mercy care

Arizona Health Care Cost Containment System (AHCCCS) Arizona Long Term Care System (ALTCS) Program

Solicitation # YH24-0001
Due Date: 10/02/2023
Due Time: 3:00pm, AZ Time

Part A

EXHIBIT A: OFFEROR'S CHECKLIST

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

OFFEROR'S CHECKLIST ALTCS EPD RFP #YH24-0001		
	SUBMISSION REQUIREMENT	**OFFEROR'S PROPOSAL PAGE NO.**
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B2	Cite Contracts 1-page limit - Utilize Template	16
B3	Health Equity Requirement No submission required	N/A
B4	5-page limit	17
B5	4-page limit	22
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	26
B7	4-page limit	32
B8	4-page limit	36
B9	4-page limit	40
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	N/A
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The Deadline to submit the Intent to Bid form is August 31, 2023, BY 3:00 PM ARIZONA TIME

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

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

1	NAME:	Dena M. Stukenberg
2	TITLE:	Executive Director, Medicaid RFP
3	EMAIL ADDRESS:	stukenbergd@aetna.com
4	PHONE NUMBER:	708-860-6083
5	COMPANY NAME:	Mercy Care (Administered by Aetna Medicaid Administrators)
6	COMPANY ADDRESS:	4500 E Cotton Center Blvd, Phoenix, Arizona 85040
7	COMPANY WEBSITE:	mercycareaz.org

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

Signature: _____ **Date**: 8/11/2023

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

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

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

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

1	NAME:	Lisa Gudmunsen
2	TITLE:	Medicaid Proposal Director
3	EMAIL ADDRESS:	gudmunsenl@aetna.com
4	PHONE NUMBER:	763-923-8110
5	COMPANY NAME:	Mercy Care (Administered by Aetna Medicaid Administrators)
6	COMPANY ADDRESS:	4500 E Cotton Center Blvd, Phoenix, Arizona 85040
7	COMPANY WEBSITE:	mercycareaz.org

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

Signature: _____ **Date**: 08/10/2023

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

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

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

Issue Date: August 1, 2023

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

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

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

OFFER AND ACCEPTANCE

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

Not applicable

Federal Employer Identification No.:

86-0527381

For clarification of this offer, contact:

Name: Lorry S. Bottrill

Title: President & Chief Executive Officer, Mercy Care

E-Mail Address: Lorry.Bottrill@mercycareaz.org

Phone: 602-400-7082

Mercy Care	Lorry Bottrill
Company Name	Signature of Person Authorized to Sign Offer
4500 E. Cotton Center Blvd.	Lorry S. Bottrill
Address	Printed Name
Phoenix AZ 85040	President & Chief Executive Officer, Mercy Care
City State Zip	Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

This contract shall henceforth be referred to as

Contract No. _____

Contract Service Start Date: _____

Award Date: _____

_____

MEGGAN LAPORTE, AHCCCS CHIEF PROCUREMENT OFFICER

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

Mercy Care
OFFEROR NAME

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

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

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

Lorry Bottrill
Lorry Bottrill (Aug 28, 2023 08:50 PDT)

Authorized Signature

08/28/23

Date

Lorry S. Bottrill

Print Name

President & Chief Executive Officer, Mercy Care

Title

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

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

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

This Solicitation is amended as follows:

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

B. This Solicitation is also amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL: Lorry Bottrill Lorry Bottrill (Aug 28, 2023 08:51 PDT)	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: **LORRY S BOTTRILL**	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: **President & Chief Executive Officer, Mercy Care**	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: 08/28/23	**DATE:**

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

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

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

This Solicitation is amended as follows:

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

B. This Solicitation is also amended as follows:

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

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL: Lorry Bottrill Lorry Bottrill (Sep 5, 2023 11:15 PDT)	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: **LORRY S BOTTRILL**	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: **President & Chief Executive Officer, Mercy Care**	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: 09/05/23	**DATE:**

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

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

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

This Solicitation is amended as follows:

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

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

INCORPORATED in this Solicitation Amendment:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL: Lorry Bottrill Lorry Bottrill (Sep 11, 2023 07:11 PDT)	**SIGNATURE:** SIGNATURE ON FILE
TYPED NAME: LORRY S BOTTRILL	**TYPED NAME:** MEGGAN LAPORTE, CPPO, MSW
TITLE: President & Chief Executive Officer, Mercy Care	**TITLE:** CHIEF PROCUREMENT OFFICER
DATE: 09/11/23	**DATE:** 9/8/2023

Part B

B1 - Executive Summary

Mercy Care (MC) is a trusted partner to the State with a legacy of helping Arizonans achieve better health and contributing to AHCCCS initiatives and improvements for every new Medicaid program implemented since 1985. Throughout our response we demonstrate our strategies to work with AHCCCS to achieve the Quintuple Aim of improving health outcomes, promoting health equity, improving the member and provider experience, and lowering the cost of health care. **MC collaborates with AHCCCS to improve the cohesiveness and effectiveness of the Arizona health care system, reduce fragmentation in care for ALTCS members and their families, incentivize quality outcomes, leverage health information technology, and work with private sector partners to further innovation.** We have received NCQA Health Plan Accreditation and will receive NCQA LTSS Distinction by October 1, 2024, and Health Equity Accreditation by October 1, 2025. Addressing inequities is at the core of our mission, and we use this icon to highlight areas throughout our proposal that demonstrate how we are promoting equitable member care by addressing health care disparities and structural and health-related social needs (HRSN), as requested in B3.

Overview of MC

We are a local, not-for-profit 501(c)(3) provider sponsored organization by Dignity Health and Ascension Health. MC is administered by Aetna Medicaid Administrators, LLC, a CVS Health company. For the last 37 years, we have lived, and will continue to live, our mission of addressing and advocating for the comprehensive health of members and families, including circumstances that impact their well-being, with special consideration for the underserved and those with complex health needs. Since MC became one of the original AHCCCS Medicaid managed care health plans, we have expanded to serve members with disabilities and older adults through a range of publicly funded health care programs. **We serve more than 468,000 Arizonans** and with **nearly 1,200 personnel** residing throughout the state. We:

- Began serving members with developmental disabilities in 1991 and started to operate a statewide contract as the Division of Developmental Disabilities (DDD) health plan in 2019.
- Started administering our first ALTCS contract in 2000 and expanded our ALTCS contract to Pima County in 2011 and Pinal and Gila counties in 2017.
- Launched our MC Advantage Dual-eligible Special Needs Plan (D-SNP) in 2006.
- Became the first Regional Behavioral Health Authority (RBHA) in Arizona to integrate physical health (PH) and behavioral health (BH) care services for persons with a Serious Mental Illness (SMI) designation in 2014.
- Started a statewide Department of Child Safety (DCS) contract in 2021.

Our Relevant Experience Providing Health Care to ALTCS Members

MC has been coordinating, managing, and providing LTSS, PH/BH integrated care, and case management services to ALTCS members for 23 years, operating in alignment with AHCCCS values of choice, dignity, independence, individuality, privacy, and self-determination. With our deep understanding of the ALTCS program, **we currently serve 10,562 ALTCS members (41% of all ALTCS members), with membership in Gila, Maricopa, Pima, and Pinal counties.** Examples of our key achievements in serving ALTCS members and the ALTCS program include:

- Although 100% of our ALTCS membership is eligible to receive 24-hour skilled nursing care, we help **79% of our ALTCS members to live in the community, up from 74% in 2017**, supporting Home and Community Based Settings rules.
- **We have strategically infused over $24 million in local Arizona community-based organizations (CBOs)** and the community at large, in alignment with the AHCCCS Whole Person Care Initiative, to promote the delivery of whole-person care, address HRSN, reduce health care disparities, and promote equity in health care.

Since 2016, we have provided **$1.6 million in funding to support the Farm Express Mobile Market program,** which brings the Farm Express Bus and Farm Express Produce Van to serve members at 40 locations in communities where disparities in access to nutritious food occur. 019.AZ23

- We have demonstrated our ability to successfully build statewide, integrated networks in new Geographic Service Areas during our ALTCS, D-SNP, RBHA, DCS, and DDD expansions. MC has increased our statewide network of integrated clinics **from 42 to 657 since 2017, an increase of 1450%.**
- We partner closely with the AHCCCS Targeted Investment program and have been intimately involved in the program development since its inception. We've **consistently performed better than the all-plan aggregate for 16 of the 18 Targeted Investment 1.0 Measures** for Adult PCP, Adult BH, Hospital, Pediatric BH, and Justice programs, set according to AHCCCS historical performance on national benchmarks (e.g., NCQA HEDIS, Centers for Medicare and Medicaid Services (CMS) Adult and Pediatric Core Sets, and the CMS Scorecard).

Our Proposed Unique Approach to Meet Contract Requirements

We are confident that AHCCCS will find MC to be the best-positioned managed care organization to support its strategic goals of improving ALTCS member outcomes and experience. We have significant experience serving ALTCS members and other specialty populations with complex needs, a mission-driven approach, stakeholder relationships, and organizational processes to create the strongest and most productive partnership. We will augment our existing best practices and scale innovations to **meet the whole-health needs of ALTCS members, support their caregivers, deliver quality outcomes, promote health equity, develop the LTSS workforce, and prevent abuse, neglect, and exploitation.** We embrace ALTCS's guiding principles through our unique approach, as described in the table that follows.

ALTCS Principles	MC Approach	Examples of our Proposed Unique Approach and Demonstrated Success
Person-Centered Service Planning and Member-Centered Case Management	MC leverages our expertise in serving individuals with special health care needs to coordinate culturally responsive, person-centered care and reduce fragmentation in the health care system. For over 23 years, we have provided leadership, innovation, and results to evolve with the ALTCS program and exceed the expectations of members, providers, and AHCCCS.	• We are training all our ALTCS BH case managers (CMs) to be **Certified Personal Medicine Coaches** to empower member voice and choice, recognizing members know what works best to meet their needs. • We have dedicated ALTCS BH and medically complex specialty teams. – We scored **100% on ensuring members receive medically necessary BH services** documented on the Person Centered Service Plan (PCSP) in our 2023 Operational Review. • We are investing in health information technology, such as: – Collaborating with Contexture on a unique initiative to enhance **CommunityCares** by including members' AHCCCS ID number to increase interoperability with our systems. – Implementing **FamilyCare Central**, our integrated health record for sharing the PCSP and health information with members and caregivers. – Creating our **proprietary ALTCS Referral database** to facilitate coordination of Home and Community Based Services (HCBS) for members. Since inception in 2021, this tool has assisted with the closure of 96.5% of HCBS referrals, with an average time of 1.6 days.
Member-Directed Options	We innovate culturally responsive solutions to increase engagement of ALTCS members, to improve the member experience, to address HRSN, and to promote equitable health care delivery.	• We offer innovative, easy-to-use digital member support tools, like **Pyx Health,** to engage members and address members' HRSN, such as loneliness and health literacy. – 1,750 MC members have used Pyx Health since May 2021, experiencing a **63.1% decrease in PH hospital admissions and a 63% decrease in BH hospital admissions.** • We are investing $670,000 to partner with **Contexture and Hospice of the Valley to develop the "Choose Your Person" campaign**, which helps Arizonans create and register their directive with the **Arizona Health Directives Registry.** – We scored **97.75% on the NCQA HEDIS Advance Care Planning** measure.
Most Integrated Setting	We foster dignity, independence, and improved health outcomes for ALTCS members, helping them thrive in settings of their choice based on cultural needs, while reducing the growth in health care costs.	• We are supporting **Mercy Housing** to bring health and wellness resources to residents of 13 Arizona affordable housing properties (9 senior housing communities), by funding a health navigator and a resident services coordinator to bring services to members where they live. • We refer ALTCS members to our partner, **Benefit Results,** when we identify that they are able to transition out of a nursing facility, but face income related barriers. – Since 2020, through this program, we have helped over 60 ALTCS members return to the community and have helped them **acquire over $1.7M in annual income, saving the Arizona health care system $5M.**
Accessibility of Network and Consistency of Services	MC delivers exceptional access to equitable, high quality, whole-person, coordinated care for Arizonans with special health care needs throughout the state. To achieve our mission to serve the ALTCS program, we expand access to LTSS, PH and BH, and deliver culturally responsive solutions for HRSN.	• We will establish a Dementia and Related Disorder Center of Excellence (COE) and COE for Direct Care Workers (DCWs). • We are collaborating with providers, such as **CareBridge, Monogram, Imagine Pediatrics, and Oak Street** to leverage telehealth technology to provide remote consultations, monitoring, and follow-up for ALTCS members in underserved areas. • We support providers to adopt electronic visit verification (EVV) and adhere to AHCCCS EVV requirements by providing training and technical assistance. – Since 2021, we have connected with over 220 providers subject to EVV. We **increased EVV compliance from 87% in January 2023 to 97% in June 2023** by educating providers on EVV requirements.
Collaboration with Stakeholders	We lead with compassion, advocating for person-centered health care, partnering with providers and CBOs who meet members' cultural needs, and developing the infrastructure and workforce needed to deliver services to members in the right place at the right time.	• We collaborate with the **United Way of Southern Arizona** and the **Pima Council on Aging and the Elder Alliance** to develop a program to recruit, train, and place DCWs in Pima County, where need is high. **MC is funding an additional $750,000 to continue the program and project the program will result in hiring 420 to 500 DCWs.** • We work with **Area Agencies on Aging (AAA) in our ALTCS Transition of Care (TOC) program.** AAA transition coaches support members' TOC needs for 30 days post-discharge. – The TOC Transition program contributed to a **decrease in our HEDIS Plan All Cause Readmission Rates from 20% (MY 2019) to 10%, with an observed/expected readmissions ratio of 0.6714, exceeding the HEDIS 95th percentile in MY 2020.**

B2 - Cite Contracts [1 page]

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
1.	Mercy Care H5580	Mercy Care Advantage HMO SNP	Arizona

Description:
Mercy Care is a state-wide HMO SNP, which provides Medicare services and benefits to people who are eligible for both Medicare Parts A and B and Medicaid assistance from AHCCCS. Mercy Care has been administering an integrated model of both physical and behavioral health benefits as a D-SNP since 2006. We continue to execute a successful model of care as evidenced by our 100% score on the most recent CMS NCQA Model of Care evaluation. Our membership as of August 2023, was 13,503 members.

Our service areas for the following Medicaid programs are:

- AHCCCS Complete Care and Regional Behavioral Health Agreement — Maricopa, Pinal, and Gila counties (HIDE SNP)
- Arizona Long Term Care System — Maricopa, Pinal, Gila and Pima counties (FIDE SNP)
- Division of Developmental Disabilities — All counties in the state of Arizona (HIDE SNP)

Mercy Care has offered this D-SNP for 17 years. The contract became effective on January 1, 2006 and is current and active.

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
2.	Not applicable.		

Description:

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
3.	Not applicable.		

Description:

B4 - Narrative Submission Requirements

Mercy Care (MC) leads with compassion, advocating for person-centered health care and partnering with culturally responsive providers and community-based organizations. **MC has more than 37 years of Medicaid experience in Arizona, nearly 23 years as an ALTCS plan, and is the only plan that has served members in all AHCCCS Medicaid programs.** We are an industry-leader in the administration of comprehensive, culturally sensitive, equitable, and effective services and case management support for ALTCS members with multiple complex chronic conditions. **Our Case Management team has a combined 1,397 years' experience at MC.** Our case management leadership has already developed and implemented evidence-based, member and family-centered case management practices, which foster effective whole-person integrated care coordination with members and providers. We promote seamless transitions and active engagement with members, their families, health care decision makers (HCDM), and designated representatives (DR). Our local case managers (CM) are experts in coordinating social and community support services and we use multiple data sources to identify and track members' complex needs and manage their outcomes. We leverage our expertise in our ACC-RBHA and DCS Comprehensive Health Plan (CHP) programs to provide high touch coordination for ALTCS members who require high needs case management (HNCM). Our case management monitoring activities verify that members receive the services and support they need and inform enhancement of our Case Management program. We are on track to meet NCQA LTSS distinction by October 2024.

a. Reducing Duplication/Enhancing Coordination with Physical/Behavioral Health Providers

Effective care coordination and communication leads to positive member outcomes. Our integrated case management policies and practices comply with AHCCCS Medical Policy Manual (AMPM) Chapter 1600 policies related to coordination with physical health (PH) and behavioral health (BH) providers. ALTCS members have complex PH/BH conditions, functional impairments, and health-related social needs (HRSN), and may get care through multiple payers. Regardless of the payer, we work with all PH and BH providers to prevent duplication of care and enhance coordination activities. To do this, we offer multidisciplinary CMs and integrated Person Centered Service Planning (PCSP), education about integrated care, specialized BH support, and technology to promote communication and coordination with our providers.

We employ **case management staff with PH and BH expertise, including registered nurses and licensed BH CMs,** PH and BH medical directors, including those with geriatric experience, clinical pharmacists, and case management assistants (CMA). We provide all CM/CMA staff **over 65 hours of initial training** in topics including whole-person assessment, PCSP principles, covered PH/BH services, and integrated care coordination to equip them to effectively coordinate with PH and BH providers. We assign our CMs to specialty teams such as pediatrics, skilled nursing facilities (SNF), assisted living facilities (ALF), high risk BH, medically complex members, and transition teams for members who are hospitalized at the time of enrollment. Specialty BH CMs consult with non-BH CMs regarding local BH providers to support coordination.

All CMs conduct comprehensive, whole-person assessments of members' strengths, PH and BH needs, functional abilities, cultural experiences, and HRSN, and include input from members' PCP and PH and BH specialists in the assessment process. CMs facilitate interdisciplinary PCSP review meetings with members and their HCDM/DR, inviting both PH and BH providers to participate in the discussion, creation, and updating of service plans, as requested or permitted by the member. These PCSP review activities encourage providers to contribute ideas and helps them to be on the same page about coordination of the member's chosen services. During PCSP reviews, we verify there is no duplication of care regardless of who the payer is, and we confirm members are receiving services and making progress toward their self-identified goals. In these meetings, we assign responsible parties to various tasks to prevent duplication in coordination activities. CMs also monitor health information exchange (HIE) information, electronic visit verification (EVV), and reports, which identify potential duplication or an atypical mix of services, such as if a member is receiving attendant care at the same time as personal care services or home delivered meals. They determine if an override authorization is in place, or if there is a need to discuss the potential duplication in a PCSP review meeting.

CMs also explain to members with complex PH/BH needs that integrated PH/BH providers offer enhanced and more seamless care coordination between the CM, providers, and the member. If the member/HCDM/DR is agreeable, our CMs make timely referrals to integrated service organizations, such as integrated health homes who conduct internal coordination between PH/BH providers. **The percentage of members receiving PH and BH care in an integrated setting within the last 12 months has increased by 14.5% between May 2022 and May 2023.**

Our specialty BH CMs help members with BH needs identify a BH provider and connect members to their chosen provider. In fact, **MC scored 100% in the 2023 ALTCS Operational Review for ensuring members received medically**

necessary BH services. Our practices align with all requirements of AMPM 1620-G regarding coordination of BH services. If a member is at risk of losing a placement due to BH issues, CMs coordinate with members, their BH/PH providers, and our BH coordinator to understand the circumstances and create a plan to support the member and preserve the placement.

If a member is starting a new BH service, CMs send a notification letter to the member's PCP about the new service. **This occurs 100% of the time.** 011.AZ23

Providers can access members' assessments/service plans in our provider portal, which displays the member's services/providers, eases provider coordination, and reduces duplication of care. CMs also monitor our case management platform's event notifications about action steps they need to take to coordinate with providers and use our provider referral portal to make attendant care, housekeeping, personal care, and home health nursing referrals to contracted providers. Providers can respond directly in the portal about their capacity to accept the referral.

b. Assisting Members Prior to and Throughout Transitions

MC 7-day follow up after mental health hospitalization (FUH)
MC demonstrated the highest rates for 7-day FUH in the 2020 External Quality Review Organization report as compared to other plans. Our audited HEDIS rate for 7-day follow up in **measurement year (MY) 2022 improved to 55.56% from MY 2021's rate of 48.00%.** 002.AZ23

We communicate clearly and work with members/families/HCDMs/DRs prior to and throughout transitions of all kinds, including changes in level of care/placement setting, life transitions, and transitions to or from our plan in alignment with AMPM 520, 530, and 1620. We conduct transition activities within required timeframes, acting more urgently as needed, based on members' unique situations. We promote members living in the least restrictive, most integrated setting possible, considering their strengths, preferences, and whole-person needs. Upon admission to a new setting/facility, CMs may use our supplemental assessment or Readmission Intervention Assessment (depending on the setting), our proprietary 10-day placement change event, and Whole-Person/HRSN tool to identify members' functional, PH, BH, and social needs. CMs help members/HCDMs/DRs create a transition plan in collaboration with the placement's admission and discharge planning teams and the member's outpatient providers. We include caregivers in transition planning discussions and offer support for caregivers via the **Trualta platform,** which includes support groups and training to provide better care and reduce stress, as well as adult day health centers and family support providers. The following table details a few types of setting transitions.

Transition Type	Transition Process
Transitioning from the community to a facility or hospice	CMs help members/HCDMs/DRs choose the most appropriate, least restrictive living arrangement, and inform them of community options, including ALF and home and community based services (HCBS). If members/HCDMs/DRs determine facility-based care or hospice is necessary, CMs coordinate to secure necessary authorizations and work with the member, HCDM/DR, PCP, and facility to promote continuity of services, medications, DME, etc., in the new setting. The CM helps the member/HCDM/DR create new PCSP goals and helps arrange transportation to the facility, if needed. **For members who need someone to take care of their pets during medical emergencies, we offer pet foster care through our Mercy Paws program.** CMs educate members about the service and help them make an advance directive plan for their pet. A caring "foster parent" takes care of the pet in their own home for as long as the member needs it.
Transitioning from a facility to the community	Upon facility admission, the assigned facility-based CM coordinates a meeting with the member, the receiving outpatient CM, HCDM/DR, and PCP or other specialist(s) to create a safe and effective discharge/transition plan to continue medications and schedule outpatient PH/BH services within appropriate timeframes. They make and track referrals to community services to address HRSN via our **Community Resource Guide (CRG) and the closed-loop CommunityCares system**. The CM facilitates continuance of DME and connection to home modification/accommodation resources as needed, secures LTSS authorizations as needed, and confirms members receive scheduled follow-up services within timeline requirements.
Transitioning to a new housing program	Our housing experts help members and CMs identify members' housing needs, goals, benefits, and options. They provide information about housing vouchers for people with Serious Mental Illness (SMI) and HUD benefits for all ALTCS members. CMs connect members to rental deposit and utilities assistance programs to support the transition.

Life transitions: Starting when members are 16 years old, our transition aged youth coordinator and ALTCS CMs, who are trained in the Transition to Independence Process, proactively work with members/families/HCDMs/DRs, and service providers in Child and Family Teams (CFT) to identify the necessary services and steps to help members transition to adulthood and the adult health care system. We ask about the member's goals related to education/employment, living setting preferences once they become an adult, and how they view transitioning to adult health care providers. CMs educate members/families/HCDM/DRs regarding available services/programs, facilitate care plan updates, and connect members to the programs/providers they have selected to help them reach their goals without disruption to care. We smoothly transition members to a new CM after they turn 21, if necessary, involving their prior CM for continuity, as needed. If possible, we honor member preference to remain with their same care providers after age 18.

Plan transitions: MC policies regarding coordination of plan-to-plan transitions and continuity of coverage/services align with AMPM 520. Our transition of care coordinators support new enrollees transitioning to our plan. They review the incoming Enrollment Transition Information (ETI) form and help assign the right CM for the member based on geography, placement type, case weights, and special needs, such as primary language. The new CM contacts the member's prior plan CM and providers, as needed, and engages the member/HCDM/DR in the PCSP review to preserve continuity of services, authorizations, providers, medications, and DME during the transition. Our CMs are also well-versed in service delivery requirements for members with SMI who transition to our plan. If a member transfers from MC to another plan, we complete the ETI form and share records with the new plan/new providers, in alignment with HIPAA and with member permission, to prevent disruption in any/all services.

Technology to support transitions: CMs monitor HIE/Contexture notifications of hospital admissions and our near real-time interactive census report, which tracks all admissions to the hospital, SNFs/ALFs, and other HCBS settings, so they can promptly outreach members who need transition support. CMs document information necessary to support the transition in our electronic case management system. Additionally, our **FamilyCare Central (FCC) platform and our provider portal** give members/HCDM/DRs and providers information on placement changes/hospitalizations.

c. Improving Member Engagement

99% of members in our ALTCS program actively engage with PCSP as evidenced by care plans signed by the member and two-way interactions between CMs and members in telephonic or face to face contact. 012.AZ23

Member engagement is crucial to members' success in achieving their integrated health and HRSN goals. Immediately upon enrollment, we review the Pre-Assessment Screening tool to assign members to well-matched local CMs who understand local health disparities, speak the member's preferred language, and have education and experience best suited to meet the member's whole-person needs. For example, we assigned a Navajo speaking CM for a Navajo speaking member. CMs use their training in motivational interviewing, PCSP, abuse/neglect/member safety, and trauma-informed care to build rapport with members/HCDMs/DRs and to assess members' whole-person needs. CMs learn members' views on their quality of life and health, culture, preferred living arrangements, and preferred method of contact, and encourage them to voice their self-identified health and HRSN goals in collaboration with the family members/HCDMs/DRs they include on their planning team. CMs use their training and knowledge of cognitive barriers and physical disabilities to interact at the member's level and to arrange for accommodations and assistive devices, as needed. CMs engage in **follow-up "check-in" discussions with new members 10 days after creating their PCSP** and provide reminders ahead of upcoming PCSP review meetings to confirm they are able to attend. We ask members for feedback about the PCSP review process and verify they are participating in all services in their care plan. We respond quickly to member reports of barriers to care and conduct reassessments and PCSP reviews more often than the required 90 or 180 days based on member needs and life/condition changes. Additionally, we train our BH specialty CMs to be Certified Personal Medicine Coaches (CPMC), an evidence-based practice developed by Dr. Patricia Deegan, an esteemed psychologist, researcher, disability rights advocate, and co-founder of the National Empowerment Center. CPMCs empower member voice and choice, recognizing members know what works best to meet their needs. We also offer disease management education to encourage members to engage in healthy behaviors, promote self-sufficiency, and positively affect outcomes. For example, our diabetes management activities contributed to our MY 2020 performance where **we demonstrated superior performance for HbA1c control for members with diabetes, with only 25.8% of members demonstrating an HbA1c greater than 9%,** exceeding the NCQA HEDIS 90th percentile.

Knowing members in the ALTCS program may need additional technology-based support and touchpoints to stay engaged, we offer our member portal, member handbook, and provider directory. Additionally, we offer:

- Our FCC member and caregiver engagement platform, which combines multiple data sources to allow members access to their assessments, care plan, medication information, and authorizations.
- Pyx Health, an evidence-based digital support app to address loneliness and isolation. CMs monitor Pyx data to identify members with HRSN or isolation who require additional follow-up. We also offer **Cognitopia**, a web-based tool to help members with intellectual and developmental disabilities build skills and receive support for school, work, and living independently, and **Healthmine,** which provides members self-management tools and incentives.
- Our resource library, housed within our **Consolidated Outreach and Risk Evaluation (CORE ® 2.0)** predictive risk platform, includes health information to send to the member based on their unique conditions and risks.
- Mobile devices and unlimited 5G network coverage to members to reduce the impact of the urban versus rural digital divide in partnership with **Thrive Health Mobile.** Each phone comes preloaded with MC's mobile application and CM

and PCP contact information. Our **Mercy Connects** program also distributed 100 tablets to members residing in SNFs and ALFs to help connect them to available applications. We will continue this program moving forward.

Other member engagement opportunities: Our member-led Member Advisory Council, Youth Leadership Council, and ALTCS Member Council meetings give us feedback from members and families with diverse cultural backgrounds, inclusive of tribal members in all counties we serve on how to best engage members. We gather anonymous member input through CAHPS and member experience surveys, as well as customer service calls and grievance and appeals investigations. Additionally, through attending and sponsoring community events statewide, we share information and obtain input from members of tribal communities which is brought back to our Culturally and Linguistically Appropriate Services (CLAS) Committee which includes tribal representation. We review all member feedback during quality improvement activities to make case management policy changes to support member engagement.

Based upon a suggestion from our Member Advisory Council, our CMs send well wishes to members in handwritten cards during the holidays to maintain rapport and foster continued engagement. Between 2020 and 2022, we sent more than 8,000 letters to members. One of our SNF providers in Tucson responded: **"Thank you for the holiday cards that you sent out to our residents. This is typically a difficult time as most of them have little to no family. These cards put smiles on their faces and got them in the holiday spirit."** 003.AZ23

d. Coordinating Social and Community Support Services

CMs know the available local social and community services, including those that address HRSN, and the support services described in Section D. Program Requirements, page 67. ALTCS members may face unique HRSN, such as social isolation, barriers to healthy food and transportation, and home environment challenges. In alignment with the AHCCCS Whole Person Care Initiative, we address HRSN through comprehensive data analysis and monitoring to verify members receive services, which level the playing field regarding HRSN. CMs view **SocialScape** analytics, which integrates multiple data sources related to community-level social risk, such as claims, demographics, commercial business data, consumer data, and race/ethnicity/language data, with individual-level details to generate a social risk score. The social risk score identifies risk exposure with respect to financial strain, food insecurity, housing instability, transportation barriers, health literacy challenges, and COVID-19 vulnerability. CMs assess and identify members' unique HRSN/social risk during PCSP review meetings, using motivational interviewing to guide discussions that help members identify HRSN goals and available services to address their specific HRSN. We link them to food banks, social connectedness programs, housing supports, and other social services, which address their HRSN using our CRG and the CommunityCares closed-loop referral system. We also follow up to confirm the member receives these services.

Coordinating support services: We educate members/families/HCDM/DRs about available personal care services, home care training, self-help/peer services, therapeutic foster care, unskilled respite care, and transportation. In alignment with AMPM 1300, we describe all member-directed options and help members implement any options they choose. ALTCS members may be eligible for services through multiple payers. We review their benefits and where they receive services in all PCSP review meetings. We help them choose support service providers that will help them meet the needs/goals in their service plan. CMs create/coordinate service authorizations, depending on the service type/payer, and refer members to their selected providers within required timeframes. CMs explain how to schedule rides with our transportation vendor via our member services line and assist members with these calls, if needed. CMs call members the day after any service is scheduled to begin to verify they received the service and are happy with the provider. If the member is dissatisfied, the CM helps identify and refer them to a new provider. CMs also check in with members' support service providers every six months to make sure members are receiving authorized services and address any issues with access to care.

When comparing the period of June 2021-May 2022 with June 2022-May 2023, **Home Care Training services per 1,000 members increased by 20.2% and self-help/peer services per 1,000 members increased by 21.2%.** 016.AZ23

e. Identifying, Tracking, and Managing Outcomes for Members with Complex Needs

CMs use several assessments, the HIE, Children's Rehabilitative Services and SMI flags/indicators, and SocialScape to identify members' unique complexity and needs. Based on BH screening, CMs identify members who may meet SMI eligibility criteria and connect them to that process, as needed. CMs also monitor our **CORE 2.0** predictive modeling analytics before member visits and during hospitalizations/discharge planning. CORE identifies and prioritizes members with complex needs using medical claims, demographics, HRSN, and prescription data to generate an overall risk score. CMs view members' baseline CORE 2.0 risk score on PH, BH, HRSN, and other clinical factors in our **Clinical Engagement Console.** CORE predicts which members may be high risk (inpatient risk), medium risk (emergency department (ED) risk, multiple chronic conditions/providers/medications, high-cost/high-utilization), or low risk (low utilization). CMs increase contact with members whose risk is rising and track their progress with service plan goals,

attendance at services, and EVV service gap information. Our CM documentation platform tracks PCSP activity and generates action reminders for CMs. Staff track resolution of social needs referrals through our **Community Resources Referral Event (CRRE**) and **CommunityCares.** They also review gaps in care, immunization, and preventive screening reports. CMs manage outcomes via regular contact with members and during PCSP reviews. If a member is not making progress toward their goals, the CM facilitates discussion in the PCSP review meeting to generate solutions. If a member reports a barrier to a service or a complaint about a provider, CMs coordinate with the provider and/or our Grievance and Appeals or Provider Relations Teams to resolve the complaint. Supervisors also conduct chart audits and monitor inter-rater reliability (IRR) data to verify we meet members' complex needs. For members with complex pharmacy needs, our clinical pharmacist reviews all their medications/supplements and calls the member, prescriber and/or CM if they find polypharmacy, new medication, or drug interaction issues. CMs also consult experts, including medical directors, in internal interdisciplinary care team meetings to staff discharge plans and help members with challenging behaviors or frequent ED/hospital stays.

In MY 2022, MC's 76.54% rate for Adherence to Antipsychotic Medications for Individuals with Schizophrenia **exceeded the NCQA HEDIS MY 2021 Medicaid 95th percentile mark.** 004.AZ23

f. Identifying Members for HNCM, CM Support, and Reducing Member and Family Burden

We leverage our **experience as an ACC-RBHA and the sole DCS CHP plan** working with children who qualify for HNCM, to provide this more intensive level of case management to eligible ALTCS members. Our ALTCS CMs conduct the CALOCUS for children with co-occurring diagnosis during their first contact and every six months, or when there is a significant change, to identify those aged 6–17 with score of 4, 5, or 6, who meet criteria for HNCM. The CM shares these scores at the PCSP review meeting. If the member is not already assigned to a BH specialty CM at time of eligibility for HNCM, the current CM coordinates transition to a BH specialty CM, if the family/DR agrees. The BH CM builds rapport with the member/family/DR and engages with them often, conducting reassessment and PCSP reviews in CFTs as often as weekly, based on the child/family's needs. Children in HNCM may be served through multiple systems and their CFT may include representatives from the child's school, juvenile justice, and DCS to verify assessments reflect the child's whole-person needs and the child/family's strengths. The CM helps the member/family/DR and CFT create a person and family-centered service plan to address their PH, BH, social, developmental, and educational goals. HNCM aligns to the Arizona Vision–12 Principles for Children's BH Service Delivery and supports timely access to care per AHCCCS Contractors Operations Manual (ACOM) policy 417. We assess the need for more support to reduce burden on members and families and may help schedule appointments or transportation or connect the member/family to respite services and/or Trualta. We also refer families/caregivers to family support services with **Raising Special Kids and Family Involvement Center.**

g. Monitoring CM Performance and Responding to Identified Issues

We monitor individual CMs to confirm adherence to AMPM Chapter 1600/1620. **Case management supervisors audit 100% of newly hired CMs' work and audit two member charts per month for each established CM.** Audit reviews cover documentation of 20 elements, including needs/goals, PCSP, HRSN, cultural beliefs, health literacy level, health disparities, and whether the member received the services in their service plan. Our most recent audits found **CMs scored at 98% or above for documentation of visual/hearing needs, BH cognitive status, and members' social functioning**. Supervisors attend in-home member visits with CMs annually to observe CM performance and conduct telephone calls with members or their families to evaluate the member's satisfaction and experience. Supervisors conduct quarterly IRR reviews focusing on specific PCSP actions, such as assessment completion, development of member-identified goals, identification of least restrictive environments and resources, and the PCSP itself. Supervisors use information from monitoring activities to give prompt feedback to CMs in monthly 1:1 supervision and mid-year and annual performance reviews and assign more training or performance counseling, if needed. Case management leadership uses findings related to CM monitoring to drive when/how we clarify, update, or improve case management policies. To monitor our Case Management program at the system level, case management supervisors review weekly/monthly reports on elements such as cost-effectiveness, service initiation, advance directives discussions, caseload ratios, CM contact requirements, and placement/service authorization. Once implemented, supervisors will also review the findings of the quarterly PCSP performance standards audit. We also conduct an annual quantitative analysis of our Case Management program using clinical, cost, utilization, process/outcome, HEDIS performance, member satisfaction/experience, and grievance and appeal data. We present this analysis to the Medical Management/Utilization Management Committee and develop corrective action plans related to CM performance, as needed. We review policy/program changes and program performance results with our CM team and conduct refresher trainings to help CMs meet performance expectations.

B5 - Narrative Submission Requirements

For more than 23 years, Mercy Care (MC) has fostered dignity, independence, and improved health outcomes for ALTCS members, helping them thrive in culturally responsive settings of their choice. We proactively use person-centered approaches to understand members' health care goals and health-related social needs (HRSN) and connect them to whole-person care. To fully engage members, families, health care decision makers (HCDM), designated representatives (DR), and caregivers in Person Centered Service Planning (PCSP), we use evidence-based practices, ALTCS Guiding Principles, and NCQA LTSS standards. We assess and address all aspects of members' quality of life and empower members, families, and HCDM/DRs to lead the discussion and creation of a service plan that aligns with their needs and wishes. Our experienced local case managers (CMs) have access to our innovative programs, which help members to remain in the community, if they prefer, and connect them to their chosen home and community based services (HCBS) in the least restrictive settings. Our case management practices and data analytics drive member access to high-quality, equitable, cost-effective care. To promote PCSP principles, we adhere to AHCCCS Medical Policy Manual (AMPM) Policy 1630 and train our CMs on ALTCS Guiding Principles, cultural competence, health disparities, member-centric outreach and assessment, member/family-centered care planning, motivational interviewing, trauma-informed care, HRSN, personal medicine coaching, employment first principles, the Americans with Disabilities Act, and Visibility Matters, which includes LGBTQ perspectives. We confirm alignment to PCSP principles via ongoing monitoring of case management practices and member experience and satisfaction.

99% of members in our ALTCS program actively engage with PCSP as evidenced by care plans signed by the member and two-way interactions between CMs and members in telephonic or face to face contact. 012.AZ23

a. Approach to Active Engagement with ALTCS Members

Our high-touch case management engagement activities empower members' active involvement and self-determination at every stage of their care. Upon enrollment, we assign new members to a CM who lives in their community, and whose experience, education, and languages spoken are best suited to meet the member's unique physical, behavioral, cultural, and social needs. Our CMs engage with members according to AMPM Policy 1620-A and 1620-E timeframes. To welcome new members and build a trusting relationship, the CM makes an initial call to the member/HCDM/DR to introduce themselves and provide orientation to MC and our Case Management program. The CM asks about their preferred method of contact, and availability/preferred location to conduct the first face to face PCSP review meeting, following the member's lead about what works for them within the required timeframes. At the initial PCSP review meeting, the CM asks the member about what matters most to them, what works and what does not, and their attitudes toward health care. The CM learns about their culture, religious beliefs, and who they want to invite to their planning team, which includes their HCDM/DR and may include their PCP, other specialty providers, other family members, and, for members with Serious Mental Illness (SMI), special assistance advocates, who help CMs coordinate care and educate members about their rights and how to access care. The CM invites members to voice their whole-person goals and explains our member handbook/member portal, member rights/responsibilities, and covered services. We help members develop their own service plans with their families/HCDMs/DRs/planning team and connect them to their chosen physical health (PH) and behavioral health (BH) services to foster early engagement in care.

While 11% of MC ALTCS members in 2021-2022 reported a non-English language as their language, **17% of our CMs are Qualified Bilingual Staff. 26% of our CMs in Pima County speak Spanish.** 006.AZ23

At the end of the first PCSP meeting, the CM arranges the date/location for the next PCSP review meeting in alignment with member/HCDM/DR preference. Going beyond minimum engagement requirements, 10 days after the initial PCSP meeting, the CM calls or visits the member/HCDM/DR to complete a new member "check-in" to get their feedback about their satisfaction with their introduction to the program and to ask if they have any questions, concerns, or issues. **We have successfully completed these check-ins for 97% of new members who had an initial PCSP review meeting.** For future PCSP review meetings, the CM makes reminder calls to the member/HCDM/DR both 14 days and 2 days prior to the next meeting to promote active member engagement in ongoing PCSP reviews. We confirm members have their first service no later than 30 days from enrollment and that they continue to receive services per their service plan.

We offer digital tools and resources to support members' maximum engagement in healthy behaviors and communication with their CM during ongoing PCSP discussions. For example, we mitigate health disparities for members who otherwise lack access to technology by providing mobile devices and unlimited 5G network coverage to members in partnership with **Thrive Health Mobile.** Each phone comes **pre-loaded with MC's mobile app and relevant contacts** (e.g., MC member services, the member's assigned CM, PCP, transportation services, and our provider directory), texting capability, and the **Pyx Health app** to reduce loneliness. Phones provide medication adherence and appointment

reminders, and resources for stress reduction, mood tracking, and mindfulness exercises. Knowing that members in the ALTCS program might not know how to use technology to stay connected to their CM, providers, and other supports, we offer members in-person and virtual digital navigation through **Televeda** as a value-added benefit. This program provides members education and coaching on the use of smartphones or tablets, connecting, and navigating the internet, as well as using telehealth. To encourage caregiver engagement and reduce caregiver stress, we offer the **Trualta Caregiver platform** that provides support groups training on caregiving skills, and an online community for people managing care for their loved ones in a HCBS setting. Trualta offers a Care Coach program to offer live support from a family caregiver expert. According to a recent survey, **100% of caregivers using Trualta felt more connected and 92% reported they learned something new.** Finally, our **FamilyCare Central** (FCC) platform keeps members/HCDMs/DRs engaged via secure messaging, health care document uploads, and access to members' assessments, medications, appointments, and authorizations.

b. Approach to Include all Aspects of Quality of Life

While our CMs are trained in the Center for Disease Control and Prevention's definition of health-related quality of life, quality of life is ultimately defined by each member and their family/HCDM/DR. To understand the members' view of the quality of their life, and where they would like it to be, CMs use motivational interviewing, the PCSP review tool, and other tools to learn about members' physical, behavioral, functional, and social needs, preferred living setting, and employment and community involvement interests. We use the evidence-based **InterRAI Assessment,** which includes questions about whole-person quality of life areas, on topics such as cognition/memory, vision/hearing, nutrition, supports, and ability to perform activities of daily living (ADL) and instrumental activities of daily living. We also use the Skin/Fall (SAFE) assessment, the Uniform Assessment tool, the HCBS Needs assessment, and review of Pyx Health data to assess members' quality of life. CMs use their training in SafeTALK to assess BH quality of life and to identify members with suicidal thoughts or mental health or SUD needs. CMs also view geographically aligned social risk data via **SocialScape** to identify potential social risks a member may experience, such as financial strain, food insecurity, housing instability, transportation barriers, social isolation, and health literacy challenges. We discuss these HRSN areas with members and how they impact their quality of life. With member permission, we get information about their quality of life from their HCDM/DR, family members, caregiver(s), providers, and system stakeholders the member may be engaged with, such as school and justice system representatives, to confirm assessments, goals, and services address all aspects of quality of life. We conduct assessments of quality of life during each PCSP review meeting. Our HEDIS measurement year (MY) 2022 MCA ALTCS rate for **Care for Older Adults Functional Status assessment was 96.35%.** Per the Health Outcomes Survey, the number of MC Advantage dual members stating that their BH is "better or the same" improved between the 2020 and 2022 cohort and those stating their PH is "better or the same" improved from the 2021 to 2022 cohort.

c. Consistency with Individual Needs and Wishes

CMs listen to members' voice and wishes, respecting their rights of privacy, dignity, individuality, independence, and self-determination. We encourage members to share their health/HRSN goals, culture/worldview, and preferences related to living, learning, and working in the least restrictive setting. CMs provide education about available health and HRSN services so members/families/HCDMs/DRs can make informed choices in selecting services/providers, including home modifications, HCBS, or DME. CMs have thoughtful conversations with members/families/HCDMs/DRs in alignment with AMPM 1300 and 310-HH regarding member-directed care options and advance directives, so they can identify what works best for their situation. **79% of members in our ALTCS plan have completed their advance directives paperwork and an additional 19% are in process.** We review and use our **Life and Health Planning Toolkit** to help members/HCDMs/DRs organize health care information and document end of life decisions, so it is available when needed. Our PCSP model supports members' needs and wishes as follows:

- Members can review the **Life Planning–5 wishes end of life brochure** with their CM/HCDM/DR/family to indicate their personal, medical, emotional, legal, and spiritual wishes and how they want to be treated if they become extremely ill and are unable to make decisions for themselves.
- Members choose the attendant or personal care worker they want and days/times of service.
- Members/HCDMs/DRs identify their preferred living setting and tour options provided by the CM.

MC invested $670,000 and partnered with Contexture and Hospice of the Valley to develop the "Choose Your Person" campaign, which encourages and helps Arizonans to create an advance directive, choose and appoint a Medical Power of Attorney, and register their directive with the Arizona Health Directives Registry. **The campaign benefits diverse demographic and population groups, with a special focus on reaching traditionally underserved populations including Hispanic, Black, and LGBTQA communities.** 007.AZ23

- Members have options which support their autonomy based on their identified functional needs, such as adult day health programs that enhance access to the community and improve socialization.
- Members are aware of and may select in-home and community BH counseling and peer/family support services.
- Members of working age are aware of and may choose individualized employment options per AMPM 1240-J.
- Members have access to CMs/providers who speak their language, Language Line translation, and interpretive services to support discussions in the member's language of choice and are referred to providers with whom they feel comfortable from a cultural and rapport perspective.

Members and HCDMs/DRs sign off on the service plan to indicate it reflects their needs and wishes and that they agree with the authorized services. If a member/HCDM/DR disagrees with the authorized services or refuses to participate in PCSP, we provide Adverse Benefit Determination notification, in alignment with AMPM 1620-E and AHCCCS Contractors Operations Manual (ACOM) 414. We share the PSCP in FCC and also print a copy for the member and HCDM/DR.

d. Approach to Promote Access to Services in Home and Community-Based Settings

Although 100% of our ALTCS membership is eligible to receive 24-hour skilled nursing care, 79% live in a community setting.

From 2019 to 2022, the percentage of members who were discharged from a SNF admission of greater than 30 days and **remained in an alternative HCBS setting for more than 180 days afterwards improved from 55.5% to 64.6%** (an increase of 15.7%). 008.AZ23

We prioritize members' wishes to age in place, receive HCBS in the least restrictive setting with as much independence as possible, and to fully engage in activities in the community. Members and their family members/HCDMs/DRs take the central role in making PCSP decisions, and the CM serves as the discussion facilitator at PCSP meetings. PCSP meetings include members, their HCDM/DR, family members, caregivers, and their multidisciplinary team of providers, peer support, social services representatives, and others as chosen and allowed by the member/DR. In PCSP discussions, CMs use tools like the HCBS needs assessment, as well as our expertise, to provide information about available HCBS to help members/HCDMs/DRs make informed decisions about services to include in their plan, including member-directed options, in alignment with AMPM Chapter 1300. We developed a free, user-friendly portal through which CMs can enter member care needs and make attendant care, housekeeping, personal care, and home health nursing referrals to contracted providers. Providers can respond directly in the portal about their capacity to accept the referral. CMs connect the member to the health services provider(s) identified in their plan and use our Community Resource Guide and the closed-loop referral platform, **CommunityCares,** to make referrals to HRSN services. If there are barriers related to the members' chosen HCBS services or living setting, the CM helps identify solutions and alternatives. At each PCSP review meeting, we confirm that members are receiving the covered and non-covered services documented in their service plan. Beyond these practices, we made investments and created partnerships to offer the innovative HCBS solutions described below.

HCBS Program	Description
In-Home PCP program	Our statewide In-Home PCP program provides care to members in their own homes and assisted living facilities (ALF). This program improves access to PCP and BH care, expedites solutions to medical issues, includes community health worker (CHW) support, and decreases unplanned preventable hospitalizations and emergency department (ED) utilization. To improve continuity between placement settings, we extended our in-home PCP program to serve members in skilled nursing facilities (SNF). Members may elect to continue seamlessly with the same PCP as they transition between the home, ALF, or SNF settings. **39% of eligible ALTCS members use our in-home PCP program.**
Eviction prevention and move-in assistance	Our Mercy C.A.R.E.S. (Community Action Resources Education Service) community reinvestment program helps ALTCS members who have an SMI designation remain in their homes by offering eviction prevention, move-in, and utilities resources through financial support of up to $1,500 lifetime/member. One member who received this support said: **"Awesome! Thank you! I feel relieved. I'm now in a much better position and happy to know my lights will remain on. I really appreciate it."**
Benefit Results program	The Benefit Results program helps members in SNFs who are ready for discharge to a less restrictive setting but are not able to move due to financial barriers, secure another living arrangement. **We are the only plan who offers a vendor partner who meets with members in SNFs to help identify missing or forgotten income sources and assist with benefits applications that may have stalled, so the member may move into a less restrictive setting.** For example, we helped an 87-year-old member in a SNF identify income they were entitled to through the Veteran's Administration, which allowed them to pay toward the cost to move to the community and receive HCBS. Since starting in 2022, this program has helped 28 of our members transition from a SNF to a less restrictive level of care and has **secured over $1.7M of annual income for participating members.**
Mercy Pets program	The positive impact pets have on members' emotional wellbeing to reduce loneliness, stress, and isolation is clear. Through our **Mercy Pets** program, we offer robocats and dogs, which provide comfort, compassion, and companionship to those living with Alzheimer's and dementia in all settings. TapRoot, a BH research and data collection organization that helps caregivers personalize approaches and interventions for residents experiencing Alzheimer's and dementia-related symptoms, found that **86% of the time, members who interact with robopets experience decreased confusion, delusions, and aggressive behavior and improved cooperation with ADLs.**

e. Delivering High-Quality, Equitable, Cost-Effective Person-Centered Care

From 2021 to 2022, MC members diagnosed with diabetes had a **6.7% increase in nephropathy screening and a 7.2% increase in retinal eye exams.**

Our ongoing 2023 Diabetes Study consists of year-round case management efforts to encourage diabetic members to have a retinal eye exam and Hemoglobin A1c lab test done at least one time during the year.

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To promote high-quality outcomes, CMs respond to members/HCDMs/DRs requests within one business day and also educate them about our robust network of qualified providers and programs best suited to meet their needs in the least restrictive settings. CMs remind members of recommended routine and preventive screenings, testing, and visits quarterly, or based on seasonal events, such as flu vaccinations. If a member has a complaint regarding quality of care, the CM helps them file a grievance and follows up with the assigned provider representative. To evaluate CM/PCSP quality, we also conduct an annual analysis of our case management strategy using relevant clinical, cost, utilization, process/outcome, HEDIS performance, and member satisfaction/experience measures, including grievance and appeal information. We present the outcomes of the analysis to our Medical Management/Utilization Management (UM) Committee and develop corrective action plans as indicated. To drive equitable care, we recently enhanced our assessment to capture race/ethnicity/tribal affiliation data to conduct more complete analysis of potential disparities related to race/ethnicity. CMs also monitor gaps in care, social risk, our **Consolidated Outreach and Risk Evaluation® (CORE 2.0) predictive modeling,** reports related to ED and claims utilization, and our health equity and LTSS dashboards, which can identify health disparities related to elements such as PCP visits, ED utilization, and prescription counts. This data, along with CMs' cultural competency and health equity training, drives discussions with members and referrals to appropriate services and condition-specific disease management programs to support members' equitable access to care and health education. Our ALTCS membership analysis did not identify statistically significant health disparities based on race or ethnicity alone, but we did see ZIP code-based disparities in four ZIP codes with lower mammography screening completion (85201, 85323, 85705, 85741), two of which have higher Latino populations. We ran a targeted education campaign in these ZIP codes to close the gap and **achieved an improvement of 108% to 323% in breast cancer screening rates** during 2022, the first re-measurement year. CMs monitor placement/cost effectiveness information in the Client Assessment and Tracking System at minimum once a year as well as any time a Cost Effectiveness Study (CES) related factor changes. CMs review high needs/high-cost data in our UM dashboard and conduct root cause analysis after inpatient/ED admissions to help members identify what led to the admission and alternatives they can use in the future. By offering members HCBS alternatives, **99.9% of our members are within CES thresholds and we are in the 95th percentile for HEDIS readmission rates.** We enhance our network in a targeted way to offer options that allow members to age outside of costly institutional settings. When we began our plan in Pima County, we saw a need for care in less restrictive settings for members on ventilators. We **developed two new adult foster care vent homes in Tucson,** which serve members who need 24-hour nursing care and might otherwise be in a SNF, **saving $2,717,460 in the last five years.**

Monitoring and Evaluating CM Services, Member Experience, and Member Satisfaction

We monitor CMs' compliance with AMPM Chapter 1600 and ACOM 405 and conduct quarterly Inter-Rater Reliability (IRR) reviews of PCSP actions, such as assessment completion, development of member-identified goals, identification of least restrictive environments and community resources, and the PCSP itself. **Recent IRRs demonstrated a departmental average of 95%.** Case management supervisors also audit 100% of a new CM's work and complete two chart audits for every established CM monthly. Audits cover 20 documentation elements, including services and service plans, HRSN, cultural and health beliefs/health literacy, and if the member received the services in their service plans. Our most recent audits found **CMs scored at 98% or above for documentation of visual/hearing needs, BH cognitive status, and members' social functioning.** Supervisors monitor reports related to service plan cost-effectiveness, completion of advance directives, and placement/service authorization, and observe CMs during CM/supervisor joint PCSP reviews with members. Once implemented, supervisors will review the findings of the quarterly PCSP performance standards audit in alignment with AMPM 1630. We monitor and evaluate member experience and satisfaction feedback via new member “check ins” after the initial PCSP review, customer service/grievance and appeals feedback, and results from anonymous surveys, such as CAHPS, the NCQA New Member Experience survey, and, starting in 2024, the AHCCCS E/PD National Core Indicator survey. We also get feedback through Member Advisory Council reports and case management supervisor calls to members to ask about their satisfaction with their CM and service plan. **In 2022, only .01% of MC ALTCS members chose to disenroll during their Annual Enrollment Choice, indicating high member satisfaction.** Supervisors review CM monitoring results and member feedback with the CM during monthly 1:1 meetings and their performance reviews and may use this information to drive improvements to case management policies and procedures.

B6 - Narrative Submission Requirements

Mercy Care's (MC) Approach to Data Collection, Monitoring, and Analysis to Improve Member Health Outcomes and Inform Program Initiatives

MC's comprehensive experience in data management provides a strong framework and commitment to meeting AHCCCS' Quality Strategy, the Arizona Health Improvement Plan, and AMPM Chapter 900. Our ongoing success in NCQA accreditation, **scoring 100% in quality improvement and population health management**, reflects our dedication to continuous quality improvement (CQI) and supporting the Quintuple Aim. Overseen by MC's board of directors, the Quality Management Performance Improvement (QMPI) program is directed by our chief medical officer who supports the vice president of quality management and the director of performance management. This leadership team guides our CQI strategy and harnesses the power of analytics and metrics to measure, monitor, and enhance our processes and outcomes. CQI efforts include participation from a robust committee structure that starts with the Community-Based Integrated Health and Clinical Services Committee and includes interdepartmental collaboration with Utilization Management (UM), ALTCS, Case Management (CM), Grievances and Appeals, Systems of Care, and Network. **MC's committee participants include advocacy groups and community-based providers who work with rural, tribal, special needs, and LGBTQ populations.** Our care delivery model uses data and analytical tools to create solutions and provide equitable access to culturally sensitive and cost-efficient high-quality, whole-person, integrated care.

Data Collection: Our data structure and reconciliation process optimize our ability to compare multiple types of data and ensures completeness of the data collected. MC collects comprehensive data, both qualitative and quantitative, in a reliable and standardized format from a variety of sources. The types of data, described in the following table, are analyzed, and monitored to inform program initiatives and track progress in improved member health outcomes.

Data Type/Source	Description
Health Equity (HE) and Disparity Identification	Disparity data includes race, ethnicity, and language (REaL), health-related social needs (HRSN), health literacy, sexual orientation, gender identification, and cultural/geographical equity factors, including member specific Z-codes, Homeless Management Information System, and public data, such as the US Census and the Williams Institute. Network provider HE data, including demographics, ensures a diverse provider network to serve our populations.
Claims and Utilization	Claims data includes physical, behavioral, dental, pharmacy, and electronic visit verification. Utilization data includes HCBS distribution, hospital admissions, emergency department and crisis service visits, and under/over UM trends.
Care Management and Special Healthcare Needs (SHCN)	Member-centric data obtained from **Person Centered Service Plans (PCSP),** InterRAI Assessment, and the supplemental HRSN tool. Data used to identify members with SHCN who have qualifying Children's Rehabilitation Services conditions, HIV/AIDS, Serious Mental Illness designation, and IDD.
Health Information Exchange (HIE)	**HIE (Contexture**) and electronic health record data provides supplemental data sources, such as admission, discharge, transfer (ADT) alerts, laboratory results, and continuity of care documents.
Member Feedback and Surveys	Survey data, including HE indicators, collected in partnership with members using CAHPS, Net Promoter Scores, and starting in 2024, E/PD National Core Indicators. Feedback from the Member Advisory Committee, member led ALTCS Member Council, Youth Leadership Council listening sessions and focus groups, family members, and caregivers.
Provider Performance Data	Response data obtained from provider surveys that examine network adequacy, accessibility, burden, and satisfaction. Provider feedback data obtained from focus group sessions with assisted living facility (ALF) and skilled nursing facility (SNF) providers and the **Culturally and Linguistically Appropriate Services Committee**, which includes tribal representation. Provider monitoring data, such as results from SNF and ALF audits, to identify quality, safety, and systemic issues and trends across all providers in addition to the identification of individual provider improvement needs.
Performance Benchmarking	Outcomes data from CMS Core Measure Sets, NCQA HEDIS measures, LTSS HEDIS measures, and SAMHSA quality measures. Comparison data rates through EQRO and AHCCCS' Performance Measure Performance Standards.
Regulatory Compliance	Data obtained from tracking and trending of member grievances, quality of care concerns, fraud, waste, and abuse of benefits and services, and actionable outcomes data identified from the Office of Inspector General reports.
Member Engagement Tools	Real-time, actionable data from member engagement tools such as Pyx Health, Healthmine, Thrive Health Mobile, and Cognitopia to improve member experiences, such as wellness promotion, health coaching, and addressing HRSN.

Data Monitoring and Analysis: MC has a thorough understanding and the appropriate systems in place to adhere to all requirements set forth in Contract Section F, Attachment F3. Our data engineering hub cohesively consolidates, monitors, and analyzes all data sources, including data sources from delegates, to generate meaningful, actionable, and timely drill down reports to enhance day-to-day workflows, inform program initiatives, and initiate CQI strategies and activities. We align with AHCCCS' contract requirements by continuously evaluating data systems and infrastructures to ensure data integrity by testing for reliability and validity and creating solutions to mitigate any system limitations. Data integrity evaluation occurs annually, both internally and through third party sources. We use a variety of evidence-based and

statistical analytical methods and tools that incorporate health equity and disparity analysis including, but not limited to, HEDIS methodologies, predictive analytics and modeling, risk stratification, and artificial intelligence. Our analytic platforms, as described in the following table, empower staff to implement impactful interventions by tracking and evaluating performance and making informed decisions.

Data Analytic Platform	Description of Analytical Functions to Support Program Initiatives and Quality Improvement Activities
Consolidated Outreach and Risk Evaluation (CORE) 2.0	CORE 2.0, our enhanced risk stratification tool, applies baseline predictive risk scores, such as admissions, CDPS Rx, and clinical impact factors, such as chronic conditions, medication adherence, utilizations, and HRSN to identify and prioritize impactful interventions for case management through the Clinical Engagement Console (CEC).
Health Equity Dashboards	Health Equity dashboards identify gaps in care, over/under-utilization patterns, deficient performance metric trends, and vulnerable populations outcomes. Advanced evaluation and analysis focus on understanding disparities by using gender, REaL, and disability data to identify differences by sub-population groups.
MC Utilization Dashboard	A dashboard that provides a customized view of population utilization trends of members, providers, and categories of expense, including top tier high need/high cost, to support alternative interventions for case management processes.
MC Health Assistant (Healthmine) and Opportunity Manager	A quality improvement tool that measures, monitors, and manages key metrics, such as HRA completion, CAHPS, HEDIS measures, and member feedback, to make data-driven decisions for ensuring efficiently tailored care management. Members are empowered to take the right actions by using self-management support tools through communication channels, such as emails, phone calls, and in-app notifications, based on member choices.
Decision Point Health and Opus	Advanced platforms, embedded within Healthmine, that leverage predictive analytics and artificial intelligence to guide system-wide effectiveness strategies to promote and enhance whole-person care.
SocialScape	**SocialScape** analyzes member level data and community ZIP code details to determine risk drivers associated with HRSN risk exposure indices and member level social risk factors. SocialScape's member and community level health inequities identifiers proactively determine members' HRSN prior to their first meeting with a CM.
Analytics Hub	Analytics Hub provides advanced reporting and data analytics technology to support case management, population health, and QMPI efforts. Management Information System platforms leverage data to build contract-related reports with drill down capabilities, self-service provider profile reports through Availity, and actionable internal reports.
Value-Based Incentives and Performance Evaluation Report (VIPER)	An interactive web-based dashboard offering VBS partners actionable, member level, performance-based data that provides a quick look at members' care needs and fosters data-led conversations between multiple providers who collaboratively improve member outcomes by targeting gaps in care, health inequities, and sharing best practices.

Approach to Processes Utilized to Inform/Initiate Improvement Activities and Processes Used for Member/Population Specific Data Analyses and MCO Decision-Making

In alignment with AHCCCS's Quality Strategy and AMPM 980, CQI activities and decision-making are guided by evidence-based protocols, constant forecasting of market landscape changes and trends, and the development of an innovative data management and reporting system. Key components of the CQI process align with our QMPI goals, which emphasizes the use of the find-organize-clarify-understand-specify (FOCUS) model, initiating and monitoring corrective action plans and performance improvement projects in clinical and non-clinical focus areas. QMPI program staff oversee CQI initiatives using data analytics, monitoring, and reporting. Team organization is determined by QMPI staff who learn and study the problem using deep dive analytics, conduct root cause and barrier analyses, develop targeted interventions, and use the plan-do-study-act (PDSA) cycle to assess and evaluate whether CQI activities made an improvement, as shown in **Figure 6-1**. Upon completion of the CQI steps, decision

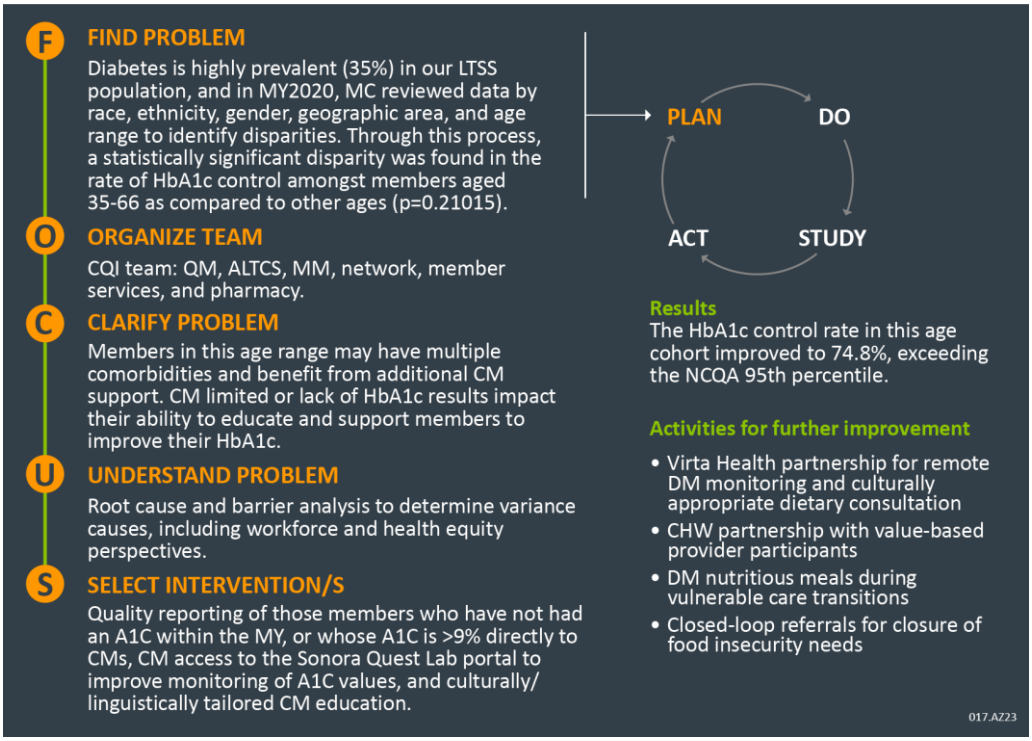


Figure 6-1: CQI Example using MC's FOCUS Model and PDSA Cycle.

making occurs to determine whether outcomes are adopted, refined, or abandoned. The QMPI Team shares results and outcomes, including those from performance measures and dashboard indicators, with members and families, providers, the State, and key stakeholders, including other MCOs, through our committee structure, member and family councils, external stakeholder meetings, and state workgroups where feedback is obtained, and best practices are discussed.

Examples of Tools, Partnerships, and Monitoring Technologies

The following examples provide a brief overview of how MC uses data, analytical tools, and the CQI process to advance our abilities in meeting members' needs and creating innovative approaches to promote equitable care. Used together, these tools allow us to effectively evaluate disparities, target interventions that are impactful in promoting health equity, measure the effectiveness of disparity-reduction initiatives, and continue to deliver high-quality care to all members.

CORE 2.0 Reporting Tool: Data collected from claims, HRSN, Z-codes, and SocialScape were analyzed using MC's Utilization dashboard and identified a high rate of hospitalizations resulting in a higher total cost of care. CMs utilized the Readmission Intervention Assessment tool to identify members' needs post discharge and referred high-risk members to Pyx Health, our technology-based member engagement tool, to address HRSN, enhance disease management education, and connect with their PCP. **In 2023, MC decreased total cost of care by 25% (control 14%; p<0.0001), hospitalizations by 49% (control 8%; p<0.0001), and increased depression medication adherence by 15% (control 4%; p=0.0019) by utilizing these multidimensional case management tools.** In addition, Core 2.0 enhancements include risk stratification results be available to CMs in the CEC that resides within our electronic case management system and provides CMs with ease of workflow processes and meaningful member engagement.

Value-Based Provider Partnership: Using pharmacy and medical claims, our electronic care management platform, the Arizona State Immunization Information System, and our UM and HEDIS dashboards, we determined a gap in care for members receiving influenza vaccines. By partnering with **Emcara**, our value-based services (VBS) provider, **we improved our measure year (MY) 2022 influenza vaccine performance rate by 10% (from 51% in MY 2021 to 56% to MY 2022).** Based on feedback from our VBS provider partners, MC created VIPER. VIPER is a meaningful, drilldown, visual, and analytic reporting tool for users of all skill levels to track performance and trends allowing for swift course correction. We expect VIPER to reduce provider burden and improve performance.

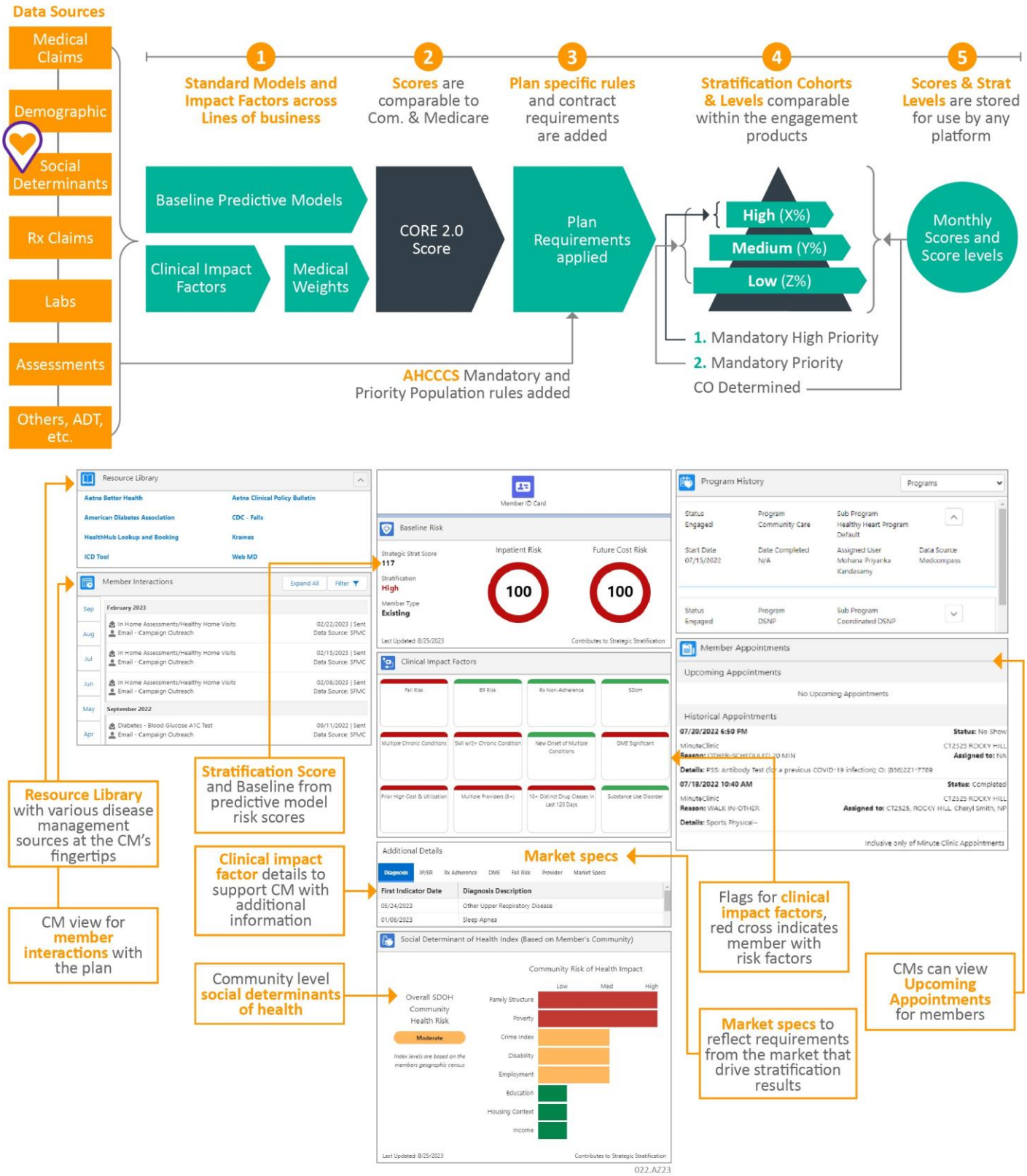
Member-Based Partnership: In December 2021, the QMPI Team identified a health inequity in the HEDIS rate for colorectal cancer screening in the MC ALTCS population (51.8%) that has more mobility and disability issues compared to MC ACC results (69.8%) and national benchmarks and goals. As a result, MC adopted and implemented our local partner's, Sonora Quest Labs', evidence-based Home Screening program, which encompasses innovative access, engagement, and service delivery methods. **This partnership model improved the colorectal cancer screening rate by 16.4%, with an ending result of 60.3% in MY 2022.** Further, MC is expanding to offer an additional In-Home Colorectal Cancer Screening program through Exact Sciences.

Member Specific Monitoring Technology: MC used claims, PCSP data, and our UM dashboard to identify a high prevalence of members with a history of falls. A CQI team, including quality management, ALTCS, CM, UM, and our external vendor, Valued Relationships, Inc. (VRI), a personal emergency response system (PERS), developed an intervention plan to decrease the occurrence of falls identified with ALTCS members. In partnership with 911 responders, ALTCS CMs receive falls and emergency assistance alert notifications for members who live alone or have periods of time when they are alone from VRI. PERS providers assist members with de-escalation and triaging of non-emergent concerns, HRSN, health care education, care coordination, and community resources. Through the PERS program, **MC decreased members with a history of falls by 14.7% in February to April of 2023 compared to the same period in 2022.** As a result, MC is expanding VRI's Medication Dispenser, a home-based medication compliance system that simplifies the management of multiple medications and reduces the risk of missed or double doses. The program also collects barriers to medication survey data and includes reporting capabilities.

Population Health Monitoring Technology: MC ALTCS CMs receive admission, discharge, and transfer (ADT) alerts from the HIE. CMs incorporate these ADT alerts into their daily workflow to support care transition encounters and refer members to the Area Agency on Aging (AAA) Transition program. AAA transition coaches visit hospitalized members prior to discharge, conduct home visits within 24 to 48 hours post discharge, ensure scheduling of PCP follow-up visits, conduct medication reconciliation, provide disease education, and complete a comprehensive psychosocial/home safety assessment. The AAA program lasts 30 days. For the remainder of the 30 days post discharge, the transition coach calls the member weekly to assess ongoing needs and provide reassurance. This ADT alert procedure and Care Transition program contributed to a **decrease in our HEDIS Plan All Cause Readmission Rates from 20% (MY 2019) to 10%, with an observed/expected readmissions ratio of 0.6714, which exceeded the NCQA HEDIS 95th percentile in MY 2020**.

Approach for One-Page Sample Utilization Reports or Other Sample Data to Demonstrate Monitoring and Analysis Processes

CORE 2.0



Health Equity Dashboards

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Market Summary

Choose desired Market (Plan) and optional filters to view measure rates:

Line of Business	Plan Type	Product	Plan Name	Plan Code / Book Name	Urban/Rural	Measurement Year	Admin or Hybrid	Denominator at Least:
Medicaid	All	Multiple values	Mercy Care	All	All	2021	Admin	1

Limit Measure Choices to:	Gender	Race	Ethnicity	Age Grouping	Choose Target Rating:
Diabetes Measures	All	All	All	All	4 Stars

Measure Listing - Mercy Care

Line of Business	Measure Name	Numerator	Denominator	Health Plan Rating	Min. Chosen Star Target Rate	Members to Target Rating
Medicaid	CDC - Comprehensive Diabetes Care - Eye exam (retinal) performed	2,453	4,094	★★★★	54.74%	-
	CDC - Comprehensive Diabetes Care - HbA1c good control (<8.0%)	1,833	4,094	★★	52.80%	329
	SPD - Statin Therapy for Patients With Diabetes (Statin Adherence 80%, T..	960	1,456	★★★	70.00%	60

Select a measure in the graph to the left to see the breakouts by Race, Ethnicity, Age, and Gender below.

Star Rating
★★
★★★
★★★★

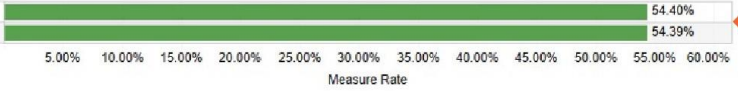
Our health equity dashboard analyzes subsets of measures at the eligible population level.

We overlay other demographic data such as race and ethnicity from SocialScape, community level data from the US Census and collaborating with HIE for supplemental feeds.

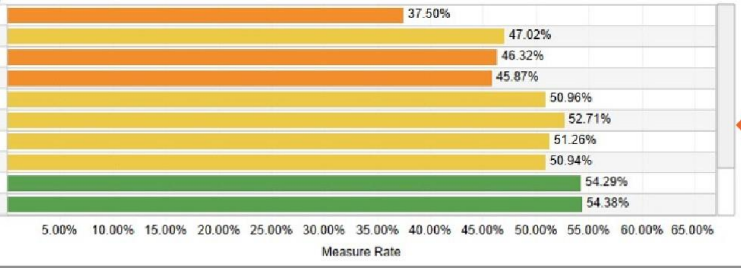
Data analysis to determine rates by ethnicity, gender, and age grouping to identify disparities.

Ethnicity	Numerator	Denominator	Health Plan Rating	Members to Target Rating
Hispanic or Latino	460	923	★★★	28
Not Hispanic or Latino	98	186	★★★	1
Unknown Ethnicity	4,688	8,535	★★★★	-

Gender	Numerator	Denominator	Health Plan Rating	Members to Target Rating
Female	2,893	5,318	★★★★	-
Male	2,353	4,326	★★★★	-



Age Grouping	Numerator	Denominator	Health Plan Rating	Members to Target Rating
15-19	12	32	★★	5
20-24	79	168	★★★	10
25-29	88	190	★★	13
30-34	100	218	★★	16
35-39	159	312	★★★	6
40-44	233	442	★★★	1
45-49	264	515	★★★	8
50-54	487	956	★★★	18
55-59	867	1,597	★★★★	-
60-64	1,385	2,547	★★★★	-



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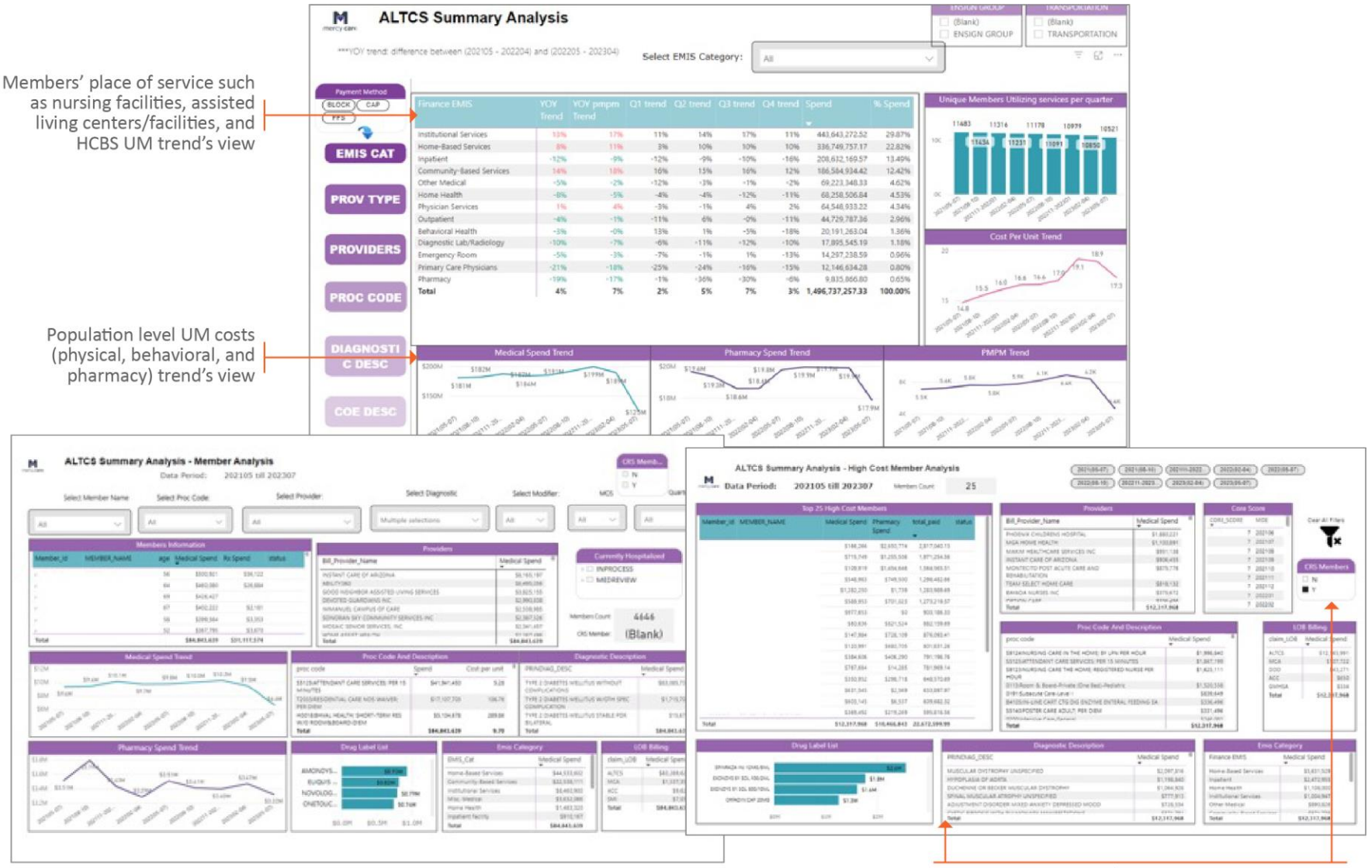
Mercy Care's Utilization Dashboard

Members' place of service such as nursing facilities, assisted living centers/facilities, and HCBS UM trend's view

Population level UM costs (physical, behavioral, and pharmacy) trend's view



Top tier high need/high cost SHCN members drill down trend's view

B7 - Narrative Submission Requirements

Mercy Care (MC) leverages our expertise in serving individuals with Special Health Care Needs (SHCN) and our statewide presence as the **only health plan serving members across all AHCCCS programs.** Over our 23-year history serving the ALTCS program, our network has grown to include 5,411 medical providers, 1,688 behavioral health (BH) providers, 861 long-term care (LTC) providers, 146 hospitals, and 275 provider arrangements in Arizona border states, supporting choice, accessibility and compliance with all network standards, including ACOM 436 and 417. Our priority is to ensure ongoing access to equitable and high-quality care in the member's setting of choice. As such, our network delivers Home and Community Based Services (HCBS); institutional capacity; and primary, specialty and BH services, to meet the unique needs of members. Through our statewide footprint, we have demonstrated our ability to successfully build networks with smooth transitions in expanded regions to ensure network sufficiency with ACOM 436 standards.

Network Development Strategy

Our overall network development strategy focuses on developing, maintaining, and monitoring a comprehensive statewide provider network that supports the unique, diverse needs of AHCCCS members across all services and settings. Key elements of our strategy include continuous network evaluation and optimization, eliciting feedback, innovation, expansion, mitigation of health inequities, and quality of care. Our approach emphasizes building HCBS providers and institutional capacity, in accordance with the critical requirements in Section D of the Contract, in developing a sufficient and effective network to meet member needs while maximizing available resources. Detailed at the end of this response, **we established a three-year strategy and timeline that will progressively achieve measurable outcomes**, including but not limited to, expanding the network of skilled nursing and assisted living facilities with specialty care for dementia, traumatic brain injury (TBI), SUD, persistent aggressive behaviors and other BH services; promoting the benefits of peer and family run organizations (PRO/FRO); promoting social connection; increasing family involvement; enhancing cultural competency; expanding value-based services (VBS) to include establishing Centers of Excellence (COE) for Dementia and Direct Care Workers (DCW); and launching innovative care delivery models.

Experience and network achievements. We are confident we can achieve these outcomes based on our experience in our existing Geographic Service Areas (GSAs), where we have achieved several key accomplishments through our comprehensive provider network and expansion activities, such as **maintaining a provider retention rate of over 99%; scoring number one for provider satisfaction** in the most recent AHCCCS survey and for compliance with minimum time and distance standards on the 2022 External Quality Review (EQRO); and scoring 100% on the "Network meets requirements for evaluating access to care" on AHCCCS' 2023 Operational Review (OR).

Overall approach: Our local network administrator oversees network development, sufficiency, and reporting ensuring member choice of providers across settings and deploying resources to address areas of need. We have an established Network Development and Management Plan (NDMP), which details our strategy and which we evaluate and update annually. We submit the plan to AHCCCS as an assurance of our network sufficiency in accordance with ACOM 415. Our NDMP demonstrates sufficiency across our GSAs, accomplished through our overall network development strategy, which incorporates established monitoring processes to continuously improve our network, as follows:

- **Data analysis.** We review multiple data sources to continuously assess member needs, identify gaps and proactively enrich the network. Sources include performance against ACOM 436 and 417 standards, member grievances, quality of care, utilization data, satisfaction survey results, member placement data, timeliness of DME services, Health Professional Shortage Areas, information from electronic visit verification, and AHCCCS population data. Disparity data includes race, ethnicity, language, health-related social needs (HRSN), sexual orientation, gender identification, cultural/geographical equity factors, and information from SocialScape, such as Z-codes, the Homeless Management Information System, and public data. Health equity data ensures a diverse provider network to serve our populations.
- **Stakeholder feedback.** We regularly discuss network needs with providers, members, families, advocates, and other stakeholders through our established Provider Forums, Member Advisory Councils, ALTCS Member Council, and Culturally and Linguistically Appropriate Services (CLAS) Committee, which includes tribal representation. The CLAS committee oversees MC and contracted providers' adherence to the enhanced Culturally and Linguistically Appropriate Services standards and the development of initiatives to advance health equity. To solicit feedback on needs and opportunities, we met with **94 providers and organizations statewide** such as **Haven, Area Agency on Aging, Circle of Life, Compassus, and the Elder Task Force in Southern Arizona**. Through discussions, MC identified opportunities to support skilled nursing facility (SNF) and HCBS providers in addressing social isolation, transportation,

resource deserts, and workforce challenges. We applied their feedback toward the initiatives in our three-year timeline.

- **Internal collaboration.** Medical Management (MM), Case Management, Quality Management (QM), and others identify needs through daily interactions with members and collaborate with our Network Team to promote recruitment. Our **Network Strategy and Sufficiency Committee (NSS),** which includes leadership across operational areas, approves our annual NDMP, evaluates network sufficiency, shares findings with our quality committees, and offers recommendations that the Network Team implements.
- **Provider partnerships and innovative strategies.** The above monitoring processes identify providers for recruitment to fill any gaps and proactively enhance the network. Using this process, **we increase the adequacy and accessibility of our network by 50 to 100 providers each year.** We also develop innovative arrangements with providers aimed at creating services and increasing capacity for members in their setting of choice. We develop provider relationships and offer incentives to promote provider participation and retention.
- **Ongoing provider support**. Our dedicated, local network relations representatives (NRRs) live in the community and work with providers statewide. They offer direct support from contracting through the "Mercy Care 101" orientation and increase operational efficiencies and satisfaction for providers. In an independent survey, MC scored within the **92nd percentile** for the quality of our orientation process and the **91st percentile** for our policies and communications.

Methods to Build HCBS Providers and Institutional Capacity in Rural Areas and Maximize Resources

We stand ready to expand our ALTCS presence statewide. Based on sufficiency in accordance with ACOM 436, **our current statewide network is ready to serve ALTCS members on day one in our expansion areas**. We will employ specific methods to build HCBS providers and institutional capacity, which will incorporate and comply with the requirements in Section D of the Contract.

- **Supporting the member's service plan.** We will ensure consistent, accessible services across settings to fulfill the member's Person Centered Service Plan (PCSP). Our case managers (CMs) identify member needs, track social risk factors, and connect members to timely services. CMs collaborate with the Network Team to communicate needs. On AHCCCS's ALTCS 2023 OR, **we scored 100% on ensuring members received medically necessary BH services**, as documented on the PCSP. MC also partners with many organizations to advance the community health worker (CHW) pathway, including **Arizona State University, Association of CHWs, and Helping Other Promotores Excel.** We are implementing a new model with **Home Assist Health** that pairs CMs and CHWs to better assist members.
- **Support of informal support systems.** We will provide Trualta's caregiver engagement platform to support families and caregivers with tools to help care for their loved ones at home. Caregivers can access trainings and on-demand personalized education. Support tools include virtual drop-in assistance; support groups and specialty groups, such as dementia and LGBTQ; caregiver wellness toolkits to help manage stress; and a Latino/Hispanic Toolkit and video series. **Trualta results include an overall Net Promoter Score of 82 with 92% saying they learned something new and 100% saying they feel more connected**. We will also offer free health seminars targeted toward health issues minority groups experience.
- **HCBS for SHCN**. We will develop HCBS settings to meet the needs of members with SHCN through a combination of our contracted network that includes all **FQHCs** located in the State along with field, virtual, and multi-specialty interdisciplinary clinics. We use innovative strategies to increase the availability of these services through provider partnerships, like those in the Innovative Strategies table below. MC will expand COEs that implement evidence-based practices and track outcomes for these members.
- **Specialty programs in SNFs/ALFs.** Our network currently serves members with BH conditions residing in SNFs and ALFs statewide. In our current GSAs, we have **41 SNFs and 34 ALFs** that provide special BH programs for TBI, dementia, SUD, and aggressive behaviors, and we will build these specialty programs in our expansion areas.
- **Cultural Competency.** We will promote culturally competent services to all members, including those with Limited English Proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. We actively identify and recruit providers who deliver culturally competent care, such as **Empower Homecare,** an organization owned by a member of the Navajo tribe that offers services to the Navajo Nation. We use member and provider demographic data to identify contracted providers who can meet members' cultural preferences. We incorporate religious affiliation and other cultural preferences as part of the Strength, Needs, Culture and Diversity (SNCD) to identify and address social needs and specific service delivery opportunities. We train providers on cultural competency aligned with CLAS standards and will increase **Visibility Matters** training, which covers challenges LGBTQ older adults experience as they age, move into SNFs and face end-of-life care planning.

- **Network adequacy.** We assure timely access to community-based providers that maximizes member choice and complies with ACOM 436 and 417 standards, which we exceed in our existing GSAs today. Our dedicated, local NRRs support providers and increase operational efficiencies that incentivize provider participation, such as **97% first time clean claim adjudication**, multiple check runs per week, single-submission process for Medicare and Medicaid members, and subsidized claims processing costs.
- **Service delivery innovations**. We will continue to implement innovative arrangements through technology and relationships, detailed below, to provide remote consultations, monitoring, and follow-up in underserved areas. We also offer **FamilyCare Central,** our integrated health record used by members, caregivers, CMs, and providers.
- **Community-Based Family Support.** We will promote availability of community-based family support providers with a strong PRO/FRO network, such as **Center for Health and Recovery and Stand Together and Recover,** to address social isolation and family connectiveness. **We increased utilization of Peer and Family Support Specialists by 54.3% between 2022 and 2023.**

Maximizing resources. Particularly in rural areas, developing a culturally competent integrated network that serves members' unique needs poses issues that are often difficult to mitigate. **MC will apply innovative solutions that prioritize service delivery in the least restrictive setting,** promoting whole-person integrated care by creating availability of services that previously did not exist. These are described in the following table. We will actively refer members to these services during the health risk assessment process.

Innovative Strategies	Description
Hospital and SNF at Home	**Dispatch Health and Your Health Connection** will offer acute care in the home that would otherwise require hospital admission or SNF placement. They use daily physician and RN visits, ancillary services and remote monitoring, home health, and acute care visits to support the transition to a community PCP within 30 days.
Bariatric Program in SNF/ALF	We collaborated with **Ensign and Blue Sky** through enhanced rates to create bariatric levels of care within SNFs and Assisted Living Centers (ALC)/Assisted Living Homes (ALH) for resources needed to care for morbidly obese members. Members receive support for weight reduction from a registered dietician and work toward goals, which may include bariatric peer support groups, specialized exercise, and counseling. **This resulted in opportunities to receive care in the least-restrictive setting and an individual member cost savings of 90%** based on avoidance of high-cost utilization.
24/7 Virtual and In-Home Care for Complex Conditions	Through **CareBridge**, members receive a cellular enabled tablet at no cost with direct access to applications to connect to services. Members also have access to the **CareBridge "red button" and connected phone support** to further ease access barriers for members and families.
Health Care and Social Programs for Older Adults	**Oak Street Health**, a network of primary care centers located in medically underserved areas where there are designated mental health provider shortages and 86% of members have one or more chronic conditions. A Center-based team of employees keep seniors active and healthy with activities such as movie parties, chair yoga, and bingo. Transportation is provided. Oak Street's performance outcomes show a 51% reduction in hospital admissions, 42% reduction in 30-day readmission rates, 51% reduction in ED visits, and a net promotor score of 94%. Focused on culturally competent care and addressing health inequities, more than 50% of their membership identify as Black, Latino, or Indigenous, and almost 50% report housing, food, or isolation risk factors at time of referral.
Remote Patient Monitoring and In-Home Visits	**Your Health Connection** offers home-based primary and transitional care enabled by advanced diagnostic and audio/visual technology. A medical technician in the home operates a mobile unit, allowing a remote provider to have "virtual hands on" with digital vital signs, portable HD exam cameras, and a digital stethoscope. The remote provider interacts with the member and technician allowing complex care 24/7 in the member's home rather than a facility.
Home Modifications	We are partnering with **Hidrent,** a group of retired and inactive firefighters who understand how home safety affects a member's health, and **Tyler's House,** an agency that assists homeowners in need of emergency home repairs, to expand the availability of these services statewide.

Assist Rural Nursing Facilities Seeking to Expand into Community-Based Care

To allow members to age in place, we will collaborate with SNFs seeking to expand their service offerings to ALH or other community-based care. We met with SNFs across the state, to gather input regarding how MC can assist with expansion. We learned that workforce and licensure are barriers. As a result, we developed a four-pronged approach to assist rural SNFs in community-based care expansion that includes:

- **Assessment.** Meet with existing providers to support their self-assessment and readiness to expand. We will identify specific areas of need, create heat maps that highlight growth opportunities, and share this information with providers, such as **Emblem and Hospice of the Valley,** who have indicated they are ready to grow with MC.
- **Collaboration.** Create a provider collaborative with SNFs, **The Arizona Health Care Association, Arizona Center for Rural Health, Arizona Rural Health Association, AHCCCS, the Arizona Department of Health Services,** and other key

growth partners to develop a rural health strategy that supports expansion of HCBS and to allow providers to discuss barriers, share lessons learned, and strategize solutions.

- **Incentives and support.** We help providers secure licensing and registration and develop evidenced-based care models. **We will offer 25% of our CRI funds to support SNF efforts to expand into HCBS,** including upfront funding for infrastructure. MC will expand Continuing Care Retirement Communities, which are inclusive of independent living, assisted living, and SNF services, allowing members to change levels of care within the community and age in place.
- **Local dedicated resources.** We will deploy a boots on the ground approach with the introduction of a **rural health specialist (RHS)** to serve as a direct liaison between MC and SNF and HCBS providers. The RHS will meet with providers to identify needs, barriers, and develop and implement strategies. We will support the development and implementation of CHWs, recognizing their work to connect members to care and close gaps in health inequities. We have two tribal relations liaisons who facilitate care coordination for tribal members living in rural communities.

Action Steps and Timeline for First Three Years of Contract

Our timeline for the first three years of the contract builds on our successful achievements over the past 10 years. **Our goal is to progressively increase network access and capacity, health equity, and member satisfaction over the three-year period.** We will collaborate across operational areas in an integrated fashion to address network needs. Our Network, MM, Member Services, Case Management, SOC and other teams will work together through regular meetings, communication, and shared data. We will review initiatives through our NSS Committee and demonstrate progress in our annual NDMP. Upon award, we will conduct a comprehensive assessment of expansion areas by engaging local providers, community organizations, members, and caregivers to understand needs, challenges, and opportunities.

Measurable outcomes across all three years. We have identified the following measurable outcomes to assess our success in achieving a comprehensive network over the three years:

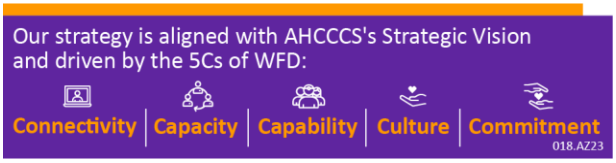
- Maintain or exceed compliance with ACOM 436 in our GSAs, including non-emergency transportation (NEMT) services
- Train at least 80% of providers in cultural competency
- Increase the number of rural nursing facilities successfully expanding into community-based care in rural areas by 10%
- Increase utilization of PRO/FRO services by another 5% in all GSAs
- Establish one SNF and ALF with specialty BH services in each GSA to decrease the number of placement changes
- Assist SNFs/ALFs seeking to add transportation services to address need in rural areas
- Ensure that at least 80% of members receive services in HCBS settings statewide
- Increase locally based providers through promotion of graduate medical education and CHW scholarships
- Enhance quality outcomes by establishing at least one DCW and Dementia Care COE per GSA
- Improve member satisfaction scores related to access to care by 5%

We will implement network development actions beginning in year one and continuing through years two and three, measuring outcomes each year. To achieve outcomes, we will take the action steps described in the table that follows.

Year	Action Steps
Year One	**Develop a network expansion plan** using our assessment results and implement efforts to achieve the outcomes above. We will collaborate, recruit, and maximize resources to develop a statewide network that complies with Arizona Early Intervention Program requirements, enhanced with PRO/FRO and BH professionals. We will include incentives to attract local providers in underserved regions, implement workforce development initiatives, and our NRRs will deliver training, ongoing technical assistance, resources, and mentorship programs. We will also have an escalation process for providers to reach MC leadership for timely resolution of needs. Our year one priority will be ensuring immediate access to care to meet minimum sufficiency standards, followed by development to enhance member choice. We will continuously evaluate progress for each action during year one, adjusting priorities as needed. We will formally evaluate goals and identify priorities for year two in our NDMP. We will follow our network development strategy to advance our network, including data analysis, stakeholder feedback, and ongoing internal collaboration, including NSS meetings.
Year Two	**Refine initiatives and continue progress** through recruitment, expanding partnerships with local organizations, and providing financial support to providers. We will ensure providers are equipped to meet quality standards and deliver comprehensive care. By the start of year two, we will focus on enhancing member choice, as we expect to achieve a minimally sufficient network during year one. Indicators of success include ongoing improvements in access, provider capacity, and member satisfaction measured by incremental improvements across each measurable outcome. We will continually evaluate progress and add goals and priorities for year three in our NDMP.
Year Three	**Continuously refine and expand the network** based on lessons learned and ongoing implementation of action steps. We will measure outcomes annually, identify areas of improvement, address challenges, expand partnerships, and deliver ongoing support. Our goal by the end of year three is to have progressively achieved a network for members to reside in the setting of their choice, aligned with their PCSP. We will support the network with incentives and value-based arrangements that promote quality, culturally competent, and preventive care through collaborative and innovative provider partnerships, community associations, and informal supports.

B8 - Narrative Submission Requirements

Mercy Care's (MC) workforce development (WFD) strategy integrates WFD operations (WFDO) across the organization, uses data analytics to forecast needs, and builds and invests in collaboratives to connect providers with system stakeholders. Our strategy supports MC's WFD philosophy that expanding access to long-term care, delivering culturally responsive solutions for social health risks, and addressing the challenges of the health care workforce are at the core of MC's mission to serve the ALTCS Program.



MC's WFDO, led by the WFD administrator, oversees our ALTCS Program and continuously monitors workforce capacity and capability to inform our short- and long-term strategies. Our WFD administrator is a certified Project Management Professional® and under her current professional development plan she is earning a certification by the Society of Human Resource Management. MC's robust WFDO is staffed with seven fulltime professionals who offer comprehensive provider assistance and participate in collaborations, such as Arizona Association of Health Plans, Arizona Healthcare WFD Coalition, and Arizona WFD Alliance-ALTCS. **MC's WFDO leads three of the five AHCCCS American Rescue Plan (ARP) workgroups**. We meet or exceed AHCCCS provider WFD requirements, including annual submission of a Network WFD Plan, the requirements in RFP Section D, and AHCCCS Contractors Operations Manual (ACOM) 407.

ALTCS DCW Program Success
MC's ALTCS DCW program achieved the following between September 2019 and December 2022:

- Over 8.8 million impressions on social media
- Nearly 35,000 DCW applications received
- Nearly 4,000 DCWs hired

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We use data to inform our WFD strategies verify their effectiveness, and assess outcomes. For example, in response to a 2015 survey of Arizona providers identifying a shortage of direct care workers (DCW), we initiated an ALTCS DCW program. This program tested and identified new and innovative strategies, such as mentoring programs, to improve recruitment, training, and retention of DCWs. As part of the program, MC provided nearly **$1.7 million** to six home and community based services (HCBS) providers and two community agencies that provided recruiting, certification training, and placement services. As a result, participating HCBS providers successfully hired **nearly 4,000 new DCWs** between September 2019 and December 2022. This achievement occurred during the pandemic when challenges to hiring and retaining DCWs were exacerbated. **MC will fund over $1.6 million**, under this new contract, to continue to develop and implement best-in-class practices to achieve AHCCCS's WFD vision.

a. Assisting and Incentivizing Providers to Improve Planning and Implement Strategic Efforts

We continue to expand our comprehensive programs to assist and incentivize providers to be more strategic in their WFD activities, including efforts to recruit, select, train, deploy, and support their staff. Many of our ALTCS providers have limited WFD experience and resources. To meet their needs, we offer a range of no-cost, easy to use resources and tools to support providers in being more strategic in their WFD efforts. For example, we have a county-level WFD trend and forecast report that uses interactive software drawing from multiple datasets, such as labor market, county health equity composition, electronic visit verification (EVV) data, closed-loop referrals acceptance rates, member and provider demographics, and health-related social needs (HRSN) details. One of our partners, **Arizona Community Health Workers Association (AZCHOW),** is currently performing a service needs and provider gaps assessment of Arizona's rural counties and communities. MC will be incorporating this information in our report to better assist providers in forecasting and developing a culturally competent workforce. We will educate providers on incorporating the report data in their hiring plans via 1:1 technical assistance and in-person quarterly provider forums. As a **lead participant in AHCCCS's ARP Workforce Database and Policy Decision Support System**, we are also involved in system efforts to collect, analyze, and model data on key aspects of Arizona's provider workforce. We will assess our WFD trend and forecast report based on the ARP Workforce Database when it is available.

We will continue our efforts to address Arizona's shortages of DCWs. Per the Paraprofessional Healthcare Institute's 2021 Survey, Arizona will need more than 190,000 new DCWs by 2030. We are also continuing to increase availability of CHWs to provide newly covered AHCCCS services. CHWs are critical to promoting equitable care and improving member experience by serving as trusted liaisons to local services that align with member cultural preferences. Research from the University of Pennsylvania shows that individuals served by CHWs use the emergency department about 66% as much as those who are not. The following table details our diverse programs to support provider WFD activities.

Program	Description
MC Programs that Assist Providers Recruit, Select, Deploy, and Retain Their Staff	
Provider Supports to Improve DCW Recruitment, Hiring, and Onboarding	Through our ALTCS DCW program, MC meets with participating providers bi-annually to offer 1:1 technical assistance. Through this process we assessed best practices and have developed guidance for ALTCS providers on key topics, such as job descriptions, hiring practices, and onboarding processes. We have provided, and will continue to provide, WFD education via industry conferences and provider forums. For example, we gave presentations at the 2022 State of Reform Conference and at the 2022 Arizona LeadingAge Annual Conference & Expo on our ALTCS DCW program findings. We offer ongoing WFD education on effective hiring and onboarding strategies with all providers via 1:1 provider technical assistance and in provider joint operating committees (JOCs).
Provider Supports to Improve DCW Retention	Per the 2021 ALTCS MCO WFD Survey, the average length of employment is one to four years with most DCWs leaving due to higher paying jobs and burnout. Using our ALTCS DCW program findings, we are creating provider guidance and tools, including: • Offering technical assistance and guidance documents on how to improve DCW retention, including creative compensation, staff recognition programs, and having a culture of diversity, equity, inclusion, and belonging. We also provide technical assistance on and resources to address and prevent DCW burnout, stress management, and compassion fatigue. • Offering DCWs and professional direct caregiver education and support through Trualta, a virtual engagement platform that includes hundreds of courses and learning opportunities that help caregivers manage burnout and build skills. **Support tools include virtual drop-in assistance; support groups and specialty groups, such as dementia and LGBTQ; and caregiver wellness toolkits to help manage chronic stress; and a Latino/Hispanic Toolkit and video series.**
MC's Programs to Incentivize Provider WFD Efforts	
WFD Plan	MC is developing provider payments, based on AHCCCS's HCBS model DAP payments, to incentivize providers to develop WFD plans. WFDO offers providers 1:1 technical assistance to improve the effectiveness of recruiting, hiring, training, and retaining staff. We will monitor provider WFD plans and use the results to inform our strategies to assist and incentivize providers. Our WFD Taskforce, described below, will review the results of the provider WFD monitoring to assess achievement of expected outcomes.
Provider Recognition and Rewards	• We have recognized nearly 1,000 individuals and organizations that provide services to MC members, since 2015, through our RISE (Resilience, Innovation, Services, and Empowerment) awards. We are expanding this program by recognizing provider WFD innovations and results, which will be based partially on demonstrating effectiveness of their WFD plans as described above. • We will use member feedback from our Thrive Mobile member surveys, described below, to identify DCWs who positively impact member experience; high performing DCWs will be added to a monthly drawing for a delivered meal paid by MC.
Value-Based Incentives	MC is implementing innovative provider incentives to promote WFD and HCBS provider retention, including: • Creating a new **Center of Excellence (COE) for providers who employ DCWs**, based on their use of best practices to recruit, train, and retain staff, such as having coaches, a dedicated recruiter, and a certified direct care training center. • Offering value-based incentive contracts to COE to improve staff retention, staff satisfaction, and member outcomes by closing gaps in care. We will use pay for quality incentives administered through the COE and paid directly to the caregiver. • Participating providers will demonstrate operational excellence through adherence to EVV, timely acceptance of referrals, and use of technology, such as the health information exchange.
MC Programs to Support Provider Recruitment and Hiring by Developing Arizona's Health Care Workforce Pipeline	
Public/Private Partnerships to Build and Enhance Arizona's Health Care Provider Pipeline	We assist providers and the State expand the pool of capable health care workers by supporting AHCCCS's pipeline initiatives, collaborating with workforce partners, and assisting diverse populations. Programs we have or are implementing include: • **Increasing Provider Participation in the Arizona Healthcare Career HUB (HCH):** MC's provider relations staff help educate providers on the benefits of participating in the HCH, one of the AHCCCS ARP projects, and help connect non-participating providers during the onboarding process. We will work with the HCH to identify current MC providers who are not yet participating and conduct targeted outreach. • **Marketing the HCH:** A multipronged approach to increase the awareness and use of the HCH by individuals interested in pursuing health care careers, such as traditional and vocational high schools, Arizona Community College District Gateway Colleges, Highschool Home Health Aid program graduates, and transitional aged youth. Our marketing plan includes social media and targeted traditional informational materials, including postcards with QR codes to easily connect to the HCH. We will leverage our provider network, including those offering peer employment and serving transitional aged youth and community and workforce organizations, to help distribute HCH marketing materials in key educational and community environments. • **Partnering with Phoenix Bioscience Core,** a collaboration with Arizona's universities and colleges to increase health care workforce capacity focused on diverse recruitment and rural placements. These initiatives align health care education to workforce learning for students, boost student engagement, attainment of health care credentials, and provide experiential learning in work-based internships for a range of health care jobs, such as physicians, nurses, and behavioral health providers. MC is funding approximately **$300,000** for a fulltime position at Phoenix Bioscience Core to track goals, such as creating 10 internship sites with MC providers, hosting meetings with stakeholders, and creating two to four pathway programs. • Increasing awareness of AHCCCS's new **Transformative Healthcare Scholarships** via provider notices and targeted follow-up to peer employment service providers and using Member Advisory Committee input on member marketing campaigns. • **Sponsoring and Participating in Job Fairs:** MC staff lead and help organize the annual Dream Job Fair and Pre-Dream Fair. In 2022, the event attracted more than 220 job seekers and 44 employers ready to hire qualified candidates on site. We will also host an annual ALTCS job fair in each region where we have members. We will hold the job fair in conjunction with our ALTCS in-person provider forum to integrate provider WFD education, forecasting data, and attention to local cultural and service needs. We will also partner with local faith-based and community organizations and invite AHCCCS members as part of our efforts to connect individual's seeking employment with providers who are hiring to diversify the workforce pipeline. • **Connecting Veterans and Families**: MC will continue to collaborate with CVS Heroes2Careers Military program. We are expanding our current work with Be Connected and the Arizona Coalition for Military Families to engage veterans, military members, and their families who are interested in health care careers.

Program	Description
	• **Collaborating with Tribal Nations**: MC and the **Nineteen Tribal Nations (NTN)** began meeting in June 2023 to share WFD activities and resources. The NTN is a coalition of 13 tribes serving tribal members on and off tribal land across the State. MC is sharing information from the NTN with providers to help them better serve American Indian/Alaskan Native members. • **Supporting Medical Residency Programs**: MC is a training site for Honor Health Informatics fellowship, which focuses on health equity and HRSN. Creighton University Psychiatric Residents, University of Arizona College of Medicine Graduate Medical Education (GME) programs, and several of our medical directors serve as faculty. GME trainees participate in our Quality Management/Performance Improvement and Medical Management/Utilization Management committees to enhance the pipeline of physicians invested in AHCCCS programs. • **Partnering with the United Way:** As part of the ALTCS DCW program, we worked with the **United Way of Southern Arizona**, in collaboration with **Pima Council on Aging and the Elder Alliance**, to develop a program to recruit, train, and place DCWs in Pima County. **MC is funding an additional $775,000 to continue the program for three years,** which will operate under a full-time CHW. We project the program will result in **hiring 420 to 500 DCWs, helping 90 new DCWs become certified,** and providing ongoing coaching to develop capabilities of newly placed DCWs. This program will target hiring of under-represented populations, such as young adults, men, refugees, and people in rural areas. MC WFD will monitor performance via bi-annual reports and JOCs to discuss performance and achievement of expected outcomes. MC and the United Way are expanding this program in other regions where we serve ALTCS members to address long-term needs.
Supporting Family Members in Becoming Professional Direct Care Givers	MC educates family members about becoming professional direct caregivers, offers resources to help them become certified, and educates them on career pathways when family members no longer need DCW services. **MC will fund a $200 per month stipend for travel expenses** incurred by the professional direct caregivers. Other enhanced supports include: • **Benefit Eligibility Triage and Education (BETE)**: BETE provides new ALTCS members who select MC with a postcard with a QR code that navigates to the MC website. The website contains step-by-step guidance for family members on how to become a paid professional direct caregiver, links to agencies offering DCW certifications, and information on MC reimbursement of fees. • **Trualta**: MC exceeds expectations by making Trualta's caregiver engagement platform available to ALTCS members' families and offers access to trainings, on-demand personalized supports, and support groups to help care for loved ones at home.
Increasing CHWs Across the State	MC partners with many organizations to advance the CHW pathway, including Arizona State University, Association of CHWs, and Helping Other Promotores Excel. MC is implementing a new model, with Home Assist Health, that pairs case managers and CHWs to better assist members. We are providing funding to **AZCHOW's CHW Training Institute, Mapping Arizona CHW Potential (MAP), and CHW advisory group.** The MAP project will identify community health needs and CHW availability statewide, inform the Institute's initiatives, and improve access to care. We continue to use community investment dollars to support CHWs, such as: • **$10,000** to the CHW Scholarship program at Scottsdale Community College in the Spring of 2022 for students pursuing careers in direct care and behavioral health, with 100% of recipients successfully completing the program. • **$145,800** in funding of Pathways to Wellness program sponsoring CHWs at Chandler Regional and Mercy Gilbert Medical Centers using the Pathways Community Hub model to enhance community health outcomes by addressing the unique HRSN for the ALTCS population experiencing congestive heart failure, chronic disease, and co-morbidities. • **$92,000** for the development of the Pathway Pilot program, which focuses on supporting CHWs to augment work with ALTCS members in Maricopa County to address risk factors and help navigate and access HRSN and health care needs.

b. Assisting Providers to Improve Coaching and Supervision to Improve Member Outcomes

MC led the development of HCBS provider mentoring programs and funded provider agency mentors via our ALTCS DCW program. Providers participating in the ALTCS DCW program **achieved 4.4% higher in 2022 and 6.2% higher in 2023 on HEDIS measures.** One participating provider reported the mentoring program positively impacted DCW retention, and they now achieve **9 out of 10** on staff satisfaction surveys. We use a wide range of sources to continuously inform and enhance our programs, including AHCCCS' ARP Professional Development in WFD Best Practices and findings from the ALTCS MCO WFD Survey. The following table describes our programs, all of which improve quality by helping providers improve coaching and supervision of DCWs.

Program	Description
Provider Mentoring Initiatives	In the ALTCS MCO Workforce Provider Survey 2021, DCWs cited supervisor support as the most common reason for staying at an agency. To help providers develop mentoring programs we will offer a Train-the-Trainer program to help providers grow mentors within their organizations. We partner with the **National Council for Mental Wellbeing** to host an Integrated Care webinar series. **MC, the only AHCCCS health plan with membership in the Association for Talent Development (ATD), has been integral to bringing together the collaborative efforts of ATD and AHCCCS's ARP Best Practices in the WFD project**.
ALTCS Provider Education and Training Resources	We know, from provider feedback, quality audits, claims data, and other sources that many ALTCS providers need support and resources specifically designed to address the nuances of the ALTCS program and member conditions. We offer ALTCS provider resources focused on high-quality care, reducing provider burden, and more effectively supporting staff, such as: • Offering resources, such as a WFD toolkit, level three training effectiveness evaluations, job aids, and competency guides. • Hosting in-person, quarterly ALTCS provider consortiums across the State with customized content by ALTCS provider type. • Offering access to free educational credits, such as Trualta and FreeCME.com. Trualta's training library includes hundreds of courses, including working with people who have autism spectrum disorder, dementia or related disorders, and persistent aggressive behavior. We are developing content on working with people who have traumatic brain injuries or are pregnant/post-partum, and scenario-based training on identification of abuse and neglect. DCWs can access the training at no cost to meet the continuing education requirements per AHCCCS Medical Policy Manual 1240-A. MC providers can also access Trualta to support

Program	Description
	compliance with ACOM 407 training requirements and other DCW training needs. Trualta works — it has an overall **Net Promoter Score of 82** with **92%** of users saying they learned something new and **100%** saying they feel more connected.
Provider Tools to Improve Member Connectivity	We invest in tools and data that improve connectivity between providers and members to improve member experience and outcomes. These member engagement and care coordination support tools include Valued Relationships' E3 live agent calls and fall alert system; a 24/7 ALTCS Referral Database for HCBS; Cognitopia, a mobile application for members with intellectual and developmental disabilities that helps improve independence and supports caregivers; medication reminders through Thrive Health Mobile and Med Ready; and HCBS supports via Carebridge, which provides members with tablets to help connect with physicians, nurses, physical therapists, and others to support personalized independence goals. We also offer FamilyCare Central to support care coordination by providing an electronic forum to share key information among all authorized individuals in a member's care circle. In addition to improving member outcomes, these tools help reduce provider burden and stress.
Staff Performance Data	MC collects and analyzes member satisfaction and outcome data from a variety of sources to inform our WFD programs, including training. We are developing reports for HCBS providers to monitor if DCW apply and effectively use skills to identify opportunities for improvements and to recognize high performing DCW to improve retention. This data will include: • **Thrive Health Mobile:** Using EVV data, we will solicit real-time visit feedback within 30 minutes of the visit through surveys administered via Thrive, our mobile phone solution for ALTCS members. • **MC Health Assistance used for Health Mine:** We use technology-enabled engagement and rewards solutions to outreach to ALTCS members through digital and traditional modes to help members self-manage health risks and conditions. • **Trualta:** We will use data on the use of Trualta's training resources use to identify trends HCBS providers can use to inform their staff training, to support initiatives, and to identify new training topics to improve staff capabilities and member experience.
Investments in Targeting Training	MC supports providers and agencies in delivering targeted trainings, such as: • **Covenant Health Network:** MC funded **$186,700** for 6 mental health workshops for skilled nursing facilities' staff, which focused on interpersonal skills and creating a culture of wellness. Led by Caring for our Workforce, nearly 420 individuals attended. • **Oakwood Creative Care:** In 2022, MC invested **$400,000** for training on interdisciplinary, evidence-based interventions for persons with dementia and their caregivers, including coaching sessions, a dementia inclusive community center, and classes to understand dementia and address challenging behaviors without relying on unnecessary medication or institutionalization.

c. Integrating WFD Operations within Network, Medical, and Quality Management

MC's WFDO works closely with network, medical management, and quality management (QM) to make sure our provider workforce is diverse and has the capacity and capability to effectively care for ALTCS members. Network and WFDO collaboratively identify provider WFD needs, including provider training and targeted technical assistance to improve the effectiveness of provider hiring, training, and retention. MC offers an ALTCS specific provider orientation and onboarding. In an independent survey performed on behalf of MC, we scored within the **92nd percentile** for the quality of our orientation process and the **91st percentile** for our policies and communications. Through our Network WFD Plan, we jointly analyze network gaps, conduct market research, and implement recruitment campaigns to achieve a robust and diverse provider network. MC is launching **ALTCS Provider Quarterly Forums, giving ALTCS providers a dedicated forum** to provide feedback, share best practices, and obtain information, including WFD forecasting reports.

Our WFDO works hand-in-hand with Medical Management to connect provider training and development initiatives with our care management programs. This integration helps ensure providers have the capability and capacity to effectively deliver high-quality, evidence-based care to ALTCS members. We also collaborate on performance improvement initiatives, leveraging workforce data to identify areas for provider education and technical assistance.

As a current ALTCS health plan, we have an established Provider Monitoring and Oversight program to ensure members receive high-quality care in community and facility settings. Our QM department audits HCBS providers to ensure they comply with all provider requirements, such as fingerprint clearance cards, CPR first aid, and training as required by ACOM 407 Section III D. 1-3 and Section D Program Requirements. QM reports their monitoring findings to the WFDO Taskforce, which we use to inform our WFDO Provider Education program to improve their capability and performance.

We formally coordinate WFD activities through our quarterly WFD Advisory Board and Taskforce. The taskforce reviews the Network WFD Plan, provides strategic advice on factors impacting WFD, and helps ensure compliance with WFD oversight requirements outlined in ACOM 407. WFDO leads the taskforce, which includes **medical management, network, QM**, Adult and Children's System of Care, crisis, **health equity administrator**, Prevention and Court Programs, Grant Fund Administration, ALTCS, marketing and communications, and Office of Individual Family Affairs and Advocacy. Through this forum we integrate data from across the organization to inform our WFD activities. The taskforce reports its findings and recommendations to the QM and Network Strategy and Sufficiency committees where we develop action plans to address identified priorities. MC's integrated approach is how we incorporate AHCCCS's WFD principles of connectivity, capacity, capability, culture, and commitment to grow our diverse network of providers and improve member experience and outcomes.

B9 - Narrative Submission Requirements

As one of the longest serving ALTCS MCOs in Arizona, serving 41% of all ALTCS members, Mercy Care (MC) leads with compassion. We partner with culturally responsive providers and community-based organizations (CBOs) to meet each ALTCS member where they live, providing a whole-person health care model. With our member-centric and data driven approach, we understand the impact of social risk factors on ALTCS members' whole-person care and use our Mercy Wellbeing strategy to address structural and health-related social needs (HRSN) and promote health equity. Through analysis of our internal data, we know problems related to housing, economic circumstances, lack of social support, and insufficient social insurance and welfare support continue to be the top HRSN facing ALTCS members, and we create programs and innovative initiatives to address these needs, as described throughout this response. Driven by our population health management framework, we align our Mercy Wellbeing strategy with the AHCCCS Quality Strategy 2021–2025 and the Arizona Health Improvement Plan. We help members live in the most integrated and least restrictive setting possible, and maintain dignity, self-determination, and independence. All of which, improve quality of life.

Strategies to Address Social Risk Factors

Our ALTCS case managers (CMs) engage members in their homes and the community to develop a Person Centered Service Plan (PCSP) that supports coordination of member-centered, whole-person care. CMs help members develop a PCSP that captures members' strengths, preferences, goals, and needs, including HRSN, and then serves as the primary source of referrals and support for members to address their HRSN. Our CMs receive specialized training on how to assess for and address HRSN, including use of the tools and methods summarized in the table that follows.

Identifying Members' Social Risk Factors	We use the following methods to understand ALTCS members' social risk factors: • **HRSN Z-codes**: We train our CMs to use our Z-code dashboard, reviewing for systemic trends, and our CMs also review, assess, and address HRSN during member interactions. We educate our network providers on timely and evidence-based screening tools to capture HRSN and to report Z-codes, resulting in **130 more providers reporting Z-codes to date this year.** • **SocialScape, our social risk data aggregation solution:** CMs leverage SocialScape to enhance their understanding of HRSN at the member and community level, which they incorporate into discussions with members during the PCSP process. For example, using SocialScape, we know 30% of MC members experience food insecurity. • **Consolidated Outreach and Risk Evaluation (CORE 2.0):** CORE 2.0 is our proprietary, enhanced risk stratification tool, which incorporates HRSN risk data from SocialScape. CMs use our **Clinical Engagement Console**, a visual display of CORE 2.0, to quickly determine members' most impactful HRSN, incorporate them into the PCSP, and prioritize referrals and HRSN solutions.
Addressing Social Risk Factors	• **Community Resource Guide (CRG)**: CMs use our proprietary, publicly available CRG to connect members to local resources that address HRSN. Our directory houses almost **17,000 Arizona resources** and is available on our website (per ACOM Policy 404). We update the CRG at least quarterly, using data analytics and evaluation of community and member social risk scores, including SocialScape data, to ensure focus on the needs and geographic areas of members. We are partnering with Solari to offer an enhanced, easily accessible co-branded CRG curated for specialty populations that aligns with 211 Arizona and that will be available for members, caregivers, and providers via our website. • **CommunityCares**: Our CMs also use CommunityCares, the Arizona Closed-loop Referral System (CLRS), to refer members to CBOs that can address their identified HRSN and then track and close those referrals. We are working to **enhance CommunityCares with our members' AHCCCS ID number** to increase interoperability with our other systems. We will support providers screening for HRSN using screening and referral tools available through, or compatible with, the CLRS. Additionally, we will actively encourage providers to use the CLRS. Our case and care management staff will use the CLRS to refer members to CBOs and providers to address HRSN. We will collaborate with Contexture to outreach CBOs to participate in the CLRS.
Community Initiatives to Address HRSN	**The Mercy C.A.R.E.S. (Community Action Resources Education Service) Team** collaborates with departments across our organization to identify strategic and innovative ways to deliver community reinvestment focused on promoting equitable member care and improving member outcomes in the following key areas: managing chronic conditions, supporting mental health and wellbeing, empowering recovery from substance use, and addressing housing security. In 2023, we made **13 ALTCS-related grants for nearly $2.3 million and reinvested nearly $9.8 million through 38 total grants and other programs, including:** • **Wraparound Housing and Healthcare Services:** We are collaborating with Mercy Housing to bring health and wellness resources to residents of 13 affordable properties. We fund a full-time health navigator and part-time resident services coordinator who provide education and aid to members to improve access to services and supports, which address HRSN and help them remain in their home. **Mercy Housing is recognizing us with the 2023 Resident Services Partner Award.** • **Social Supports:** We funded the Pima Council on Aging with **$130,000 to facilitate Dementia Capable Southern Arizona Memory Cafes and Visibility Matters,** a training curriculum covering the unique challenges and inequities LBGTQ older adults experience as they age, move into nursing facilities, and face end-of-life care planning, palliative care, and hospice care. • **Tribal Initiatives:** We created **18 community reinvestment projects to support the delivery of health care to tribal members, totaling $1.45 million since 2020,** most focusing on addressing health inequities and structural social needs and HRSN. To improve health outcomes and reduce health disparities in under-resourced communities, Aetna Medicaid Administrators LLC, part of the broader Aetna Medicaid organization, a subsidiary of CVS Health Corporation (CVS), created a **Health Zone in the South Mountain neighborhood in Phoenix in 2022**. CVS has **invested $405,000** in local CBOs to address HRSN. In the past two years, **adult vaccination rates in the ZIP codes near South Mountain increased an average of 34.7%.**

Providing Timely Access to Services and Supports

Our ALTCS CMs coordinate timely access to services and support for members. We use SocialScape as a tool for understanding the needs of communities and for bringing providers and CBOs into our network based on community social needs. For example, SocialScape helps us identify disparities in HRSN across rural ZIP codes based on community characteristics (**Figure 9-1**), helping us target our initiatives. The table below summarizes our strategies for providing timely access to services and supports.

SocialScape | Community Risk Baseline — % Of Residents At Elevated Risk

State Intervention Rank	ZCTA	State Name	Total Residents	State Population Rank	Two or More	$					
300	85926	Arizona	852	338	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%
267	85553	Arizona	1,522	309	100.0%	0.9%	93.6%	0.0%	88.7%	99.1%	100.0%
317	85135	Arizona	374	371	97.5%	0.0%	0.0%	100.0%	95.5%	95.5%	2.6%

Figure 9-1: SocialScape community HRSN data for rural ZIP codes in Gila County

Members Residing in Rural Communities	• We have a statewide network of providers who offer integrated and telehealth services, **contract with 38 rural health clinics, including all Geographic Service Areas (GSAs).** We contract with providers, such as Instant Care of Arizona, to conduct home certifications in rural areas. As many rural areas border other states which are geographically closer for members, we have **275 provider border state agreements,** so members can access care closest to them, promoting equitable access to care. • We have a robust provider network with mobile and telehealth capabilities to serve rural members and address disparities in access to care. We had a **49.3% increase in BH telehealth visits per 1000 rural members** in 2022 compared to 2021. • **CVS Project Health Mobile Clinics** address transportation barriers for our members by bringing health care screenings and HRSN resources (e.g., information on where they can access culturally appropriate health care and well-being and quality of life resources). Through CVS, we bring low/no cost health care services to underserved communities and members.
Tribal Members	• Our **tribal liaisons** use their experience living in and working with Arizona tribal communities to inform development of a holistic health care system for tribal members and to improve access to timely services and supports. Tribal members have unique choice in the tribal health care delivery system and there often are multiple health care providers (e.g., Indian Health Services (IHS), Tribal 638 facilities, and Urban Tribal Organizations) and other network providers caring for tribal members, which can result in fragmented care. Our tribal liaisons collaborate with CMs on complex cases, relying on their relationships with tribes, providers, and CBOs to inform and facilitate coordination to equitable care. Our tribal liaisons have facilitated timely, **culturally responsive care coordination for 204 tribal members since November 2019.** • To improve timely access to behavioral health residential facilities, we collaborated with Tribal 638 facility leaders to streamline referral processes for Salt River youth enrolled in MC who also receive care from a Tribal 638 facility, easing the requirement to complete the CALOCUS, respecting Salt River tribal sovereignty, and getting members timely access to the level of care they need. • We have **27 provider groups delivering tribal specific services at 56 locations across the state.** We have **increased treatment services for mental health or substance abuse problems provided by qualified traditional healers services by 15.7% from 2020 to 2022** (in terms of total units delivered) for members across all lines of business.
Members in Need of Community Resources	As described above, CMs use our suite of Mercy Wellness tools and the PCSP process to understand members' whole-health needs. CMs document referrals using the **Community Resources Referral Event** (CRRE) in our case management platform, which assists with tracking and closing the referral loop when the referral is outside of the CLRS. Since deploying the CRRE, **we have closed the loop on over 1,400 referrals for community resources,** helping ALTCS members get the supports they need.
Members in Need of Peer and Family Support	To help members immediately access resources and recovery tools, we partner with **Center for Health and Recovery** (CHR), a peer-run organization, in the delivery of peer and family support. CHR offers a mobile personal health and wellness app, which helps ALTCS members stay on track, overcome barriers, gain skills, manage symptoms, feel connected, and reduce hospitalizations or crisis situations. If they want, members can use the CHR app to use the Daily Living Assessment-20 tool to track their functional improvement. In addition to CHR, we have a robust network and providers for peer and family support. For ALTCS members, we **increased utilization of peer and family support by 54.3%** in June 2022–May 2023 compared to June 2021–May 2022.

Monitoring Outcomes

Through our Quality Management (QM)/Performance Improvement program, we use a continuous quality improvement process to monitor how well we are addressing members' HRSN, improving access to timely services and supports, and promoting equitable care. We incorporate review of Z-codes, health information exchange, and electronic visit verification (EVV) data, with other HRSN data, into our annual Health Disparity Plan to more completely identify social risk factors that contribute to barriers to care. Using this information, we implement interventions to address those barriers. For example, seeing a need to support providers with EVV submission, we **increased EVV compliance from 87% in January 2023 to 97% in June 2023** by outreaching and educating providers on EVV requirements and supporting the delivery of needed Home and Community Based Services (HCBS) to members.

We also include feedback from all departments, including but not limited to, Case Management, Health Equity, Systems of Care, the Office of Individual and Family Affairs, Network, Grievances and Appeals, Medical Management, Utilization Management, Pharmacy, and Finance to get a 360-degree view of whether members are connecting to the services they need and developing action plans to ensure access if they are not. For example, from our case management data, we know in the first six months of 2023, **95.7% of all new members had a service in place within 30 days of enrollment.**

For the priority populations of rural members, tribal members, members with community resource needs, and members in need of Peer Support Services or Family Support Services, we:

- Use dashboards (e.g., our Health Equity Dashboard) to track HEDIS measures and segment data by member characteristics, such as rural versus urban residence or race/ethnicity to determine which health outcomes could relate to unmet HRSN and establish cross-departmental collaborations to implement initiatives to address them. For example, we have identified a disparity in informal caregiving based on ethnicity, with 31.5% of tribal members reporting no informal caregiver support, higher than any other ethnic group, which we are addressing with our Tribal Community Health Worker (CHW) program, as described below.
- Seek representation of each of AHCCCS's priority populations in our member, provider, and stakeholder listening sessions and ALTCS Member Council and incorporate their feedback via our quality committees.
- Include review of our quality data by our health equity administrator and tribal liaisons and report their findings specific to each priority population to the QM Committee.

When we identify the need for performance improvement, we conduct root cause analysis, deploy appropriate teams to lead improvement efforts, and develop and implement targeted interventions. We evaluate improvement efforts using Find-Organize-Clarify-Understand-Specify and Plan-Do-Study-Act methods and quantitative and qualitative analyses.

Strategies to Address Barriers to Care

The table that follows summarizes our strategies to address barriers to care for each of AHCCCS's priority populations.

Members Residing in Rural Communities	Rural communities face challenges and disparities in access to health care due to health care workforce shortages, geographical isolation, limited infrastructure, economic challenges, lack of awareness, and limited health literacy. To address this: • We increase access to mobile and virtual integrated physical health (PH) and behavioral health (BH) services with providers such as Terros and the Spectrum Health Anywhere Care program. In addition, we use our **partnership with CareBridge to offer 24/7 virtual care to rural members.** CareBridge uses a specially trained interdisciplinary team, which can assist CMs in building PCSPs and includes addressing members' HRSN. • We bring best-in-class digital engagement solutions to rural members and caregivers, such as **Pyx Health, Thrive Mobile Health, Trualta** (all described in more detail in the subsection on best practices that follows), which provide access to easy-to-use services and supports to address HRSN. Through **Televeda**, we will offer digital education and navigation for members to bridge the digital divide, helping them use our range of solutions to support whole-person wellbeing. • MC will offer **$200 in gas reimbursement** to members living at home receiving attendant care; caregivers use reimbursement to drive members to community resources, addressing disparities in access to community resources. • We promote delivery of medication through mail (90 days' supply) to improve medication adherence. • Our **proprietary ALTCS Referral database** reduces the time CMs spend on coordination of referrals, reducing wait times to access needed services for our rural members, while providing our HCBS providers a line of sight into opportunities to provide services to members. Since we deployed the ALTCS Referral database in 2021, it has assisted with the **closure of 96.5% of HCBS referrals, with an average time of 1.6 days.**
Tribal Members	• We will provide an enhanced **traditional healing supplemental benefit of up to $300** annually to offer a culturally responsive service that supports tribal members' cultural identity and overall wellbeing. • MC funded **$12,500 in grocery gift cards to Native American Connections and Native Health** to combat food insecurity. • We will offer an enhanced adult tribal dental benefit to address oral health disparities experienced by tribal members.
Members in Need of Community Resources	• We offer multiple options to support food security, including home-delivered meals through **Mom's Meals, Mobile Meals of Southern Arizona, Farm Express Bus**, food boxes, and connection to CBOs. For example, **we increased delivery of home-delivered meals by Mom's Meals by 15%** between January 2023 and June 2023. • By offering **Cognitopia,** we will help our members with intellectual developmental disabilities foster independence in living, learning, and work environments through visual, web-enabled tools, such as goal setting, task completion, and creating routines. • We make cell phones with unlimited talk/text/data through **Thrive Health Mobile**, which members can use to access our CRG, message their CM to discuss their social needs, or look up community resources independently. • Our CMs refer members to utility discount programs. In partnership with Arizona Public Service, CMs use a MC QR code to support members completing the application process, so they can save up to 35% on utilities, if eligible.
Members in Need of Peer and Family Support	CMs assist members to develop their PCSP, which incorporates Medicaid covered Peer and/or Family Support Services, based on member preferences. They also refer members to non-covered peer and family supports offered by CBOs. • We work with our network of providers, including peer and family run organizations, to offer virtual peer and family support, so members and their families do not need to attend services on site if they choose. • MC **provided Ryan House with $56,400 in funding** to increase access to non-covered family respite services to support families. • We engage multiple partners to bring tablets or smartphones, which support digital navigation and access to virtual Peer Support Services and Family Support Services to our members, including the **CHR**, **Televeda** (for members receiving HCBS), **Elevate Charities** (for members residing in skilled nursing and assisted living facilities), and **Thrive Mobile Health**. Through all programs, we **estimate 750 members will receive a device the first year,** addressing the digital divide for ALTCS members. • MC collaborates with **Raising Special Kids** to promote access to their **Positive Parenting program** and individualized support to connect the parents of members enrolled in ALTCS with family support specialists with personal experience in advocating.

Best Practices

The table that follows summarizes our best practices to address member social risk factors by priority population:

Members Residing in Rural Communities	• MC engages in meaningful collaboration with rural communities, local governments, and AAAs to learn about their priorities and identify opportunities to work together and are a member of the **Gila County Social Service Inter-Agency Team.** • We proactively build our network and measure network adequacy. We have an adequate network to support the ALTCS population in the Northern and Southern GSAs, supported by our network analysis. • We use community health workers (CHWs) to address whole-health needs, HRSN, and health care system navigation. • MC **strategically hires CMs and provider services representatives who live in rural areas,** such as Buckeye, Green Valley, Marana, Oro Valley, Sahuarita, San Tan Valley, Vail, Waddell, Wickenburg, and others. With a strong local presence, we build relationships, know the local providers and resources, and understand the needs of rural members, helping to address health care inequities. • Members who reside in rural areas can and do participate in our ALTCS Member Council, which is specific to their GSA. To encourage participation, we offer virtual attendance, arrange transportation, and provide interpretation services. Currently, **63% of the council is comprised of members, caregivers, and advocacy groups,** exceeding the requirement of 50%.
Tribal Members	We acknowledge the historical and ongoing trauma tribal members experience, and to reduce the negative impacts of these experiences, we use the following strategies: • We produced a **3-video long-term care educational series presented in Diné Bizaad** (Navajo language), available on YouTube. • Our tribal liaisons partner with tribes/providers to address needs of those impacted by recent exploitation and fraud. • MC educates our staff and providers about tribal history, culture, strengths, and needs. One hundred percent of ALTCS CMs have participated in our **"Advancing Health Equity for MC's ALTCS Tribal Members"** training. Since 2018, we have offered **over 25 required trainings, educating over 200 participants** on topics such as the Indian Child Welfare Act; how to collaborate with tribal social services and respecting tribal sovereignty; the tribal health care delivery system; impact of trauma on tribal members; unique choices available to tribal members in choosing health care; importance of timely care coordination across federal, state, and tribal systems; and diversity of each tribal nation and community. • We will have a **tribal specialty CHW program,** with workers who speak native languages and employ a multifaceted approach through education, awareness, and connection to members and local resources to address HRSN and health care needs, while addressing unique challenges, such as cultural preservation to promote health equity. • We integrate culturally specific questions such as tribal affiliation and connectedness into our HRSN screening tool.
Members in Need of Community Resources	• We advance the use of CHWs in health care through collaborative training programs with **Scottsdale Community College, Dignity Health Foundation, and St. Joseph's Foundation.** We fund CHWs at Chandler Regional, Mercy Gilbert Medical Centers, and St. Joseph's Hospital using the Pathways Community Hub model, which is an evidence-based practice for identifying and addressing social risk factors. Through our partnership with **Emcara,** we pair a CHW with each ALTCS member to assist with addressing HRSN by connecting members to local resources. In 2022–2023, Emcara completed 370 of their own HRSN screenings with 100% completion in 30 days of first contact with an ALTCS member; the top needs addressed were financial strain and family support. **Partnering with Emcara, we improved our influenza vaccine rate by 10% (from 51% in MY2021 to 56% to MY2022).** • From 2020 to date, we referred over 800 members to **Benefit Results,** our revenue recovery partner who identifies available benefits to increase income (e.g., Social Security Disability Insurance, Supplemental Security Income, Medicare, Veterans benefits, etc.) for members facing low income. Since 2020, we have **helped over 60 members transition out of nursing facilities** by identifying additional income and have helped our members **acquire over $1.7M in annual income.** • We partnered with FSL on a **Department of Energy federal grant to provide home weatherization services for 100 members,** with a focus on ALTCS members residing in Maricopa County, to improve symptoms of their chronic health conditions. We use Z-codes in combination with diagnosis of a chronic condition (e.g., chronic obstructive pulmonary disease), to identify participants. • We educate members about financial exploitation, fraud, and ways to decrease the risk of future exploitation through our partnership with **R.O.S.E. (Resources/Outreach to Safeguard the Elderly)**. Since inception, we have educated over **200 participants at 11 facilities in Maricopa County.** We are expanding to educate ALTCS members and providers in Pima County.
Members in Need of Peer and Family Support	• Over 20 years, we have built a strong network of peer and family run organizations and **our network achieved a score of 94% on the Western Interstate Commission for Higher Education fidelity audits for consumer operated services.** According to the Mercer 2023 audit of our RBHA network, "Maricopa County excels in making peer support services available to people in need." • We are partnering with CHR training their peer support specialists to become Certified Personal Medicine Coaches (CPMCs) who will promote self-determination and resiliency for our ALTCS members. Personal medicine is an evidence-based practice meeting SAMHSA recovery practice standards developed by Dr. Pat Deegan. It celebrates members' intrinsic strengths and empowers them to improve self-care and engagement in treatment. Our BH CMs began receiving CPMC certification in September 2023. • Through **Trualta,** an industry-leading caregiver engagement platform, we offer education, coaching, and peer support so caregivers can build skills, increase confidence, and feel less alone. CMs incorporate caregivers' needs in PCSPs and introduce members to options, such as local family support services and Trualta, so they have a choice of how to access services. Trualta's studies, published in the *Journal of Alzheimer's Disease Reports,* demonstrate increases in caregiver skills and self-care, a decrease in caregiver distress, and a decrease in burnout for caregivers supporting loved ones with highly complex needs. • Trualta is also convening a **Caregiver Advocacy Council** on behalf of MC to assist us in identifying additional ways to better support ALTCS members' informal caregivers. CMs can educate caregivers on the council and refer them for participation. • Through **Pyx Health,** ALTCS members who experience loneliness and social isolation can access human or chat bot support. Members (across all lines of business) who used the Pyx Health application experienced a **63.1% decrease in PH hospital admissions** (25% decrease in the control group), a **63% decrease in BH hospital admissions** (32.4% decrease in the control group), and a reduction in total cost of care of 28.3% (10.8% in the control group).

B11 - Narrative Submission Requirements

#	Medicare Plan Name	Medicare Contract Number	Corresponding Contract From B2	Type of Plan (FIDE/DSNP; SNP; Medicare Advantage)	Star Rating
1.	**Mercy Care**	H5580	Mercy Care Advantage HMO SNP	DSNP	3.0

B12 - Oral Presentation Information

Listed below are the individuals who will be participating in the Oral Presentations on behalf of Mercy Care. Resumes for these individuals can be found on the pages that follow.

- Tad Gary, Deputy Chief Executive Officer
- Cynthia Leach, ALTCS Administrator
- Blythe FitzHarris, Chief Clinical Officer & Interim Office of Individual and Family Affairs Administrator
- Sandra Wendt, Vice President of Quality Management
- Yaminikrishna Sabesan, M.D., Adult Healthcare Administrator
- Denise Ochoa-Puchi, Case Management Administrator

Alternates

- Lorry Bottrill, President and Chief Executive Officer, Mercy Care
- Gagandeep Singh, M.D., F.A.P.A, Medical Director/Chief Medical Officer
- Chad Corbett, Director of Strategic Planning
- Christie MacMurray, Director/Adult System of Care Administrator
- Colleen Soeder, RN, Performance and Quality Improvement Coordinator
- Mike Cunningham, ALTCS Program Manager

TAD GARY

Deputy Chief Executive Officer

Professional Summary

A dynamic healthcare leader with intimate knowledge of Mercy Care, dedicated with over 20 years of experience leading and delivering high-quality member care of all network operations. With his passion for mental health, he has dedicated his career to improving others' lives providing substantial support and guidance regarding government relations to improve member care, the provider experience, and the community at large.

Experience

Mercy Care

Deputy Chief Executive Officer

2021 – Present

- Lead all aspects of business development and function activities encompassing operation, clinical, and financial.
- Manage multiple lines of business, including integrated service benefits for Medicaid and Medicare populations.
- Administer benefits to populations including, AHCCCS Complete Care; LTC; Maricopa, Pinal, and Gila Counties, Regional Behavioral Health Authority, Developmental Disabilities (DD) Department; Department of Child Safety Comprehensive Health Plan, and Medicare DSNP.
- Establish, nurture, and lead a high-performing team of 1,200 employees.

Chief Operating Officer

2018 – 2021

- Responsible for the overall operations; $4 billion in yearly revenue and membership of more than 470,000 covered lives across various lines of business.
- Oversee populations, including traditional Medicaid, adults with serious mental illness, individuals with intellectual disabilities, dual eligible, and LTC members.
- Manage the Maricopa County behavioral health (BH) crisis system for more than 4 million covered lives.
- Guide government relation efforts to enhance member care, improve provider experience, and benefit the community at large.

Mercy Maricopa Integrated Care

Chief Operating Officer, Regional Behavioral Health Authority (RBHA)

2017 – 2018

- Collaborate with CEO to provide day-to-day leadership, management, and oversight of Mercy Maricopa's operations and a large team.
- Generate timely, accurate, and comprehensive reports on operational performance.
- Develop policies and procedures for assigned areas, ensuring that other impacted areas reviewed new and updated information.
- Formulate and execute strategic and tactical plans to drive organization growth, development, and positive financial results.
- Actively monitor legislative and political developments affecting the organization.
- Cultivate and maintain ongoing relationships with key agencies, providers, physicians, hospitals, advocacy groups, and Arizona state officials.

Board of Directors

- Vitalyst Health Foundation, 2023–Present
- Phoenix Chamber of Commerce, 2023–Present

Licensure & Certification

- Licensed Professional Counselor (LPC) – Arizona

Education & Training

- Master of Education (Southeastern Louisiana University)
- Master of Arts-Rehabilitation Counseling (University of Arizona)
- Bachelor of Science (Northern Arizona University)
- Finance and Accounting (The Wharton School, Philadelphia, PA

Awards and Recognition

- Institute for Medicaid Innovation Best Practices Award – implementation of a program to address homelessness and other needs for adults with SMI
- PSA Champion In Behavioral Health

Chief Clinical Officer, RBHA

2013 – 2017

- Manage multiple departments and oversaw the majority of the BH service delivery system across Maricopa County and parts of Pinal County for over 900,000 covered members.
- Oversee the development for Adult and Children's Systems of Care and the Maricopa County Behavioral Health Crisis System, including integrated care, individual and family affairs, clinical operations, cultural diversity, tribal affairs, and overall initiatives, strategies, and programs to address social determinants of health.
- Oversee the development and implementation of a supportive housing program for adults with mental health and substance use that received the 2017 Arizona Department of Housing Hero Award.

Vice President, Integrated Care Management,

2011 – 2013

Director, Integrated Care Management

2010 – 2011

- Direct the activities of a large department that included functions related to BH and complex case management.
- Work to enhance the quality of care and services provided to members by pursuing opportunities to improve care coordination, integration, communication, and use of resources within and across departments, as well as among the Mercy Care Plan (MCP) provider network.
- Serve as technical, professional, and business resource regarding integrated care, case management, and BH.
- Member of the Quality Management/Utilization Management Committee, Policy Committee, Medicare Joint Operating Committee, and the Quality Improvement Committee.

Clinical Services Manager, BH

2010 – 2010

- Responsible for day-to-day operations of behavioral health functions for all MCP lines of business, recruitment of behavioral health staff, and oversight of clinical supervision staff.
- Develop and monitor behavioral health policies and procedures.
- Oversee annual Organization Financial Review and CMS audit for all behavioral health standards and regulations.
- Work to integrate behavioral and physical health services to improve healthcare outcomes.

Publications

Breitborde, N., Labreque, L., Moe, A., Gary, T., & Meyer, M. (2018). Community-Academic Partnership: Establishing the Institute for Mental Health Research Early Psychosis Intervention Center, Psychiatric Services, 69(5), 505-507.

CYNTHIA LEACH

ALTCS Administrator

Professional Summary

With more than 35 years of health care experience in Arizona, Cynthia is passionately dedicated to the effective administration and delivery of quality care. Cynthia has experience with operational oversight for the ALTCS population, including actively directing and prioritizing work and operations of the organization. Her experience demonstrates a deep understanding of government and program requirements and compliance.

Experience

Mercy Care
ALTCS Administrator
2021 – Present

Mercy Care
Vice President, Long Term Care
2020–Present

- Develop, implement, and evaluate Long Term Care (LTC) program.
- Direct and oversee interventions and day-to-day interactions.
- Develop connections and partnerships in workforce development, home services, community-based services (HCBS), and institutional programs.
- Evaluate and assign resources to case management, health, social, cultural, and financial data to ensure effective cost and quality outcomes.
- Lead large case management department, ensuring cost-effective medical, and other related services, for individuals eligible for ALTCS services.
- Provide long-term behavioral health and case management services in accordance with the AHCCCS Medical Policy Manual.

CopperSands, Inc.
Owner/Chief Operations Office
1995 – 2020

- Provide oversight of operations in multiple assisted living communities, skilled nursing facilities (SNFs) and continuing care retirement communities in Arizona, Colorado, and Nevada with annual revenues over $30 million.
- Design, plan, and implement residential care business strategies, policies, and procedures.
- Negotiate contracts and provider reimbursement by cultivating professional partnerships with health plans, government agencies and other business associates.
- Use clinical and administrative skills to ensure the financial and operational viability of facilities across the continuum of care, including independent living, assisted living and skilled nursing.

Life Centers of America
Total Quality Manager and Director of Nursing
1985 – 1995

- Provide total quality management and clinical leadership on a national level for over 20 SNFs.
- Serve as Director of Nursing for 196 bed SNF.

Key Qualifications

- Engages in direct, impactful collaboration with AHCCCS as the CEO of the ALTCS population
- Exercises comprehensive oversight over ALTCS contract operations and maintains accountability to federal and state regulatory bodies, ensuring adherence to all requirements and obligations

Licensure & Certification

- Licensed Nursing Home Administrator in the State of Arizona
- Assisted Living Manager in the State of Arizona
- Registered Nurse in the State of Arizona

Education & Training

- Bachelor of Science, Health Administration (University of Phoenix)
- Associate Degree, Nursing (Des Moines Area Community College)

BLYTHE FITZHARRIS, PH.D.

Chief Clinical Officer & Interim Office of Individual and Family Affairs Administrator

Professional Summary

Blythe is the Chief Clinical Officer with Mercy Care and Interim Office of Individual and Family Affairs Administrator (OIFA). With more than 20 years of experience in Arizona, Blythe forges strong partnerships with individuals, families, youth, and key stakeholders in her mission to promote recovery, resiliency, and wellness. She drives strategy to address health related social needs and coordinates with system stakeholders, advocates and works across the organization to address member and family feedback and facilitates and establishes the structure and mechanisms needed to increase member and family voice in and the development of clinical programs and service environments that are supportive, welcoming and recovery oriented.

Experience

Mercy Care

Interim OIFA Administrator

May 2023 – Present

- Oversee the Peer and Family Support Services by monitoring utilization reports and other avenues to monitor, track, and trend these services.
- Monitor and assist development of PROs and FROs as defined in the Arizona Health Care Cost Containment System (AHCCCS) Contract and Policy Dictionary.
- Create an OIFA Strategic Plan in alignment with the AHCCCS OIFA Strategic Plan.
- Collaborate with AHCCCS/DCAIR, Office of Individual and Family Affairs (OFIA) in projects and initiatives.
- Participate in projects, initiatives, and events with DDD Subcontracted Health Plan Individual and Family Affairs Administrators and AHCCCS/DCAIR, OIFA in projects, initiatives, and events.
- Coordinate with the AHCCCS Office of Human Rights, the Independent Oversight Committee (IOC) to provide information to regional IOCs.
- Collaborate with Contractor OIFAs to recognize and strengthen the interconnected provider relationships with health plans.

Chief Clinical Officer

2017 – Present

- Manage and oversee the System of Care.
- Develop and oversee clinical program development of large public health delivery systems, including adult and children's behavioral health systems of care and the Maricopa County Behavioral Health Crisis System.
- Collaborate with the Individual and Family Affairs committee, federal grants through SAMSHA, cultural diversity and tribal affairs initiatives, and other programs to address social determinants of health.
- Act as point of contact for coordination of care with system stakeholders including ADES/DDD, DCS/CMDP, Arizona Department of Justice, and other state agencies and collaborators.
- Ensure cross-departmental compliance with regulatory requirements.

Key Qualifications

- Executes OIFA activities in support of the AHCCCS OIFA mission and its strategic deliverables
- Drives key strategies and programs to address social determinates of health.
- Implements TIC service delivery approaches and pioneers other innovative initiatives

Licensure & Certification

- Arizona Licensed Clinical Social Worker (LCSW # 10542)

Education & Training

- Doctor of Philosophy in Social Welfare (Arizona State University)
- Master of Social Work (Arizona State University)
- Bachelor of Psychology (Mary Washington University)

Adult System of Care Administrator

2014 – 2017

- Lead all Adult Serious Mental Illness (SMI) services with an estimated population of 22,000 members for the Regional Behavioral Health Authority of Maricopa County which includes direct services, housing and rehabilitation, and employment services.
- Oversee network sufficiency, including access to quality care, addressing network gaps, and developing programs.
- Assist in the implementation of integrated care and payment reform, which includes identification and implementation of contract payment models and value-based contracting.

PSA Behavioral Health Agency

Chief Clinical Officer

2012 – 2014

- Provide clinical oversight to all programs operated by PSA Behavioral Health Agency.
- Monitor program outcomes, accreditation standards and program operations to ensure compliance.
- Supervise and guide clinical staff in day-to-day service delivery and training needs.
- Assist in program expansion through collaboration with external and internal departments.

Arlington County Department of Mental Health

Program Director for Assertive Community Treatment

2010 – 2012

- Provide day-to-day oversight of and training for clinical and administrative operations.
- Conduct individual and group supervision.
- Coordinate day-to-day activities to ensure client needs were met.
- Review treatment and assessment documentation.
- Review and complete monthly chart audits, reviews, and trend findings.

SANDRA WENDT

Vice President of Quality Management

Professional Summary

Sandra is an innovative and versatile leader with over 20 years' experience in healthcare managing large scale teams and projects, building, and executing strategies, collaborating with a variety of operational areas, improving team performance and reengineering business processes.

Experience

Mercy Care

Vice President of Quality Management

2018 – Present

- Develops and implements Quality Assessment and Performance Improvement (QAPI) programs and policies.
- Maintains relationships with providers, facilities, plan sponsors, regulatory agencies.
- Partners in network development, product design, strategic planning.
- Continuously assesses the effectiveness of functional processes and leads progressive improvement initiatives applying principles of process excellence.
- Teaches, coaches, and mentors leadership and employees at all levels in quality improvement.
- Works closely with community partners such as the foster care system and juvenile justice system.
- Represents quality and continuous improvement for the executive team.

Mercy Maricopa

Quality Management Administrator

2014 – 2018

- Developed and managed clinical operations focused on improving clinical and financial outcomes, member engagement, and satisfaction.
- Served as liaison with regulatory and accrediting agencies and other health business units.
- Formulated and implemented strategies for achieving applicable department/unit metrics and provided operational direction.
- Developed, implemented, and evaluated policies and procedures, which met business needs across multiple business functions.
- Implemented and monitored business plan and oversaw any implementations or business transitions impacting service operations.
- Collaborated and partnered with other business areas across/within regions or segments and within other centralized corporate areas to ensure all workflow processes and interdependencies were identified and addressed on an ongoing basis.

Key Qualifications

- Knowledge of Quality Assessment and Performance Improvement (QAPI) programs
- Quality Improvement initiatives and quality monitoring tools, including the development of monitoring of performance metrics and outcome measures
- Possesses extensive experience with evidence-based practices such as trauma-informed care

Licensure & Certification

- Certified Professional in Healthcare Quality (CPHQ), July 2016

Education & Training

- Master of Education, Elementary Education (University of Phoenix 2004
- Bachelor of Social Work (Arizona State University 1994)

Magellan Health Services
Director of Quality Management
2009 – 2014

- Coordinated and supervised activities which ensured the agency's provision of quality services, promotion of continuous quality improvement and oversaw/monitored the agency's compliance with all applicable quality management requirements, including the *Arizona Department of Health Services (ADHS) / Division of Behavioral Health Services (DBHS), Bureau of Quality Management Operations (BQMO) Specifications Manual,* and the *Arizona Health Care Cost Containment (AHCCCS) Medical Policy Manual, Chapter 900.*
- Promoted improvement in the quality of care provided to members through established quality management and performance improvement processes, including the analysis and synthesis of medical record review data, outcomes data, provider dashboards and quality of care investigations.
- Ensured 100% compliance with ADHS/DBHS annual administrative review quality management standards over two years' time.
- Applied a root-cause analysis in collaboration with contracted providers to identify and implement targeted improvement actions to improve coordination of physical and behavioral health care performance measures required under the AHCCCS and ADHS/DBHS contract.
- Developed and implemented a comprehensive provider monitoring program to ensure timely access to covered services and appropriate care for vulnerable populations, including children with serious emotional disturbance and adults with serious mental illness (SMI).

Magellan Health Services
Regional Director
2008 – 2009

State of Arizona Department of Health Services
Arnold vs. ADHS Compliance Analyst/Project Manager
2006 – 2008

State of Arizona Department of Health Services
Compliance Analyst/Project Manager
2006 – 2008

YAMINIKRISHNA SABESAN, MD

Adult Healthcare Administrator

Professional Summary

Yaminikrishna is responsible for the design and oversight of the ACC, RBHA, and DDD lines of business and reports directly to the chief medical officer (CMO), confirming coordination of needed crisis services, addressing barriers to delivery of health care services, and guaranteeing coordination with system stakeholders. Expertise in medical and pharmacy management, care and utilization management, and quality improvement processes. Unique experience serving in both academic and administrative settings and delivering cross-cultural healthcare in India and Arizona.

Experience

Mercy Care

Adult Healthcare Administrator

10/1/2020 – Present

- Serves as the expert in strategic planning, informational technology, and QI process development.
- Provide strategic, innovative, creative strategies with a special emphasis on quintuple aim.

Associate Chief Medical Officer

2020 – Present

- Supports the CMO with clinical, medical management and quality management functions.
- Responsible for the oversight of Medical Director functions.
- Monitors performance for adult and children quality measures.
- Reviews quality of care cases.
- Peer reviews committee lead.
- Reviews utilization trends and oversees activities to improve performance.
- Coordinates with key stakeholders internally and externally.
- Address barriers to health delivery.

Banner University Health Plan

Medical Director

2005 – 2020

- Responsible for medical and quality management activities.
- Reviewed utilization management and pharmacy cases for criteria/medical necessity.
- Participated in IDT meetings for ALTCS as well as JOC meetings.
- Reviewed appeals for all lines of business.
- Participated in OAH/ ALJ hearings.
- Reviewed concurrent review and credentialing cases.
- Presented appropriate quality cases to peer committee.
- Reviewed mortality cases and HCAC cases regularly.
- Routinely communicate with community physicians and provided educational presentations to various audiences.

District Medical Group

Attending Physician

2005 – 2015

- Taught internal medicine residents both in hospital and clinical setting.
- Mentored for medical students from University of Arizona-Phoenix campus.
- Provided clinical care for patients in hospitals, nursing facilities and clinics.

Key Qualifications

- Board-certified Internal Medicine Physician

Licensure & Certification

- Arizona Medical License (active)

Education & Training

- Mini-MBA in Healthcare (University of Arizona-Eller Executive Education)
- Internal Medicine Residency (Maricopa Integrated Health System)
- MD (BJMC)
- MBBS (Stanley Medical College)

- Was Medical Director for the Comprehensive Health Clinic at MIHS and oversaw all physician and clinic performance.
- Held quality and performance improvement committee clinical lead.
- Provided educational presentations to various audiences.
- Routinely communicated with other physicians in the system and community physicians.

Presentations

- "Medical Screening," Mortality and Morbidity Conference. Maricopa medical center, Phoenix, AZ, September 2005.
- "Quality and VBP update," Provider Offices, AZ, 2015–2020.
- "Value Based Programs and Outcomes," CMS Quality Conference, Baltimore, MD, January 2019.
- "COVID Update," ALTCS Member Council, Arizona, March 2021.
- "COVID Vaccine ", April 2021, Islamic Community Center, Phoenix, Arizona, USA.
- "Fostering Partnerships to Address Health Care Disparities," ACP Chapter Meeting, Phoenix, AZ, October 2021.

DENISE OCHOA-PUCHI

Case Management Administrator

Professional Summary

With 20 years of health care experience, Denise has a wealth of experience in case management administration. With a commitment to effective case management across diverse settings, she is responsible for compliance monitoring of AHCCCS mandated case management requirements. Since 2017 Denise has worked within case management at Mercy Care, where she has overseen and led large teams of case managers to ensure continuity of care for all members under the direction of case management supervisors.

Experience

Mercy Care

Case Management Administrator

2022 – Present

Long Term Care Case Management Manager

2020 – 2022

- Lead case management supervisors by using meticulous performance tracking systems.
- Establish seamless continuity across the case management unit.
- Collaborate with various Mercy Care departments, fostering enhanced communication to spearhead collaborative, multi-departmental projects, and proactively identify opportunities for continuous improvement.

Long Term Care Case Management Supervisor

2017 – 2020

- Direct and manage 14 case managers, ensuring the fulfillment of member needs by conducting rigorous case audits and offering hands-on guidance to staff.
- Conduct individual and team meetings to enhance understanding and improve performance of care case employees through audit and performance measurement.
- Serve as lead for specialty caseloads and support case managers through subject matter expertise.

UnitedHealthcare

Long Term Care Case Manager

2011 – 2017

- Assist in leading assigned case management team, assisted Case Management Manager (CMM) with support, team training.
- Mentor case managers to grow their training and knowledge of procedures.
- Provide case management to members enrolled in ALTCS.
- Conduct member visits in accordance with applicable rules and regulations and completed assessments for social, behavioral, medical, and functional needs to develop and implement appropriate and cost-effective service plans.

Pima Health System

Long Term Care Case Manager

2004 – 2011

- Mentor case managers to improve their knowledge of procedures.
- Maintain member records and documents in compliance with AHCCCS case management requirements.

Key Qualifications

- Monitor compliance of AHCCCS mandated case management requirements
- Engage in ALTCS Member Council meetings and ensure annual goals are met

Education & Training

- Bachelor of Science, Family and Consumer Resources (University of Arizona)

LORRY BOTRILL

President and Chief Executive Officer, Mercy Care

Professional Summary

Lorry is President and Chief Executive Officer for Mercy Care. She focuses on strategy, growth, and health plan performance. She is an expert in Health Plan finances and operations.

Experience

Mercy Care

President and Chief Executive Officer, Mercy Care

2018 – Present

- Direct responsibility for all operational and financial results for a Health Plan serving more than 468,000 Medicaid and Medicare Dual SNP members.
- Oversaw the implementations of the ACC, RBHA, DDD, and DCS including directing and prioritizing work.
- Accountable to regulators for compliance with contract requirements.

Chief Operating Officer

2010 – 2018

- Responsible for all operational results including appeals, Dual SNP product and sales, ALTCS case management, network management, enrollment, and provider relations.
- Executive lead for the Strategic Development Committee collaborating with the Mercy Care board of directors to support Health Plan Initiatives.

Chief Financial Officer

2008 – 2010

- Responsible for all financial results including budgeting and forecasting to improve financial performance of Health Plan serving more than 350,000 Medicaid and Medicare Dual SNP members.

Health Net

Regional Finance Officer

2007 – 2008

- Responsible for forecasting and budgeting Arizona Health Plan with over $1 Billion in Revenue with 200,000 fully-insured commercial and Medicare members.
- Led the Finance team for the national Senior Products Division, including Private-Fee-For-Service and Part D only membership, representing over $600 Million in revenue and 500,000 members.

Pacificare/United Healthcare

Vice President, Network Management

2006 – 2007

- Responsible for managing internal business unit contracting efforts to provide marketable provider networks for Medicare members at competitive price points.

Senior Program Director, Customer Service

2006– 2006

- Responsible for leading member and provider call centers in multi-state locations with over 500 FTE's including vendor management for outsourced calls.

Key Qualifications

- Health Plan financial and operational expert
- Knowledge of challenges impacting Medicaid and Medicare Dual SNP members
- Knowledge of Health Plan network building and contracting best practices

Licensure & Certification

- Arizona Certified Public Accountant (8818)

Education & Training

- Bachelor of Science (University of Arizona)

Vice President, Operations

2003 – 2005

- Responsible for over 600 employees providing claims, customer service, billing and enrollment services for the Arizona, Nevada and Colorado markets with HMO, PPO and ASO business.
- Executive sponsor and key project lead for system conversion completed within twelve months for 200,000 senior HMO members, involving over 400 Business and IT employees.

Various Progressive Positions

1994 – 2003

- Progressive positions including Director of Strategic Development, Director of Network Management, Director of Finance Operations, Accounting Manager, Finance Manager.

GAGANDEEP SINGH, MD, F.A.P.A.

Medical Director/Chief Medical Officer

Professional Summary

Gagandeep is the Medical Director and Chief Medical Officer for Mercy Care. He is skilled in managing contract compliant physical health and behavioral health services. He actively collaborates with leaders across the Health Plan to design infrastructure and procure staffing resources to ensure all contract services are available and integrated within the organization.

Experience

Mercy Care
Medical Director/Chief Medical Officer
2021 – Present

- Directly responsible for all clinical performance measurements, quality of care, quality improvement, member and provider complaints, credentialing, adverse actions, utilization management, and fair hearing processes in a manner that brings consistency, fairness, and resolution, while increasing the respect for the plan among community physicians.
- Maintains top-tier quality ranking among peer health plans through achievement of high performance in and improvements of HEDIS, CMS Star, and other State-directed performance measurement processes.
- Contributes to network development and contracting initiatives.
- Directs value-based purchasing initiatives.

Banner Health
Chief Medical Officer, Behavioral Health Service Line
2015 – 2021

- Provided clinical care in multiple settings including inpatient adult and detoxification units, crisis, C/L, ECT, and tele-psychiatry.
- Led significant improvements in quality and core measures across the service line.
- Built payer and community partnerships for enhanced operational performance.
- Spearheaded initiatives in reduction of ED behavioral health holds with drop in average ED hold time for adults from 21.1 hours (2015) to 12.1 hours (2020).

Banner Medical Group
Chairman, Department of Behavioral Health
2013 – 2015

- Provided operational and clinical leadership to behavioral health department with over 40 providers including psychiatrists, psychologists, and nurse practitioners.
- Responsible for rebuilding provider teams and reducing costs.
- Spearheaded programs in tele-psychiatry leading to initiation of tele behavioral service with 24/7 coverage for emergency departments.
- Spearheaded pilots in primary care integration with health psychology demonstrating improved depression and diabetes management.

Key Qualifications

- Health Plan physical and behavioral health expert
- Active medical license in three states
- Knowledge of contract requirements

Licensure & Certification

- Arizona Medical License (48443)
- Colorado Medical License (DR.0056600)
- Pennsylvania Medical License (MD469170)
- Diplomate of the American Board of Psychiatry and Neurology in the specialty of Psychiatry
- Diplomate of the American Board of Psychiatry and Neurology in the subspecialty of Psychosomatic Medicine
- Diplomate of the American Board of Preventative Medicine in Addiction Medicine

Education & Training

- Psychiatry Residency (Mayo Clinic)
- Bachelor of Medicine and Surgery (University of Delhi)

Inova Health System

Associate Medical Director, Behavioral Health Service Line

2011 – 2013

- Integrated clinical operations encompassing 84 inpatient psychiatry beds, 18 detox beds, ambulatory care, psychiatry PHPs, and addictions IOPs across 3 different sites.
- Spearheaded new EMR roll out (EPIC) in behavioral health.
- Designed a new crisis assessment center and tele behavioral services.

University of Utah

Assistant Professor, Department of Psychiatry

2005 – 2011

Ellsworth Municipal Hospital/Mercy Medical Center North Iowa

Staff Psychiatrist and Medical Director

2001–2005

CHAD C. CORBETT

Director of Strategic Planning

Professional Summary

Chad is the Director of Strategic Planning for Mercy Care. He focuses on developing, implementing, overseeing, and evaluating all aspects of the Long-Term Care program. Chad is an expert in developing innovative programs for elderly and physically disabled populations. In addition, Chad is experienced in case management, program design, and advocacy.

Experience

Mercy Care

Director of Strategic Planning

2020 – Present

- Coordinate and prepare ALTCS strategic initiatives for statewide growth.
- Coordinate analytical support of the business plan process that includes the development of a comprehensive market assessment and incorporating collective input from facilities and senior executives as part of the process to create the strategic plan.
- Conduct ad-hoc research and analysis in support of the expansion.
- Serve as point of contact and resource for operational and financial insights, as well as data-driven recommendations for growth.

Vice President, Long-Term Care

2009 – 2020

- Developed, implemented, oversaw, and evaluated Mercy Care Plan long term care program.
- Over fifteen years of management/supervisory experience in the health care field.
- Developed connections and partnerships in the area of workforce development, HCBS program operations and institutional transitions.

Key Qualifications

- Health Plan Long-Term Care expert
- Skilled in implementing programs that impact elderly and disabled populations
- Knowledge of Value-Based programs, case management, and program design

Education & Training

- Master of Public Administration (Western International University)
- Bachelor of Science (University of Arizona)

Board Memberships

- Alzheimer's Association, Desert Southwest Chapter

Manager, Case Management

2006 – 2009

- Managed case management services staff including the organization and development of high performing teams.
- Evaluated case management and financial data and assigned resources accordingly to ensure cost effective quality outcomes.
- Provided feedback to the business segments on ALTCS and its integration into medical services and prepared monthly and quarterly utilization reports.
- Assessed developmental department needs and collaborated with others to identify and implemented action plans that supported the development of high performing teams.

Supervisor, Case Management

2004 – 2006

- Implemented day-to-day case management services, including recruiting, hiring, and training new case managers.

Maricopa Long-Term Care

Case Management Manager

2000 – 2004

- Responsible for training, mentoring, supervising, and evaluating case management staff.
- Conducted cost benefit analyses to ensure cost effective use of resources to meet client and member needs.

- Trained contracted providers to uphold quality standards.
- Provided consultation and interventions to assure all responsibilities to ALTCS clients and families were met.

Program Coordinator/Trainer
1998 – 2000
- Led the ALTCS alternative residential programs.
- Responsible for special project assignments including data analysis and database management.
- Conducted case management audits and compiled audit results.

Case Manager II
1995 – 1998
- Led the ALTCS alternative residential programs.

Yavapai County Long-Term Care
Case Manager II
1993 – 1995
- Case Manager for ALTCS EPD Program.

Meeting the Challenge — Home for Boys
Executive Director
1990 – 1993
- Therapeutic Foster Home.
- Family based placement option for children with serious emotional, behavioral needs.

Yavapai Big Brothers/Big Sisters
Case Manager II
1989 – 1990
- Case Manager.
- Responsible for matching children with mentors.

CHRISTIE MACMURRAY

Director/Adult System of Care Administrator

Professional Summary

Christie is the Director/Adult System of Care Administrator for Mercy Care. She is an expert in providing support for adult system of care members including housing, supported employment, substance use treatment, and integrated care.

Experience

Mercy Care

Director/Adult System of Care Administrator

2015 – Present

- Directly responsible for the Adult System of Care Team, which focuses on housing, supported employment, assertive community treatment, substance use treatment, outpatient behavioral health, and integrated care.
- Accountable for regulatory, financial, value-based, clinical, provider oversight, and marketing program aspects.

Crisis Preparation and Recovery

Evaluator and Crisis Counselor

2014 – 2015

- Provided crisis consultation services in emergency room settings and medical floors.
- Completed behavioral health and risk assessment treatment recommendations.
- Coordinated higher level of care and/or discharge to community-based services.
- Completed assessments of and referrals to state agencies for individuals who qualified for a specialized Medicaid program for those determined seriously mentally ill.

Choices Network

Clinical Director

2008 – 2014

- Oversaw clinically appropriate outpatient behavioral health services for more than 1,500 members determined seriously mentally ill.
- Responsible for staff compliance with Medicaid and regulatory guidelines and requirements.
- Facilitated the integration of the recovery philosophy for persons determined seriously mentally ill into everyday clinical practices and operations.

Key Qualifications

- Health Plan adult system of care expert
- Knowledge of adult system of care supports

Licensure & Certification

- Arizona Licensed Master Social Worker (LMSW-14041)

Education & Training

- Master of Social Work (Arizona State University)
- Master of Criminal Justice (Arizona State University)
- Bachelor of Science (Arizona State University)

COLLEEN SOEDER, RN

Performance and Quality Improvement Coordinator

Professional Summary

Colleen is the Performance and Quality Improvement Coordinator for Mercy Care. She is an expert in process improvement, clinical quality performance measures, performance improvement plans, and analyzing data to develop and implement outcome improvement intervention strategies.

Experience

Mercy Care

Performance and Quality Improvement Coordinator

2011 – Present

- Leader for a highly regarded Medicaid Quality organization in Arizona.
- Oversight and management of the annual HEDIS® medical record audit.
- Management of population health quality improvement programs for Medicare dual-eligible, Medicaid, LTSS, I/DD members and members diagnosed with a Serious Mental Illness (SMI).
- Drive continuous quality improvement (CQI) throughout the system of care, resulting in improved member, family, and provider experiences; increased timely access and satisfaction; maximized program efficiency while limiting operational costs; and continuous advancements in health and quality outcomes with an emphasis on efficacy and responsiveness.
- Implementation of interventions which resulted in significant improvements in Medicaid performance measures, Medicare HEDIS®, STAR, CAHPS and HOS measures.
- Collaboration with senior leadership to ensure that CQI is a core value throughout the organization beginning with and supported by plan sponsors and executive leaders.
- Implementation of impactful member and provider interventions to address gaps in care; identification of best practices.
- Analysis of data and survey results to identify opportunities for improvement.
- Promotion of continuous quality improvement by leading the interdisciplinary Quality Improvement Committee
- Oversight of over two hundred fifty Medicaid performance measures.
- Management of the EPSDT and Maternal Child Health programs.
- Data reporting related to HEDIS® measure, contract performance measures and other quality initiatives.
- Management of over 40 employees, including managers, project managers and call center staff, through direct and indirect reporting relationships.

Registered Nurse, Quality Management Nurse Consultant

2009 – 2011

- Improvement in HEDIS® rates for AHCCCS and CMS performance measures through management and oversight of a variety of interventions.
- Participation in the annual HEDIS® medical record audit.
- Management of member and provider interventions related to maternal child health and women's health.
- Coordination of Mercy Care Plan's participation in multiple community health fairs.

Reading Hospital and Medical Center

Registered Nurse, Assistant Nurse Manager, Surgical Specialty Trauma Unit

2008 – 2008

- Facilitation of growth and change among the staff and unit, allowing for the highest level of patient care.

Key Qualifications

- Health Plan Performance and Quality Improvement expert
- Knowledge of process improvement and performance improvement plans
- Experienced Registered Nurse

Licensure & Certification

- Registered Nurse (RN154425)

Education & Training

- Associate of Science (Gwynedd Mercy College)

- Initiation of changes to improve patient flow, including redesigning the role of the unit facilitator and restructuring the unit's shared governance model.
- Provision of educational support to unit staff, allowing the unit the ability to open the hospital's first Progressive Care beds.
- Review and analysis of Press-Ganey survey results, identification of target opportunities for improvement and design and implementation of corrective action plan.

Grandview Hospital

Graduate Nurse, Registered Nurse

2003 – 2007

- Acquisition of a significant amount of clinical knowledge through a variety of experiences.
- Management of assignments of three to five patients, including those requiring wound care, long-term ventilators, and multiple cardiac drips, including Nitroglycerin, Integrillin and Cardizem.
- Functioning as the charge nurse where the responsibilities included managing admissions, working with the house supervisor to facilitate the moving of patients, acting as a resource to the nurses on the unit, and modeling to them how to keep a level head during emergency situations.
- Acting as a transport nurse on emergent and routine inter-hospital transports, and participation in rapid response and code blue situations.
- Triaging, assessing, and treating urgent and emergent patients in the hospital’s emergency department.

MIKE CUNNINGHAM

ALTCS Program Manager

Professional Summary

Support Mercy Care Training Program goals by leading a large staff in the design of new processes, training and implementation of programs, and auditing and reporting of both internal and external deliverables ensuring member needs are met or exceeded. Collaborate with other Mercy Care departments providing mentorship, training, and support of AHCCCS behavioral health (BH) and mandated case management requirements.

Experience

Mercy Care

ALTCS Program Manager

2019 – Present

- Oversee the Mercy Care Training Program for both newly hired staff and ongoing refresher training for existing staff. Supervise the training staff and support training design and implementation.
- Lead the team of ALTCS project managers and support the research, design, development, and implementation of all initiatives across the department.
- Oversee departmental support staff related to data entry, report production, analysis, and reporting for deliverables.
- Collaborate with Mercy Care departments to enhance communication, collaborate on multi-departmental projects, and identify opportunities for improvement.

ALTCS Project Manager

2017 – 2019

- Developed and facilitated the annual BH Provider presentation.
- Attended AHCCCS workgroups such as Agency with Choice and PCSP.
- Supported projects related to member electronic charts and documentation platforms.
- Supported departmental trainers as needed.

Long Term Care Trainer

2012 – 2017

- Facilitated monthly new hire trainings.
- Conducted ad hoc trainings per departmental need.
- Conducted post training audits with new case managers.
- Developed and implemented training processes for any initiatives and incorporated into the job flow for all staff.
- Maintained attendance records and documents in compliance with AHCCCS case management requirements.

Long Term Care Case Manager

2009 – 2012

- Mentored case managers individually to assist with their training and knowledge of procedures.
- Provided case management to members enrolled in ALTCS, with experience in HCBS and SNF settings.
- Conducted member visits in accordance with applicable rules and regulations and completed assessments for social, behavioral, medical, and functional needs to develop and implement appropriate and cost-effective service plans.

Key Qualifications

- Participate in AHCCCS related workgroups
- 14 plus years of Mercy Care knowledge and experience
- Supported the implementation of critical projects which include Dynamo, Person-Centered Service Planning, Licensed Health Aid Service, interRAI Assessment tool
- Development and oversight of Mercy Paws

Education & Training

- Bachelor of History/Political Science and Education (Arkansas Tech University)

Part C

C1 - Agreement Accepting Capitation Rates

The Offeror shall submit an agreement that the Offeror will accept the actuarially sound capitation rates computed prior to October 1, 2024. The agreement shall be signed by the Offeror's Chief Executive Officer. **This is a required submission.**

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

Administrative and case management cost components will be bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides.

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

As a requirement of the capitation submission for the AHCCCS Arizona Long Term Care System (ALTCS) Program, Mercy Care agrees to accept actuarially sound capitation rates computed prior to October 1, 2024.

MERCY CARE

Lorry Bottrill
Lorry Bottrill (Sep 11, 2023 07:10 PDT)

Signature

Lorry S Bottrill
Printed Name

President and Chief Executive Officer
Title

09/11/23
Date

AHCCCS
Arizona Health Care Cost Containment System

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Input fields
Formula driven fields

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.48	$ 376,298	$ 47.08	$ 389,468	$ 48.72	$ 403,100	$ 50.43	$ 417,208	$ 52.19	$ 431,810
Occupancy	$ 0.43	$ 603,835	$ 0.44	$ 624,969	$ 0.46	$ 646,843	$ 0.47	$ 669,483	$ 0.49	$ 692,915
Depreciation	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -
Care Management/Care Coordination	$ 10.45	$ -	$ 10.81	$ -	$ 11.19	$ -	$ 11.58	$ -	$ 11.99	$ -
Professional and Outside Services	$ 85.99	$ -	$ 89.00	$ -	$ 92.11	$ -	$ 95.33	$ -	$ 98.67	$ -
Office Supplies and Equipment	$ 7.16	$ -	$ 7.41	$ -	$ 7.67	$ -	$ 7.94	$ -	$ 8.22	$ -
Travel	$ 0.82	$ -	$ 0.85	$ -	$ 0.88	$ -	$ 0.91	$ -	$ 0.94	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ 1.23	$ -	$ 1.27	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.41	$ -
Insurance	$ 0.86	$ -	$ 0.89	$ -	$ 0.92	$ -	$ 0.95	$ -	$ 0.99	$ -
Marketing	$ 0.87	$ -	$ 0.90	$ -	$ 0.93	$ -	$ 0.96	$ -	$ 1.00	$ -
Interest Expense	$ 1.59	$ -	$ 1.65	$ -	$ 1.71	$ -	$ 1.77	$ -	$ 1.83	$ -
Pharmacy Benefit Manager Expenses	$ 2.88	$ -	$ 2.98	$ -	$ 3.09	$ -	$ 3.19	$ -	$ 3.31	$ -
Fraud Reduction Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health Care Quality Improvement	$ 10.96	$ -	$ 11.34	$ -	$ 11.74	$ -	$ 12.15	$ -	$ 12.57	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 1.36	$ -	$ 1.40	$ -	$ 1.45	$ -	$ 1.50	$ -	$ 1.56	$ -
Other Administrative Expenses [2]	$ 0.69	$ -	$ 0.71	$ -	$ 0.74	$ -	$ 0.76	$ -	$ 0.79	$ -
Total Admin Costs	$ 170.76	$ 980,133	$ 176.74	$ 1,014,437	$ 182.92	$ 1,049,943	$ 189.33	$ 1,086,691	$ 195.95	$ 1,124,725

Member Months Assumed in Bid		17,500		17,675		17,852		18,030		18,211

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.
2) If "Other Administrative Expenses" is greater than 5% of the total then please provide a detailed list describing what's included, with amounts.

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Input fields
Formula driven fields

ALTCS-EPD Administrative Component Bid										
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Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.48	$ 376,298	$ 47.08	$ 389,468	$ 48.72	$ 403,100	$ 50.43	$ 417,208	$ 52.19	$ 431,810
Occupancy	$ 0.43	$ 603,835	$ 0.44	$ 624,969	$ 0.46	$ 646,843	$ 0.47	$ 669,483	$ 0.49	$ 692,915
Depreciation	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -
Care Management/Care Coordination	$ 10.45	$ -	$ 10.81	$ -	$ 11.19	$ -	$ 11.58	$ -	$ 11.99	$ -
Professional and Outside Services	$ 85.99	$ -	$ 89.00	$ -	$ 92.11	$ -	$ 95.33	$ -	$ 98.67	$ -
Office Supplies and Equipment	$ 7.16	$ -	$ 7.41	$ -	$ 7.67	$ -	$ 7.94	$ -	$ 8.22	$ -
Travel	$ 0.82	$ -	$ 0.85	$ -	$ 0.88	$ -	$ 0.91	$ -	$ 0.94	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ 1.23	$ -	$ 1.27	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.41	$ -
Insurance	$ 0.86	$ -	$ 0.89	$ -	$ 0.92	$ -	$ 0.95	$ -	$ 0.99	$ -
Marketing	$ 0.87	$ -	$ 0.90	$ -	$ 0.93	$ -	$ 0.96	$ -	$ 1.00	$ -
Interest Expense	$ 1.59	$ -	$ 1.65	$ -	$ 1.71	$ -	$ 1.77	$ -	$ 1.83	$ -
Pharmacy Benefit Manager Expenses	$ 2.88	$ -	$ 2.98	$ -	$ 3.09	$ -	$ 3.19	$ -	$ 3.31	$ -
Fraud Reduction Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health Care Quality Improvement	$ 10.96	$ -	$ 11.34	$ -	$ 11.74	$ -	$ 12.15	$ -	$ 12.57	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 1.36	$ -	$ 1.40	$ -	$ 1.45	$ -	$ 1.50	$ -	$ 1.56	$ -
Other Administrative Expenses [2]	$ 0.69	$ -	$ 0.71	$ -	$ 0.74	$ -	$ 0.76	$ -	$ 0.79	$ -
Total Admin Costs	$ 170.76	$ 980,133	$ 176.74	$ 1,014,437	$ 182.92	$ 1,049,943	$ 189.33	$ 1,086,691	$ 195.95	$ 1,124,725
Member Months Assumed in Bid		52,500		53,025		53,555		54,091		54,632

Footnotes:

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ALTCS-EPD Administrative Component Bid										
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Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.48	$ 376,298	$ 47.08	$ 389,468	$ 48.72	$ 403,100	$ 50.43	$ 417,208	$ 52.19	$ 431,810
Occupancy	$ 0.43	$ 603,835	$ 0.44	$ 624,969	$ 0.46	$ 646,843	$ 0.47	$ 669,483	$ 0.49	$ 692,915
Depreciation	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -
Care Management/Care Coordination	$ 10.45	$ -	$ 10.81	$ -	$ 11.19	$ -	$ 11.58	$ -	$ 11.99	$ -
Professional and Outside Services	$ 85.99	$ -	$ 89.00	$ -	$ 92.11	$ -	$ 95.33	$ -	$ 98.67	$ -
Office Supplies and Equipment	$ 7.16	$ -	$ 7.41	$ -	$ 7.67	$ -	$ 7.94	$ -	$ 8.22	$ -
Travel	$ 0.82	$ -	$ 0.85	$ -	$ 0.88	$ -	$ 0.91	$ -	$ 0.94	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ 1.23	$ -	$ 1.27	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.41	$ -
Insurance	$ 0.86	$ -	$ 0.89	$ -	$ 0.92	$ -	$ 0.95	$ -	$ 0.99	$ -
Marketing	$ 0.87	$ -	$ 0.90	$ -	$ 0.93	$ -	$ 0.96	$ -	$ 1.00	$ -
Interest Expense	$ 1.59	$ -	$ 1.65	$ -	$ 1.71	$ -	$ 1.77	$ -	$ 1.83	$ -
Pharmacy Benefit Manager Expenses	$ 2.88	$ -	$ 2.98	$ -	$ 3.09	$ -	$ 3.19	$ -	$ 3.31	$ -
Fraud Reduction Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health Care Quality Improvement	$ 10.96	$ -	$ 11.34	$ -	$ 11.74	$ -	$ 12.15	$ -	$ 12.57	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 1.36	$ -	$ 1.40	$ -	$ 1.45	$ -	$ 1.50	$ -	$ 1.56	$ -
Other Administrative Expenses [2]	$ 0.69	$ -	$ 0.71	$ -	$ 0.74	$ -	$ 0.76	$ -	$ 0.79	$ -
Total Admin Costs	$ 170.76	$ 980,133	$ 176.74	$ 1,014,437	$ 182.92	$ 1,049,943	$ 189.33	$ 1,086,691	$ 195.95	$ 1,124,725
Member Months Assumed in Bid		87,500		88,375		89,259		90,151		91,053

Footnotes:

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Formula driven fields

ALTCS-EPD Administrative Component Bid

Detail Admin Break Out [1]	CYE 25 (10/1/24 - 9/30/25) Variable Cost PMPM	CYE 25 (10/1/24 - 9/30/25) Fixed Cost Total Dollars	CYE 26 (10/1/25 - 9/30/26) Variable Cost PMPM	CYE 26 (10/1/25 - 9/30/26) Fixed Cost Total Dollars	CYE 27 (10/1/26 - 9/30/27) Variable Cost PMPM	CYE 27 (10/1/26 - 9/30/27) Fixed Cost Total Dollars	CYE 28 (10/1/27 - 9/30/28) Variable Cost PMPM	CYE 28 (10/1/27 - 9/30/28) Fixed Cost Total Dollars	CYE 29 (10/1/28 - 9/30/29) Variable Cost PMPM	CYE 29 (10/1/28 - 9/30/29) Fixed Cost Total Dollars
Compensation	$ 45.48	$ 376,298	$ 47.08	$ 389,468	$ 48.72	$ 403,100	$ 50.43	$ 417,208	$ 52.19	$ 431,810
Occupancy	$ 0.43	$ 603,835	$ 0.44	$ 624,969	$ 0.46	$ 646,843	$ 0.47	$ 669,483	$ 0.49	$ 692,915
Depreciation	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -
Care Management/Care Coordination	$ 10.45	$ -	$ 10.81	$ -	$ 11.19	$ -	$ 11.58	$ -	$ 11.99	$ -
Professional and Outside Services	$ 85.99	$ -	$ 89.00	$ -	$ 92.11	$ -	$ 95.33	$ -	$ 98.67	$ -
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Travel	$ 0.82	$ -	$ 0.85	$ -	$ 0.88	$ -	$ 0.91	$ -	$ 0.94	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ 1.23	$ -	$ 1.27	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.41	$ -
Insurance	$ 0.86	$ -	$ 0.89	$ -	$ 0.92	$ -	$ 0.95	$ -	$ 0.99	$ -
Marketing	$ 0.87	$ -	$ 0.90	$ -	$ 0.93	$ -	$ 0.96	$ -	$ 1.00	$ -
Interest Expense	$ 1.59	$ -	$ 1.65	$ -	$ 1.71	$ -	$ 1.77	$ -	$ 1.83	$ -
Pharmacy Benefit Manager Expenses	$ 2.88	$ -	$ 2.98	$ -	$ 3.09	$ -	$ 3.19	$ -	$ 3.31	$ -
Fraud Reduction Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health Care Quality Improvement	$ 10.96	$ -	$ 11.34	$ -	$ 11.74	$ -	$ 12.15	$ -	$ 12.57	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 1.36	$ -	$ 1.40	$ -	$ 1.45	$ -	$ 1.50	$ -	$ 1.56	$ -
Other Administrative Expenses [2]	$ 0.69	$ -	$ 0.71	$ -	$ 0.74	$ -	$ 0.76	$ -	$ 0.79	$ -
Total Admin Costs	$ 170.76	$ 980,133	$ 176.74	$ 1,014,437	$ 182.92	$ 1,049,943	$ 189.33	$ 1,086,691	$ 195.95	$ 1,124,725
Member Months Assumed in Bid		122,500		123,725		124,962		126,212		127,474

Footnotes:

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

AHCCCS
Arizona Health Care Cost Containment System

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

Input fields
Formula driven fields

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.48	$ 376,298	$ 47.08	$ 389,468	$ 48.72	$ 403,100	$ 50.43	$ 417,208	$ 52.19	$ 431,810
Occupancy	$ 0.43	$ 603,835	$ 0.44	$ 624,969	$ 0.46	$ 646,843	$ 0.47	$ 669,483	$ 0.49	$ 692,915
Depreciation	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -
Care Management/Care Coordination	$ 10.45	$ -	$ 10.81	$ -	$ 11.19	$ -	$ 11.58	$ -	$ 11.99	$ -
Professional and Outside Services	$ 85.99	$ -	$ 89.00	$ -	$ 92.11	$ -	$ 95.33	$ -	$ 98.67	$ -
Office Supplies and Equipment	$ 7.16	$ -	$ 7.41	$ -	$ 7.67	$ -	$ 7.94	$ -	$ 8.22	$ -
Travel	$ 0.82	$ -	$ 0.85	$ -	$ 0.88	$ -	$ 0.91	$ -	$ 0.94	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ 1.23	$ -	$ 1.27	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.41	$ -
Insurance	$ 0.86	$ -	$ 0.89	$ -	$ 0.92	$ -	$ 0.95	$ -	$ 0.99	$ -
Marketing	$ 0.87	$ -	$ 0.90	$ -	$ 0.93	$ -	$ 0.96	$ -	$ 1.00	$ -
Interest Expense	$ 1.59	$ -	$ 1.65	$ -	$ 1.71	$ -	$ 1.77	$ -	$ 1.83	$ -
Pharmacy Benefit Manager Expenses	$ 2.88	$ -	$ 2.98	$ -	$ 3.09	$ -	$ 3.19	$ -	$ 3.31	$ -
Fraud Reduction Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health Care Quality Improvement	$ 10.96	$ -	$ 11.34	$ -	$ 11.74	$ -	$ 12.15	$ -	$ 12.57	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 1.36	$ -	$ 1.40	$ -	$ 1.45	$ -	$ 1.50	$ -	$ 1.56	$ -
Other Administrative Expenses [2]	$ 0.69	$ -	$ 0.71	$ -	$ 0.74	$ -	$ 0.76	$ -	$ 0.79	$ -
Total Admin Costs	$ 170.76	$ 980,133	$ 176.74	$ 1,014,437	$ 182.92	$ 1,049,943	$ 189.33	$ 1,086,691	$ 195.95	$ 1,124,725
Member Months Assumed in Bid		157,188		158,760		160,348		161,951		163,571

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.
2) If "Other Administrative Expenses" is greater than 5% of the total then please provide a detailed list describing what's included, with amounts.

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Input fields
Formula driven fields

ALTCS-EPD Administrative Component Bid										
	CYE 25 (10/1/24 - 9/30/25)		CYE 26 (10/1/25 - 9/30/26)		CYE 27 (10/1/26 - 9/30/27)		CYE 28 (10/1/27 - 9/30/28)		CYE 29 (10/1/28 - 9/30/29)	
Detail Admin Break Out [1]	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**	Variable Cost **PMPM**	Fixed Cost Total **Dollars**
Compensation	$ 45.48	$ 376,298	$ 47.08	$ 389,468	$ 48.72	$ 403,100	$ 50.43	$ 417,208	$ 52.19	$ 431,810
Occupancy	$ 0.43	$ 603,835	$ 0.44	$ 624,969	$ 0.46	$ 646,843	$ 0.47	$ 669,483	$ 0.49	$ 692,915
Depreciation	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -	$ 0.00	$ -
Care Management/Care Coordination	$ 10.45	$ -	$ 10.81	$ -	$ 11.19	$ -	$ 11.58	$ -	$ 11.99	$ -
Professional and Outside Services	$ 85.99	$ -	$ 89.00	$ -	$ 92.11	$ -	$ 95.33	$ -	$ 98.67	$ -
Office Supplies and Equipment	$ 7.16	$ -	$ 7.41	$ -	$ 7.67	$ -	$ 7.94	$ -	$ 8.22	$ -
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Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ 1.23	$ -	$ 1.27	$ -	$ 1.32	$ -	$ 1.36	$ -	$ 1.41	$ -
Insurance	$ 0.86	$ -	$ 0.89	$ -	$ 0.92	$ -	$ 0.95	$ -	$ 0.99	$ -
Marketing	$ 0.87	$ -	$ 0.90	$ -	$ 0.93	$ -	$ 0.96	$ -	$ 1.00	$ -
Interest Expense	$ 1.59	$ -	$ 1.65	$ -	$ 1.71	$ -	$ 1.77	$ -	$ 1.83	$ -
Pharmacy Benefit Manager Expenses	$ 2.88	$ -	$ 2.98	$ -	$ 3.09	$ -	$ 3.19	$ -	$ 3.31	$ -
Fraud Reduction Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health Care Quality Improvement	$ 10.96	$ -	$ 11.34	$ -	$ 11.74	$ -	$ 12.15	$ -	$ 12.57	$ -
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interpretation/Translation Services	$ 1.36	$ -	$ 1.40	$ -	$ 1.45	$ -	$ 1.50	$ -	$ 1.56	$ -
Other Administrative Expenses [2]	$ 0.69	$ -	$ 0.71	$ -	$ 0.74	$ -	$ 0.76	$ -	$ 0.79	$ -
Total Admin Costs	$ 170.76	$ 980,133	$ 176.74	$ 1,014,437	$ 182.92	$ 1,049,943	$ 189.33	$ 1,086,691	$ 195.95	$ 1,124,725
Member Months Assumed in Bid		192,188		194,110		196,051		198,012		199,992

Footnotes:

1) Case Manager Costs will be reflected in the Offerors Case Management Bid Component which can be found on tab "Case Management Bid" in this workbook.
2) If "Other Administrative Expenses" is greater than 5% of the total then please provide a detailed list describing what's included, with amounts.

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ALTCS-EPD Case Management Component Bid										
	North GSA			Central GSA			South GSA			
Assumptions:	**Non-SMI**	**SMI**	**Total**	**Non-SMI**	**SMI**	**Total**	**Non-SMI**	**SMI**	**Total**	
Number of ALTCS-EPD enrollment: [1]	2,194	171	2,365	5,375	463	5,838	2,856	256	3,113	
Institutional Mix %: [1]	28.8%	26.5%	28.7%	19.6%	33.9%	20.7%	25.6%	38.7%	26.6%	
Acute Care Only Mix %: [1]	2.9%	1.4%	2.8%	3.0%	0.9%	2.8%	1.7%	1.1%	1.6%	
Alternative Home and Community Bases Service (HCBS) Mix %: [1]	23.0%	33.7%	23.7%	29.4%	42.1%	30.4%	21.6%	33.0%	22.6%	
HCBS (own home) Mix %: [1]	45.3%	38.4%	44.8%	48.0%	23.1%	46.1%	51.1%	27.2%	49.2%	
Average Case Management Manager total compensation (includes ERE)	$ 88,072	$ 88,072	$ 88,072	$ 89,036	$ 89,036	$ 89,036	$ 88,072	$ 88,072	$ 88,072	
Average Case Management Supervisor total compensation (includes ERE)	$ 106,009	$ 106,009	$ 106,009	$ 114,681	$ 114,681	$ 114,681	$ 106,009	$ 106,009	$ 106,009	
Average Case Management Administration Support Staff total compensation (includes ERE)	$ 62,984	$ 62,984	$ 62,984	$ 75,152	$ 75,152	$ 75,152	$ 62,984	$ 62,984	$ 62,984	
Maximum Members per Case Manager (Institutional) [2]	96.0	68.0	93.4	96.0	68.0	91.1	96.0	68.0	91.5	
Maximum Members per Case Manager (Acute Care Only) [2]	96.0	96.0	96.0	96.0	96.0	96.0	96.0	96.0	96.0	
Maximum Members per Case Manager (Alternative HCBS) [2]	53.0	50.0	52.7	53.0	50.0	52.7	53.0	50.0	52.6	
Maximum Members per Case Manager (HCBS Own Home) [2]	43.0	32.0	42.1	43.0	32.0	42.4	43.0	32.0	42.3	
Average Travel Expenses per Case Management Manager	$ 6,641.00	$ 6,641.00	$ 6,641.00	$ 2,028.00	$ 2,028.00	$ 2,028.00	$ 5,091.00	$ 5,091.00	$ 5,091.00	
Average Case Managers per Supervisor	14	14	14	14	14	14	14	14	14	
Average Administrative Support Staff per Supervisor	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	
Calculations:										
Case Management Manager FTEs required	39.9	3.9	43.8	102.5	9.6	112.1	53.7	5.4	59.1	
Case Management Manager salary and ERE	$3,510,335	$343,449	$3,853,783	$9,124,089	$853,700	$9,977,789	$4,731,899	$472,169	$5,204,068	
Case Management Supervisor FTEs required	2.8	0.3	3.1	7.3	0.7	8.0	3.8	0.4	4.2	
Case Management Supervisor salary and ERE	$301,804	$29,528	$331,333	$839,435	$78,542	$917,978	$406,829	$40,595	$447,425	
Case Management Administration Support Staff FTEs	2.3	0.2	2.5	5.9	0.5	6.4	3.1	0.3	3.4	
Case Management Administration Support Staff salary and ERE	$143,451	$14,035	$157,486	$440,075	$41,176	$481,250	$193,370	$19,295	$212,666	
Travel Costs	$264,694	$25,897	$290,592	$207,822	$19,445	$227,267	$273,527	$27,294	$300,821	
Total Annual Case Management Cost	$4,220,284	$412,910	$4,633,193	$10,611,421	$992,863	$11,604,285	$5,605,625	$559,353	$6,164,979	
Total Case Management PMPM			**$163.27**			**$165.65**			**$165.05**	

Input fields
Formula driven fields
AHCCCS Prescribed Values

Footnotes:

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

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

4500 E Cotton Center Blvd
Phoenix, AZ 85040

aetna®

ACTUARIAL CERTIFICATION
MERCY CARE
AHCCCS ALTCS ADMINISTRATIVE COST PROPOSAL BIDS: CENTRAL, NORTH AND SOUTH GSAS
OCTOBER 1, 2024 – SEPTEMBER 30, 2029
SEPTEMBER 22, 2023

I, Steven Clark, am an employee of Aetna Life Insurance Company, the administrator for Mercy Care. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board.

The purpose of this capitation rate certification is to comply with the Instructions to Offerors contained in the Arizona Long-Term Care Services (ALTCS) Request for Proposal YH24-0001 issued by AHCCCS. This certification is intended solely for use in the evaluation of Mercy Care's Cost Proposal and may not be appropriate for other purposes.

The scored bid components by risk group and GSA to which this certification applies are attached in AHCCCS' required Bid Template sheets and shown in the table below. The bid components apply to the period October 1, 2024 through September 30, 2029.

ALTCS/EPD RFP Bid Template Totals

Administrative Component	Variable Cost (PMPM)	Fixed Cost (Dollars)
CYE 25	$170.76	$ 980,133
CYE 26	176.74	1,049,943
CYE 27	182.92	1,014,437
CYE 28	189.33	1,086,691
CYE 29	195.95	1,124,725

Case Management Component	PMPM
North	$163.27
Central	165.65
South	165.05

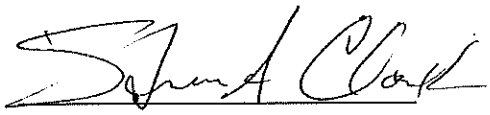
I have examined the financial records, assumptions and methods used to develop the case management and administrative expense components proposed by Mercy Care for the ALTCS Program contract.

In developing the assessment, I relied upon the financial records provided by Mercy Care and AHCCCS. I have accepted the data without audit and have relied upon Mercy Care and AHCCCS for the accuracy of the data. I have also relied upon the historical expenses specifically for Mercy Care to ensure each of the components proposed by Mercy Care would be sufficient to cover their specific current and future projected expenses based on all known costs as of this certification.

In my opinion, the bid components are adequate to fund the case management and administrative expenses for an average ALTCS population for each risk group and GSA.

My assessment of the proposed components is based on a projection of future events. Actual experience can and will vary from the experience assumed in the projection. Differences between the projection of future events and actual results depend on the extent to which future experience conforms to the assumptions made during the evaluation. It should be recognized that future events frequently do not occur exactly as expected; there are usually differences between projected and actual results. The projections were developed based on a best estimate of future events and should be viewed as such.

The methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board and meet the requirements of Code of Federal Regulations Title 42 Part 438.5(e), whose standards form the basis of this statement of opinion.



Steven Clark, FSA, MAAA
September 22, 2023

Part D

D1 - Intent to Provide Insurance

Mercy Care is pleased to submit this response to AHCCC's RFP for Arizona Long Term Care System (ALTCS) Program, RFP # YH24-0001. If notified of a contract award, Mercy Care will submit to AHCCC's, for review and acceptance, the applicable certificate(s) of insurance as required within this RFP within ten business days of such notification.

Mercy Care	
LEGAL CONTRACTOR NAME	DBA, IF APPLICABLE
ALTCS E/PD	2025
LINE OF BUSINESS	CONTRACT YEAR ENDING

The Contractor shall complete all information requested below and, in the attachments incorporated by reference. Do not leave any portion blank. If the Contractor believes that particular information is not applicable, the Contractor shall indicate "Not Applicable" in the inapplicable section and in a footnote include the legal and factual basis for its determination. Failure to provide all complete and accurate disclosures and an attestation signed by an individual with appropriate authority may result in the withholding of payments under the Contract and/or the recovery, recoupment, and/or offset of any monies remitted without limitation.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED, NON- COERCION, AND COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING

I, Lorry S Bottrill, certify that I have authority as specified in 42 CFR 438.606 to sign this Certification on behalf of the Contractor.

By signing this certification, the Contractor certifies, under penalty of law, that the information, documentation, and data provided, and all submissions made pursuant to this Attachment/Certification are true, correct, and complete to the best of Contractor's knowledge, information, and belief. The Contractor also acknowledges that should investigation at any time disclose any misrepresentation, omission, or falsification, any current or subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS. By signing this certification, the Contractor certifies, under penalty of law, that it has not made to any Provider any requests or inducements not to contract with another potential Contractor. By signing this certification, the Contractor certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the "Stark I" and/or "Stark II" laws governing any related-entity and any compensation therefrom. If the Contractor provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneously with this certification, copies of the information required to be sent to the Centers for Medicare and Medicaid Services (CMS) [Refer to 42 USC § 1320a-7b, PL 101-239, PL 101-432, and 42 CFR 411.361].

By signing this certification the Contractor certifies that it has consulted with counsel prior to the submission of the disclosures, is fully aware of the contents of these disclosures and of their legal effect and has had the opportunity to consult with counsel of its choosing regarding the disclosure requirements set forth in the Contractor's contract with AHCCCS, AHCCCS policies, and State and Federal law, rules, regulations, and/or policies.

Lorry Bottrill Lorry Bottrill (Sep 14, 2023 10:33 PDT)	President & Chief Executive Officer, Mercy Care
SIGNATURE OF AUTHORIZED REPRESENTATIVE	JOB TITLE
Lorry S Bottrill	09/14/23
PRINTED NAME OF AUTHORIZED REPRESENTATIVE	DATE

2. CONTRACTOR GENERAL INFORMATION

a. If other than a government agency, when was the Contractor organization formed?

1985

b. License/Certification: Attach a list of all licenses and certifications (e.g., Federal HMO status or State certifications) maintained by the Contractor organization over the last 10 years. On a separate sheet of paper list all license requirements and the renewal date(s) for each license and/or certification listed regardless of whether the license or certification is **currently** maintained.).

Has any license or certification been denied, revoked, or suspended within the past 10 years?
Yes ☐ **No** ☒

If yes, for each denial, revocation, or suspension provide the date of each action and explain the basis for each action:

N/A For a list of licenses and certifications see attachment: Section I Exhibit I Disclosure of Information-License Certification

c. Accessibility Assurance: Does the Contractor organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Contractor's facilities (including the facilities of the Subcontractors) are inaccessible to or unusable by persons with disabilities? (Check Federal and State law, regulations, rules, and local zoning ordinances for accessibility requirements) **Yes** ☒ **No** ☐

If yes, describe how such assurance is provided or how the Contractor organization is taking affirmative steps to provide assurance.

Mercy Care (MC) assures compliance with all federal and state laws related to accessibility for persons with disabilities including Title VI of the Civil Rights Act of 1964, 45 C.F.R. Part 80, Title IX of the Education Amendments of 1972, 45 C.F.R. Part 86, The Age Discrimination Act of 1975, 45 C.F.R. Part 91, and Section 1557 of the Affordable Care Act, 45 CFR Part 92. MC assures compliance with accessibility standards for buildings and facilities. It is MC's standard operating procedure and required by executed contracts with facilities and providers that each of its facilities and provider sites (offices, hospitals, clinics, pharmacies, emergency rooms and urgent care centers) are accessible and usable by members regardless of disability. Further, we monitor network compliance with these standards through, including but not limited to, membership in the AzAHP Credentialing Alliance, pre-contracting site audits, subsequent site visits and quality reviews. Moreover, MC assures compliance with accessibility to communications including websites, written materials, and member services resources (Member Services and Prior Authorization phone numbers). For members with disabilities, MC provides appropriate alternative forms of communication to meet their individual needs in accordance with Section 1557 of the Affordable Care Act, 42 CFR 438.10, Section 508 of the Americans with Disabilities Act, Section 504 of the Public Health Service Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. MC monitors compliance with these non-discrimination and accessibility requirements through routine auditing and a robust compliance program.

d. Provide the name(s) and address(s) of any in-house or independent actuary, or actuarial firm, used by the Contractor or any Subcontractors to assist in developing capitation rates and/or reviewing published capitation rate information.

Dazhi Fan, FSA, MAAA
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

e. Did any other firm or organization provide the Contractor with any assistance in making this certification (includes any firm or organization that provided any assistance with developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)?

Yes ☐ **No** ☒

If yes, list all name(s) and address(es) of all firm(s) or organization(s) that provided the assistance:

N/A

f. Has the Contractor contracted or arranged for Health Information Systems as described in 42 CFR 438.242, software, or hardware, for the term of the Contract? **Yes** ☒ **No** ☐

If yes, is the Health Information System being obtained from a vendor? **Yes** ☒ **No** ☐

If yes, please provide the vendor's legal name and any d/b/a under which the vendor has conducted business, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with any other Medicaid programs.

Our Management Information System (MIS) combines carefully integrated modular, third party, and proprietary applications. Our systems are configurable and designed specifically to support the Medicaid, Medicare, and Long-Term Care populations. These systems are widely regarded as the premier, best-in-class option to address the unique requirements of Medicaid eligibility, enrollment, and payment functions. We use standard servers running current versions of Microsoft Operating Systems and Databases. Server and environment configuration provides redundancy and scalability to meet future growth.

We employ the following key vendor business applications (in addition to several ancillary applications) to support the MC lines of business:

- QNXT™ (from Trizetto) - Health management information system for care operations - Member Services, Provider Services and Claims Administration
- CaseTrakker Dynamo™ (from HMA Technologies) for Integrated Care Management

The above listed core business applications have been utilized to manage the existing contracts with AHCCCS and also with other HMOs/managed care entities and Medicaid programs.

Has the Contractor complied with 42 CFR 438.242 and made all collected data available to AHCCCS upon its request? **Yes** ☒ **No** ☐

g. Has the Contractor organization ever filed for, or received a discharge through, bankruptcy or bankruptcy related reorganization proceeding? **Yes** ☐ **No** ☒

If yes, for each bankruptcy related proceeding provide the jurisdiction, case name, case caption, year of filing and disposition, if available:

N/A

SECTION I: Exhibits; EXHIBIT I: Disclosure of Information

2.b. License/Certification

Medicare Advantage License/Certification

AHCCCS Medicare Advantage D-SNP Certification

Medicare Advantage Plans Serving Dual Eligible- AHCCCS Beneficiaries Certification Requirements:

- File State Certification Request
- Minimum equity per member requirements
- Performance bond requirements
- Ongoing monitoring and reporting

Filed: 02/25/2005
One time certification must be repeated upon service area expansion or utilization of new business

Filed: 11/01/2018
Notice of intent to apply filed for 2020 and included expansion for DDD Contract.

Updated Certification: 02/11/2019
Certification was updated to include expansion for DDD Contract

Filed: 02/14/20
MA-PD and SNP applications – Renewal only

Filed: 2/17/21
MA-PD and SNP applications-Renewal only

Filed: 7/2/22
State Medicaid Agency Contract (SMAC)/MA-PD and SNP applications - Renewal only

Filed: 7/3/23
State Medicaid Agency Contract (SMAC)/MA-PD and SNP applications - Renewal only

OFFEROR ATTESTATION

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

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

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

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

OFFEROR	
Mercy Care	09/26/23
OFFEROR NAME	**DATE**
LORRY S BOTTRILL **PRESIDENT & CHIEF EXECUTIVE OFFICER, MERCY CARE**	Lorry Bottrill Lorry Bottrill (Sep 26, 2023 12:26 PDT)
PRINTED NAME AND TITLE OF INDIVIDUAL AUTHORIZED TO SIGN	**SIGNATURE OF INDIVIDUAL AUTHORIZED TO SIGN**
PHOENIX, AZ **85040**	**LORRY.BOTTRILL@MERCYCAREAZ.ORG** **602-400-7082**
CITY **STATE** **ZIP**	**EMAIL ADDRESS** **PHONE NUMBER**

AHCCCS DETERMINATION – FOR AHCCCS USE ONLY

AHCCCS

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

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

☐ **Approved, no occurrences identified**

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

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

Explanation:

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

EXHIBIT E: BOYCOTT OF ISRAEL DISCLOSURE

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

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

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

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

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

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

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

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

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

Lorry Bottrill
Lorry Bottrill (Aug 28, 2023 08:48 PDT)

Signature of Individual Authorized to Sign

Lorry S Bottrill
President & Chief Executive Officer, Mercy Care

Printed Name and Title

				lorry.bottrill@mercycareaz.org
Phoenix	AZ	85040		602-453-8361
City	State			Email Address Phone Number

D4 - Moral or Religious Objections

Mercy Care, the single brand and legal entity for the AHCCCS ALTCS E/PD contract, will continue to offer family planning benefits in the same manner that Mercy Care has done for many years, as explained below. Mercy Care (f/k/a Southwest Catholic Health Network Corporation) was formed as an Arizona nonprofit corporation in 1985, after representatives of AHCCCS invited local Catholic hospitals to participate in the Medicaid program. The sponsors of those hospitals, Carondelet Health Network (now part of Ascension called Ascension Care Management Insurance Holdings), and St. Joseph's Hospital and Medical Center (a member of Dignity Health and now part of CommonSpirit Health), created Mercy Care as a mission-based entity to serve Medicaid members in Arizona. The sponsors strongly believed that the formation of Mercy Care was an important extension of the Catholic mission to serve the poor and persons with special needs.

Federal law mandates that state Medicaid agencies provide coverage for certain identified "family planning services." Some of these benefits may conflict with Catholic teaching and values and the Ethical and Religious Directives for Catholic healthcare organizations. Mercy Care's founding sponsors have religious and moral objections to providing those conflicting benefits listed in the AMPM Section 420. In the early years of Arizona's Medicaid program, AHCCCS contracted directly with providers for these benefits. However, AHCCCS discontinued direct contracting in 1997 and moved responsibility for all family planning benefits to health plans contracted with AHCCCS to administer Medicaid benefits.

At that time, Mercy Care presented a plan to engage a third-party administrator for family planning benefits to Arizona Catholic leaders and AHCCCS. A third-party administrator was engaged in April 1997 and began providing the benefits on October 1, 1997. With some revisions over the past two-and-a-half decades, a third-party administrator arrangement continues today.

Mercy Care's non-voting member, Equality Health Foundation, has contracted with Aetna Medicaid Administrators (Aetna Medicaid) to administer those family planning benefits for Mercy Care members that Mercy Care's Catholic sponsors will not provide, either directly or indirectly, for religious or moral reasons. This type of arrangement, implemented with approval by AHCCCS, continues today. All covered and medically necessary services will be available to AHCCCS members by Mercy Care to meet the covered services requirement. Any payments due to Aetna Medicaid for the activities defined in their contract will be the responsibility of Mercy Care, through the third-party arrangement without the involvement of the two Catholic sponsors.

In accordance with A.R.S. §36-2907(A)(8), Mercy Care's election does not disqualify Mercy Care from delivering all other covered health and medical services, and Mercy Care's non-voting member has selected Aetna Medicaid for administering family planning and certain OB/GYN services. Therefore, all covered and medically necessary services will be available to AHCCCS members through Mercy Care.

Exhibit F: State Only Pregnancy Termination Agreement

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

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

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

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

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

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

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

1.1.2 Seriously impairing a bodily function of the pregnant member,

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

1.1.4 Exacerbating a health problem of the pregnant member, or

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

1.2 Conditions, Limitations and Exclusions:

1.2.1 The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the *Certificate of Necessity for Pregnancy Termination* and clinical information that supports the medical necessity for the procedure, as referenced in the AHCCCS Medical Policy

Manual (AMPM), Chapter 400, Policy 410, *Maternity Care Services*. This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief Medical Officer or designee for Fee-For-Service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

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

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

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

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

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

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

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

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

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

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

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

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

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

Mercy Care	*Lorry Bottrill* Lorry Bottrill (Aug 28, 2023 08:50 PDT)
Offeror Name	Signature of Person Authorized to Sign
4500 E Cotton Center Blvd	Lorry S Bottrill
Address	Printed Name
Phoenix AZ 85040	President & Chief Executive Officer, Mercy Care
City State Zip	Title