXIX/XXI funding. Our teams recognize that different grants and funding sources have priority populations who may benefit from services, such as traditional healing; assessments to determine SMI eligibility; crisis intervention; supported housing; bed holds/home passes for members in BH residential facilities; and Naloxone kits to prevent opioid overdoses. Whether coordinating grants directly, such as the COVID-19 suicide grant, or providing grants through community reinvestment dollars, we monitor the quality of services delivered and the spend-down of funds. Our provider network includes 100 percent of Southern Arizona's current SABG, MHBG and the State's Opioid Response Grant (SOR) providers. Upon award of the CCE, we will facilitate and accept transition of the associated grant funded services offered by these providers. Also, we commit to improving the integration of TXIX/XXI and Non-TXIX/XXI funding, and to growing the capacity of grant-funded services to promote access and availability across the urban and rural landscape of the south. This will be accomplished in recognition of the demographic diversity of each county and the associated health equity and social needs. To further support our background and experience with Non-TXIX/XXI service delivery, **our leadership team** has more than 300 years of combined experience overseeing the delivery of SABG, MHBG and State-funded grants for RBHAs in all three regions of Arizona. As part of the **delivery system**, Banner provides Non-TXIX/XXI services through its BH provider entities.

C. TRUSTED ADMINISTRATION OF NON-TXIX/XXI FUNDING SOURCES: BUFC and The Banner Foundation collaborate closely with Banner Research and Development (R&D) team, providing more than **\$12M** in annual R&D grants and managing nearly **\$600M** in State and federal grants. Banner Research houses the administrative staff and resources necessary to maintain compliance with federally-funded grants and awards. Banner maintains records and schedules of all federal and non-federal awards and their expenditures; performs sub-recipient monitoring; monitors compliance with federal award guidelines; monitors spending; and provides financial reports. Banner receives grant awards from a variety of sources, including National Institution on Aging (NIA); National Institute of Mental Health (NIMH); ADHS; Alzheimer's Association; and other State and federal organizations (e.g., Average Annual Federal Expenditures of more than **\$14M** for the past five years; total federal grant expenditures of **\$133M** for the past 10 years; and 2020 federal funds exceeding **\$400M**, including CARES Act and COVID-19 Relief Funding). In managing these diverse dollars, there have been no findings on our externally administered uniform guidance federal audits. Finally, we provide grant funding to providers through our community reinvestment program. Solicitations are issued to identify projects and providers to fund, based upon their experience and the scope of services to be delivered. We confirm their scope of work is not funded through TXIX/XXI or Non-TXIX/XXI or other federal or State-only grants and meets the needs of our complex and vulnerable populations and communities. We administer, allocate, and monitor funds in alignment with AMPM 320-T1 and 320-T2.

WE PLAN, DELIVER, AND LEAD- through our unprecedented experience as a valued health plan, trusted delivery system, and trailblazing leadership, we bring care and coverage together for individuals with an SMI designation.

- B3. Describe how the Offeror will use the limited Non-Title XIX/XXI funding to maximize the timely provision of quality services to members. At minimum, the Offeror's response shall address each of the following:**
- a. All sources of Non-Title XIX/XXI funding that the Offeror will be allocated (e.g., Grant, Federal, General Fund, County, Local),**
 - b. The Offeror's process for the prioritization and delivery of services,**
 - c. How the Offeror will encourage and further enable and assist Non-Title XIX/XXI members to become Title XIX/XXI eligible, and**
 - d. How the Offeror will timely coordinate provision of Non-Title XIX/XXI services that have been referred or recommended by all other AHCCCS Managed Care Organizations (MCOs).**

B3. With more than 300 combined years of RBHA health plan, delivery system and leadership experience, Banner-University Family Care’s (BUFC’s) team understands the complexities of the allocation, oversight and utilization of Non-Title XIX/XXI (Non-TXIX/XXI) funding.

A. DEPENDABLE PARTNER IN NON-TITLE FUNDING: BUFC is well-positioned to maximize and leverage these funds to improve the health care system across the South GSA (S-GSA). Our grants administrator will oversee all components of the federally funded grants, with support from, and in close collaboration with, our Non-TXIX/XXI funding coordinator and our value-added Non-TXIX/XXI financial analyst. BUFC will align the allocation of Non-TXIX/XXI payments to performance metrics through alternative payment models (APMs) to incentivize providers to exceed grant requirements and to improve upon targeted measures, including relevant Healthcare Effectiveness Data and Information Set (HEDIS®) measures. We will maximize the impact of limited Non-TXIX/XXI funding by supplementing with Banner Foundation and community reinvestment contributions. As a non-profit organization, we will be uniquely positioned as the ACC-RBHA to apply directly for new grant funding as potential resources to supplement the expansion of Non-TXIX/XXI services. As good stewards of the funds, we will offer an opportunity to scale up cost-effective solutions to reach an increased number of members. As the ACC-RBHA, we will follow the schedule provided by AHCCCS that specifies the funding sources by program for services and populations not covered by Title XIX/XXI (TXIX/XXI) funding. Our understanding of all sources of Non-TXIX/XXI funding from the Non-TXIX/XXI FYE21 allocation to the S-GSA is outlined in **Table B.3.1**.

Table B.3.1. All Sources of Non-TXIX/XXI Funding

Funding Source	Summary of Utilization to Maximize Timely Provision of Quality Services
State Funds	
Non-TXIX/XXI Crisis	Funds will be blended into existing crisis system funding with a focus on maximizing third party liability billing to preserve scarce Non-TXIX/XXI funding. Assistance to members will be provided when completing applications for AHCCCS and other benefits.
Non-TXIX/XXI Serious Mental Illness (SMI)	We will offer the same covered services as for Title XIX/XXI and will also include room and board whenever there is no other payor. Funds will be offered to create wraparound services and to continue care if there is a break in eligibility.
Non-TXIX/XXI SUD	Funding will be used to increase outreach, navigation and identification of under- and uninsured members with an opioid use disorder (OUD), as outlined in AMPM Policy 320-T2.
Non-TXIX/XXI SMI Housing	Funding will cover AHCCCS approved services, including rental subsidies, move-in kits, assistance with deposits, utility payments and eviction prevention efforts.
Federal Funds	
MHBG-SMI	Funds will be prioritized to continue care for individuals with SMI who lose AHCCCS eligibility, and for Title XIX/XXI members to access Non-TXIX/XXI services.
MHBG-First Episode Psychosis	BUFC will continue to fund existing sites providing these services for continuity of care. We will expand this program to outlying and rural communities through University of Arizona (UA) EPICenter, Centers of Excellence (COEs) and telehealth.
MHBG-SED	Funds will be used for outreach efforts to identify members with SED who do not have other funding sources. We will develop school and community programs to address suicidal ideation.
SABG-General Services	We will utilize funding to provide treatment to priority populations and provide additional access to Substance Use Disorder (SUD) treatment in areas where current treatment options are limited.
SABG-Pregnant and Parenting Women	As an area of high priority, BUFC will focus on engagement efforts, provide real-time information regarding the availability of funding (services, locations) and focus on educating the community on the availability of treatment for priority populations.
SABG-HIV Early Intervention	Programming will include risk assessment, HIV testing, pre-and post-test counseling, referrals for treatment and testing for Hepatitis C.
Discretionary Grants	
State Opioid Response II	BUFC will implement the outlined grant activities, with a primary focus on increasing access to Medication Assisted Treatment (MAT) and overdose reversal medications throughout the S-GSA.
County and Other Funds	
Pima County IGA	We will focus on collaboration with county partners to complete COE screenings for members and transition to treatment, where needed, as well as crisis services for Non-TXIX/XXI.

Liquor Service Fee	Funds will be used for existing programs and will support crisis, detox, outpatient and COE, as appropriate.
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B. EXCEPTIONAL DELIVERY OF SERVICES THROUGH PRIORITIZATION, COORDINATION, AND DATA: As a current ACC plan, BUFC has extensive experience in identifying and referring eligible members to the RBHA for Non-TXIX/XXI services. Our process for prioritization and delivery of services uses demographic information in compliance with the specific requirements of the funding allocation. We will prioritize Non-TXIX/XXI funds to priority populations, as outlined in AMPM 320 T1 and members with the highest needs, so funds are maximized. Services will be delivered in a manner most appropriate for the member and may include in-home, community, office or virtual settings. All services will be implemented using the AHCCCS system of care model and BUFC will closely monitor service delivery, including maintaining and reporting on adherence to fidelity. The Banner Foundation has in-depth experience managing and reporting on grant funding, with no findings on our Uniform Guidance Federal audit for the past five years. We will conduct **real-time reconciliation** to adjust and re-allocate funds throughout the year. BUFC will implement the full continuum of crisis care for all Non-TXIX/XXI members, which will follow the same requirements that apply to our TXIX/XXI members. We are prepared to track all crisis encounters to provide outreach and follow-up, as well as to identify areas for improvement. All Non-TXIX/XXI metrics will be included in our Monthly Operating Report (MOR) and reported to our senior leadership team (SLT), as well as through our Quality Management (QM)/Performance Improvement (PI) Committee. BUFC will adhere to all Non-TXIX/XXI reporting requirements, as outlined in the CCE YH20-0002, Section G, chart of deliverables.

BUFC understands the specific needs of the community, including disparities and unique geographical needs. The S-GSA includes many rural/border communities that often lack adequate transportation and access to community providers. As the ACC-RBHA, we intend to leverage existing relationships across our network and expand to fill gaps, including adding virtual services to address any access to care barriers. Our intention is to balance the continuity of care for members currently receiving Non-TXIX/XXI services from designated providers, with an opportunity to transition the system to improved performance and member outcomes. We are open to contracting with all licensed, credentialed, high-quality providers in the S-GSA. **Our contracted provider network includes 100% of southern Arizona’s current SABG, MHBG and SOR providers, and all FQHCs and existing behavioral health (BH) Integrated Health Homes (IHHs) that serve our ACC GMH/SU members today.** Upon award, we will facilitate and accept transition of funds and the associated grant-funded services offered by these providers. Delivery of services will be offered through our existing network of providers, with the opportunity to expand based on identified needs and new funding sources.

For services we do not currently offer as an ACC plan, such as the Oxford House model, we will monitor ongoing use of SABG funds in compliance with AHCCCS’ approved implementation plan. Following a six-month transition period working directly with Non-TXIX/XXI providers, we intend to release a Request for Proposal (RFP) in collaboration with AHCCCS, providers and community stakeholders. Providers are encouraged to develop innovative solutions, such as utilizing matching funds from charitable giving or other grants to maximize funding to meet the Non-TXIX/XXI system needs and requirements. Prior to releasing the RFP, we will analyze the utilization of Non-TXIX/XXI funds throughout the S-GSA and then overlay with population and census data to determine an appropriate network size and scope. If there are changes based upon our RFP process, we will closely monitor a transition plan with current providers that includes member-level data for coordination of care and program-level data so there is no loss of outcome measurement. We will facilitate quarterly Joint Operating Committee (JOC) meetings with awarded providers for ongoing monitoring, transparency and coordination, with additional ad hoc meetings as needed. BUFC will provide training and technical assistance to providers to understand the goals and purpose of the funding, funding descriptions and how to access available resources. Upon award, immediate action will be taken to widely publicize the availability of SABG services for pregnant women, women with dependent children, individuals who inject drugs and uninsured or underinsured members with SUD who do not meet eligibility for TXIX/XXI. With the S-GSA ACC-RBHA contract, we will bring technology to collaborate with other RBHAs and ACC plans. Our **Banner Technology Enabled Care (BTEC)** will offer providers and members a suite of tools, including customized risk stratification emphasizing physical and behavioral health and Social Determinants of Health (SDOH) factors; referral tracking systems, such as NOWPOW, to coordinate handoffs in real time; digital solutions to bring care to members in rural/border communities; and alert systems to notify partners whenever a member has ‘slipped through the cracks,’ including linkage to the statewide crisis system, criminal justice system, community-based organizations and Health Information Exchange, to name a few.

C. NON-TITLE TO TITLE XIX/XXI MEMBER ADVOCATE: The BUFC AHCCCS eligibility liaison will serve as the single point-of-contact to monitor the TXIX/XXI eligibility process, including provider training, education, monitoring, oversight and problem resolution. The liaison’s contact information will be published online and will be communicated to providers

through our onboarding process and Neighborhood Advisory Councils (NACs). This individual will disseminate BUFC policies and procedures, with specific information on how to set up a clinical consultation with a behavioral health medical professional, should a member with an SMI be unwilling to complete the AHCCCS screening/application process or to enroll in a Medicare Part D plan as specified in AMPM Policy 650. Through our Member Advisory Councils (MACs), we will develop person-centered, culturally competent outreach materials to educate Non-TXIX/XXI members about the eligibility process and to highlight the additional benefits available to eligible members. This material will be available at the provider level to be given to the member at initial screening, and we will send a mailer with this information to each Non-TXIX/XXI member upon receipt of their 834-enrollment file from the provider. Through BTEC, we will identify and track members who have not completed eligibility screenings and/or re-screenings. In partnership with providers and community partners, outreach and engagement strategies are developed to increase and improve member screenings and/or re-screenings. This report will be distributed to providers for follow-up, and to our Peer and Family Run Organization (PRFO) partners, who will assist with member outreach to complete the eligibility screening and/or re-screenings. To maintain attribution, providers under an APM will be incentivized to conduct additional screenings, above and beyond the verification and screening requirements outlined in AMPM 650. If a member is found ineligible for TXIX/XXI at initial screening, we will incentivize providers to complete re-screenings every 90 days, far exceeding the annual/significant change requirement. ***We contract with Hope, Inc., the Family Involvement Center, and will expand with other interested PRFOs, to conduct additional outreach to potential members and those in need of eligibility redetermination.*** They can answer questions, address concerns, and offer education and support (e.g., attaining required documentation) in completing the AHCCCS application. For members with an SMI, these organizations will connect them with enrollment in a qualified health plan through the Federal Health Insurance Exchange, assist them in choosing to enroll during open enrollment periods and qualified life events and continue to assist members in accessing Non-TXIX/XXI covered services not covered under their Exchange plan.

Through our quality management/utilization management processes, we will closely monitor over- and under-utilization of services for consistent and appropriate usage of funds, and will reallocate funds, as necessary, to maximize impact. BUFC will use electronic health records to flag all Non-TXIX/XXI members who have no utilization within a 120-day period following outreach at the 30-, 60- and 90-day marker. Members with no utilization within a 120-day period and after unsuccessful engagement efforts will be terminated from services, as outlined in Section G of the CCE YH20-0002 contract. BTEC tracks member eligibility changes (e.g., Non-TXIX/XXI to TXIX/XXI) so that we can monitor the retroactive recoupment and re-allocation of the Non-TXIX/XXI funds. Additionally, we will use electronic records to prohibit the use of Non-TXIX/XXI funds for unallowable expenses, including premiums, deductibles and certain copays. For specific funding that allows these expenses, our grants administrator will be responsible for flagging members to update the eligibility. Non-TXIX/XXI funding streams are tracked and reported at the encounter level, as outlined by the encounter reporting requirements (where applicable), to allow for reporting, fund reconciliation, stakeholder feedback, etc. and/or through required contract deliverables. This enables near real-time reconciliation, with the capability of a weekly report updated by fund type. BUFC offers analytic capabilities to prioritize specific categories of members. We use algorithms to identify members likely to qualify for TXIX/XXI services to provide a coordinated approach to engage and support members through this process.

D. TIMELY COORDINATION OF NON-TITLE XIX/XXI SERVICES THROUGH PARTNERSHIPS: BUFC recognizes the need for a clear and repeatable process for partnerships with other MCOs in the S-GSA to ensure all members requiring Non-TXIX/XXI services are identified and equally prioritized for service provision. Through our listening sessions, we have learned that the current process is overly cumbersome, to the point where ACCs may not even attempt to access the Non-TXIX/XXI funds for their members. With our current ACC contract, we are uniquely qualified to utilize and enhance our existing community and provider partnerships, as well as key relationships and touchpoints in the community. Serving as the single point-of-contact, our AHCCCS eligibility liaison will streamline the process and reduce confusion and burden on providers and members. BTEC tracks all incoming and outgoing referrals, providing a closed-loop referral process back to the referring MCO. In alignment with member choice, we offer a network of diverse providers, facilitate referrals and use peer support specialists (PSSs) to engage and support members. This process is enhanced with the support of our PRFO partners to assist in accessing services. We value the opportunity to collaborate with other MCOs and continue to demonstrate leadership by bringing solutions and innovations that improve the overall health care delivery system. BUFC remains focused on meeting the needs of our members and Arizona. Through continuous engagement and partnership, we make health care easier so life can be better.

- B4. There are many opportunities for clinical quality improvement for care of individuals living with Serious Mental Illness (SMI). The Offeror shall:**
- a. Describe methods the Offeror uses to assess disparities or improvement opportunities for broad-based (system-wide) quality improvement and the related actions taken,**
 - b. Describe areas the Offeror has identified as presenting the greatest opportunities for broad-based (system-wide) quality improvement and the related actions taken,**
 - c. Describe the Offeror’s experience in achieving quality outcomes for individuals living with an SMI or similar Medicaid populations. When applicable, provide statistically relevant results of previous interventions implemented by the Offeror, and**
 - d. Describe the Offeror’s proposed approach to a clinical Performance Improvement Project (PIP) designed to improve outcomes for individuals living with an SMI. [Note: AHCCCS will review the Awarded Offeror’s PIP and may require the Offeror to implement the proposal as an AHCCCS-mandated PIP (subject to AHCCCS-required adjustments) for the Geographic Service Areas (GSAs) served].**

B4. Banner-University Family Care (BUFC) is a thought leader, member champion and collaborative partner that sets the bar for *care and coverage*, with a passion for serving our local communities. Under the leadership of our Chief Medical Officer (CMO) and Chief Executive Officer (CEO), our Quality Management (QM)/Performance Improvement (PI) structure and processes guide our quality program, in full compliance with AMPM, ACOM, State and federal requirements and Section 22 of the ACC-RBHA Competitive Contract Expansion (CCE). We restructured our QM/PI Committee using a Plan-Do-Study-Act (PDSA) approach as *quality is everyone's responsibility at BUFC*. Our cross-functional QM/PI Committee structure encompasses senior leaders; directors; managers; the Office of Individual and Family Affairs (OIFA); providers; members; and family, exceeding AHCCCS and National Committee for Quality Assurance (NCQA) requirements. We employ a *broad-based (system-wide) approach to continuous QI*, focused on data-driven, community-wide improvement plans, with active involvement from our Neighborhood Advisory Councils (NACs) and non-traditional partnerships to break down silos necessary to achieve true integration and fully meet members' needs.

A. DATA DRIVEN PATHWAY TO ASSESS DISPARITIES AND IMPROVEMENT OPPORTUNITIES: Our QM program brings together all health plan functions to develop initiatives that respond to identified gaps and to address the whole health needs of members. We maintain an annual PI work plan, which is used to continually evaluate all functional areas, with a focus on physical health (PH), behavioral health (BH), Social Determinants of Health (SDOH), rural and urban underserved areas, pandemic recovery/resiliency and overall health equity. **Methods:** BUFC assesses health disparities and improvement opportunities through its QM/PI process, beginning with a comprehensive population health analysis. All methods align with the Arizona Health Disparities Center, with strategically planned interventions aimed at eliminating racial and ethnic health disparities in chronic diseases and illnesses, including SMI. Specifically, **(1)** We analyze national, statewide and local sources of health information, including the AHCCCS Strategic Plan; AHCCCS Quality Services Draft; Arizona Health Improvement Plan; Arizona State Health Assessment; Healthy People 2030; U.S. Census Bureau; CMS; and SAMHSA. **(2)** We focus on content learned from the CDC-administered REACH program and other areas, including reduction and prevention of diabetes; metabolic syndromes common to those on psychotropic medications; and cardiovascular disease and related conditions, such as obesity among African-American, American Indian and Latino and Asian Pacific Islander communities. **(3)** BUFC uses best practice methods, including environmental scans; routine provider and member input; analysis of quantitative and qualitative data; trending of Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results; external quality review findings; and national best practices. **(4)** This knowledge is combined with internal data from our health information system (e.g., health risk assessments (HRAs); claims; encounters; ICD-10 codes; utilization; risk scoring; grievances and appeals; and quality of care concerns) to identify disparities linked to social, economic, racial, ethnic, language and/or environmental disadvantages across populations. **(5)** We utilize multiple tools within our PDSA cycles, such as root cause analyses (RCA); key driver diagrams; 5 Whys; process mapping; and failure modes and effects analysis (FMEA) to remove barriers necessary to improve health outcomes and total cost of care for diverse groups of members. **Actions:** To address disparities and improvement opportunities for broad-based (system-wide) QI, we have taken or will take the actions that follow: **(1)** Implement a cross-functional Health Equity Committee, with health plan representation from all clinical and operational areas and peers/families to address health disparities, such as diabetes, healthy eating, opioid pain management and high-risk pregnant mothers, as described in our Health Disparity Summary and Evaluation Report deliverable and detailed strategic plan. **(2)** Utilize content from the National Partnership for Action to End Disparities to drive BUFC's work in its NACs and Governance Committee. Through these committees, we mobilize comprehensive, community-driven and sustained approaches to combating health disparities, while impacting each community. Our NACs include local providers, members and key stakeholders; the Governance Committee is composed of members, peers and family members. The NACs enabled rapid detection and response to the opioid and BH epidemics associated with COVID-19. For example, the Governance Committee identified oral health disparity for substance use disorder (SUD) members in Yuma, resulting in a committee-driven proposal to utilize community reinvestment funds necessary to assist members with preventive dental expenses. BUFC also participated with AHCCCS on the NORC Medicaid Managed Care Organization Learning Hub on member engagement, highlighting our collaborative work to elevate member voices using advisory councils. **(3)** Identify and utilize successful interventions used by other national/state organizations, such as through our relationship with Association for Community Affiliated Plans and participation in national task forces on SDOH and health disparities. **(4)** Promote a positive impact on disparities and QI through board membership and financial support of approximately **\$500K** to Home Matters to Arizona. This project demonstrates measurable and positive outcomes focused on specific populations and geographic areas. In addition, BUFC has donated approximately **\$1.5M** in community reinvestments funds to address health disparities among populations, such as Hispanic, African-American and Native American, which are experiencing less than optimal health outcomes due to SDOH (e.g., food insecurity, lack of affordable

housing and education). **(5)** Work collaboratively via our QM, UM, Provider, and Value-Based Purchasing teams to develop **alternative payment models (APM)** using validated performance measures aimed at priority improvement opportunities. **(6)** Incorporate appropriate statistical standards—sampling methodology, sample size calculation and account for measurement periods and seasonality effects—into all formal QI initiatives. Examples of recent improvement actions taken include medication adherence PDSA; forming an Opioid Task Force led by our CMO; developing a Banner-wide Integrated Care Strategic plan; initiating a Grants Program to empower local agencies to propose their actions for identified local disparities to spread hope throughout each unique community of Southern AZ; and *partnering with Pyx Health to pioneer a solution to address loneliness and social isolation.*

“Banner’s early interest and passion for our mission was truly visionary. CEO James Stringham and CMO Dr. Sandra Stein, have been invaluable partners in launching our earliest programs for the Medicaid population and supporting the innovation of new ways to address loneliness in vulnerable populations.” Cindy Jordan, Founder & CEO, Pyx Health, Inc.

B. COURAGEOUS INNOVATIONS FOR QUALITY IMPROVEMENT: The most significant opportunity for broad-based (system-wide) QI is the achievement of truly integrated care necessary to meet the individual needs of members in the communities we serve. The opportunities that follow improve whole-person care for individuals with SMI. Through increased collaboration between delivery entities, the health plan and community providers and supports, and by leveraging technology, we will develop an effective synergistic system, as opposed to a collection of poorly coordinated services. Because improved integrated care delivery has a broad-based impact on improving multiple Core Set measures, these projects within our ***Integrated Care Strategic Plan*** will be facilitated by our QI team using PDSA methods, including analysis with Core Set measures. These projects include: **(1) Improving screening and detection of BH conditions by PH providers and facilitating expedited access to care:** We will improve evidence-based proactive screening for depression, suicide, anxiety, SUD/opioid use disorder (OUD) and SDOH in all levels of care, including ambulatory, inpatient, emergency room (ER) and crisis settings. With positive screenings, there is a multipronged approach to facilitating access to care, including real-time on-demand access to BH services (e.g., face-to-face or virtual); warm handoffs; scheduling specific follow-up appointments, paired with proactive and intensive peer and family supports to enhance ongoing engagement; and developing additional capacity for treatment in primary care settings. BUFC promotes behavioral health screenings (including SDOH and trauma) by PH providers through the Continuing Medical Education (CME) being developed in partnership with the University of Arizona (UA) Department of Psychiatry, *Psychiatry for Non-Psychiatrists* and Enhancement of Collaborative Care Model Programs, as well as PharmD consultation available to PCPs to support psychopharmacologic treatment. **(2) Enhancing the continuum of integrated care by building capacity and innovative collaborative models:** Services include bringing care to members, as demonstrated by the planned access to specialty PH services for BUFC members at Banner’s Whole Health Clinic and the community provider referral program to Banner Urgent Care to defer away from ERs or other crisis facilities. ***Urgent health issues were resolved for more than 83% of Banner Urgent Care patients, with \$573 in estimated cost savings per patient.*** Through Banner Technology Enabled Care (BTEC), we maximize the use of telecare technology, with proven efficacy for anxiety and depression, and application-based programs, such as SilverCloud, for cognitive behavioral therapy. Through APMs, we will collaborate with providers to decrease ER utilization; inpatient utilization; incarceration; and court ordered treatment and improve key performance measures. In addition, the BUFC-specific EPICenter Program will provide innovative family-focused treatment for early identification and onset of SMI, consistent with the AHCCCS Transition to Adulthood Practice Tool. In addition, PCP treatment of BH conditions and Medication Assisted Treatment (MAT) within their scope of practice will continue to be enhanced, which also expands the continuum of care for members with Special Health Care Needs including those with OUD and with co-occurring pain and OUD. These PCP MAT providers always coordinate with BH providers for the psychotherapeutic component of treatment. **(3) BUFC-specific Psychiatric Center of Excellence (COE), in partnership with UA Department of Psychiatry:** Members with PH and BH co-morbidities, complex medication regimens, including polypharmacy and multiple readmissions, and members in need of comprehensive diagnostic and treatment reassessment, will have access to this COE by the end of 2021. Attending physicians will review history and diagnosis and make recommendations for treatment improvements. This has long been identified as a priority community need to improve the care of members who disproportionately experience some of the worst outcomes. **(4) Stigma reduction:** The stigma associated with BH services for individuals with SMI is a common reason for not accessing care. Through intensive training for members, providers and key community stakeholders, and through social media, OIFA, peers and our NACs, we implemented a multi-pronged approach to minimize stigma and to support access to services. For example, our BH Epidemic Response Plan focused on addressing the growing BH impacts of COVID-19, including a broad-based public health

education campaign. Through this initiative, we provided leadership and brought together more than 85 providers, key stakeholders and AHCCCS to share information about BH diagnosis and its relation to the COVID-19 pandemic, and to provide easy access to information regarding BH, SUD treatment and SDOH. **(5) Enhancing integrated care management:** Through a 'One Team, One Platform' approach, BUFC embraces true integration, wherein PH and BH medical directors; social workers; nurses; pharmacists; dieticians; discharge coordinators; peers/family/OIFA; and others collaborate in daily discharge coordination meetings, utilization rounds and integrated care staff meetings. Teams are trained on evidence-based practices, including motivational interviewing, with testing to meet fidelity, trauma-informed care, QPR suicide prevention, Mental Health First Aid and a wide range of BH and PH guidelines. ***This approach resulted in a 67% reduction in prescribed opioids for members in our integrated opioid program during Q2 and Q3 2020.*** Our BTEC platform provides greater sophistication internally for risk stratification, including identification of members with high risk and rising risk, predictive analysis, artificial intelligence and invaluable data for care management and provider case management coordination. The goal is to reduce ER, crisis and inpatient utilization by providing community-based care. These tools will support coordination with provider case managers who serve as the 'boots on the ground' for members. In addition, BUFC and provider staff will be available 24/7/365, with access to medical records to coordinate with crisis providers and divert members from ERs and inpatient settings and leverage SDOH resources. Our BH attribution model will enable BUFC care managers to identify members' providers at any given time. This will facilitate timely collaboration around service delivery, including discharge planning and crisis prevention, and management consistent with member choice and the adult 9 Guiding Principles, with support of APMs for quality-of-care initiatives.

C. EXPERIENCED AND TRUSTED PARTNER FOCUSED ON HEALTH OUTCOMES: BUFC has continually served Dual Special Needs Plan (DSNP) members, including individuals with an SMI designation, for more than 15 years, including as past partners with the Southern Arizona RBHA. We are experienced in achieving quality outcomes, such as **(1)** Proactively addressing vaccination disparities found nationally, wherein individuals with SMI receive influenza vaccines at half the rate of the general population. No such disparity exists for our DSNP members with SMI who received COVID-19 and Influenza immunizations at rates 3% to 4% higher than our members without an SMI designation. We worked in tandem with AHCCCS, county officials and other health plans to deploy a multi-pronged approach, including member outreach, transportation support, proactive care management and member and provider education. We also brought COVID-19 vaccinators to ALTCS members with SMI, resulting in ***ALTCS vaccination rates reaching nearly 80%, the highest among ALTCS E/PD plans.*** BUFC continues as an active partner to increase the rate of vaccinated Medicaid members. **(2)** From NACs input, national literature and review of our own health outcomes data, BUFC identified medication adherence as an essential opportunity for improvement for our DSNP members, including those with an SMI designation. Individuals with SMI are known to experience higher rates of hypertension, diabetes and dyslipidemia, which negatively impact their quality of life and lifespan. Medicare emphasizes these measures due to their direct impact on health outcomes. The BUFC QM team partnered with the Pharmacy and Medical Management teams to initiate a PDSA initiative, with weekly workgroup meetings and root-cause analysis using a Fishbone Diagram to identify health-, system-, patient- and provider-related factors impacting medication adherence rates. We then established objective measurable targets and began related interventions. The three measures for diabetes, hypertension and dyslipidemia all had statistically significant increases in 2020, ranging from 2.5% to 9%, all $P < .05$. **(3)** BUFC identified an opportunity to improve the rate of Health Risk Assessments (HRA) completion for our DSNP members and to use the HRA findings to support members in achieving improved health outcomes, which is foundational to member-centric care. In 2019, we were trending below our internal monitoring dashboard benchmark. The QM/PI Committee tasked the QI and Care Management teams with improving this metric by the end of 2020. Root cause analysis was completed and adjustments were made to our outreach mailings and member materials to include talking points to help guide members to health care resources. The QI team met monthly to track the HRA completion rate and to assess the impact of interventions. Modifications were made using a rapid cycle PDSA process. Prior to our preset target date, the team exceeded the internal goal and increased the rate by 16% for the 2020 measurement year ($P < .0001$). This initiative is now in a second formal PDSA cycle, with higher target goals established. **(4)** Through coordinated performance improvement for our DSNP, BUFC exceeded the 4-Star cut point for the CAHPS survey on "Getting Needed Care and Getting Appointments and Care Quickly" and reached three STARS (a two-Star improvement from 2019) in care coordination.

D. MEMBER-CENTRIC APPROACH TO PERFORMANCE IMPROVEMENT PROJECT (PIP): BUFC follows the approach described in AMPM 980, including Attachments A and B, to select both clinical and non-clinical performance improvement projects (PIPs) designed to improve outcomes for members. We continually monitor external and internal data, trends and best practices to identify PIPs to correct significant system problems and/or to achieve significant improvement in health outcomes and member satisfaction.

Project Topic: Improve the care of individuals with SMI using **Person Driven Outcomes Measures (PDOMs)**.

Rationale: Studies document a large inequity in the reported care experience of individuals with SMI. AHCCCS CAHPS for individuals with SMI averaged one STAR, while results for adults without SMI were generally three to four STARS. This is important as studies have found patients reporting improved care experiences had improved addiction treatment outcomes, as well as those with chronic kidney disease reporting worse care experiences had poorer clinical outcomes. NCQA has worked collaboratively over seven years to develop and test PDOMs, and successfully demonstrates feasibility and scalability through a demonstration project. PDOMs are personalized, structured and measurable goals identified by members to measure what matters most to them. The 7th Guiding Principle, “*Persons in recovery define their own success,*” is best achieved through the use of PDOMs; we believe fidelity to this principle is critical to improving the care experience and is also related to clinical outcomes. Having one’s voice heard is foundational to trust; in turn, this improves engagement in care. AHCCCS is recognized nationally as an innovative Medicaid leader; PDOMs directly align with the AHCCCS Quality Strategy to drive improvement of member-centered outcomes. Based upon the NCQA pilot, BUFC predicts the introduction of PDOMs, using NCQA methods, will result in objective improvements in care.

Primary Aim: Improve PDOMs from baseline year by 5% ($P < .05$) in each re-measurement year.

Secondary Aim: Obtain statistically significant increases ($P < .05$) in two Core Set measures—adherence to antipsychotic medications for individuals with schizophrenia and initiation and engagement in alcohol and other drug abuse or dependence treatment.

Study Question: Do members with a PDOM score better on these Core Set measures than those without a PDOM?

Project Indicators: BUFC will use the methods developed by NCQA, including a standardized **Goal Attainment Scale (GAS)**, to measure the performance of the unique PDOMs, which allows for aggregated population-level outcome reporting foundational to system accountability and APM models. The **GAS ranges** from -2 to +2 and is centered on zero, which indicates completion of PDOM. Scores from -2 to less than 0 demonstrate partial or no completion of the PDOM, while scores above 0 to +2 demonstrate the PDOM exceeded the targeted goal. Using the **GAS** will allow final reporting of population-based assessments of outcomes and improvements, such as the percentage of members who achieved a PDOM of $\geq +1$ and mean GAS improvement. Adult Core Set measurement will follow standard methodology.

Procedures, Analysis and Timelines: We propose initiating this PIP for all SMI members. We anticipate a statistically significant sample size due to aligned incentives through our newly formed Clinical Integrated Network (CIN), Integral Health Network of Southern Arizona (IHNSA), which will also be supported by BTEC, our technology solution. Upon CCE award, BUFC will immediately bring together a PDOM QI team to initiate the Pre-Planning phase. Training on PDOMs will occur during this PIP-pre-planning phase to prepare for the baseline year. We anticipate completion of the Pre-Planning phase in the initial cohort of our providers by the end of 2022. By early 2023, baseline data collection will begin for member PDOMs; in parallel, BUFC’s PDOM QI team will initiate RCA of identified post-implementation issues throughout 2023. Fishbone Diagrams and FMEA tools will be particularly helpful in this continuing RCA process. The specific PIP interventions to support members in achieving their goal(s) will be implemented by provider case managers and BUFC care managers, with QI facilitation. Upon baseline year completion, BUFC will have objective baseline measures of population-wide performance, such as population average improvement along the GAS and percent of members achieving 0, +1 and +2 goal attainment. A hybrid-audit methodology with targeted random audits will be completed following inter-rater reliability training and testing, with results shared with providers so they are consistent with PIP expectations. In calendar year 2024, we will monitor quantitative improvements in the PDOM, during which time we also anticipate continued resolution of issues using rapid PDSA cycles, while expanding this initiative to additional providers as their capacities permit. We also expect to introduce provider-based patient satisfaction scores into our analysis. Core Set measures will be reported and analyzed annually using standard statistical practices. During 2025, we anticipate maintaining and building upon our improvements seen during Year 2 and dialogue with AHCCCS regarding the scaling of this PIP. For example, introduction of PDOMs to the Division of Developmental Disabilities and ALTCS plans may also be considered to meet the diverse whole person needs of these high-need populations. This individualized, unique approach brings accountability to the delivery system, while respecting each member’s choices, values and outcomes.

BUFC’s ongoing focus on innovation and, relentless improvement, coupled with its mission to make health care easier, so life can be better, will serve as a value-added, personalized approach to broad-based (system-wide) quality improvement.

B5. GSA Specific Submission Requirement:

b. If submitting a Proposal for South GSA Describe the Offeror’s experience with the unique aspects of service delivery to members in the South GSA. What current or planned strategies will the Offeror employ to ensure the effective delivery of services? Provide evidence supporting and/or expected outcome of the approach.

B5.b Banner-University Family Care (BUFC) boasts more than 30 years of experience as a health plan in the South GSA (S-GSA), with headquarters in Tucson, Arizona and co-located satellite sites in Yuma, La Paz and Cochise. We serve as a safety-net plan focused on meeting the needs of the communities in which we live and work. **Not only are we part of Southern Arizona—we ARE Southern Arizona.**

EXPERIENCE WITH UNIQUE ASPECTS OF SERVICE DELIVERY IN THE SOUTH GSA (S-GSA): Our ACC, ALTCS and Dual Special Needs Plan (DSNP) programs serve nearly 300,000 members in the Central and S-GSA (including border communities) and a range of populations, such as GMH/SU; SMI; transitional age youth; LGBTQIA; and tribal. We maintain strong relationships across the S-GSA with providers, tribal nations, and county-specific community stakeholders, including first responders, the criminal justice system and community organizations. Our network offers a diverse suite of services and resources in urban and rural communities. Across the seven counties comprising the S-GSA, there are great strengths upon which to build and opportunities to enhance community services. Urban communities, such as Tucson and Yuma, have strong services and support but often do not work as a coordinated system of care, resulting in missed opportunities and individuals ‘falling through the cracks.’ While rural communities have a core set of resources and support through hospitals, FQHCs and community-based providers, they are overly dependent upon urban settings for specialty services. This creates long transports, increased cost and time and avoidance or gaps in care. These disparities are more significant as they relate to Social Determinants of Health (SDOH). The poverty rate in rural communities is twice the urban poverty rate, with unemployment nearly twice as high in rural communities. County health data also points to the key trends that follow. **Cochise:** Higher prevalence of mental health/substance use disorder (SUD), education/resources needs on healthy eating, obesity and diabetes. **Graham:** Focus on chronic disease prevention, access to care and need for increased physical activity. **Greenlee:** High prevalence of SUD and mental health needs. **La Paz:** Focus on safe neighborhoods and infrastructure development. **Pima:** High prevalence of injuries/accidents, SUD, anxiety, depressive disorders and suicide. **Santa Cruz:** Transportation, access to health care, obesity management and lack of mental health providers. **Yuma:** Obesity management, health care services for low-income families and mental health support.

CURRENT AND PLANNED STRATEGIES FOR EFFECTIVE DELIVERY OF SERVICES: Since the launch of ACC, BUFC has participated in or facilitated more than 250 community meetings in the S-GSA. Meetings include recurring provider CEO-to-CEO meetings; CMO/clinical director meetings; tribal leadership meetings; provider forums; neighborhood advisory councils (NACs); and small-group meetings with provider CEOs, chiefs of police, sheriffs, county officials, district attorneys, Peer-Run Organizations (PRO), members/families and others. Based upon feedback received, overarching themes center on the need for a system ‘quarterback;’ local decision-making; improved member attribution; increased opportunities for member, provider and stakeholder voice in system design; and alignment of funding with outcomes. We are partnering with local providers to develop two Clinically Integrated Networks (CIN)—**Banner Network Southern Arizona (BNSA)** and **Integral Health Network of Southern Arizona (IHNSA)**. Combined for the first time in Arizona, these CINs marry primary care; physical health (PH) specialty services; hospitals/emergency rooms (ERs); urgent care; FQHCs; independent physicians; and social services with a high-performance integrated behavioral health (BH) network that includes integrated health homes (IHH), crisis providers, peer and family support agencies and other community-based organizations. IHNSA will be powered by **Blaze Advisors’** BH experience, tools and technology, including experience advancing high-performance CINs in New York (NY) and North Carolina (NC), while BNSA is a collection of the S-GSA Banner delivery system and community providers. This partnership will **(1)** shift payment incentives across providers through **Alternative Payment Models (APMs)**, such as shared risk agreements and bundled payment arrangements. All SMI Health Homes will be offered an APM by the end of the first year of the contract; **(2)** leverage **Banner Technology Enabled Care (BTEC)** tools comprised of industry-leading technology to enhance care delivery across providers and payers. These tools will be available to providers by 10/1/22 and will include a customized risk stratification tool, real-time patient tracking, alert notifications and care team communication; **(3)** increase behavioral health capacity through PCPs by increasing PCP education and access to standardized tools that screen for anxiety, substance use and SDOH. We will develop dashboards to quantify PCP screening use, including risk stratification, and how it impacts downstream treatment and crisis diversion. Supporting evidence and expected outcomes for this entire S-GSA strategy is improved coordination, reduction of unnecessary bed days, increased access to care and improved members outcomes, while bending the cost curve. The Blaze Advisors’ networks in NY and NC realized a 70% increase in routine PCP screenings for co-occurring BH conditions; a 48% reduction in 30-day readmissions; an 18% reduction in ER utilization; and a 40% reduction in hospital stays. Rooted in the S-GSA communities, BUFC understands the importance of specific strategies for rural areas. Over the past year, we have implemented or planned the strategies that follow to address the unique aspects of service delivery.

1) Improved overall access to behavioral health services: Access to timely psychiatric and BH services is challenging; with workforce shortages, issues have increased, particularly in the rural S-GSA. BUFC is committed to increasing access to BH services by leveraging technology and developing the workforce. **Evidence Supporting/Expected Outcomes:** Include increased appointment availability, improved access to care, decreased member wait times and improved whole-health outcomes. **Commitment:** Through our CIN, we will introduce COPA Health (COPA) to the S-GSA to address identified gaps. Through virtual psychiatric support, COPA can offer bridge appointments to members transitioning and conduct warm hand-offs from higher levels of care to their IHH, augmented with a team of virtual licensed social workers/counselors to perform initial intake assessments and expedite care. In partnership with the University of Arizona (UA) we will host a series of educational events to address psychiatric workforce shortages and sponsor a conference series on behavioral medicine for primary care. UA will provide a practical update to enhance the clinical skills of PCPs and related providers to effectively communicate about and manage these conditions. By treating low-to moderate-risk BH members at PCP offices, capacity at more traditional BH sites will increase and focus on higher acuity members.

2) Remote care delivery through technology: In rural communities we will bring care to the member. Through community reinvestment, we partnered with Transitional Living Center Recovery (TLCR) in Yuma to develop secure telehealth video hubs where members can connect with PCPs and specialty providers who are unavailable in their communities. **Evidence Supporting/Expected Outcomes:** Launched during the COVID-19 pandemic; 2,000 telehealth services provided including health assessments; peer support; case management; wellness education; and skills training, with a 30% reduction in no-show rates. Expected outcomes include improved treatment engagement, medication adherence, and reduced use of BH crisis services, residential care, and ER/hospitalizations and readmissions for both PH and BH. **Commitment:** In partnership with Resilient Health, we are adding telehealth video hubs in Parker (La Paz County) and Bisbee (Cochise County). In addition, we will collaborate with our NACs to identify and use other sites and communities that may benefit from this technology, including local libraries and community centers as hubs. Funding will be provided to cover site build-out costs.

3) Substance use Centers of Excellence (COE): Because access to evidence-based SUD services is challenging in many communities, we are working with existing providers, such as CODAC's Women's Medication Assisted Treatment (MAT) and Recovery Program, CBI and La Frontera, to develop enhanced SUD COEs in the S-GSA. **Evidence Supporting/Expected Outcomes:** Improved member engagement, with at least one face-to-face contact at 30, 60, 90, and 180 days; engagement in vocational/educational services; member self-evaluation of progress; initiation of MAT services; longer length of sobriety; reduced hospitalizations/ER utilization rates; and improved member engagement in PH care. **Commitment:** We will expand COEs prior to launch, including one Cochise County and SUD COE telehubs in Greenlee and Santa Cruz.

4) Peer support expansion: The role of peer- and family-run organizations is under-utilized, particularly in rural areas, and offers a cost-effective way to help fill service gaps. To ensure effective system delivery, our TLCR program in Yuma supports jail re-entry by co-locating a peer within the public defender's office. At our Banner Tucson hospital, we work with HOPE, Inc. to provide peer support services to engage members prior to discharge and to improve connection to outpatient services. In addition, we will work with CBI to add peer crisis navigation to augment crisis mobile teams and to improve wait times, particularly in rural communities. We will partner with UA Rise and Camp Wellness to enhance peer support curriculum to address cultural/traditional aspects of care (e.g., for tribal communities). **Evidence Supporting/Expected Outcomes:** In the TLCR initiative, 54 members participated in services; 61% enrolled in BH services post-release; 56% enrolled in outpatient services; and 53% of all referrals were to service providers other than TLCR. Through the HOPE project, peer crisis navigators improve community stabilization, reduce officer transports and realize as much as a 20:1 return on investment. **Commitment:** We will expand upon existing programs and co-locate peer support at crisis stabilization centers, while adding peer crisis navigators in rural counties, such as Cochise and La Paz. In addition, we will work with PRO and the tribal nations to develop a peer tribal support team.

5) Health education and promotion: Access to timely and informative health education is a gap identified in many of the S-GSA County Health reports. **Evidence Supporting/Expected Outcomes:** Members with co-morbid chronic conditions experience lower life expectancy. The impactable behaviors affecting this are preventable by lifestyle changes. Through a targeted campaign, we anticipate improved member engagement in health literacy, resulting in increased PCP alignment, improved nutrition and increased activity, including exercise. **Commitment:** BUFC and UA College of Public Health will develop public health literature community campaigns through targeted health fairs, public health announcements, member mailings and social media. In addition, we will collaborate with our NACs to develop strategies that address the county health data previously noted, as well as other local needs.

By implementing the strategies outlined above, along with others outlined in the CCE response, we will shift how services are coordinated, delivered, and reimbursed in the S-GSA. **Our role as a local partner enables us to collaborate directly with the community and offer flexible funding strategies that keep funds within the S-GSA community.**

B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

a. Contractor care management

B6.a. Establishing the bar for care and coverage, Banner-University Family Care (BUFC) provides services to vulnerable members with limited time and resources, and who are concerned about the health and well-being of their families, loved ones and themselves.

OPPORTUNITY: BUFC's Integrated Care Management (ICM) program is compliant with AHCCCS AMPM Policy 1021. Our ICM team undergoes training that extends beyond policy requirements, including components of integrated care; assessing Social Determinants of Health (SDOH); trauma-informed care; suicide prevention and intervention; motivational interviewing; and the AHCCCS guiding principles and BUFC mission and values. Our ICM team has access to real-time data from multiple data sources that supports whole person-centered activities. This team directly outreaches and coordinates with providers to address the whole-health and SDOH needs of complex members. This collaboration between BUFC ICM and providers improves member outcomes and expedites care delivery. At times, traditional communication pathways between the ICM team and providers can result in costly treatment and service delays. To address this issue, our ICM leadership team met with providers in 2020 to identify strategies to impact real-time coordination and collaboration between our ICM team, providers and community partners.

INITIATIVE: Our initiative is the development of a single enterprise platform, ***Banner Technology Enabled Care (BTEC)***, to establish efficient processes and data-sharing capabilities. This robust solution aggregates real-time information from multiple sources, automating actionable population and member-level data and enabling the ICM team to view the whole health of every member we serve. The bi-directionality of BTEC also allows our providers to access data in real-time so they can intervene to impact a member's risk trajectory and improve health outcomes. To date, BTEC is the most impactful effort BUFC has undertaken to identify, stratify and support the integrated health needs of complex members, including members with an SMI, and to facilitate provider practice transformation. We will build upon this initiative to support ACC-RBHA members. Objectives of this initiative are to reduce emergency room (ER) use; inpatient admissions/readmissions; address SDOH needs; facilitate member engagement/re-engagement; and eliminate service duplication. BTEC includes **(1) Risk stratification**, a key functionality of the platform that separates members into three risk tiers. The ICM team will receive refreshed data daily of members with higher acuity stratified to tier two and tier three. Risk stratification data will include behavioral health (BH), substance use disorder (SUD), physical health (PH), pharmacy, risk screening data, SDOH and demographics to capture health disparities at the neighborhood zip code level. As an innovation to common off-the-shelf risk stratification software, we will customize our criteria specifically to Arizona by adding data elements essential to accurately targeting the needs of members with an SMI. Examples of this data include members with special health care needs (SHCN); legal system information; SMI special assistance; NOWPOW capabilities; DUGless data; blind-spot data; crisis data; and suicidality risk and priority population data. **(2) BTEC accurately attributes** members to their primary BH case management providers so that our ICM team can communicate in real-time with the member's outpatient care team. **(3) BTEC pushes real-time aggregated data**, analytics, registries and gaps in care alerts to providers, notifying them whenever a member experiences a change in health status. The format is an easy-to-use dashboard with member-level drill-down capability and alerts for when member outreach is required. **(4) The platform includes a clinical quality improvement module** for conducting virtual medical director Interdisciplinary Care Team (ICT) meetings with the ICM team, providers and member, and accommodates referrals for SDOH needs. **(5) Providers will be incentivized to use BTEC tools and coordinate with our ICM team through alternative payment models (APMs).**

OUTCOMES: Prior to BTEC, data-sharing with providers was a manual process. Using APMs to incentivize providers, 48% of members engaged in the initiative were connected to a PCP and 100% of those hospitalized received 7- and 30-day follow-up without readmission. We anticipate a decrease in hospitalizations and readmissions, ER visits and crisis stabilization utilization. **Member Story:** *"Brian" was referred to our ICM program as an acute referral following inpatient hospitalization at a physical health rehabilitation facility as a result of multiple accidental injuries. The team partnered with his mother, discharge team and outpatient Integrated Health Home (IHH) COPE Community Services to develop a person-centered discharge plan. Through BTEC, we provided COPE with real-time data, such as pharmacy utilization and hospital discharge records. The team participated in weekly care collaborative meetings with COPE to ensure the member received a comprehensive care plan to address all his PH, BH and SDOH needs. Providing continuous data enables COPE to monitor Brian's progress toward his care plan goals. Working in concert with his care team, Brian was empowered to continue his journey of recovery.*

RBHA APPLICATION: By automating the ICM processes used in this initiative through BTEC, we anticipate a reduction in avoidable ER visits, inpatient admissions and readmissions by 2% annually over the contract term. We will also more accurately identify and attribute members to an IHH for improved coordination and communication, increase capacity to meaningfully engage more members and improve process flow efficiencies.

B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

b. Provider case management

B6.b. Banner-University Family Care (BUFC) understands the unique challenges with which our members are confronted when navigating the health care delivery system.

OPPORTUNITY: In March 2021, our ACC Integrated Care Management (ICM) team observed that a portion of GMH/SU members with complex behavioral health (BH) and co-morbid physical health (PH) conditions experienced frequent admissions, readmissions, emergency room (ER) visits and crisis encounters. With similarities to complex, difficult-to-engage members with an SMI, these members were referred for and awaiting, or denied, an SMI determination. Despite the efforts of our ICM team, members were ‘falling through the cracks.’ To determine why, we met with providers and reviewed utilization trends and outreach data. We discovered that whenever members cannot be located, community-based case management outreach and engagement efforts are not covered by Title XIX/XXI (TXIX/XXI) or Non-Title XIX/XXI (Non-TXIX/XXI) funding in a traditional fee for service model. Therefore, providers lack the funding resources necessary for successful ‘boots on the ground’ community outreach to members who are difficult to engage. In March 2021, we met with integrated health home (IHH) providers to collaboratively discuss programs to meet the needs of this population.

INITIATIVE: Our initiative, the **Community Action Mobile Outreach (CAMO) team approach**, leveraged a collaborative care model design to align disengaged members through outreach and engagement, utilizing an Alternative Payment Model (APM). We developed an APM to fund promising IHH initiatives to engage members and to reduce unnecessary utilization of higher levels of care. The COPE Community Services (CCS) concept resulted in enhanced case management outreach and engagement and produced sustainable outcomes. In collaboration with the BUFC ICM team, CCS selected a member cohort representing the top five percent of CCS utilizers accounting for 50 percent of the total spend. Members were either minimally engaged or not engaged in outpatient services and required outreach from clinical and peer support specialists (PSSs) to break the negative utilization spiral. BUFC and CCS were aware that access to PSSs and enhanced provider case management is shown to help members remain more engaged in their recovery. The APM allowed the provider those flexibilities necessary to support members in addressing Social Determinants of Health (SDOH) needs, such as obtaining identification cards, birth certificates and assisting with move-in expenses, many of which are non-funded services. The four primary **objectives** were to **(1) Reduce potentially avoidable PH and BH care utilization**, such as inpatient (IP) admissions, ER visits and crisis observation stays; **(2) Provide community-based engagement** activities to reduce suicidality and opioid use risks; **(3) Increase the quality of outpatient care**; and **(4) Support recovery and develop self-care capabilities**. The CCS initiative utilized five primary **strategies**, including **(1) Use of an APM to facilitate funding for non-billable services required for high-touch, person-centered engagement and outreach in accordance with the recent CMS guidance to Medicaid Authorities**. CCS continued billing covered TXIX/XXI services at its contracted rate. The APM for the cohort group was based upon utilization and engagement history, determined collaboratively with CCS and billed on the first of the month. **(2) The CAMO team, available 24/7/365, paired a clinician with a PSS and focused on finding high-risk, complex members who use high-cost services in the community**. To engage members, CAMO teams proactively searched under bridges, combed streets, or visited shelters and homeless encampments. Team members are specially trained in motivational interviewing, trauma-informed care, suicide intervention and prevention, recovery, peer support, engagement techniques and wraparound-support services. The CAMO team’s in-depth training, coupled with lived peer experiences, facilitates engagement and fosters the development of trusting relationships critical to recovery. **(3) The BUFC ICM team pushes data to the CAMO teams and coordinates care through a single point-of-contact**. BUFC and CCS meet routinely to discuss successes, barriers and solutions. **(4) SMI evaluation is conducted to ensure appropriate status conversion**. **(5) Care coordination occurs with members’ PH providers to address chronic PH conditions**.

OUTCOMES: Six months pre- and post-cohort group results indicated 53% were connected to a primary care provider (PCP), representing a 160% increase; ER use decreased 48% and IP admissions decreased 88%. Additionally, 87% secured stable housing; 60% secured employment or vocational training; 100% adhered to the terms of their court-ordered treatment (COT); and 53% engaged in substance use treatment, including medication assisted treatment. **Member Story:** *The CAMO team outreached a 21-year-old male, “John,” who had 5 ER visits, one IP admission and 5 crisis episodes in the six months prior to engagement in the program. John is currently living in a shelter and is on COT. Since engaging with the team, he has developed a strong relationship with his PSS. In partnership with the PSS, John is fully adherent with his COT, with no hospitalizations. He has only had one crisis episode, is employed and working on securing permanent housing.*

RBHA APPLICATION: BUFC will expand this initiative and institute APMs to all IHHs to enhance provider case management capabilities for outreaching complex, difficult-to-engage individuals with SMI across the South GSA. Introduction of these models will shift relying upon costly IP, ER and crisis services to less costly outpatient services facilitated by an IHH or other providers with whom the member has trust. BUFC will continue to monitor performance and person-centered measures and will evaluate strategies to enable PCPs and PH providers to access enhanced case management.

B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

c. Outreach and education

B6.c. Banner-University Family Care (BUFC) provides VIP access to the best integrated health care solutions, beginning with outreach and education. ***We ensure members matter in an often impersonal and complicated system.***

OPPORTUNITY: In late 2020, through analysis of county-specific health care utilization and integrated care management (ICM) trends, we determined a portion of our ACC members residing in Casa Grande, Arizona had high-need behavioral health (BH) conditions, complex medical co-morbidities and were experiencing frequent emergency room (ER) and inpatient hospitalization at Banner Casa Grande Medical Center (BCGMC). These members had diagnoses and symptom severity levels similar to individuals with SMI. Additionally, they were likely to be impacted by trauma, stigma and social injustice resulting in Social Determinant of Health (SDOH) needs. They were also less likely to seek treatment with primary care and behavioral health providers and required a variety of high-touch outreach and educational strategies.

INITIATIVE: Our ***cross-sector member engagement initiative*** leverages a collaborative care model to connect disengaged members through **outreach and education**. In January 2021, we implemented an evidence-based integrated health home (IHH) initiative in partnership with Resilient Health (RH) and Crisis Preparation Recovery (CPR) to improve member outreach and education. This initiative uses the University of Washington Collaborative Care Model (CCM), an evidence-based integrated health approach. The initiative targets members with three or more ER visits in the last six months, complex behavioral health and/or physical health (PH) diagnosis, and/or SDOH needs, and who have no connection to outpatient services. This initiative includes the following **strategies**: **(1)** The BCGMC ER referral coordinator sends real-time referrals and provides a **warm handoff** to RH/CRP to initiate outreach activities. **(2)** BUFC's ICM team provides **real-time data** to RH/CRP to support provider case management. **(3)** RH/CRP's peer support specialist (PSS) **leverages trauma-informed care** approaches to move engagement from 'what's wrong' to 'what happened' and to build and foster trusting relationships. The PSS conducts multiple outreach and education activities, including meeting members at their residences or local establishments, or by searching for them at well-known homeless encampment areas. **(4)** Because SDOH often drives unnecessary ER and inpatient utilization, the PSS **educates members** on community resources to address food insecurity, employment/vocational training and housing needs. Often, members initially only want assistance with SDOH needs; however, through continuous engagement, they become more trusting and open to additional services. **(5)** BUFC secures hotel vouchers for members facing homelessness to **provide a safe environment** to begin their journey to recovery. **(6)** The PSS works to connect members to services, educating them on their **whole health needs** and in-network treatment options. **(7)** The PSS continues to attend appointments, provides transportation and serves as a **member advocate** in partnership with members' care team. **(8)** PSS collaboration ensures an integrated care plan necessary to address member needs; facilitates care coordination; reduces service duplication; and **teaches members** to use engagement and education applications, such as Pyx Health and our member portal. **(9)** The BUFC ICM team routinely meets with RH/CRP to discuss **member progress**, barriers, and successes. BUFC and RH/CPH utilize monthly reports to analyze performance metrics and outcomes. **Objectives** include **(1)** decreasing ER/inpatient use; **(2)** educating members on total health needs, ER use, provider choices, and use of engagement applications; **(3)** addressing SDOH needs; **(4)** increasing PCP care; and **(5)** ensuring completion of SMI evaluations.

OUTCOMES: Through outreach and education, this initiative engaged 119 members. Prior to inception of the initiative, none of the members were active in treatment; currently, 48% are engaged in treatment. In the 90 days prior to participation, the same 57 members accounted for a staggering 180 ER visits. Following participation in the program, preliminary results reveal a 63% reduction in their ER use; 73% received PCP care coordination and additional education; 26% received temporary housing; and 13% received SMI evaluations and determination. In addition, results indicated completion of 10.2 outreaches per member and 46 SDOH referrals. **Member Story:** *"Tonya," a 32-year-old homeless female experiencing a substance use disorder (SUD), was referred to the RH/CPR IHH and PSS engagement after visiting the BCGMC ER. Initially reticent, following several outreach attempts she began to share her needs for employment, housing and a driver's license. Tonya was seen and treated by the IHH PCP and BH providers, who provided health and prevention education. Tonya also attended SUD groups, vocational services, and received temporary housing support. Through increased engagement, Tonya obtained full-time employment and her driver's license was reinstated. DCS, which no longer requires drug screenings for Tonya, anticipates closing the case soon and is permitting increased visitation with her three children who are in the care of their grandmother.*

RBHA APPLICATION: Based upon the success of our collaborative work with RH/CPR, improvement in outreach and education of high-needs members with an SMI designation who overutilize community hospital services is realized. We will expand this initiative in other communities, including Yuma and Cochise Counties, to continue promoting member engagement through outreach and education. BUFC and RH/CPR will collaborate with Copper Queen Hospital in Bisbee and Yuma Regional Medical Center.

B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

d. Stakeholder input

B6.d. Banner-University Family Care (BUFC) is a transparent and collaborative partner with all stakeholders that embraces community voice and participation, consistently following through on its bid commitments. ***Stakeholders are engaged in our shared solutions because we live and work alongside them in the communities we serve.***

OPPORTUNITY: To prepare for the YH19 ACC RFP, BUFC held community stakeholder forums in Yuma. During these meetings, we consistently heard that there was an opportunity for a system quarterback to assist with the coordination and timely engagement of stakeholders across the county's diverse rural and urban areas. We solicited input to identify how to promote the development of a culturally responsive local system of ***care and coverage***, and garnered feedback regarding federal and State policy, health care access, performance measures, barriers, unique health disparities and opportunities to improve or strengthen service delivery in these communities. We also received recommendations regarding ways to engage the diverse community and its interests across Yuma County.

INITIATIVE: Based upon this invaluable feedback, BUFC evaluated potential solutions and determined the optimal way to increase stakeholder engagement was to create our ***Neighborhood Advisory Council (NAC) initiative***, a representation model that supports distinct and diverse local neighborhoods across region. *We made this an ACC bid commitment and followed through.* For example, in 2018, BUFC created the Yuma NAC and an additional eight NACs across ten counties. Four NACs were created in the South GSA (S-GSA), representing population centers, including Pima North, Pima South and Cochise (along with Pima). **Objectives:** The Yuma NAC **(1)** affords the opportunity for BUFC, local providers, members, families and other stakeholders to build mutual **understanding** of system expectations, inform vision and goals, participate in strategic planning and define BUFC success; **(2)** facilitates BUFC's understanding of **local health disparities** and Social Determinant of Health (SDOH) needs to promote total health outcomes; and **(3)** promotes **mutual accountability** and performance improvement using best practices, while recognizing the demographic, cultural and geographic differences of Yuma County. This initiative includes the following **strategies:** **(1)** The Yuma NAC includes diverse and representative membership based upon the community's demographics and needs. NAC members include the Regional Center for Border Health; Arizona's Children Association; TLC Recovery; Yuma Food Bank; BUFC leaders and staff (e.g., ACC administrator, medical directors, Provider Relations representatives); and community members and families. In addition, we received insight and input from Yuma Regional Medical Center, first responders, Tribal Health Services and American Indian (AI) representatives. To facilitate participation, diversity and community representation, we offer a \$75 stipend and provide transportation to participating members and families. **(2)** The NAC reports to our Quality Management (QM)/Performance Improvement (PI) Committee and to the BUFC senior leadership team (SLT) to monitor evaluation and follow-through on recommendations. **(3)** The NAC receives assistance and support from BUFC teams, including the Office of Individual and Family Affairs (OIFA), Medical Management; Chief Medical Officer (CMO); Housing; Employment/Vocational; Tribal; Provider Network; and Care Management. The BUFC teams are empowered to offer real-time solutions to issues and barriers that extend beyond covered services. **(4)** The NAC uses formal charters to outline objectives and goals, such as a holistic approach to care and coverage, and are charged with collaboratively resolving issues to improve the whole health of BUFC's members. Each NAC charter outlines its purpose, functions, structure and authority. The NAC meets monthly between formal and ad hoc discussions, and actively engages and communicates through online platforms, such as Teams. **(5)** The NACs are supported through BUFC administrative funds, community reinvestment, foundation dollars and collaborative community partnerships. **(6)** NACs address topics, such as local health disparities; prevalent social needs (e.g., non-emergent transportation and housing insecurity); integrated care; the medical impact of the COVID-19 pandemic and vaccination education; the behavioral health and opioid use epidemic; and suicide prevention.

OUTCOMES: This grassroots initiative revealed diabetes as a major issue in the region. Rates were evaluated per zip code to appropriately target our response and activities. For example, Transitional Living Center Recovery (TLCR) leveraged peer support specialists (PSSs) to promote a weight loss challenge for members with diabetes where hemoglobin A1Cs were measured. In addition, TLCR also engaged the Yuma Food Bank to provide member education on healthy eating. Another outcome from the Yuma NAC was the formation of an opioid use disorder sub-group to help address the impact of this disorder on members and their families. As a result, we appropriately targeted Naloxone distribution sites. **NAC QUOTE:** *"Never before has collaboration been so valuable as new clients are coming to us with fear of the virus, job loss early in the pandemic to now seeing more depression with those still coming to the Food Bank. The Yuma NAC held virtually, was a great way to look at how our community is doing post pandemic."* Shara Whitehead, CEO, Yuma Community Food Bank

RBHA APPLICATION: All our S-GSA NACs will be expanded to include individuals with SMI and system stakeholders, such as first responders, criminal justice stakeholders, IHH and crisis providers. Spanish translators are provided to encourage participation by mono-lingual Spanish-speaking members. In addition, TLCR will implement pre/post studies of AC1 results to align with the quality measure of diabetes screening for members who are using antipsychotic medications.

B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

e. Justice system/justice-involved individuals

B6.e. Banner-University Family Care (BUFC) is a member champion and collaborative partner. To bridge the gap between two disparate publicly funded institutions, the health care delivery system and the criminal justice system (CJS), we developed an initiative to improve coordination of care for justice-involved members.

OPPORTUNITY: Members in the CJS with an SMI often face longer detention periods and harsher penalties as a result of delayed intervention by treatment providers. BUFC’s approach to justice-involved members follows the evidence-based **SAMHSA GAINS Center Sequential Intercept and Risk-Need-Responsivity** models. Our primary focus is to avoid members entering the CJS; however, whenever a member is arrested, we are committed to intervening as early as possible during **Intercept 2—Initial Detention/Initial Court Hearings**—as opposed to waiting for them to penetrate further into the CJS, and begin engagement when assigned to a specialty/mental health court, during re-entry, or even later during Community Corrections/Probation (Intercepts 3, 4 and 5). This emerging best-practice approach exceeds contract justice reach-in requirements and is unique to Arizona, as well as to the nation. This model is transforming the interface between the CJS and health care systems, resulting in additional opportunities for therapeutic jurisprudence.

INITIATIVE: Based upon this opportunity, we launched the **Public Defender/Legal Defender Co-Location Project (PLDP)**, in partnership with Transitional Living Center Recovery (TLCR) in Yuma County, in April 2021. Our goal was to expedite connections for justice-involved members to integrated health services, including physical health (PH), behavioral health (BH) and Social Determinants of Health (SDOH) through **expedited reach-in** activities. BUFC funded TLCR to co-locate peer support specialists (PSSs) in the Public and Legal Defenders Office to engage members as soon after arrest as possible, ideally prior to initial appearance hearings. Attorneys refer clients to TLCR who assign a PSS to meet with members to help them understand available services and their benefits. They discuss how services may address the behaviors that resulted in the arrest and reduce the criminal penalties through pre- and post-adjudication diversion options. TLCR’s PSSs are specifically trained and tasked with implementing BUFC and AHCCCS’ commitment to **‘voice’ and ‘choice,’** encouraging members to select providers based upon their own preferences, as opposed to what is convenient for the system of care. PSSs with lived experiences in the justice and integrated health care delivery system are more effective in engaging with justice-involved members because they personally understand the anxiety, depression and trauma often associated with incarceration. Following the initial meeting, TLCR creates a member-centered release plan for members who are interested, using an existing template provided by the Yuma County attorney’s office, which is familiar to the courts and judges. Whenever members return to court, defense attorneys present to judges the release plans as an alternative to incarceration. Historically, members with mental illness/substance use disorder (SUD) spend more time in jail. Our approach addresses this disparity, accelerating release from jail and back to the community. BUFC tasks TLCR PSSs with helping to provide service coordination and address SDOH, including arranging for transportation, warm hand-offs to provider organizations and housing. Members may choose to access services from TLCR or other provider organizations, using TLCR telehealth video hubs to **eliminate barriers** to care created by unresponsive transportation options or limited public transportation. Through TLCR or its telehealth hubs, members have access to assessment and service planning, intensive outpatient treatment, mental health visits, Moral Reconciliation Therapy (MRT) and primary health care. These activities are connected through Banner Technology Enabled Care (BTEC), a suite of technology solutions to solve current fragmentation and barriers to truly integrated care. BTEC helps to identify and flag members most at risk and in need of more intensive outreach. Member release plans are available within BTEC for care coordination and implementation for both TLCR and members’ Integrated Health Home (IHH).

OUTCOMES: This project demonstrates significant outcomes, with 61% of those offered the program accepting and engaging in services. As the initiative continues, we anticipate increased connections to integrated health care, while reducing recidivism, length of stay and opioid-related overdoses for members re-entering the community from the CJS.

Member Story: *“Jenny,” referred by her attorney to the PLDP, indicated she was experiencing BH challenges and was not engaged with an IHH. The PSS developed a release plan that was approved by the attorneys and judge. The PSS also scheduled an intake with an IHH. The PSS transported Jenny to the IHH where she completed her intake and received her medications. Jenny is currently in residential treatment and has been sober for 60 days.*

RBHA APPLICATION: Not all IHHs have the skill set, capacity and system relationships necessary to work with the CJS. As the RBHA, we will expand this service to members with an SMI. By supporting provider case managers with PSSs who are well-versed in the CJS, BUFC will increase the ability to engage members in the least restrictive setting. Initial outcomes far exceed BUFC’s original expectation, and we will develop processes to expand the model to other counties. We will also utilize our plan and provider workforce development processes to assist members in attaining gainful employment. As the ACC-RBHA, we will establish alternative payment models (APMs) and pay for performance incentives, including incentives based upon the number of members successfully engaged in outpatient services.

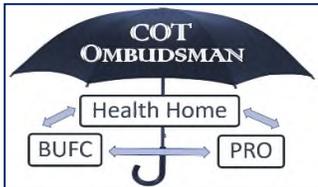
B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

f. Court Ordered Treatment

B6.f. Banner-University Family Care (BUFC) is well-positioned to implement court-ordered treatment (COT) system improvements in the South GSA (S-GSA).

OPPORTUNITY: COT requires members and their supervising Integrated Health Homes (IHHs) to comply with extensive administrative and legal requirements. Due to the involuntary nature of the process, members on COT may be less adherent with treatment expectations. Historically, this has resulted in challenges with the effective administration of COT and high numbers of members cycling through inpatient facilities and the legal system, increasing the effects of trauma.

INITIATIVE: Our **COT Integrated Care Initiative**, facilitated by our COT Ombudsman—a BUFC value-added position that will report to the Behavioral Health (BH) medical director—will help to bridge the gap and provide oversight of core COT functions, including health plan, IHHs and Peer Run Organization (PRO) activities. The ombudsman’s role is to provide an objective lens to ensure the blend of compliance, recovery and community safety are woven into the service delivery



model and working toward a common purpose, supporting how we make health care easier, so life can be better. While the elements of this framework are currently in place across the system, they are fragmented and can be challenging for members to navigate. Through the COT Integrated Care Initiative, our ombudsman will serve as a ‘quarterback’ across the delivery system to coalesce these key activities into a holistic, recovery-focused approach to care. **(1) BUFC Health Plan Activities:** The BUFC Utilization Management team will work

collaboratively with members’ IHH, inpatient team and community supports to identify both BH and physical health (PH) needs of members and to develop discharge plans to address those needs. BUFC conducts a BH/PH medication reconciliation, including review by a BH pharmacist, along with any recommended adjustments to simplify the medication regime. The care team will ensure member’s appropriate for a long-acting injectable will receive an initial dose prior to discharge. All members on COT will be assigned to a complex care manager, who will work through a collaborative care conference approach, involving staff from the health plan, inpatient and outpatient teams for care coordination purposes. The COT Ombudsman will make sure all members of the care team are actively engaged in the collaborative care conference and tracks key performance indicators, such as COT amendments, crisis interactions, hospitalizations and diversions. **(2) Health Homes Activities:** BUFC will collaborate with the IHH, which serves as the supervising agency, confirming appropriate integrated outpatient services, including proactive engagement efforts. The COT Ombudsman will offer insights and strategies to the IHHs, as appropriate, to make sure least restrictive and person-centered efforts are the first approach, as opposed to defaulting to a revolving door of COT amendments. This includes an expectation of all IHHs to utilize assertive and sustained outreach attempts if members fail to attend scheduled appointments and to utilize appropriate medication management techniques, including long-acting injections and/or medication boxes or bubble packs. We will leverage technology solutions to monitor evidence-based outpatient treatment/co-morbid substance use disorder treatment to optimize adherence and the development of an integrated member-centric care plan. **(3) Peer Support Activities:** In addition to the traditional IHH clinical and oversight activities related to COT, BUFC will augment its efforts by offering a peer support specialist (PSS) to all members on COT (including tribal) from an independent Peer Run Organization (PRO), as an additional level of support for members and IHHs. BUFC contracts with HOPE, Inc. and other PROs to assist with engagement. The PSS brings a level of empathy and understanding to members, while also engaging natural supports and family members who are often vital in improving outcomes for members on COT. PSS’s function more as advocates than as compliance supervisors, providing a personalized, added level of emotional support and ‘going the extra mile’ to help address members Social Determinants of Health (SDOH) needs, which often complicate COT adherence. This service is designed to complement, not replace, the IHH responsibilities as the supervising agency. The COT ombudsman makes sure an added level of support is available directly to members, regardless of IHH affiliation.

OUTCOMES: The support of the COT ombudsman complement those of the IHH, with the goal of increasing member engagement, thus reducing the number of COT amendments; improving medication adherence; decreasing polypharmacy; improving member quality of care; and reducing the overall cost of care. **PRO Quote:** “We appreciate BUFC’s thoughtful whole person approach for members on COT. This approach provides an added level of member and family advocacy to ensure members are educated and feel supported during an often-complicated process.”—Dan Haley, CEO, HOPE Inc.

RBHA APPLICATION: The COT Ombudsman will support all members with an SMI on COT. BUFC will commit to funding PROs, augmented with Alternative Payment Models (APMs). We have piloted a similar initiative with COPE that is demonstrating positive outcomes, such as a reduction of amendments and unnecessary bed days. Preliminary data shows 100% of members on COT are adherent. Upon award as the ACC-RBHA, we will implement this holistic approach for all members on COT across the entire S-GSA and, specifically, in rural areas.

B6. For each of the following topics below, describe the single most impactful initiative or effort the Offeror has undertaken (and is still in effect), or will undertake, to provide the best care and to improve outcomes for individuals with an SMI designation. If the Offeror provides more than one initiative per topic below, only the first initiative described will be considered for scoring.

g. Dual alignment of Medicare and Medicaid members

B6.g. Banner-University Family Care (BUFC) collaboratively undertakes initiatives and innovates in a safe, productive and results-oriented environment, with members at the core of our decision-making. Our Dual Eligible Special Needs Plan (DSNP) has grown significantly over the last 15 years and includes more than 180 individuals with a serious mental illness (SMI). Because navigating health care can be challenging and may result in missed opportunities, we promote alignment between our Medicare and Medicaid plans. Through our efforts, our DSNP plan is 87 percent aligned with our ACC and ALTCS plan. Our Quality Management (QM) program continually assesses disparities in member care and outcomes to identify opportunities and to develop strategies consistent with the Quadruple Aim. Components of our QM/Quality Improvement (QI) program include **(1)** system-wide quality performance tracking and trending; **(2)** identification of interventions to improve member outcomes; **(3)** use of cross-functional tools for root-cause analyses on underperformance; **(4)** QM/QI charters outlining the purpose and fundamental components; and **(5)** QI plans with organizational accountability.

OPPORTUNITY: Individuals with SMI experience early mortality, in part because of co-morbid physical health (PH) conditions, such as diabetes and hypertension. Nationally, Medicaid and Medicare members lag the general population in quality measures for the treatment of these conditions. For individuals with SMI, performance measures trail by as much as 14 to 49 percent. BUFC identified the opportunity to improve medication adherence for diabetes, hypertension, and dyslipidemia among its DSNP members; improving these measures is foundational to improving their overall health. This is particularly important for our members with an SMI designation, as poor control of these conditions is associated with metabolic complications and often made worse by the use of psychotropic medications. In addition, for individuals with SMI, there is an overall increased risk for emergency room (ER) use; physical and behavioral health (BH) hospital admissions; admissions to crisis units; substance use disorder co-morbidity; and overall suicide risk.

INITIATIVE: BUFC formed a DSNP Med Adherence QI Project team, which developed a **QI Roadmap**. The roadmap includes an analysis of historical and current adherence trends within a control chart to identify statistically significant trends with a t-test. To identify root causes, analysis was reviewed by a cross-functional QI team composed of Pharmacy, Claims, Data Analytics and Provider Relations staff. Using a fishbone diagram, barriers to optimal care were identified and associated actions taken, including provider education and member outreach. **Provider education** included materials focused on adherence and rate calculation of the proportion of days covered, along with training of provider-facing teams to educate BH and PH providers, including use of 90-day prescriptions, long-acting injectables and home delivery services. Provider-friendly reports, updated monthly and distributed by the provider-facing teams, showed actionable member-level adherence gaps. **Member outreach** incorporated a team of pharmacy technicians and licensed practical nurses who conducted more than 2,000 high-touch member outreach calls to offer refill reminders and facilitation, address any barriers to adherence or to care, such as care management or Social Determinants of Health (SDOH) referrals. This team intervened to promote adherence by partnering with members and their PH and BH prescribers whenever new prescriptions were required; facilitating prior authorization; transferring prescriptions to other pharmacies to minimize member transportation barriers; and implementing additional interventions to promote adherence and optimal integrated care.

OUTCOMES: From 2019 to 2020, medication adherence improved for each of the targeted conditions, with increases of 9% for diabetes, 2.5% for hypertension and 6.5% for statins, all of which were statistically significant ($P < .05$). Additionally, we monitored pharmacy claims information to identify other targeted interventions. For example, whenever members incurred claims for multiple antipsychotic or antidepressant therapies, our Board-certified behavioral health clinical pharmacist contacted prescribers to address these variances and to simplify medication regimens. Our pharmacists also attended all Care Management rounds, along with our medical directors, to address adherence and to support overall improved care planning and member outcomes.

RBHA APPLICATION: Low medication adherence for the SMI population is a known disparity. During the transition, we will ingest the DEF/non-DEF files into our Banner Technology Enabled Care (BTEC) platform to identify members with chronic conditions. In coordination with our medical directors, we will conduct member and/or provider outreach by 10/1/22 and during the first three critical months following member transitions. Additionally, our Pharmacy team will continue to monitor impending prior authorization expiration dates to contact prescribers proactively for refills to avoid disruption to therapy. BUFC will also partner with Sonora Quest Laboratories and Banner Health in a value-add pilot to incorporate pharmacogenomic testing to improve longstanding treatment failure in complex needs members, with the goal of increasing medication adherence and effectiveness. For select members (with their consent), pharmacogenomic testing can guide drug selection, dosing and monitoring plans with a new level of precision. Our clinical pharmacists will collaborate with medical directors and providers to review and execute recommended pharmacotherapy plans.

- B7. AHCCCS expects Contractors to continually strive to improve the system of care for individuals with an SMI designation through the pursuit of innovation and advancing best practices. Describe opportunities for improvement the Offeror considers to be important and proposed strategies for each of the following:**
- a. Advancing an enhanced integrated care model to improve member health outcomes,**
 - b. Co-occurring SMI/SUD service delivery,**
 - c. Improving access to evidence-based outpatient behavioral health services and the delivery system framework to access meaningful services,**
 - d. Ensuring equitable health care and eliminating existing disparities, and**
 - e. Utilizing technology to maximize member engagement.**

B7. Banner-University Family Care (BUFC) is rooted in the communities we serve and a long-time trusted partner to our members, providers, the community and AHCCCS. This mutual trust enables us to collaborate with community partners and stakeholders to develop innovative care solutions to improve integration across the delivery system.

A. BRINGING CARE AND COVERAGE TOGETHER TO IMPROVE HEALTH OUTCOMES: Through meetings with members, providers and community stakeholders we have identified opportunities to enhance the integrated care model in the South GSA (S-GSA) and to improve member health outcomes. In 2021, we hosted our second annual Integrated Health Care Summit, which brought providers together from a multitude of disciplines to discuss initiatives to better align services for physical health (PH), behavioral health (BH) and Social Determinants of Health (SDOH) through a collaborative care approach. The provision of truly integrated care **requires strategies at the health plan and provider practice level.** Members with an SMI experience a shorter life expectancy than the general population due to untreated PH conditions. These conditions can be treated or avoided with improved screening, diagnosis and treatment. During the summit, we discussed specific strategies, including improved access to high-quality coordinated care for members with an SMI and enhanced screening for co-occurring PH, BH and substance use disorders (SUD) to improve overall health outcomes.

BUFC's Integrated Care Management (ICM) program includes a multi-disciplinary team composed of Arizona-based PH and BH trained staff. The team—led by Kristin Frounfelder, Senior Director, Behavioral Health—holds daily care team meetings where members' whole person care is discussed to remove any barriers to care. Studies have shown SDOH account for 80% of a member's overall health. The ICM team leverages BUFC's Office of Individual and Family Affairs (OIFA) team to assist with engaging members and addressing SDOH needs, such as housing and food insecurity, through identification of community resources. We recognize providers have the therapeutic alliance with members. Through a collaborative approach, the BUFC ICM team works in tandem with the provider Case Management team to provide additional data, such as pharmacy data, gaps in care and predictive risk modeling through our technology suite, **Banner Technology Enabled Care (BTEC).** This approach enables us to collaborate with providers to proactively identify members at risk, intervene timely and impact a member's risk trajectory, thus improving member health outcomes.

BUFC is uniquely positioned to reduce the current fragmentation of integrated care in the S-GSA through its relationship with Banner Network Southern AZ (BNSA). To improve provider and member satisfaction, BNSA is a Clinically Integrated Network (CIN) comprising community-based PH providers who provide high-quality care at the lowest cost. To build upon BNSA, BUFC engaged **Blaze Advisors** to develop a high-performance BH CIN, Integral Health Network of Southern AZ (IHNSA), which will work in concert with BNSA to provide truly integrated care. BNSA and IHNSA will bring together primary care, BH, hospitals, medical specialties, crisis and SDOH providers to work collaboratively to meet the unique needs of members with an SMI. These provider-governed networks are enabled by care coordination technologies that improve care team communication and access to care, while increasing transparency and aligning network performance through integrated alternative payment models (APMs). Optimal models of provider case management are established by risk level and through bi-directional collaboration with the BUFC ICM team. Utilizing the **SAMHSA Four Quadrant Model**, we categorize members for the purpose of care planning and to provide the most appropriate and effective service level possible. The quadrant model examines diagnoses, as well as the risk level of members, to determine the most appropriate interventions that will result in positive health outcomes. IHNSA offers a robust integration platform to assist with population health stratification across provider partners and affiliates, and includes data, analytics, dashboards, registries, alerts, performance measurements and incentives to facilitate coordination with BUFC care and quality management (QM) teams. The integrated platform supports standardized screening/risk tools, tele-consult support, episodic/transitional care management and timely access to care. IHNSA's platform will link to BUFC's member engagement tools (e.g., Pyc Health) and the larger BTEC suite of solutions. IHNSA will provide gap-in-care reports to facilitate evidence-based care and a closed-loop referral system (CLRS) to capture, refer, and follow-up on SDOH needs. This proactive member-centered approach allows for diversion to appropriate lower levels of care. Connecting members back to their BH/PH providers early in this process is key to reducing readmissions and length of stay. This integrated and coordinated network approach allows providers across the delivery system to collaborate to provide whole person care to members with an SMI.

To improve screening for early identification of PH and BH conditions in members with an SMI, we must provide tools and resources to providers. PH providers often lack the resources or knowledge to act on a positive BH condition screening and vice versa for BH providers. Primary care providers (PCPs) feel more capable of addressing members with BH conditions when they are supported by a network of specialty BH providers through IHNSA. BUFC will support this effort by providing continuing education units for the completion of BH and medication assisted treatment (MAT) education modules and by providing incentives for BH screenings and treatment. For example, we developed a training program, Psychiatry for Non-Psychiatrists, in partnership with the University of Arizona (UA) Department of Psychiatry. We have

already provided three comprehensive trainings, PH Essentials for BH Providers and are planning to continue this training series and provide additional training, based upon positive feedback received from participants. BNSA will provide PH consultation to BH providers so members screened for PH conditions receive timely appropriate care. Through available real-time, on-demand telehealth consultation capabilities, members receive timely care, which improves follow-up care and improves overall health outcomes. This approach will increase service capacity in both the BH and PH delivery systems by affording members a fully integrated approach to care.

Through the IHNSA, we anticipate outcomes like those achieved by Blaze Advisors sister **ONEcare** networks in North Carolina (NC) and New York (NY). From 2017 to 2019, the NC **ONEcare** network achieved a 70% reduction in avoidable bed days and hospitalizations; a 50% reduction in average length of stay; a 48% reduction in BH readmissions; and \$30 to \$35 million in total cost savings. Similarly, in 2019, NY had an 18% BH screening rate and 37,000 BH-related emergency room (ER) visits annually. In 2021, following implementation of the **ONEcare** Network, the BH screening rate increased to 74% and BH-related ER visits were reduced by 18.3%. By implementing IHNSA and through our ICM approach, we anticipate a decrease in admissions and readmissions, ER visits, improvement in performance measures, reduction in administrative burden and total cost.

B. INNOVATION OF CO-OCCURRING SMI/SUD SERVICE DELIVERY: In a report published by the Journal of the American Medical Association and SAMSHA, approximately 50% of members with an SMI are affected by a SUD, while the rate of co-occurring BH conditions in the criminal justice system exceeds 70%. Many members struggling with SUD are disengaged in treatment and cycling through the ER, inpatient units and crisis system, often ending up in the criminal justice system. ***We understand the importance of listening and meeting members where they are on their road to recovery.*** We also recognize the State's opioid epidemic plan and the resulting public health emergency related to fatal overdoses. To break this cycle of addiction, we must improve member engagement efforts, work collaboratively with county justice partners and increase system capacity, particularly in rural areas of the S-GSA.

We recognize some members with co-occurring conditions may be pre-contemplative or contemplative about SUD treatment. This reluctance may be due to trauma, stigma, feelings of shame/guilt, concerns about past failures or the presence of a BH condition. Supporting members at all levels of change is imperative to building a trusting and non-judgmental relationship. BUFC will leverage and build upon its already robust peer support specialist (PSS) network in the S-GSA. PSSs are proven instrumental to member engagement. Meeting members where they are through motivational interviewing (MI) and then aligning interventions based upon member readiness provides members with a sense of ownership in their recovery. Often, simply listening and acknowledging their struggles opens the door to recovery. BUFC will continue to support the Camp Wellness PSS training program to promote capacity across the S-GSA and will continue to collaborate on training programs specific to certain populations, such as American Indian/Alaskan Natives (AIs/ANs), which is already in development. Because members are at different stages of change supporting the ***four pillars of harm reduction*** is key: **(1)** Prevention; **(2)** Harm Reduction; **(3)** Enforcement; and **(4)** Treatment. Our Neighborhood Advisory Councils (NACs) partnered with local neighborhoods, Peer and Family Run Organizations (PFRO), community SUD providers and Sonoran Prevention Works, a harm reduction provider, to implement initiatives around increasing education and distribution of Naloxone to areas throughout the S-GSA. The BUFC NACs also identified oral health disparity for members with SUD, which resulted in a proposal to fund local dental programs to assist members with preventive dental care.

Through our ACC experience, we understand that members are often engaged in the criminal justice system due to their SUD. As an ACC-RBHA, close coordination with the court system and/or probation will be required. Using a therapeutic jurisprudence approach, intervening early to engage members in the criminal justice system helps members successfully reintegrate back into the community and connect to outpatient service providers. Intervening early with members while they are still incarcerated builds a trusting relationship prior to release and allows for continued support once released. In April 2021, BUFC launched the Public Defender/Legal Defender Co-Location Project (PLDP), in partnership with Transitional Living Center Recovery (TLCR), in Yuma County. Our goal was to expedite connections for justice-involved members to integrated health services, including PH, BH, co-occurring and SDOH services and supports. BUFC funded TLCR to co-locate PSSs in the public and legal defenders office to engage members as soon after arrest as possible, ideally before initial appearance hearings. The PLDP project is demonstrating significant positive outcomes, with 61% invited to participate in the program accepting and engaging in services. As the initiative continues, we anticipate increased connections to integrated health care, while reducing recidivism, length of stay and opioid-related overdoses. As the ACC-RBHA, we will expand this service to members with an SMI. Initial outcomes far exceed BUFC's original expectations; we will develop processes to expand the model to other counties willing to collaborate in a similar manner.

During provider, member and community stakeholder meetings, we identified insufficient SUD or 24/7 MAT services, particularly in rural counties in the S-GSA. To meet this need, BUFC is committed to expanding and creating two additional SUD Centers of Excellence (COEs) in rural areas within the first year of the contract to include 24/7 MAT. By geographically dispersing COEs, we will increase access for members residing in remote areas. SUD COEs following the Co-Occurring Enhanced Program Guidelines will ensure member access to cognitive and dialectic behavioral therapy; dialectic motivational interviewing; behavioral modification; behavioral social skills training; and family therapy. The SUD COEs will use a multidisciplinary approach which incorporates **SAMHSA's four dimensions of recovery: (1) Health; (2) Home; (3) Purpose; and (4) Community.** Telehealth video hubs will be co-located in PFRO and Integrated Health Homes (IHHs) to promote access to evidence-based practices (EBPs) for BH and PH services in rural areas of the S-GSA, and we will increase access to evidence-based (EB) MAT services through a similar initiative. This technology provides the platform and structure to 'bring care to the member,' a critical theme gleaned from the community. We will build capacity through additional telehealth video hubs in Parker (Yuma County) and Bisbee (Cochise County) and identify other locations such as libraries or community centers, to further expand this innovative model.

Through implementation of COEs and utilization of PSSs, we anticipate increased engagement in MAT, reduced SUD hospitalizations and ER visits, decrease in overdoses and crisis interventions related to SUD. We will address the negative consequences of addiction through recovery-oriented care approaches that promote recovery and resiliency.

C. CONTINUOUS IMPROVEMENT APPROACH TO IMPROVING ACCESS AND SERVICE DELIVERY: Increased access to EB treatments can reduce health care spending, while providing higher quality of care and improved experience for members with an SMI. BUFC is committed to enhancing EB solutions, advancing innovation and investing in whole person care. We will expand and build upon existing EBPs utilizing SAMHSA protocols. Through APMs and incentives, we offer flexibility to providers to meet the priorities of AHCCCS and the ACC-RBHA for EB training (e.g., national trainings, as well as through Relias) and to pay license-use fees and initial start-up costs. We will expand already-established EB programs across the S-GSA, providing higher quality of care, lower health care costs and an improved service delivery system.

The ***University of Washington Collaborative Care Model (CoCM)***, an evidence-based integrated health approach, is proven effective and efficient in delivering integrated care. Key elements of the CoCM are the development of a member-centered care team and the creation of a single integrated treatment plan between PH and BH teams, leveraging each discipline's strengths. This approach demonstrates improved access to care and clinical outcomes, cost control and increased member satisfaction. We have implemented this model in collaboration with two provider partners and have seen strong results related to clinical member outcomes. BUFC is committed to expanding this model in two regions of the S-GSA within the first year of contract, with continued expansion throughout the contract. To provide high-touch member engagement, we will utilize APMs and incentives to support a 'boots on the ground' approach necessary to engage difficult-to-reach members.

By aligning provider partnerships through CINs, providers are motivated to share EBPs with other providers across the S-GSA and fill delivery system gaps. This collaboration enables providers to work cohesively to address the unique needs of members with an SMI. Through this partnership, providers can share EBPs, provide mentorship and assist with training and technical assistance to develop EBPs. We are developing aligned provider, member and health plan incentives to provide ongoing training and to encourage fidelity monitoring, while establishing processes that reduce provider administrative burden. BUFC, through the System of Care Committee, will develop an annual Evidence-Based Practices Strategic Plan to support, monitor and track progress year-over-year and report up to the senior leadership team (SLT) and Quality Management (QM)/Performance Improvement (PI) Committee.

In partnership with ***UA's Department of Psychiatry, we developed a psychiatric COE*** for members with PH and BH comorbidities, complex medication regimens, including polypharmacy, multiple readmissions and members in need of comprehensive diagnostic and treatment reassessment. BUFC will increase the use of the UA EPICenter to address early onset of psychosis to reduce trauma and stigma, and to provide a member- and family-focused approach to treatment.

BUFC will continue to enhance its use of EBPs such as the ***Peer Bridge Program***, which engages hospitalized members prior to discharge to improve discharge planning and follow-up care, and ***Camp Wellness's Wheels on Wellness (WOW)*** program, which promotes wellness through healthy eating and exercise, while providing self-management education to members with diabetes and other chronic health conditions. Since its inception, Peer Bridge Program members who are fully engaged have not experienced any crisis or inpatient admissions post-90 days from enrolling in the program. BUFC recognizes some members with an SMI require more frequent and consistent contacts and follow-up supported by an Assertive Community Treatment (ACT) approach. BUFC will support existing ACT models in rural areas of the S-GSA and monitor membership utilization to assess the need for expanded ACT teams. To augment these teams, we will use

technology supported by BTEC to support member engagement and outreach. BTEC will support robust telehealth platforms and local PSS engagement techniques to help fill this service gap and to provide members with high-touch case management.

Outcomes for the CoCM initiative showed referral of 119 members to the program. Prior to inception of the initiative, none of these members were engaged in treatment. Currently, 48% (57 members) are engaged in treatment. In the 90 days prior to participation, the same 57 members accounted for a staggering 180 ER visits. Following participation, preliminary results indicate a 63% reduction in ER use; 73% received PCP care coordination and additional education; 26% received temporary housing; and 13% received SMI evaluations. In addition, results showed 10.2 outreaches per member and 46 SDOH referral completion. BUFC will tie quality and utilization measures to provider APMs developed in conjunction with EBPs, such as reduction in ER, inpatient/readmissions and improvement in performance metrics addressing whole health.

D. COMPREHENSIVE OUTLOOK ON EQUITABLE HEALTH CARE AND DISPARITIES: To establish whole person care, we must expand equitable access to EBP models, address health disparities and invest in BH parity. Members with an SMI designation face some of the worst health care disparities stemming from discrimination, exclusion, stigma and criminalization. As a result, they are reluctant to seek help, subject to underdiagnoses of co-morbid PH conditions and receive unequal treatment. Additionally, chronic PH conditions, such as diabetes and congestive heart failure, poor dental health and sleep disorders are prevalent in members with an SMI, further complicated by long-standing use of psychiatric medications. As a mission-driven AHCCCS health plan, ***promoting health equity*** is fundamental to our goal of improving the health and well-being of all our members. The AZ 2021-2025 Health Improvement Plan helped to drive our planning and innovation to address health disparities.

The May 2016 Disparities Within Serious Mental Illness brief, released by the Agency for Healthcare Research and Quality (AHRQ), indicated adults with an SMI often experience gaps in access to needed health care. Such disparities are pronounced between certain groups of members with an SMI, such as racial/ethnic minorities; women; the poor (including homeless members); elderly individuals (≥ 65); members living in rural areas; gay, bisexual, transgender, intersex, queer and/or questioning, and asexual (LGBTQIA) and those with difficulty communicating in English (as a second language). Many members with an SMI face social injustices, deal with historical trauma and face stigma due to their BH conditions. Through our QM/PI processes, we conduct a ***comprehensive population health analysis*** aligned with the Arizona Health Disparities Center. This analysis enables us to plan interventions aimed at eliminating health disparities among members with an SMI.

The BTEC platform analyzes utilization and outcome data by race, ethnicity, language and gender to identify health disparities, including SDOH, through geospatial mapping to identify penetration rates of BH services at the neighborhood level. Our NACs capture community health assessment data and other analytics at the zip code level to identify disparate populations/members and urban/rural issues so that care and support is appropriately focused. ***BTEC's bi-directional data-sharing platform*** enables us to push real-time actionable data to providers. BTEC aggregates member-level data, such as risk stratification scores, gaps in care, SDOH factors, crisis system information, criminal justice system and health risk assessment data. Providing data to IHH providers is critical to addressing health disparities, closing gaps in care and addressing identified SDOH needs. During our community meetings with providers, we learned they are blind to much of the data. Through provider initiatives developed in early 2021, we created member profiles for providers with gaps in care data, pharmacy data, SDOH and utilization data to provide them with information to impact a member's health trajectory. Outcomes showed 48% of members were connected to a PH provider, 100% of members who were hospitalized received 7/30-day follow-up and 43% secured stable housing. Offering APMs as an enhancement to providers for non-billable services, such as outreach and engagement, will increase service penetration rates. The co-location of telehealth video hubs in rural areas of Arizona promotes and improves easier access to PH and BH services. BUFC collaboratively partners with providers, community stakeholders and members/families to tackle issues and to create innovative solutions in a safe, productive and results-oriented environment.

We have hired a health equity executive who assists in the development of our cross-functional Health Equity Committee to align with the broader AHCCCS Health Equity Committee initiatives. ***Banner Health Diversity and Inclusion Department (DID)*** aggregates data to identify health disparities and develops initiatives to address these disparities. BUFC participates on this team and brings plan-specific initiatives back to the Cultural Competency Committee. Initiatives, progress and barriers, as it relates to health disparities, are presented quarterly to our SLT and QM/PI Committee. Recognizing the impact stigma has on members with an SMI, our OIFA team created the Stigma Stops Here Campaign, which provides education and resources to members and providers through social media platforms, mailings and community forums. Our

NACs across the S-GSA are instrumental in identifying local health equity issues and disparities. We have implemented and funded projects related to oral health and SUD, Naloxone distribution, and telehealth video hubs in rural areas to increase access to PH/BH care. Pyx Health (Pyx) data indicated our members utilize the app most during evening and night hours. In collaboration with Pyx, we developed a BUFC specific evening and night support program for members who wish to speak to a live person to reduce higher levels of care.

Through our collaborative community relationships and technology, we will improve penetration rates for members with health disparities, improve HEDIS® performance measures to address health disparities and create targeted programs based upon data analysis to address diabetes, SUD and early entry into pre-natal care, family planning and healthy birth outcomes. Early intervention results in improved outcomes, an improved health care delivery system and a decrease in total cost of care.

E. FOSTERING ACCOUNTABILITY AND ENGAGEMENT THROUGH TECHNOLOGY: Technology and real-time actionable data is key to proactive member engagement. Currently, the system is fragmented, with data coming in from various sources with no single technology solution to aggregate it. IHHs, Federally Qualified Health Centers (FQHCs), PROs and PH providers lack a whole member profile when treating members with an SMI. BUFC developed BTEC based upon identified needs of our community partners. BTEC is a robust technology solution that will integrate member-level data from multiple sources and integrate with several other technology solutions to drive improved outcomes, including addressing PH, BH and SDOH needs, while increasing engagement and improving system capacity. BUFC develops an annual Engaging Members Through Technology strategic plan, as outlined in AMPM 920.

BTEC leverages data from multiple sources and technology platforms, providing automated actionable population- and member-level data, which can be pushed to our contracted network of providers. Blaze Advisors has successfully implemented this in NC and NY. Along with traditional claims and utilization data, BTEC also brings in data from other available BUFC technology solutions, including: **(1) Pyx Health (Pyx)**, an interactive application that help members address social isolation, depression, anxiety and SDOH needs. The goal of Pyx is to promote remote member autonomy and foster whole-health and wellness decision-making. Pyx uses interactive technology to gauge the member's mood through evidence-based screeners. Members receive real-time supportive messaging menus that provide direct resources to care internally through BUFC and externally through sources, such as 211 AZ. To-date, Pyx has engaged more than 3,000 members, with positive results showing a 36% reduction in loneliness, a 43% reduction in depression and a 36-53% reduction in hospitalization within three months following engaging Pyx. This is aggregated to an average savings of \$5,083 per Pyx member over the course of six months. **(2) Care Optimization System®(COS)**, utilized by IHNSA, creates a secure portal for referrals; care navigation; alerts; care team communication; care management monitoring; and network performance. This public utility replaces phone/fax and helps to connect/reconnect members to a care team, while continuously monitoring member needs and risks. The COS system also has an embedded remote member engagement tool that includes e-wellness screenings, PH/BH literacy, scheduling assistance and virtual engagement capabilities. The NC **ONEcare** network saw a 70% reduction in avoidable bed days, a 50% reduction in average length of stay, a 48% reduction in 30-day BH readmissions and \$30-\$35 million in total cost savings. **(3) Contexture**, Arizona's Health Information Exchange (HIE), gathers data from participating providers to assist with care coordination, discharge planning and other types of engagement. **(4) Silvercloud Digital Therapy** is a clinically validated digital BH platform, with programs proven to help improve BH outcomes. The platform offers immediate access to online supported cognitive behavioral therapy programs to address depression, anxiety or stress. **(5) Banner Total Care (BTC)** is a telehealth collaborative care model which addresses members BH needs so PCPs can focus on members PH needs. PCPs can refer members with BH needs to the BTC telehealth support program. The program provides pre/post and ongoing PHQ-9 screening for depression and GAD-7 screening for anxiety, active listening, individualized care planning, brief solution focused interventions and coordination with the member's referring PCP. When a member is not making progress towards their identified goals or symptoms are worsening, the member's BTC support coordinates with the PCP to determine the next course of treatment. If determined a member needs a referral to a specialty BH provider, a warm handoff is conducted. Members who have successfully graduated the program we have seen the following outcomes: Average PHQ-9 at initial screening was 14.59 and at discharge 4.41; Average GAD-7 at initial screening was 12.73 and at discharge 4.07. Both results indicated members at initial entry into the program scored moderate symptoms and at discharge scored no symptoms for both screenings. **(6) Social Media Platforms:** BUFC also utilizes a wide range of social media platforms, such as Facebook, Twitter and Instagram to provide educational materials to members, providers and the larger community.

BUFC continually seeks innovative ways so our member, "Ana," and her providers have the actionable data necessary to make health care easier, while improving member outcomes and lowering overall health care cost.

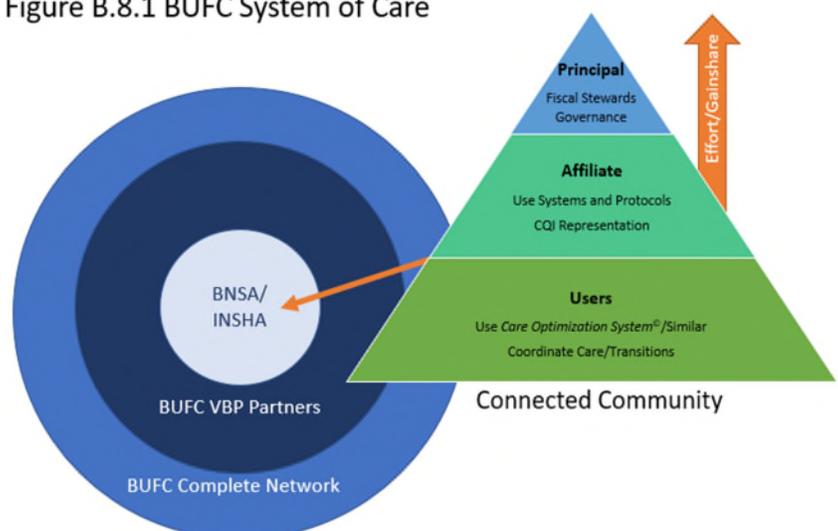
B8. Provide the Offeror's assessment of current network adequacy and describe the Offeror's ability to serve members with complex or specialized health care needs to ensure members can be timely and effectively served in the least restrictive setting. Describe how the Offeror will monitor for gaps in the continuum of care, address any identified gaps and implement strategies to resolve network deficiencies. Include any existing relationships and community partnerships the Offeror has, or intends to establish, with providers and stakeholders to enhance collaboration and coordination of care, routinely assess the continuum of care, and strengthen the network to meet the unique needs of individuals served under this Competitive Contract Expansion.

B8. Banner-University Family Care’s (BUFC) high-performing and culturally diverse support system and network **exceeds adequacy and accessibility requirements** to consistently provide **whole-person care** to its members. As a provider-based plan, we are committed to the needs of Arizona's most vulnerable populations, including those with complex or special health care needs (SHCN). We embrace a ‘no wrong door’ policy by offering to providers and stakeholders unfettered access to BUFC staff and leadership who work in concert with providers to resolve barriers timely. Furthermore, our comprehensive system of care is enhanced with a tiered high-performing network model that engages providers along the value-based transformation continuum, in alignment with the Learning Action Network (LAN), to improve member health outcomes. In addition, providers and community stakeholders are organized into BUHP Neighborhood Advisory Councils (NACs) to solicit input regarding network adequacy and to create customized local strategies necessary to support members' unique strengths, needs, cultural preferences and Social Determinants of Health (SDOH) needs.

BRINGING CARE AND COVERAGE TOGETHER THROUGH A COMPREHENSIVE NETWORK: Our expansive network of more than 13,000 unique providers and more than 57,000 service locations across Arizona consistently exceeds network adequacy requirements and aligns with the current southern Arizona RBHA's network. Our system of care comprises primary care providers (PCPs) and behavioral health groups and is also well-positioned to serve members with SHCN. Our wide-ranging, least restrictive approach includes both large and small providers spanning the continuum of integration and includes specialty providers; Federally Qualified Health Centers (FQHCs); targeted investment providers; Patient-Centered Medical Homes (PCMHs); Integrated Health Homes (IHHs); Multi-Specialty Interdisciplinary Clinics (MSICs); Peer and Family Run Organizations (PFROs); AzEIP providers; providers of court-ordered evaluation services; and homeless clinics and telehealth providers. Our network also includes strong Centers of Excellence, including the Children’s Clinic; Intermountain; Jewish Family; Community Bridges; Recovia; Cope Community; Southwest Network; and Southwest Human Development. To further support our members and providers, we strive to move the needle beyond regulatory requirements with our community reinvestment strategy. Over the past year, we supported many South GSA (S-GSA) providers with funding to help cover non-reimbursable services or fund new initiatives. Some of these providers include COPA Health; El Rio; Hope Inc.; Intermountain; La Frontera; Resilient Health; and Southwest Network. In addition, **Banner, as the largest delivery system in the state, brings resources, staffing, facilities, services, and support to the table.** Together, this collective system of care supports members with SMI in all areas of their lives.

WHOLE-PERSON APPROACH TO SERVING MEMBERS WITH COMPLEX OR SPECIALIZED HEALTH CARE NEEDS (SHCN): We share AHCCCS's philosophy, *"Our first care is your health care"* and serve Arizonans in a manner that honors members’ unique needs, strengths and goals. Often, individuals with SMI have underlying co-morbid physical health (PH) conditions that must be treated along with their behavioral health (BH) condition. BUFC believes every individual deserves whole-person care in the least restrictive setting and strives to provide a system of care that is integrated and coordinated around every member, regardless of how a provider chooses to contract with BUFC. To meet the individual needs of our members and the providers that support them, we have developed a multi-prong network strategy with flexibility for providers to move through the different pathways based upon their needs and readiness. The three network participation pathways are **(1)** Alternative Payment Model (APM) contracts with clinically integrated networks (CINs), such as the newly formed **Integral Health Network of Southern Arizona (IHNSA)** and **Banner Network Southern Arizona (BNSA)**, both of which can aggregate behavioral, social and medical resources into a ‘Connected Community.’ Creating a marriage-like relationship between these two CINs fosters shared incentives and goals; discussion of best practices; shared board representation; and the challenging of one another to drive improved care. Coupled with the extensive resources embedded within the Banner Health (Banner) system, we are removing care coordination and collaboration barriers, re-defining the ways in which services are provided to this vulnerable population and ensuring the provision of care in the least restrictive and appropriate setting; **(2)** direct APM contracting with IHH and other providers along the LAN continuum; and **(3)** standard fee-for-service contracts for those unable to support APM arrangements at a given

Figure B.8.1 BUFC System of Care



point in time. ***Our system of care supports members 24/7/365 in the least restrictive setting.***

In addition to the network participation pathways previously noted (Figure B.8.1 BUFC System of Care), BUFC and IHNSA will take a **'big tent'** approach to building a provider-governed behavioral health CIN, with 24/7/365 early intervention and care through a local provider-led steering committee, with guidance from **Blaze Advisors**. This initial steering committee is composed of key providers who already serve this vulnerable population, and includes La Frontera/Empact; CODAC; Horizon Health & Wellness; Hope Inc.; COPA Health; Southeastern Arizona Behavioral Health Services; and Community Bridges. Under this model, IHNSA will more broadly invite a multitude of participants and manage performance upwards, using a **'rising tide'** approach, wherein bottom quartile performers are afforded support and the opportunity to improve performance or risk ejection from the IHNSA network. This approach improves performance on a peer-driven curve, not simply in accordance with arbitrary targets. Higher-performing, risk-comfortable IHNSA participants may become 'principal' members, affording them enhanced incentive distributions to reflect commensurate performance and fiscal responsibilities. The IHNSA integrated care model operates on the assumption that each individual with SMI will benefit from a closely connected, multi-specialty accountable care team, supported by a strong crisis stabilization and transitional care program. To complete our approach, IHNSA has developed partnerships with other CINs, including BNSA, wherein participants have access to IHNSA incentive distributions. These providers and partners are referred to as 'users.' In addition, IHNSA may set aside a portion of earned incentives to reward a social service provider for extraordinary communication and access to services that improve member outcomes. Collectively, the three tiers (principle, affiliate and user) form a 'Connected Community' fully supported and encompassed by our overall system of care. Understanding the workforce challenges, we are not seeking to marginalize small and independent providers; rather, our goal is to provide to them a structure that realizes their mission of serving vulnerable populations – they will have a seat at the table.

The BNSA CIN includes all the southern Arizona Banner delivery system including Banner University Medical Center Tucson (BUMCT); Banner Urgent Care (BUC); Banner University Medical Group (BUMG); and the Whole Health Clinic, along with dozens of independent PCPs and leading integrated providers. BUFC's participation with ***BNSA fills the current primary and specialty care access to services gap for members with an SMI designation*** by bringing these services to members through a solid partnership with INSHA and prioritized appointment availability.

Our entire system of care is supported by the ***Banner Technology Enabled Care (BTEC)*** platform, composed of industry-leading suite of tools and technology designed to enhance care delivery across providers and payers. Some of the resources include a customized risk stratification tool that emphasizes BH, PH, and SDOH factors; real-time referral systems to coordinate real-time handoffs; digital solutions to bring care to members; and alert systems to notify partners prior to members 'slipping through the cracks.' BTEC also includes linkages to the statewide crisis system, criminal justice system, NowPow and Contexture HIE, providing alerts whenever members reach these entry points. While all providers can benefit from these enhanced technological features, those providers that are aligned with IHNSA directly will have the ability to share information and coordinate across platforms, based upon their connected podiums.

DISCIPLINED FOCUSED APPROACH TO ADDRESSING CONTINUUM OF CARE GAPS: Monitoring Process: BUFC utilizes well-tested geo-analytics and payment innovation to drive needed changes in access to services. From our portfolio of BTEC solutions, we use Quest Analytics for network optimization to confirm adequate numbers of providers for each service type by geographic area. In addition to the regulatory and administrative data elements, such as geo-analytics, enrollment and regulatory deliverables, BUFC incorporates provider and member data when monitoring and defining its network. These include **provider-specific data elements**, such as **(1)** results of monitoring and oversight reviews; **(2)** culturally responsive programming, including bilingual capacity; **(3)** types of service and timely available capacity; **(4)** provider feedback; **(5)** number of contracted providers not currently accepting new members; **(6)** expected utilization rate of services, taking into account the characteristics and health care needs of specific populations represented in our network, including current unmet needs and future needs related to projected growth; and **(7)** Neighborhood Advisory Council (NAC) feedback. **Member-focused data elements** are also included, such as **(1)** member satisfaction data; **(2)** complaint and grievance data; **(3)** Member Advisory Committee (MAC) feedback; and **(4)** member feedback to care managers.

Addressing Identified Gaps: Network management data is reviewed continuously by leadership in our Monthly Operating Review, senior leadership meetings, Contracting Committee and our Regulatory Oversight Committee, to develop overarching network development and retention strategies. Whenever gaps are identified, we are responsive. For example, there is a known shortage of health care professionals in rural communities. Through community reinvestment, we collaborated with Transitional Living Center Recovery (TLCR) in Yuma to develop private and secure telehealth video

hubs where members can connect with PCPs and other specialty providers. We will expand this approach to La Paz and Cochise County prior to go-live.

Implementing Strategies: BUFC takes a proactive approach to identifying potential network gaps through continuous monitoring. We quickly partner with providers and stakeholders to initiate services and programs to address identified gaps using innovative strategies, such as **(1) Our innovative partnership with IHNSA**, which enables the direction of care to the least restrictive level of care 24/7/365. Resource-sharing by IHNSA partners facilitates 24/7 coverage for members, enabling providers to access the least restrictive level of medically necessary care across the continuum of settings. **(2)** We also understand that **close relationships** with providers, community-based organizations, and stakeholder organizations, including advocacy groups and first responders through our NACs and Community Forums, are critical to understanding availability and accessibility challenges in a specific community. **(3)** BUFC understands that individuals with SMI have SHCNs that require medically necessary care in the **least restrictive setting** using evidence-based practices. Our network focuses on ensuring the needs of these complex members are met (e.g., services provided by Hushabye Nursery and BUMCT Family Centered neonatal abstinence syndrome (NAS) Care Program to support pregnant mothers and their babies at risk for NAS). **(4)** Often overlooked is the **co-morbidity** between individuals with SMI and adult Autism Spectrum Disorder (ASD). Our network includes the Intermountain Centers ASD COE, with specialized expertise in serving these members and support to youth that have been determined to have SMI in successfully transitioning to adulthood, consistent with the Arizona Adult 9 and Children's 12 Principles. **(5)** We partner with the **University of Arizona RISE Health and Wellness Program**, also referred to as Camp Wellness, a national award-winning and highly specialized evidenced-based wellness program for individuals with BH disorders and SHCN. This partnership enables us to support workforce development efforts, such as development of a caregiver career development pathway. This initiative will encourage interested individuals to begin their health care careers as direct caregivers through career mapping technology. In addition to direct caregivers, we are partnering with Camp Wellness and our transportation vendor, Veyo, on an innovative solution to have peers (through Veyo) provide transportation services.

EXISTING RELATIONSHIPS AND COMMUNITY PARTNERSHIPS WITH PROVIDERS AND STAKEHOLDERS: Collaboration and unique partnerships with providers and community stakeholders is essential to ensuring network availability and member accessibility. We leverage these relationships to address SDOH and to keep members in the least restrictive setting, as demonstrated through our NAC approach, wherein we create accessible, supportive and collaborative neighborhoods. Our NACs (composed of provider, peer, family and community partners) play a pivotal role in offering feedback to BUFC. These Councils review local issues, solutions and data to drive local initiatives and neighborhood network models. The NACs afford providers, members, family and neighbors the opportunity to work together to solve community problems through collective impact. Tribal Health Services and tribal representatives are invited to participate in the NACs. The Councils work with support from our Office of Individual and Family Affairs (OIFA); member advocacy administrator; housing; employment/vocational; and workforce development administrators to address identified issues.

In addition to the work of our NACs, the Banner OIFA program promotes recovery, resiliency and wellness for individuals, children, youth, and families with PH and BH needs and substance use challenges. With a grassroots approach, OIFA focuses on community engagement and education, aiming to improve well-being and promoting member and family involvement in the shared decision-making process. BUFC creates a safe, secure and solid platform for members and families to exercise their voices in shaping our health care system and ensuring those we serve have the tools necessary to become active participants in their individual care.

Our Member Advisory Council (MAC) is another opportunity for members to engage in conversations regarding health policy, access to care and system improvements. Our MAC is composed of members and their families, with the goal of gathering their insights in the continual improvement of the member experience. MAC advises, assists and provides guidance to health plan leadership on the service delivery system. MAC members leverage their lived experiences to discuss issues, concerns or systematic barriers in accessing timely and appropriate care through census, and develop solutions presented to health plan leadership through a formal Governance Committee. The MAC team has representation from each Neighborhood Network and closely collaborates with the BUFC senior leadership team (SLT).

BUFC remains committed to continuously innovating its robust system of care, bringing diverse providers together to support a common cause: provide optimal, comprehensive and quality care for all. Through our CIN and system of care approach we will offer VIP access to the best integrated health care solutions in the region. We routinely partner with providers to streamline care coordination, so members receive appropriate care in the least restrictive setting. This is accomplished in collaboration with members and their individual voices. BUFC looks forward to another 30 years servicing our community and continuing to move the needle on providing high quality care that works for all.

B9. Describe the best practices of Arizona’s crisis system. Describe how the Offeror will maintain and drive continued improvement for Arizona’s crisis continuum by building on the foundation that is already in place. Provide a detailed strategy including primary objectives, actionable steps, timelines, and stakeholder involvement that will be used to drive improvements.

B9. Arizona (AZ) crisis services are available to all members in the State, regardless of payor status or underlying need. The Crisis System serves as a safety-net, with the goal of minimizing trauma and disruption to members' lives by meeting their needs in the least-restrictive community-based settings, while reducing the need (and expense) of avoidable inpatient admissions, emergency room (ER) visits and aids in diversion from the criminal justice system. Recognized as a national best practice for decades, AZ's Crisis System has influenced the crisis model promoted by SAMHSA and the 'Crisis Now' model promoted by the National Association of State Mental Health Program Directors, in partnership with the National Action Alliance for Suicide Prevention. The framework is built around three key elements available 24/7/365 to all members of the community: **(1)** Regional '*air traffic control*' crisis line; **(2)** Crisis mobile teams (CMTs) *dispatched* via the crisis line; and **(3)** Crisis receiving facilities with '*no-wrong door*' practices. Supporting these three key elements are warm lines; access to crisis plans/advanced directives; peer support; crisis residential; crisis transportation; and the strategic use of technology. The final key element embedded in the AZ Crisis System model is in close coordination with first responders to reduce the need for law enforcement involvement. Banner Health (Banner) and Banner-University Family Care (BUFC) have significant expertise related to crisis services and the interplay with coordination into higher levels of care. Banner operates the largest safety net hospital system in AZ and provided administrative oversight and psychiatrists to the Crisis Response Center (CRC).

CONTINUED OPPORTUNITIES TO ADDRESS KEY GAPS IN THE SOUTHERN ARIZONA CRISIS SYSTEM: While Southern AZ's Crisis System has strong aspects, based upon our experience and input from stakeholders, we have identified gaps and opportunities for improvement, accountability, coordination and addressing the growing trend of overreliance on inpatient utilization, much of which is avoidable. BUFC seeks to build upon the existing foundation in the south by enhancing and improving the Pima County Crisis System, while addressing disparities in the rural counties comprising the balance of the S-GSA. BUFC is committed to enhancing resources and capacity within rural counties to ensure parity, consistent common philosophy and accessibility to services. Critically, while there are some high-quality crisis services in parts of the S-GSA, the current services (even in Pima County) typically function more as independent crisis entities, as opposed to part of a more unified cohesive crisis system of care. We have learned from a variety of stakeholders, including police chiefs and sheriffs, there is a perception in the community of a *lack of oversight and a 'system quarterback,'* with limited local on-the-ground staff empowered to discuss and address emerging service system challenges. BUFC will invest in more robust services and, through increased oversight, accountability and stakeholder input, will evolve the current system to function as a more cohesive, coordinated crisis system. This singular crisis system is a key component of BUFC's larger overall population health approach, which will interface seamlessly with the ongoing outpatient delivery system, as well as support AHCCCS's Opioid and Suicide Prevention Action Plans.

Strategy: BUFC's strategy, which is based upon innovation, improvement and coordination, is built upon the existing foundation to incorporate crisis across the larger integrated health system. Our enhancements increase member experience, decrease the revolving door to crisis and reduce utilization of ERs and inpatient hospitalizations. Our strategy is to bend the cost-curve with proactive approaches, less restrictive interventions and improved care coordination post-crisis. BUFC's crisis philosophy encompasses a belief that crises are member-defined and should be viewed as an opportunity to connect members to ongoing community care. Services are member-centric, trauma-informed and help members and families feel in control, while improving self-management skills. Crisis services should be delivered in community-based settings that are welcoming, engaging, readily accessible and provided in a dignified manner, reducing the need for involuntary treatment, when appropriate, and incorporating peer-support at all levels.

Care coordination is the cornerstone to overall success. BUFC's Crisis Model is built upon the following primary principles: **(1)** Crisis services should be *community-based*, with attention given to geographic access; **(2)** The crisis continuum should encourage members to access the *least-restrictive* level of community-based care; crisis providers can then assist members to move into higher or lower levels of care, as clinically appropriate; **(3)** Move away from a disconnected array of services and evolve toward a *culture of crisis management*, through coordinated care; and **(4)** Ability to capture, monitor and evaluate *system-level data* and then share information across systems in real-time.

BUFC will serve as a '*system quarterback*' for the ACC-RBHA to provide system accountability, oversight and collaboration with the community in compliance with AMPM 590. We will ensure the network of crisis and outpatient providers are working in concert to meet the diverse needs of the community and stakeholders. We incorporate stakeholder and member input through community forums and our Neighborhood Advisory Councils (NACs). Through NACs, we seek input, share data, identify emerging trends/gaps, and foster system accountability. Through extensive outreach, we have learned the straight fee-for-service approach in the S-GSA for Integrated Health Homes (IHHs) has inadvertently resulted in less ownership by IHHs to prevent or mitigate crises for their members with an SMI. BUFC will increase expectations of IHHs

to become more involved in crisis prevention and intervention activities (e.g., access to after-hours staff, updating/loading crisis plans in Banner Technology Enabled Care (BTEC) to reduce the over-reliance on crisis services, while employing innovative alternative payment models (APMs). Crisis services will be incorporated into the Integral Health Network of Southern Arizona (IHNSA), a Clinically Integrated Network (CIN) that encourages and incentivizes 24/7 coordination of IHHs and crisis providers' efforts, creating a model wherein services and collaboration align with mutually beneficial incentives, including innovative approaches to addressing Social Determinants of Health (SDOH), a key reason members cycle through crisis. A BUFC care manager, available for consultation 24/7/365, will provide additional support during off-hours. We will align incentives with desired outcomes through increased use of outcome-based APMs within the crisis system and across the broader outpatient system. We will incorporate key crisis providers into BTEC and IHNSA within and across the broader system. BTEC will provide technology to enhance data collection capabilities, incorporate HIE data and push real-time actionable alerts to providers to improve coordination of care, and track and monitor outcome-based metrics.

Our comprehensive **crisis strategy work plan**, developed with input from stakeholders, will be used to guide and track activities and outcomes. This strategy will continue to evolve and improve based upon ongoing feedback through routine stakeholder meetings with key first responders, crisis service providers and other related community partners, ensuring health equity and cultural awareness. Based upon extensive discussions with stakeholders across the S-GSA, BUFC is committed to the objectives, actionable steps and timelines that follow. We have already begun the development and implementation of our crisis strategy work plan, headed by our crisis administrator, and will accelerate it upon award.

Objective 1	Improve coordination of care through expanding additional capabilities of a centralized crisis line		
Actionable Steps	1) Crisis Plans and IHH Attribution 2) 24/7/365 Warm Line	3) 24/7 Appointment Scheduling Ability 4) Tribal Warm Line	
Stakeholders	Providers, first responders, members and tribal communities	Timeline	Go-live

BUFC will contract for additional capabilities from the centralized crisis phone line vendor. Leveraging BTEC, we will ensure and incent IHHs to complete useful and personalized crisis plans, available to the crisis line, who can notify CMT/crisis facilities of IHH attribution and key elements to reduce risks, mitigate crises and improve coordination of care. BTEC will enable the crisis line to coordinate with outpatient providers and will include 24/7 ability to schedule appointments for members who are non-affiliated/non-SMI and offer Pyx Health to everyone for overnight and after-hours support. The crisis line will provide a 24/7/365 warm line and a tribal warm line to interested tribal communities. BUFC will work with other RBHAs to select a statewide crisis phone line vendor. If there is any delay in this process, we are prepared to operationalize a temporary transitional crisis line.

Objective 2	Reduce revolving door to crisis and inpatient hospitalizations		
Actionable Steps	1) Increased Expectations of SMI IHHs in Crisis Prevention 2) Improved Coordination: IHHs, Crisis Centers 3) Post-Crisis Peer Navigation Services	4) Increase Crisis Step-Down Options 5) Preferred Provider 'Admitting Privilege' Initiative	
Stakeholders	Providers, first responders, hospitals, members and tribal	Timeline	#1-3 go-live; #4 & #5: By Year One

BUFC will require and incent IHHs to increase involvement in crisis prevention/mitigation for members with an SMI, requiring IHHs to employ 24/7/365 on-call staff who can provide after-hours telephonic consult to assist CMT/crisis facilities by providing member insights, preferred treatment options, prevention tips and to schedule expedited IHH follow-up appointments. BUFC will provide training for outpatient workforce to improve their competency in engaging and supporting their members who are experiencing a BH crisis. We will sustain and enhance services with ConnectionsAZ at the CRC, including increased notifications and co-location of a Peer Bridger program in crisis centers to improve care coordination and address SDOH, a key reason members cycle through the crisis system. In addition to care coordination, we will ensure peer support staff are located at crisis facilities to focus on improving member experience through advocacy, shared experiences and emotional support, to increase hope, trust and respect, while reducing anxiety, in keeping with the Nine Guiding Principles for Adult BH Services and Systems. All crisis-receiving centers can incorporate PH services through telehealth, provide bridge crisis prescriptions, connect members to Medication Assisted Treatment (MAT) services and expedited virtual mental health follow-up appointments through COPA Health. BUFC will implement a post-crisis peer support model (crisis transition navigator) to members (including Non-SMI/Non-Title XIX/XXI) who are frequently contacting crisis services. Crisis transition navigators focus on rapport-building, addressing SDOH and helping connect members to community services, with the option to create a crisis transition plan that meets members' individual goals and improves future coordination. BTEC will support closed-loop referrals and help to address SDOH needs. We will also implement step-down options for members transitioning out of crisis stabilization facilities and/or other higher levels of care to reduce average length of stay. BUFC will develop an innovative preferred provider admitting privilege initiative to reduce the burden on crisis-receiving centers through avoidable crisis admissions, reduced average length of stay over

traditional inpatient hospital settings and improve member experience. We will work with select IHHs and crisis inpatient facilities to afford select IHHs the ability for direct admissions for members with an SMI into select crisis inpatient facilities through a streamlined process, further demonstrating the efficiencies of inter-connecting the crisis and outpatient systems into a unified, inter-twined model.

Objective 3	Crisis Mobile Teams (CMT): Increase capacity and accessibility		
Actionable Steps	1) 988-Related Initiatives 2) Increase and Enhance CMT Services 3) Tribal Models including Peer Support		
Stakeholders	Providers, first responders, hospitals, community, members, schools and tribal	Timeline	<ul style="list-style-type: none"> • Begin at go-live and achieved by Year One • Ongoing assessment of needs to right-size capacity

BUFC will improve the capacity and accessibility for CMTs across the entire region. We will leverage opportunities afforded by 988 initiatives to increase capacity to ensure sufficient CMTs necessary to adequately respond to the growing community need and to consistently reassess to meet evolving needs. BUFC will add at least two additional CMTs in Pima County to meet the growing needs in the community and to address CMT unavailability, which Pima County law enforcement partners are currently reporting. We will also expand the capacity of CMTs in rural communities, including the ability for two-person responses to reduce over-reliance upon law-enforcement. All rural CMTs will be provided with satellite phones and telehealth options to increase rates of community stabilization. In addition, BUFC will offer customized CMT models for tribal communities, including the use of tribal peer support.

Objective 4	Reduce over-reliance on First Responders to support members experiencing a crisis		
Actionable Steps	1) Increase CMT and Crisis Transport Options 2) Additional Police Drop-Off Options 3) 911/Crisis Line Collaboration	4) 'Familiar Faces' Solutions 5) Improve 1st Responder Collaboration & Training	
Stakeholders	Providers, first responders, hospitals, community, neighborhood councils, members, schools, tribal	Timeline	Activities begin by go-live and through the contract

BUFC is committed to reducing over-reliance on first responders and improving member experience. We will assess increased needs and existing capacity of CMTs, expand capabilities in regions experiencing added demand and provide crisis transportation and/or mobile detox transportation options, such as the crisis detox transportation initiative BUFC has already implemented to support Tucson police and fire to help address their needs, and will offer customized models for tribal communities. We will improve the capacity and access to facility-based services and police drop-offs in rural counties, specifically enhancing police drop-off options in Cochise County, while reducing the need for out-of-county transport of members experiencing a crisis. This is in direct response to concerns shared by the Cochise County Sheriff's Office to BUFC. We will collaborate with 911 entities to divert/warm transfer calls to the crisis line and/or CMTs, which do not require a police/fire response. Based upon stakeholder needs, this can include cross-training, co-location, 988-related technology and enhancements. First responders will also be able to refer individuals with whom they have frequent contact, 'Familiar Faces', to post-crisis peer support services. To enhance collaboration with first responders, we will hire a first responder liaison (a BUFC value-added role). Retired Tucson Sgt. Jim Kirk will help link the public safety and public health systems, improving the interface and communication between BUFC, providers, law enforcement and mental health support teams. BUFC will actively participate in and foster crisis intervention team training, mental health first aid, public safety and other training opportunities across the S-GSA, including offerings to tribal law enforcement. Jim Kirk and BUFC's Justice Liaison, Denise Beagley, possess extensive histories collaborating with and training first responders. In addition, BUFC contracts with Nick Margiotta, a nationally recognized law enforcement/crisis consultant, to provide system-level guidance on crisis service interplay and meeting public-safety needs, particularly in the evolving landscape of the role of law enforcement in our community. BUFC supports its first responder community, including sponsoring EMPACT's SAFeR Program (Officer Wellness) and the 100 Club's 9/11 Tower Challenge.

BUFC is committed to assuming an active leadership and oversight role necessary to advance the crisis system, ensuring ample capacity, accessibility and geographic coverage for services, and parity in rural and urban communities, as well as ensuring the crisis system and broader health care delivery system are working in a more coordinated manner to improve member experience and to reduce duplication and cost of care. **BUFC will accomplish this through continued local stakeholder engagement and input, embracing a 'boots-on-the ground' approach with teams empowered to make timely decisions.** Much of our proposed strategy is the result of insights gleaned from listening to and collaborating with our community partners, providers and stakeholders. Through increased accountability, oversight and a focus on outcomes, we will transform the way in which crisis care is experienced in our community and will ensure the crisis safety net is available at go-live and during transition. Our responses are actual strategies that are either in place today or, in process or planned with our stakeholders. BUFC remains committed to continuing its extensive history of delivering on our commitments by listening, understanding and pivoting to make necessary changes.

B10. American Indian/Alaska Native members have a unique status within the Medicaid system. Describe the Offeror's knowledge of the unique aspects of the tribal health care delivery system and how the Offeror has and will address the specific needs of this population and act to reduce health disparities.

B10. Banner-University Family Care (BUFC) has cultivated trust with its tribal partners in the South GSA (S-GSA) through a collaborative community approach respectful of tribal sovereignty and autonomy. Arizona (AZ) has a rich tribal history, and we embrace and leverage the strengths within each tribal nation. This collaboration and openness fosters positive engagement and allows for open dialogue and consultation with tribal leaders. We understand that each tribal nation is unique in terms of identity, spirituality and sense of community, all of which must be considered when working with various tribes in the S-GSA. Unfortunately, tribal communities continue to suffer from health disparities. The 2019 ADHS Health Status Profile of American Indians (AI) Report for AZ ranked AI/Alaska Native (AN) lower than the statewide average on 53 of 65 health indicators. The report indicated high rates of substance use, chronic liver disease and cirrhosis, diabetes, under-utilization of prenatal care and poor maternal health, to name a few. In addition, the Center for Disease Control (CDC) reports indicate AIs/ANs have a higher risk of dying by suicide and prevalence of tobacco use. We are particularly sensitive to the potential trauma experienced by tribal members placed on court ordered treatment (COT) by non-tribal courts. BUFC works to assure access availability to necessary treatment and the tribal order is appropriately implemented by non-tribal providers. We engage tribal nations, providers and the community, including meeting with tribal leaders to learn more about existing programs, the needs of their community and how BUFC can help to support and promote new initiatives.

Our Tribal Coordinator, Kimberly Yellow Robe, with support from our executive leadership team, has established rapport with the six tribal nations in the S-GSA. We participate in formal and ad hoc meetings with tribal leadership/elders. Upon award of the ACC-RBHA contract, BUFC will commit to adding a **second tribal coordinator** to provide support and to continue to build upon our Tribal Strategic Plan, which tracks all tribal initiatives. BUFC continuously identifies areas of opportunity through community listening sessions and data-mining activities that identify health disparity trends among AIs/ANs. Rooted in the communities we serve, BUFC ensures our members matter in an often impersonal and complicated system, recognizing that a portion of our vulnerable members with the most complex whole health and social needs, including AI/AN members, do not always seek help through our robust network of providers.

KNOWLEDGE OF THE TRIBAL HEALTH CARE DELIVERY SYSTEM AND CULTURALLY COMPETENT MEMBER-CENTRICITY: As of August 2021, BUFC has 7,800 AI/AN members, with 4,102 actively receiving care through our contracted network of providers. While 60% of AIs/ANs receive primary health care from Indian Health Services (IHS), approximately 70% reside in urban areas, with 25% of those residing in counties served by urban Indian health programs. AIs/ANs may have as many as four to five different health care payers, creating a confusing health care delivery system. In AZ, many tribal members receive health care from IHS facilities, 638 Tribal Facilities, urban Indian health programs, or TRBHAs for behavioral health services. Banner Technology Enabled Care (BTEC), our suite of technology solutions, can automate and provide actionable population health data to all providers involved in a members' care. Under federal law, tribal members can select AI Health Plan (AIHP) for their AHCCCS health plan. As of August 2021, there were approximately 129,772 statewide AIHP members. AIHP members can choose an American Indian Medical Home, which provides enhanced care coordination and health education. **Our diverse team** includes tribal care managers, registered nurses and social workers who assist members with navigating the health care delivery system and selecting options that best meet their evolving and unique cultural needs.

BUFC was founded on serving the most vulnerable members through a culturally competent approach. Whenever meeting with tribes, we understand the importance of listening and learning to understand and address their community needs in a manner that works for their community and the structure of their governing body. Our team has outreached all six tribes in the S-GSA and recently met with San Carlos Apache Tribe, Cocopah Tribe and Pascua Yaqui Tribe. Conversations continue with Fort Yuma-Quechan Tribe, Colorado River Indian Tribe and Tohono O'odham Nation. Through our outreach efforts on and off tribal lands, we have instituted several listening and learning opportunities for tribal members. Our **Neighborhood Advisory Councils (NACs)** are composed of community stakeholders, providers and tribal leaders, and address neighborhood-level health disparities. Our **Member Advisory Councils (MACs)** enable us to integrate member voice into all areas of the health plan and afford tribal members the opportunity to discuss unique cultural considerations. In addition, BUFC is engaged with the **Intertribal Council of Arizona (ITCA)** to address issues impacting tribal communities. Our tribal coordinator holds **tribal leadership meetings** with tribal leaders/elders to discuss challenges and opportunities for BUFC to support increased access to care and to develop Memorandums of Understanding (MOUs) that clearly delineate roles and responsibilities.

IDENTIFIED NEEDS AND SOLUTIONS TO ADDRESS AND REDUCE HEALTH DISPARITIES FOR TRIBAL MEMBER: BUFC recognizes the unique disparities impacting tribal communities and is committed to partnering with them to develop solutions that honor cultural beliefs and traditions, and promote member choice. We acknowledge the profound impact of historical and inter-generational trauma, which contributes to risks associated with addiction and self-destructive

behavior. Our provider network includes culturally relevant and responsive services. We also offer traditional healing providers who incorporate traditional values, rituals and spirituality into the healing process. Examples of current BUFC efforts to address identified needs and to reduce disparities include:

- **Inaugural American Indian Youth Disability Summit:** According to the CDC, 3 in 10 AIs/ANs—more than any other ethnicity or race—have a disability. In April 2021, we partnered with Ability 360 to coordinate, host and moderate the Youth Disability Summit to address resiliency during a pandemic. Speakers shared tribal culture and how community resiliency and connection is important to the survival of tribal communities during a pandemic.
- **Physical Activity Kit (PAK) Training:** AI/AN communities face some of the worst nutrition disparities in the nation. In 2009, 67% of AIs/ANs were overweight or obese. PAK training promoted physical activity, disease prevention and healthy eating using a train-the-trainer model. This approach empowers tribal members to promote health education through traditional approaches.
- **Education on the SMI Evaluation Process:** 4% of AIs/ANs experience an SMI, compared to 4.8% of the general public. During a 1:1 tribal meeting, the need for education on the SMI evaluation process was identified. We secured training for the tribe through a provider in their area who performs SMI evaluations and invited the tribe to BUFC's quarterly SMI training for all providers/community partners.
- **Utilization Management/Care Management Integrated Rounds:** AI/AN experience a lower life expectancy, quality of life and a higher prevalence of chronic conditions. We understand that culturally tailored approaches reduce risk factors and chronic disease, our tribal coordinator participates in inpatient rounds to connect AI/AN members to tribal services. She recently visited a member who desired traditional healing services and worked with Tucson Indian Health Center to secure services.
- **Pyx Health (Pyx):** Many AIs/ANs reside in isolated areas far from any social supports, contributing to poor health outcomes. Pyx app helps members to address social isolation and improve overall health through remote engagement activities and has onboarded 73 BUFC AI/AN. Initial data showed 44% indicated high loneliness (slightly higher than our total member average) at inception, but we saw a 58% improvement in loneliness and a 60% improvement in depression following the use of Pyx for an average of 60 days. We are collaborating with Pyx to tailor messaging to meet the specific cultural SDOH needs of the AI/AN populations.

Based upon tribal priorities in development, Banner's commitments include:

- **Neonatal Abstinence Syndrome (NAS) Programming:** We are partnering with tribal nations on an NAS initiative. BUFC will help to fund educational materials on risks associated with substance use during pregnancy, community resources and treatment options available.
- **Tribal Crisis Support:** We will support the development of a tribal crisis warm line and will build a network of tribal peer support specialists (PSSs) to assist tribal members with navigating the health care and crisis system of care.
- **Enhancement of Telehealth Services:** Increased need for telehealth services was identified during a one-to-one tribal meeting. While we recognize that not all tribal communities have the infrastructure necessary to support telehealth, for those that do, we will partner with tribal community health centers and community providers to enhance both physical and behavioral health services through the use of telehealth hubs.
- **Tribal Peer Support Training:** We are working with UA Rise to develop a culturally focused tribal peer support training program. Curriculum is based upon a train-the-trainer model and will incorporate cultural/traditional aspects that can be modified based upon each tribe's unique heritage.
- **Camp Wellness on Wheels (WOW):** Diabetic education specific to tribal populations was identified during a one-to-one tribal meeting. WOW travels across southern Arizona, providing education on planning healthy meals, lifestyle choices, healthy recipes and exercise modifications. WOW, BUFC and tribal communities are currently in the planning stage.
- **Arizona Smoker's Hotline (ASH):** We are collaborating with the ASH line to create an AI/AN member protocol for phone staff at ASH who are enrolling and providing cessation resources to AIs/ANs that are culturally mindful.

BUFC remains committed to investing the time and resources necessary to address the health disparities of the AI/AN population. Bringing services to members where they live is essential to improving the health status of these members, in partnership with their leaders, families and current health system. **BUFC strives to bring 'community' back to community health.** BUFC will commit to investing the time and resources to address disparities within the AI/AN population across the S-GSA.

B11. Describe how the Offeror will use existing Medicaid compensable services as well as non-covered services and supports to address social risk factors impacting AHCCCS members. Include how the Offeror will capture data related to Social Determinants of Health to ensure members are connected and have timely access to needed social services.

B11. Banner-University Family Care (BUFC) will link Medicaid compensable services with non-covered services and supports to meet the whole health needs of our members, while addressing social risk factors impacting health outcomes. Based upon our 30 years of experience providing care to Medicaid members in Arizona (AZ), we understand traditional Medicaid covered services alone often fall short, accounting for approximately 20% of overall health outcomes, while Social Determinants of Health (SDOH), such as food insecurity and housing instability, account for as much as 80% of health outcomes. To address this imbalance, the system requires a **'quarterback'** to join disparate funding sources and services, and to partner with the community as a system of care. To serve members' diverse needs, bringing together Title XIX/XXI, Non-TXIX/XXI, grants, community reinvestment, charitable dollars and contributions from community-based organizations is central to providing whole person care. We have reviewed the CMS guidance to Medicaid Authorities on options to address SDOH including a focus on State Plan Authority optional services; Section 1115 Waivers flexibility including Alternative Payment Models (APMs); Medicaid Managed Care Flexibilities; and Integrated Care Models such as Accountable Care Organizations (ACOs). Under federal Medicaid managed care rules, Medicaid MCOs can be given flexibility to pay for non-medical services through **'in-lieu-of' authority and/or 'value-added' services**. We will partner with AHCCCS to identify strategies, such as housing modifications and food insecurity, to augment covered services.

BUFC recognizes that providers accountable to provide Medicaid covered services require funding flexibility to meet members where they are. We will align incentives through Alternative Payment Models (APMs) to enable providers to perform outreach and engagement (often begun by addressing SDOH needs), to ensure transitional services and support are meaningful and impactful. BUFC will reward providers for member/community wellness, as opposed to transactional fee-for-service activity that is disconnected from other system supports.

ENHANCING MEDICAID AND NON-COVERED SERVICES TO ADDRESS SOCIAL RISK FACTORS: A CONNECTED COMMUNITY:

BUFC envisions three strategies to re-define the role, relationship and accountability of whole health providers, including Integrated Health Homes (IHHs), with their attributed and/or affiliated members. **(1)** Aligning incentives for all providers through APMs creates a sense of ownership and funding flexibility necessary to reward providers for conducting the upfront work necessary to address SDOH. **(2)** Integrating our established physical health (PH) Clinically Integrated Network (CIN), Banner Network Southern Arizona (BNSA), with the newly created behavioral health (BH) CIN, Integral Health Network of Southern Arizona (IHNSA), we will align PH and BH covered services for the first time. Aligned incentives establish member trust so they can engage in their own personal health care journeys. **(3)** Our whole health strategy connects covered services with a **Connected Community** that includes social service agencies and other non-traditional community support organizations as shown in **Figure B.11.1** above. BUFC has hired Blaze Advisors, an experienced Population Health Management Organization, network and community aggregator, to fully integrate these three components. Blaze has experienced success in launching similar structures and strategies by aligning local providers with tools, technology and purpose.

Figure B.11.1 Connected Community



Creating a high-performance SDOH network: BUFC will create a high-performance SDOH network modeling the 'Connected Community, Inc. (CCI)' implemented in North Carolina (NC) and powered by Blaze Advisors. A 501(c)(3) association of social service providers, CCI participants work with Blaze's integrated CIN in NC to provide accelerated access, coordinated monitoring and communication of members' identified SDOH needs. CCI participants agree to quickly respond to member needs, communicate back to the source that members attended their appointments, describe the resources provided and offer basic wellness observations that may trigger care team follow up. In exchange, the CIN agrees to provide CCI participants a portion of earned incentives and non-protected medical outcome data to show the impact of addressing SDOH needs has on utilization and overall health care cost. CCI participants use this data to demonstrate the community impact to philanthropic partners for future funding. BUFC is committed to launching this effort, in collaboration with Blaze Advisors; IHNSA providers; Community Services Agencies (CSAs); Contexture; NOWPOW; AHCCCS; and other stakeholders. This framework could also be replicated and coordinated with other ACC-RBHAs.

LEVERAGING BANNER-TECHNOLOGY ENABLED CARE (BTEC) TO IDENTIFY, CAPTURE AND SHARE SDOH INFORMATION:

Provider case managers play a key role in identifying and addressing member's SDOH needs. To ensure IHHs have the

information and technical supports necessary to enhance the delivery of effective acuity-based case management, in accordance with AHCCCS Medical Policy Manual (AMPM) Policy 570, we will implement **bi-directional data-sharing** between our internal Integrated Care Management (ICM) team and provider-based case management through the BTEC platform. Risk stratification and gaps in care data will be informed by assessments, claims and SDOH screening, and refreshed daily to support the ability to act upon identified SDOH needs in real-time. Because a member may have many social risk factors, member-centric care planning is crucial to identifying which need is most pressing for the member. By engaging members in conversations about their unmet SDOH needs, we address the whole health of every member. Significant SDOH needs, such as poverty, housing insecurity/homelessness, food and employment insecurity; poor access to transportation; justice/legal involvement; and loneliness and isolation often impede progress toward goal achievement. We will partner with AHCCCS and other AHCCCS health plans to select an **SDOH screening tool** that increases consistency across the provider network. At a minimum, the tool will capture housing insecurity/homelessness; food insecurity; transportation needs; employment insecurity; justice/legal involvement; social isolation/social support needs; ICD-10 Z codes; and other data sources. These sources supplement our identification of social risk factors from the health risk assessment and screening information; risk stratification data, including health disparity and social vulnerabilities; member engagement information from Pyx Health; and the Arizona Homeless Management Information System (HMIS). BUFC will partner with IHNSA, hospitals, network providers and social service providers to identify and widely deploy a standardized SDOH screening tool, the results of which are uploaded to the Arizona HIE and BTEC platform.

INTEGRATING CLOSED-LOOP REFERRAL SYSTEM INTO BTEC TO ENSURE TIMELY ACCESS TO SOCIAL SERVICES: Blaze Advisors **ONEcare Care Optimization System**® (COS), embedded in BTEC, is the technology platform for IHNSA, which includes SDOH screening tools that help to prompt PH and BH providers to complete screenings through an alert system. With success in other states, Blaze has adopted standardized SDOH screening tools into primary care physician (PCP) practices, emergency room (ER), hospital and BH workflows. Like the COS, NowPow is a CLRS that allows warm hand-offs between PH, BH and SDOH providers to ensure members are connected to necessary SDOH resources. BUFC and IHNSA will collect panel-level NowPow utilization and outcome data to incorporate into care gaps and risk stratification alerts that provide **real-time actionable data** back to providers. Through the interoperability and data integration functionality of our BTEC platform, we will ensure real-time access to relevant SDOH information and easy-to-use interactive dashboards for data reporting. We use a similar dashboard reporting design for our COVID vaccination outreach. The tool pinpoints members who are unvaccinated at the street level and allows real-time intervention, such as mobile or in-home vaccination to occur.

ACC-RBHA Application: BUFC has actively participated in the AHCCCS Whole Person Care Initiative (WPCI) and helped to launch pilots, proof of concepts and systematic changes to meet the needs of our members. We are active within the Home Matters of Arizona housing movement, including our CEO who chairs the fund committee. We support the HUD House America movement and have spent time with House and Senate leaders to secure ARPA funding for housing supports. In addition, we are a founding plan member in the **Association for Community Affiliated Plans (ACAP) SDOH Task Force**. BUFC was an early supporter of the SDOH Innovation Center's Guiding Task Force; our participation includes attending SDOH learning collaboratives, implementing benchmarking for SDOH opportunity assessments and advocacy work related to Medicaid SDOH legislation, all of which we incorporate into our local strategy and approach. Concurrently, we conducted a comprehensive analysis of the most prevalent SDOH needs in the South GSA (S-GSA), including evaluating associated covered and non-covered service needs. We perform routine county-based community health assessments, analyze our member health data, gather information from our Neighborhood Advisory Councils (NACs) and facilitate focus groups with members, providers, first responders and criminal justice stakeholders. Following completion of our research, BUFC took multiple steps to address SDOH needs and has developed plans to expand our strategy to members with an SMI as the ACC-RBHA. BUFC also continually enhances its current electronic community resource guide to ensure CSAs and Faith-Based Organizations that offer SDOH resources specific to members with an SMI are included. This comprehensive directory of services and supports will serve as the starting point of our **Connected Community**. We recognize that SDOH has a major impact on health, well-being and quality of life, which is why our community reinvestment program is prioritizing applications that address SDOH in our communities. In addition, as a not-for-profit plan, we will partner with the **Connected Community** to identify and apply for other grant dollars that support the whole person care approach. Finally, as the ACC-RBHA, we will work with our Banner Foundation to enhance our ability to support programs and non-covered supports that compliment Medicaid compensable services and address SDOH needs. BUFC will become the 'quarterback' the system requires to join these diverse funding sources in support of vulnerable members.

B12. The wellbeing of many Arizona residents has been significantly affected by the COVID-19 public health emergency for the last 18 months, contributing greatly to the need for increased behavioral health services. Describe the Offeror's role and strategies in supporting the State's recovery from the pandemic as it relates to the needs of individuals served under this Competitive Contract Expansion.

B12. Banner Health (Banner) and Banner-University Family Care (BUFC) have been *statewide leaders* in preparing for and responding to the State’s recovery from the COVID-19 pandemic. As the largest health system in Arizona, Banner has treated more than 50% of the individuals hospitalized due to COVID-19; provided nearly 80 percent of the lab testing, in partnership with Sonora Quest Laboratories (SQL); added virtual care for 90 percent of the network; conceptualized and staffed testing and vaccination sites across the State; and developed a long-hauler COVID-19 treatment center in Tucson. BUFC staff also volunteered for shifts during weekends and evenings to support our health care heroes. In alignment with AHCCCS’ mission of “*reaching across Arizona to provide comprehensive, quality health care for those in need,*” we have advocated and supported the AHCCCS and Arizona Department of Health Services (ADHS) response to COVID-19, as demonstrated by our close partnership with AHCCCS and the Arizona Association of Health Plans, to implement a coordinated strategy to support our communities. BUFC has served as a thought leader and member champion by spearheading numerous statewide efforts, such as the request for review of system flexibilities necessary to support provider viability and member access to care, including innovative transportation solutions. While many in the community focused on the physical health (PH) impacts of COVID-19, BUFC quickly identified and developed strategies to address the emerging *secondary crisis—the behavioral health (BH) epidemic*.

BUFC’S COMPREHENSIVE BEHAVIORAL HEALTH EPIDEMIC RESPONSE PLAN: Beginning in October 2020, BUFC championed community-based initiatives, bringing together more than 80 community partners, including AHCCCS; Department of Economic Security; Department of Child Safety; Arizona Council; BH and PH providers; schools; justice system representatives; members, peers and family members; faith-based community partners; and others. Together with these community partners, we developed a BH Epidemic Response Plan that includes **(1)** public health education; **(2)** use of integrated care strategies; and **(3)** expanded access to in-person and telehealth services. Utilizing our robust network of trauma-informed providers, we will expand and enhance this response plan to address the comprehensive needs of individuals with SMI. ***We will be a champion for our members and providers every step of the way.***

We are a Leader in Providing Public Health Education: With established relationships with community partners across the State, we have developed and continue to expand a robust public health education program. In partnership with Solari, 2-1-1 Arizona, SQL, and our Banner Urgent Cares, we developed a community toolkit (B.12.1 Public Health Education) of social media posts, postcards and flyers to be distributed across our communities to reduce BH stigma, to encourage individuals to seek help and to provide information on how to access services, including placing information in lab clinics, urgent care sites, PCP offices and frequently visited web portals (e.g., SQL’s lab result portal). As an ACC-RBHA, BUFC will continue in its role as a statewide leader, providing public health education around the primary and secondary impacts of COVID-19 using traditional member and provider materials and expanding our use of social media and other mediums, such as radio spotlights, billboards and bus shelter ads. We will continue to support and sponsor community events like the Arizona Palooza. In 2021, BUFC sponsored The Arizona Palooza, an hour-long uninterrupted television broadcast that aired on CBS and included vignettes about the impact of COVID-19 on social/emotional well-being and recovery and resiliency. The broadcast featured key BUFC leaders, such as our Chief Executive Officer (CEO), Chief Medical Officer (CMO), employment administrator and tribal coordinator. In addition, ***BUFC and the University of Arizona (UA) College of Public Health have entered into a formal agreement*** to study the impact of COVID-19 on the social and mental health of Arizonans. We will contribute our expertise and work with their researchers who will launch an ancillary survey, as part of the current ***AZ CoHVORT research study***, to examine social/emotional wellness (e.g., grief, depression, anxiety, and social isolation), help seeking behaviors, limitation to seeking help and to develop recommendations to improve access to community-based care. As an ACC-RBHA, BUFC will leverage this and other research partnerships to support the most impactful community initiatives and to become a statewide community voice. We will also support AHCCCS and ADHS initiatives, such as the Suicide Prevention Action Plan and the Opioid Action Plan, study and address COVID-19 long-haul and continue to invest in Mental Health First Aid.

We will Expand and Innovate our Integrated Care Strategies: We recognize that addressing the increased need for BH services requires an integrated approach that holistically addresses BH, Substance Use Disorder (SUD), PH and Social Determinants of Health (SDOH) needs. This integrated approach is particularly critical for individuals with SMI who have increased risk for co-occurring SUD and co-morbid PH conditions that increase their risk for serious COVID-19 complications or death. We launched an internal Integrated Health Care Summit with representatives from hospitals/Emergency Rooms (ERs), urgent care centers, primary care providers (PCPs) and academics at UA to address this

B.12.1 Public Health Education



Banner University Health Plans

in a systematic manner. Our integrated care approach responds to community needs through activities, such as training PCPs on BH and SUD screening; diagnosis and treatment; maximizing peer support services; and a depression care management program.

We also leverage technology, such as **expanding the use of telehealth services and the Pyx Health (Pyx) application**. BUFC assisted in launching Pyx as an ACC bid commitment and identified that more than 50% of our 3,500 members who used Pyx self-reported reduced anxiety, depression and loneliness. We will utilize Pyx's expertise in combatting loneliness and depression for all populations we serve. We also implemented a de-escalation initiative with Banner Urgent Cares and community BH providers to effectively keep high-risk BH members out of ER, crisis and inpatient settings by referring them on to an appropriate urgent care setting. Banner has also assumed a leadership role, in partnership with AHCCCS and Pima County Health Department, to implement focused care management activities and innovative approaches to support our most vulnerable members, including those enrolled in ALTCS, to receive the COVID-19 vaccination. **This program has proven highly successful, as evidenced by our ALTCS vaccination rates, which reached nearly 80% (including individuals with SMI), the highest among ALTCS E/PD plans.** We will expand this program and approach to the ACC-RBHA members, using technology to identify and address local and cultural trends in vaccination rates. As the first organization in Arizona to require employees to obtain vaccinations, we will use our platform as a trusted health care provider and health plan to promote vaccinations and address the growing disparity in vaccination rates between some AHCCCS populations and the general public. To address vaccine hesitancy, we have discussed strategies with our Member Advisory Council (MAC) and we will utilize Peer and Family Run Organizations (PRFO) and other partnerships to educate.

We will Expand Access to Services and Supports and Address Provider Capacity: The increased need and demand for BH interventions as a result of COVID-19 will continue to tax an already challenged system of care. We employ and will commit to developing strategies and solutions to increase system capacity and to expand the community workforce. Specifically, BUFC will expand BH services and improve access to care through the development of a clinically integrated network (CIN), known as the Integral Health Network of Southern Arizona (IHNSA). This integrated care approach operates on the presumption that primary care—enabled with standardized screenings/risk criterium, tele-consult support, episodic/transitional care management and timely access to BH specialists—should be the medical home for most low-risk BH members. This approach will facilitate capacity for BH specialists to address higher-risk members. As an ACC-RBHA, we will **equip PCPs with enhanced** access to specialized care and create access in rural and border communities by supporting projects, such as UA's Project ECHO. Hospital and ER resources are also scarce; to address this issue, BUFC and IHNSA will implement a **COVID-19 Resiliency and Decompression Task Force** to maximize opportunities for ER diversion and inpatient avoidance during periods of resource scarcity. This will include the identification of members who may benefit from the Banner-developed Hospital at Home program.

In addition, we will expand access to services by promoting the use of BH telehealth by expanding our initiative with COPA Health, the State's largest SMI provider, to provide **bridge appointments** for BH members who are unable to immediately visit the HH psychiatrist. We will also fund the development of telehealth video hubs in rural areas of southern Arizona and promote the use of **digital approaches** to evidence-based CBT through platforms, such as SilverCloud. We will garner input regarding our strategies from our MACs, Neighborhood Advisory Committees, and tribal communities. As an ACC-RBHA, we will partner with AHCCCS to effectively initiate implementation of the **closed-loop referral** system. Understanding that COVID-19 has exacerbated health care disparity, particularly as it relates to SDOH, BUFC is also committed to utilizing community reinvestment funds and alternative-payment models to address SDOH.

BUFC will be a Champion for Members and Providers: We understand that individuals with SMI may require additional supports to regain and attain recovery goals, as part of the COVID-19 recovery process, resulting in increased need for services, such as psychosocial rehabilitation living skills. BUFC will continue to support and expand programs, such as Camp Wellness and Art Awakening, which utilize a peer workforce model to help members build coping skills to assist with their wellness journey. In partnership with PRFO and to support community re-integration, BUFC will expand existing peer support training programs so more individuals are trained and in the workforce.

BUFC will be a **leader and partner** with AHCCCS as the system 'unwinds' from the COVID-19 pandemic, ensuring input from our member and provider forums is incorporated into our recommendations. We will support initiatives passed, as part of the American Rescue Plan Act of 2021 (ARPA). As a safety net health plan serving the most vulnerable members in our communities, BUFC will champion reforms to increase access to services and to promote public health.

BUFC continues to demonstrate its commitment as a leader in the response to, and recovery from, the COVID-19 pandemic. As an ACC-RBHA, we will bring our full resources to assist communities in emerging even stronger from this epidemic.

C1 Agreement Accepting Capitation Rates

Banner-University Family Care agrees to accept the actuarially sound capitation rates computed prior to October 1, 2022. Banner-University Family Care understands that AHCCCS' actuaries will develop components of the capitation rates including the medical services component, reinsurance offset, underwriting gain, and premium tax. These components will not be bid. The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice and will follow generally accepted actuarial principles and practices.

Banner-University Family Care
Company Name

2701 E. Elvira Road
Address

Tucson AZ 85756
City State Zip


Signature of Person Authorized to Sign

James Stringham
Print Name

VP and Chief Executive Officer
Title

Administrative Bid Component										
	SMI Rate Cell					Crisis 24 Hour Group Rate Cell				
	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27	CYE 23	CYE 24	CYE 25	CYE 26	CYE 27
MCO Compensation										
Business and Finance	\$ 129,236.00	\$ 132,466.00	\$ 135,779.00	\$ 139,173.00	\$ 142,653.00	\$ 21,038.00	\$ 21,564.00	\$ 22,103.00	\$ 22,656.00	\$ 23,222.00
Care Management/Care Coordination	\$ 3,203,999.00	\$ 3,284,099.00	\$ 3,366,201.00	\$ 3,450,356.00	\$ 3,536,615.00	\$ 521,581.00	\$ 534,621.00	\$ 547,986.00	\$ 561,686.00	\$ 575,728.00
Claims and Encounters	\$ 1,357,764.00	\$ 1,391,708.00	\$ 1,426,500.00	\$ 1,462,163.00	\$ 1,498,717.00	\$ 221,031.00	\$ 226,557.00	\$ 232,221.00	\$ 238,027.00	\$ 243,977.00
Clinical Management	\$ 1,754,257.00	\$ 1,798,113.00	\$ 1,843,066.00	\$ 1,889,143.00	\$ 1,936,371.00	\$ 285,577.00	\$ 292,716.00	\$ 300,034.00	\$ 307,535.00	\$ 315,223.00
Compliance/Legal	\$ 666,784.00	\$ 683,454.00	\$ 700,540.00	\$ 718,053.00	\$ 736,005.00	\$ 108,546.00	\$ 111,260.00	\$ 114,041.00	\$ 116,892.00	\$ 119,815.00
Dental	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Executive	\$ 189,909.00	\$ 194,656.00	\$ 199,523.00	\$ 204,511.00	\$ 209,624.00	\$ 30,915.00	\$ 31,688.00	\$ 32,480.00	\$ 33,292.00	\$ 34,125.00
Health Care Quality Improvement	\$ 1,195,076.00	\$ 1,224,953.00	\$ 1,255,577.00	\$ 1,286,966.00	\$ 1,319,140.00	\$ 194,547.00	\$ 199,411.00	\$ 204,396.00	\$ 209,506.00	\$ 214,744.00
Information Services / Technology	\$ 163,795.00	\$ 167,890.00	\$ 172,087.00	\$ 176,390.00	\$ 180,799.00	\$ 26,664.00	\$ 27,331.00	\$ 28,014.00	\$ 28,715.00	\$ 29,432.00
Interpretive Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Member Services	\$ 498,468.00	\$ 510,930.00	\$ 523,703.00	\$ 536,795.00	\$ 550,215.00	\$ 81,146.00	\$ 83,175.00	\$ 85,254.00	\$ 87,385.00	\$ 89,570.00
Pharmacy Management	\$ 15,396.00	\$ 15,781.00	\$ 16,175.00	\$ 16,580.00	\$ 16,994.00	\$ 2,506.00	\$ 2,569.00	\$ 2,633.00	\$ 2,699.00	\$ 2,766.00
Program Integrity (Fraud, Waste & Abuse)	\$ 64,583.00	\$ 66,198.00	\$ 67,853.00	\$ 69,549.00	\$ 71,288.00	\$ 10,514.00	\$ 10,776.00	\$ 11,046.00	\$ 11,322.00	\$ 11,605.00
Provider Relations and Network Management	\$ 1,215,673.00	\$ 1,246,065.00	\$ 1,277,217.00	\$ 1,309,147.00	\$ 1,341,876.00	\$ 197,900.00	\$ 202,848.00	\$ 207,919.00	\$ 213,117.00	\$ 218,445.00
Other ¹	\$ 10,202.00	\$ 10,458.00	\$ 10,719.00	\$ 10,987.00	\$ 11,262.00	\$ 1,663.00	\$ 1,702.00	\$ 1,747.00	\$ 1,789.00	\$ 1,834.00
Total MCO Compensation	\$ 10,465,142.00	\$ 10,726,771.00	\$ 10,994,940.00	\$ 11,269,813.00	\$ 11,551,559.00	\$ 1,703,628.00	\$ 1,746,218.00	\$ 1,789,874.00	\$ 1,834,621.00	\$ 1,880,486.00
Professional and Outside Services										
Business and Finance	\$ 161,450.00	\$ 179,079.00	\$ 180,870.00	\$ 182,678.00	\$ 184,505.00	\$ 27,223.00	\$ 29,152.00	\$ 29,444.00	\$ 29,738.00	\$ 30,036.00
Care Management/Care Coordination	\$ 4,688,729.00	\$ 5,200,710.00	\$ 5,252,717.00	\$ 5,305,245.00	\$ 5,358,297.00	\$ 790,551.00	\$ 846,627.00	\$ 855,094.00	\$ 863,644.00	\$ 872,281.00
Claims and Encounters	\$ 427,098.00	\$ 473,735.00	\$ 478,472.00	\$ 483,257.00	\$ 488,089.00	\$ 72,012.00	\$ 77,120.00	\$ 77,891.00	\$ 78,670.00	\$ 79,456.00
Clinical Management	\$ 659,819.00	\$ 731,867.00	\$ 739,186.00	\$ 746,578.00	\$ 754,044.00	\$ 111,250.00	\$ 119,141.00	\$ 120,333.00	\$ 121,536.00	\$ 122,751.00
Compliance/Legal	\$ 323,386.00	\$ 358,699.00	\$ 362,286.00	\$ 365,909.00	\$ 369,568.00	\$ 54,525.00	\$ 58,393.00	\$ 58,977.00	\$ 59,567.00	\$ 60,162.00
Dental	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Executive	\$ 1,692,651.00	\$ 1,877,479.00	\$ 1,896,254.00	\$ 1,915,216.00	\$ 1,934,368.00	\$ 285,392.00	\$ 305,636.00	\$ 308,692.00	\$ 311,779.00	\$ 314,897.00
Health Care Quality Improvement	\$ 161,583.00	\$ 179,227.00	\$ 181,019.00	\$ 182,829.00	\$ 184,658.00	\$ 27,244.00	\$ 29,176.00	\$ 29,468.00	\$ 29,763.00	\$ 30,061.00
Information Services / Technology	\$ 149,345.00	\$ 165,653.00	\$ 167,309.00	\$ 168,982.00	\$ 170,672.00	\$ 25,181.00	\$ 26,967.00	\$ 27,236.00	\$ 27,509.00	\$ 27,784.00
Interpretive Services	\$ 121,777.00	\$ 135,075.00	\$ 136,425.00	\$ 137,790.00	\$ 139,167.00	\$ 20,532.00	\$ 21,989.00	\$ 22,209.00	\$ 22,431.00	\$ 22,655.00
Member Services	\$ 42,467.00	\$ 47,105.00	\$ 47,576.00	\$ 48,052.00	\$ 48,532.00	\$ 7,160.00	\$ 7,668.00	\$ 7,745.00	\$ 7,822.00	\$ 7,901.00
Pharmacy Benefit Manager Expenses ²	\$ 1,005,928.00	\$ 1,234,021.00	\$ 1,662,798.00	\$ 2,921,550.00	\$ 3,833,947.00	\$ 110,388.00	\$ 201,050.00	\$ 270,863.00	\$ 475,787.00	\$ 624,154.00
Pharmacy Management	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Program Integrity (Fraud, Waste & Abuse)	\$ 378,294.00	\$ 419,601.00	\$ 423,797.00	\$ 428,035.00	\$ 432,315.00	\$ 63,783.00	\$ 68,307.00	\$ 68,990.00	\$ 69,680.00	\$ 70,377.00
Provider Relations and Network Management	\$ 31,241.00	\$ 34,652.00	\$ 34,999.00	\$ 35,349.00	\$ 35,702.00	\$ 5,267.00	\$ 5,641.00	\$ 5,697.00	\$ 5,754.00	\$ 5,812.00
Subcontractors ²	\$ 334,461.00	\$ 370,982.00	\$ 374,692.00	\$ 378,439.00	\$ 382,223.00	\$ 56,392.00	\$ 60,392.00	\$ 60,996.00	\$ 61,606.00	\$ 62,222.00
Other ¹	\$ 3,829.00	\$ 4,244.00	\$ 4,288.00	\$ 4,330.00	\$ 4,375.00	\$ 644.00	\$ 692.00	\$ 698.00	\$ 706.00	\$ 713.00
Total Professional and Outside Services	\$ 10,182,058.00	\$ 11,412,129.00	\$ 11,942,688.00	\$ 13,304,239.00	\$ 14,320,462.00	\$ 1,657,544.00	\$ 1,857,951.00	\$ 1,944,333.00	\$ 2,165,992.00	\$ 2,331,262.00
Non-Compensation										
Interest Expense	\$ 156,994.00	\$ 158,564.00	\$ 160,150.00	\$ 161,751.00	\$ 163,369.00	\$ 25,557.00	\$ 25,813.00	\$ 26,071.00	\$ 26,332.00	\$ 26,595.00
Non-Capital Equipment and Licenses	\$ 15,248.00	\$ 15,401.00	\$ 15,555.00	\$ 15,710.00	\$ 15,868.00	\$ 2,482.00	\$ 2,507.00	\$ 2,532.00	\$ 2,558.00	\$ 2,583.00
Non-Compensation Health Care Quality Improvement	\$ 73,032.00	\$ 73,763.00	\$ 74,500.00	\$ 75,245.00	\$ 75,998.00	\$ 11,889.00	\$ 12,008.00	\$ 12,128.00	\$ 12,249.00	\$ 12,372.00
Occupancy & Depreciation	\$ 93,286.00	\$ 94,219.00	\$ 95,161.00	\$ 96,113.00	\$ 97,074.00	\$ 15,186.00	\$ 15,338.00	\$ 15,491.00	\$ 15,646.00	\$ 15,803.00
Office Supplies, Equipment Repair, Maintenance	\$ 2,052,615.00	\$ 2,074,515.00	\$ 2,095,260.00	\$ 2,116,213.00	\$ 2,137,375.00	\$ 334,147.00	\$ 337,488.00	\$ 340,863.00	\$ 344,272.00	\$ 347,714.00
Printing, Postage, Fulfillment	\$ 25,074.00	\$ 25,323.00	\$ 25,577.00	\$ 25,833.00	\$ 26,091.00	\$ 4,082.00	\$ 4,123.00	\$ 4,164.00	\$ 4,205.00	\$ 4,247.00
Travel, Marketing, Insurance	\$ 489,917.00	\$ 494,816.00	\$ 499,764.00	\$ 504,762.00	\$ 509,810.00	\$ 79,754.00	\$ 80,551.00	\$ 81,357.00	\$ 82,171.00	\$ 82,992.00
Other ¹	\$ 588,704.00	\$ 594,591.00	\$ 600,537.00	\$ 606,542.00	\$ 612,606.00	\$ 95,835.00	\$ 96,794.00	\$ 97,762.00	\$ 98,739.00	\$ 99,727.00
Total Non-Compensation	\$ 3,494,870.00	\$ 3,531,192.00	\$ 3,566,504.00	\$ 3,602,169.00	\$ 3,638,191.00	\$ 568,932.00	\$ 574,622.00	\$ 580,368.00	\$ 586,172.00	\$ 592,033.00
Total Admin Dollars	\$ 24,142,070.00	\$ 25,670,092.00	\$ 26,504,132.00	\$ 28,176,221.00	\$ 29,510,212.00	\$ 3,930,104.00	\$ 4,178,791.00	\$ 4,314,575.00	\$ 4,586,785.00	\$ 4,803,781.00
Total Management Fees Included Above ³	\$ -	\$ -	\$ -	\$ -	\$ -					
Management Fee arrangement percentage (contracted)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Projected Member Months	161,455	163,069	164,700	166,347	168,010	5,151,159	5,202,670	5,254,697	5,307,244	5,360,316

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

2) Please refer to the MLR reference/guidance tool (<https://www.azahcccs.gov/PlansProviders/Downloads/FinancialReporting/MedicalLossRatioReportAndGuidance.xlsx> Tab: SubContractors and PBMs) for costs which must be reported as non-claims administrative expenses.

3) Total management fees included above, already counted in total admin dollars.



September 30, 2021

**Actuarial Certification
Banner University Family Care
AHCCCS ACC-RBHA Bids
October 1, 2022 – September 30, 2027**

I, Jonathan M. Hendrickson, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its qualification standards for rendering this opinion. I have been retained by Banner University Family Care (BUFC) to provide a certification that the non-benefit costs bid submissions for the Expansion of the Complete Care Contract under the Arizona Health Care Cost Containment System (AHCCCS) meet the requirements of 42 CFR 438.5 (e).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Expansion of the AHCCCS Complete Care Contract Request for Proposal (including amendments through the date of this certification) issued by AHCCCS. This certification may not be appropriate for other purposes.

The non-benefit costs to which this certification applies are attached in AHCCCS's required Non-Benefit Costs Bid Submission workbook. The administrative non-benefit costs apply to the period October 1, 2022 through September 30, 2027.

It is my opinion that the attached non-benefit cost components are adequate to fund administrative expenses for BUFC during the time period for which they are intended, for the Expansion of the Complete Care Contract as outlined in the RFP. If the Expanded Complete Care program were to change materially from that described in the RFP, the attached rates may not be adequate. In addition, I am relying on AHCCCS's statement that the medical cost component of the capitation rate will be "actuarially sound" as defined in the RFP, its amendments, and ASOP 49 "Medicaid Managed Care Capitation Rate Development and Certification".

Development of the Non-Benefit Costs

BUFC developed the projected non-benefit costs provided in the Non-Benefit Costs Bid Submission workbook. I reviewed the methodology and assumptions and found them to be reasonable.

The non-benefit costs were developed based on financial statement information from AHCCCS, non-benefit expense costs from BUFC's ACC and ALTCS contracts, and compensation estimates from BUFC's HR system. Adjustments were made for trend, expected new FTEs, and input from senior management on strategic initiatives.

Reasonableness of the Non-Benefit Costs

In forming my opinion, I performed several reasonableness tests. While performing these tests, I relied on BUFC's description of the process used to develop the estimates, BUFC's budgeted amounts, and the Supplemental data provided by AHCCCS.

1) I compared BUFC's projected non-benefit costs to audited CY2019 and CY2020 financial statements of current RBHA contractors in Arizona. I also compared the projected non-benefit costs to the amounts

ACC-RBHA Competitive Contract Expansion

AHCCCS is paying current RBHA contractors in their CY2021 and CY2022 capitation rates in the South region.

2) I compared the anticipated administrative costs to projected medical and behavioral claim cost levels under the RBHA portion of the Expanded Complete Care contract. In doing so I relied on claim cost information provided in the AHCCCS Supplemental data. I projected claims costs accounting for: programmatic and fee schedule changes; efficiency gains; completion; and overall trend.

I further considered the anticipated impact of the combined ACC-RBHA risk corridor. This included potential risk corridor payable or receivable amounts under the ACC contract in the absence of the ACC-RBHA combined contract, and the anticipated impact of the additional ACC-RBHA experience on the overall projected risk corridor payable or receivable amounts.

3) I also conducted scenario testing around various assumptions relating to claims trend, revenue trend, and administrative cost variability vs bid.

After examining the budget and conducting the tests described above, I have found BUFC's projected administrative costs to be reasonable.

Caveats

My determination is based on a review of the claim experience and other information provided by AHCCCS; administrative cost development and budget information provided by BUFC; and my professional judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and BUFC. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found any material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my analysis.

The administrative costs and underwriting gains in the attached bid submission sheets are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of BUFC and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience deviates from expected experience.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.



Jonathan M. Hendrickson, FSA, MAAA
September 28, 2021