Empowering Independence

Request for Proposal

ALTCS-E/PD

Arizona Long Term Care for Individuals who are Elderly and/or Have a Physical Disability

Solicitation #: YH24-0001
Proposal Due Date: October 2, 2023

Arizona Physicians IPA, Inc.
(dba UnitedHealthcare Community Plan)

United Healthcare Community Plan

Part A

Empowering Members to Build New Skills and Impact Their Communities

Volunteering can be a path to skill-building, empowerment, and community engagement. Our ALTCS member empowerment team (***me**** team) coordinates volunteer activities ranging from crafting toys for animal shelters to planting a garden at a memory care facility. The ***me**** team helps members address individual and systemic barriers to volunteering, so members can become more active and integrated within their local community.

A1
Offeror's Checklist

Since the creation of ALTCS in 1989, we have been honored to serve long-term care members and to strengthen and modernize the system of care. Building on our 40-year partnership with AHCCCS, we will continue to advance health equity and improve the experiences and outcomes of those we serve.

Empowering Independence

United Healthcare

EXHIBIT A: OFFEROR'S CHECKLIST

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

OFFEROR'S CHECKLIST ALTCS EPD RFP #YH24-0001		
	SUBMISSION REQUIREMENT	**OFFEROR'S PROPOSAL PAGE NO.**
PART A		
A1	Offeror's Checklist	1
A2	Completed and Signed Offeror's Intent to Bid	2
A3	Completed and Signed Solicitation Offer and Acceptance Offer Page	3
A4	Completed and Signed Offeror's Bid Choice Form	5
A5	Completed and Signed Solicitation Amendment(s)	6
PART B	**SUBMISSION REQUIREMENTS**	
B1	Executive Summary 2-page limit	36
B2	Cite Contracts 1-page limit - Utilize Template	38
B3	Health Equity Requirement No submission required	-
B4	5-page limit	39
B5	4-page limit	44
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	48
B7	4-page limit	54
B8	4-page limit	58
B9	4-page limit	62
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	66
B11	D-SNP STAR Rating Utilize Template	67
B12	Oral Presentation Information Participant Names, Titles, and Resumes	68
PART C	**CAPITATION AGREEMENT/ADMINISTRATIVE AND CASE MANAGEMENT COST COMPONENTS BID**	
C1	Agreement Accepting Capitation Rates	82
C2	Administrative Cost Component Bid	83
C3	Case Management Cost Component Bid	89
C4	Actuarial Certification	90
PART D		
D1	Intent to Provide Insurance	93
D2	~~Representations and Certifications of Offeror and~~ Completed Section G: Disclosure of Information Instructions and Attestation	94
D3	Boycott of Israel Disclosure	98
D4	Moral or Religious Objections	99
D5	State Only Pregnancy Terminations Agreement	100

A2

Completed and Signed Offeror's Intent to Bid

During the COVID-19 pandemic, when many members were particularly isolated from their families, friends and communities, our case managers coordinated drive-through birthday parades. We were thrilled to celebrate members reaching exciting milestones in their lives – including one member who turned 104 years old.

Empowering Independence

United Healthcare

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:	Melissa Cummings
2	TITLE:	Proposal Director
3	EMAIL ADDRESS:	melissa_b_cummings@uhc.com
4	PHONE NUMBER:	952-406-6132
5	COMPANY NAME:	Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan)
6	COMPANY ADDRESS:	1 E. Washington Street, Suite 900, Phoenix, AZ 85004
7	COMPANY WEBSITE:	www.uhccommunityplan.com/arizona

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.	MBC
My company (listed in box #5 above) intends, or is considering its intent, to submit a bid for this RFP.	MBC
I understand that submittal of this form does not obligate my company to submit a bid.	MBC
I am an employee of my company (listed in box #5 above) and not a consultant or independent contractor.	MBC
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.	MBC
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.	MBC

Signature: Melissa B Cummings **Date:** 8/8/23

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

A3

Completed and Signed Solicitation Offer and Acceptance Offer Page

We collaborate with local assisted living facilities to host fun and engaging events to keep seniors active and connected. Our dedicated case managers hosted a recent event at Grand Court of Mesa that included a Senior Prom dance for over 80 members.

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

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

Issue Date: August 1, 2023

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

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

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

OFFER AND ACCEPTANCE

OFFER

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

Arizona Transaction (Sales) Privilege Tax License No.:

N/A

Federal Employer Identification No.:

86-0813232

E-Mail Address: jean_kalbacher@uhc.com

Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan
Company Name

1 E. Washington Street, Suite 900
Address

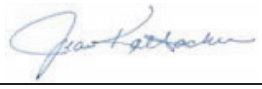
Phoenix | AZ | 85004
City | State | Zip

For clarification of this offer, contact:

Name: Jean Kalbacher

Title: Chief Executive Officer

Phone: (602) 255-8457



Signature of Person Authorized to Sign Offer

Jean Kalbacher
Printed Name

Chief Executive Officer
Title

CERTIFICATION

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

This contract shall henceforth be referred to as

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

_____
MEGGAN LAPORTE, AHCCCS CHIEF PROCUREMENT OFFICER

A4

Completed and Signed Offeror's Bid Choice Form

We teamed up with Area Agencies on Aging to bring iPads to hundreds of seniors across Arizona through a $300k investment. These iPads are being used to connect seniors with their family and friends. So far, 100 iPads have been distributed and an additional 150 are planned.

Empowering Independence

United Healthcare

EXHIBIT B: OFFEROR'S BID CHOICE FORM

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

Arizona Physicians IPA, Inc.
dba UnitedHealthcare Community Plan
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	**2nd choice**
South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties (including zip codes: 85542 85192 8550)	**3rd choice**

Authorized Signature — **September 29, 2023** **Date**

Jean Kalbacher — **Print Name**

Chief Executive Officer — **Title**

A5

Completed and Signed Solicitation Amendment(s)

Our Member Advisory Council – which includes members, their caregivers and representatives from community and consumer advocacy groups – hosts Abilities Workshops with promoting member empowerment in mind. We aim to help members work toward their personal goals by connecting with resources including peer support, employment services and community activities.

Empowering Independence

United Healthcare

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

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

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

This Solicitation is amended as follows:

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

B. This Solicitation is also amended as follows:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: Jean Kalbacher	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: Chief Executive Officer	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: August 16, 2023	**DATE:**

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

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

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

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

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

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

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

	CYE 20	CYE 21	CYE 22	CYE 23
Member Months	349,239	321,368	315,085	78,977
Placement Total	349,113	320,560	312,745	78,393
Difference	**126**	**808**	**2,340**	**584**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
27.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			There are a total of 32,201 members labeled as "Not Placed" in the Member Placement Detail File. How would AHCCCS prefer that we treat these during the rate development process? Should they be classified as HCBS or institutional? Eighty percent HCBS and twenty percent institutional? **CYE 20** / **CYE 21** / **CYE 22** / **CYE 23** Not Placed 10,485 / 9,586 / 9,644 / 2,486	**The "Not Placed" members in the Placement Detail File are excluded when calculating the HCBS mix percentage, as described in the rate development documentation. The "Not Placed" members would be included in Member Months which are used to calculate the PMPMs and can be allocated based on the calculated HCBS mix percentage as a proxy for placement.**
28.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			Health Choice has reviewed prior year rate setting documents and have identified the Nursing Facility total dollars provided in the ASFS data look to be substantially lower than the base data in previous rate setting cycles. Would AHCCCS be willing to identify what components are not included in the data book that would account for this difference?	**The question is unclear regarding what exactly is being compared from previous rate setting documents to the ASFS data. All components are included in the data book.**
29.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			Would AHCCCS be willing to provide member data on the use of self-directed care versus non-self-directed care, including county, race, ethnicity, and language data?	**Offerors may refer to the AHCCCS CYE2022 HCBS Annual Report on the AHCCCS website for additional information:** https://www.azahcccs.gov/Resources/Reports/federal.html
30.	Mercy Care	08/08/2023	Section H, 19. Contents of Offeror's Proposal	6	13	Please advise if there is a file size limit for uploads to AHCCCS Secure File Share (ASFS)?	**There is no official document size limit for the ASFS, but excessively large documents may time out when loading. Additionally, the file name has a limit of 32 characters.**
31.	Mercy Care	08/08/2023	Section H, 19. Contents of Offeror's Proposal	5	14	Please advise if Bidders can exclude signed forms, attachments, cover, tables of content, etc. from the sequential numbering requirement?	**Yes, Offerors may exclude these items from the sequential page numbering requirements but please refer to the instructions to determine if these items count toward maximum page limits. Also, see answer to Question #39.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
32.	Mercy Care	08/08/2023	Section I, Exhibit H, B9	1.c.	4	Considering that a member will be enrolled with Tribal ALTCS if he/she lives on or lived on a reservation prior to admission into an off-reservation facility, please provide clarification regarding "Members residing in tribal communities." Please confirm if these tribal communities are on a reservation and/or off-reservation?	**The RFP Submission Requirement B9 is revised as follows:** Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented. a. Members residing in rural communities, b. ~~Members residing in Tribal communities~~ Tribal members, c. Members in need of community resources, and d. Members in need of Peer and/or Family Support services.
33.	Mercy Care	08/08/2023	Section I, Exhibit H, B2	2	1	Is it expected if a Bidder wants to reference current ALTCS E/PD work, an ALTCS E/PD contract must be cited?	**In response to the Narrative Submission Requirements that ask for the Offeror's experience as well as any other responses where experience is presented, the Offeror shall refer exclusively to the experience from the identified contracts submitted for B2. Additionally, the RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.
34.	Mercy Care	08/08/2023	Section I, Exhibit H, B2	2	1	Please confirm that AHCCCS Complete Care contractors whose contract was expanded to include integrated services for Title XIX/XXI eligible individuals with Serious Mental Illness (SMI) are permitted to respond to the full scope of this contract as a single cited contract.	**The RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
35.	Mercy Care	08/08/2023	Section I, Exhibit H, B2 and B11	1	1 and 5	Non-incumbent bidders will be allowed to select contracts from markets with disparate characteristics from Arizona. How will AHCCCS evaluate "similar healthcare delivery systems to the ALTCS E/PD Program" and ensure equity in the evaluation process of experience and DSNP STAR Rating?	**AHCCCS will not be providing scoring or weighting details.**
36.	Mercy Care	08/08/2023	Section I, Exhibit C, B6	1	3	Considering there are multiple types of data included but not limited to performance metrics and data collected in partnership with members, in lieu of utilization reports are other one-page samples allowable to demonstrate the Offeror's monitoring and analysis process?	**Yes, Offerors may submit other one-page samples, in addition to or in lieu of utilization reports, to demonstrate their monitoring and analysis processes. The RFP Submission Requirement B6 is revised as follows:** The Offeror shall limit its response to the submission requirement to three pages of narrative and should include up to three, one-page sample utilization reports or other sample data to demonstrate the Offeror's monitoring and analysis processes.
37.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Part D, D4	RFP Section D, Moral or Religious Objections	59	The Offeror's Checklist, Part D, Section D4, requires bidders to identify Moral or Religious Objections. If bidders have no religious or moral objections, is a document required? If "yes," should bidders create their own?	**If bidders do not have religious or moral objections to submit for AHCCCS notification, the Offeror is not required to submit a document. The RFP is revised as follows:** **Moral or Religious Objections**: The ~~Contractor~~ Offeror shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The ~~Contractor~~ Offeror may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the ~~Contractor~~ Offeror's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored. If the Offeror does not have a Moral or Religious Objection, the Offeror is not required to submit a document for this submission requirement.

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
38.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Section H: Instructions to Offerors	Section 19. Contents of Offeror's Proposal	14	The instructions indicate that all proposals shall be in Calibri 11-point font or larger with borders no less than ½". Will AHCCCS allow a smaller, readable font size for graphics, callouts, and tables?	**Graphics, tables, and charts may be in a smaller font.**
39.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Section H: Instructions to Offerors	Section 19. Contents of Offeror's Proposal	14	The instructions indicate that all pages of the Offeror's Proposal shall be numbered sequentially, and that numbering of pages shall continue in sequence through each separate section. If we use Section Cover Sheets, are those excluded from the page limit and numbering?	**Yes, Offerors may exclude these items from the sequential page numbering requirements. Section Cover sheets do not count toward page limits. Also, see answer to Question #31.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
40.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B7	3	With the depth and accuracy required to thoroughly answer question B7, and page limits, would AHCCCS consider adding one page to the page limit?	**The page limit for submission requirement B7 will remain unchanged.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
41.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B6	3	Given the number of questions and subparts to each question in B6, would AHCCCS consider increasing the page limit for the response to 4 pages of narrative?	**The page limit for submission requirement B6 will remain unchanged.**
42.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B4	2	Question B4 identifies seven objectives. Are Offeror's asked to identify both best practices and Case Management (CM) initiatives related to the seven objectives? Or should these be treated as two separate questions to respond to? Give the number of objectives and subparts to the question, would AHCCCS consider adding an additional one or two pages?	**Offerors shall respond as needed to provide a comprehensive response to the question and meet the requirements of the RFP. The page limit for submission requirement B4 will remain unchanged.**
43.	EMAIL	N/A	N/A	N/A	N/A	Can you share any details about plans for CAHPs surveys in the future? Is there a timeframe when the 2023 ACC CAHPS will be completed?	**AHCCCS is currently in the process of conducting statewide CAHPS surveys for the adult population, child population, and the KidsCare program for 2023. The statewide CAHPS surveys do not include the ALTCS-EPD population; it is AHCCCS' expectation that results will be reported at the statewide level as well as at the ACC and DCS CHP population/line of business level. AHCCCS anticipates the 2023 statewide CAHPS surveys to be completed in March/April 2024.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
44.	EMAIL	N/A	N/A	N/A	N/A	Can you confirm that AHCCCS did not conduct an Adult CAHPs survey for 2022?	**AHCCCS is confirming that a CAHPS survey was not conducted for the adult population in 2022; however, AHCCCS conducted a 2022 CAHPS survey for the KidsCare program.**

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

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

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

This Solicitation is amended as follows:

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

B. This Solicitation is also amended as follows:

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

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: Jean Kalbacher	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: Chief Executive Officer	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: August 30, 2023	**DATE:**

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

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
							capitation rates, excluding premium tax. AHCCCS may revise the applicable underwriting gain percentage as part of capitation rate development each year. ~~AHCCCS intends to set the underwriting gain equal to one percent of the capitation rate for each risk group excluding premium tax.~~ Administrative and case management cost components will be bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides. If any moral or religious objections were submitted as part of the RFP, the Offeror shall include in its Capitation Agreement a statement attesting that the Offeror did not exclude from the administrative and case management bid submission(s) any related administrative and case management costs.

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
3.	UnitedHealthcare Community Plan	August 22, 2023	Section I, Exhibit H	B2	1	Given the current requirement for all incumbent ALTCS Contractors to offer a FIDE-SNP under a SMAC with AHCCCS, please confirm that offerors may write to the companion FIDE-SNP experience and best practices in their response under their current AHCCCS Medicaid contract number and need not separately list their companion FIDE-SNP agreement in response to B2.	**The Offeror must list the FIDE-SNP in B2 if the Offeror writes to experience related to the FIDE-SNP contract.**
4.	UnitedHealthcare Community Plan	August 22, 2023	Section H	B12	19	If an oral presentation participant identified in our response becomes unavailable to attend, may we substitute another individual after our proposal is submitted?	**Yes, if an oral presentation participant becomes unavailable another individual may be substituted; however, the information for the newly added individual must be submitted to AHCCCS (i.e., name, title, and resume) as required by the RFP.**
5.	UnitedHealthcare Community Plan	August 22, 2023	Section H	N/A	N/A	The RFP does not specify whether AHCCCS will accept electronic or digital signatures. Please confirm that AHCCCS will accept a digital or electronically placed signature in place	**Yes, AHCCCS will accept a digital/electronically placed signature in place of a written signature for RFP documents requiring signature.**

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

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						services such as ~~Day Treatment and Training (also known as day program) for persons with disabilities and~~ Supported Employment. The phrase "such as" implies that Supported Employment is just one example. What other types of habilitation will be included beyond Supported Employment?	
8.	Arizona Complete Health	8/22/23	Section D: Program Requirements	11	60	Does your policy allow for an ALTCS Tribal Member that lives on a reservation to be served by a non-Tribal ALTCS Contractor?	**No, per A.A.C. R9-28-415 Tribal members living on-reservation shall be enrolled with the tribe participating as an ALTCS Tribal program in the member's service area.**
9.	Arizona Complete Health	8/22/23	Non-Benefit Costs Bid Requirements/Submission	N/A	N/A	In response to Amendment 1 Questions and Responses Number 9, AHCCCS stated they "may incorporate underlying cost differences in the populations between GSAs when determining the overall distribution, if such an adjustment is appropriate." What about adjusting the overall total	**AHCCCS does not intend to adjust the overall total administrative cost bid itself as described in this question. If an Offeror believes that their admin costs would be impacted by being awarded a different GSA combo, they are welcome to include additional detail in their actuarial certification of the administrative rates. Offerors should bid based on their projected administrative need, whatever the Offeror determines that to be.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						administrative cost bid itself? For example, the PMPM for 100,000 member months is likely to be different for the Central + South GSAs vs the Central + North GSAs. An Offeror would likely bid differently under those two scenarios. How does AHCCCS intend to adjust for this situation?	
10.	Arizona Complete Health	8/22/23	Section I: Exhibits Exhibit H	B2	1	The RFP submission requirement was revised as follows: The Offeror shall identify no more than three contracts in addition to Arizona Medicaid contracts, which represents its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program. Given the one-page length and design of the form submission is it the intent of AHCCCS for bidders to not include AZ information, and only include that of three contracts which represent	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**

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

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

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

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						three additional non-Arizona Medicaid contracts?	
17.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Part B, B11	Exhibit H, Narrative Submission Requirements, B11	Exhibit H, Page 5, and Page 18 in the Instructions to Offerors	Given that projected STAR ratings for measurement year 2022 have been released, and the final ratings will be released in early October, would AHCCCS consider accepting the 2022 projected STAR ratings for B11, and validate the STAR rating using publicly available information? This would ensure the most current data is utilized.	**RFP B11 is revised as shown below:** The Offeror shall submit its ~~most recent~~ 2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its ~~most recent~~ 2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State: a. FIDE SNP/DSNP Plan, b. Another type of SNP, or c. Medicare Advantage Plan.
18.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Exhibit H: Narrative Submission Requirement	Exhibit H, Narrative Submission Requirements, B6	3	Given the number of questions and size of utilization reports necessary to answer B6, would AHCCCS consider allowing Offerors to submit utilization reports as 3 attachments rather than 3 one-page screen shots of reports, which may be more difficult to read?	**The requirements for submitting sample reports for B6 will remain unchanged.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
19.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Section H: Instructions to Offerors	Instructions Section 19. Contents of Offeror's Proposal, related to Exhibit H: B7	14	The instructions indicate that the submission be provided in 8 ½" x 11" page size. Would AHCCCS allow an 8 ½" x 11" page in landscape orientation to be used for the action steps and timeline portion of B7?	**Yes.**

EXHIBIT A: OFFEROR'S CHECKLIST

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

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

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

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

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

This Solicitation is amended as follows:

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

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

INCORPORATED in this Solicitation Amendment:

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

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME: Jean Kalbacher	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE: Chief Executive Officer	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE: September 8, 2023	**DATE:** **9/8/2023**

Part B

Building Community and Reducing Burnout for Family Caregivers

We are collaborating with Duet Partners in Health and Aging, an organization that serves family caregivers, to affirm and support the wellbeing of people caring for their loved ones. The organization offers support groups to connect caregivers with resources, coping strategies and safe space to share and listen. Groups are available for caregivers who are LGBTQ+, caregivers who speak Spanish and those caring for loved ones with Alzheimer's and Dementia.

B1 Executive Summary

At UnitedHealthcare Community Plan (UnitedHealthcare), the programs and services we provide stem first from member voices and their needs. We honor members' choices and empower independence, collaborate to strengthen the system of care, contain costs, advance innovation and provide timely access to equitable, high-quality care. We have worked alongside AHCCCS since 1982 and currently provide person-centered, high-quality care to more than 620,000 members through our ALTCS E/PD, AHCCCS Complete Care, ALTCS-DD and two dual special needs plan (D-SNP) contracts. Our broader organization provides medical coverage for more than 1.8 million Arizonans and employs over 8,200 individuals in the state. Our roots in all 15 counties — exemplified by our organization's contracts with more than 40,000 local providers and nearly 90 hospitals across Arizona — advance our goals in increasing timely member access to care. Our team is dedicated to serving the ALTCS E/PD program. Since the program's inception in 1989, we have ensured members' voices are heard, their dignity promoted and their choices respected, while achieving a greater level of independence and improved health care.

UnitedHealthcare's Experience Providing ALTCS E/PD Services

Our staff's enduring commitment to serving members and their families illustrates the profound fulfillment they find in serving Arizonans while enhancing the ALTCS system of care and empowering members to live the independent, safe and fulfilling lives they choose. When the ALTCS E/PD program began in 1989, 5% of members were living in the setting of their choice with home and community-based services (HCBS). Today, 76% of ALTCS E/PD members live in the setting of their choice with HCBS, and UnitedHealthcare exceeds the overall program average, with **78% of our members living with this level of independence**. More of our members are in their community of choice than any other plan due to our uncompromising focus on person-centered care, member choice and supporting the member's informal support system.

Aligned with the needs voiced by our members, UnitedHealthcare was the first to offer a fully integrated dual eligible special needs plan (FIDE SNP) in Arizona. Based on member feedback, we significantly expanded services that matter most to members, such as NEMT, fitness benefits, personal care services and our UCard, which provides quarterly funds for utilities, food, internet, and other services that support health-related social needs (HRSN). As a result, 55% of our members eligible for FIDE SNP are enrolled in our Dual Complete One special needs plan. In addition, we earned **NCQA Medicaid Health Plan Accreditation and LTSS Distinction,** validating our capability to identify members' needs and preferences and enroll them in appropriate programs. We constantly look for new solutions to help our members achieve independence and dignity. For example, we partnered with CareBridge as a way for home-based members to receive 24/7 access to medical professionals, resulting in swift response to potential medication needs, and unique to UnitedHealthcare, expedited durable medical equipment (DME) fulfillment within 24 hours for HCBS members.

Our commitment to promoting health equity in our communities drives everything we do. We identify and address health disparities among Arizonans to make sure we build culturally responsive, quality care into our population health strategy, clinical program design, quality programs, diversified workforce, employee education, provider supports, member outreach and community engagement. This commitment is reflected in our efforts such as investing in cultural competency training, advancing data-driven methodologies to monitor and track disparities in health care access, utilization and outcomes, and developing diverse talent **(e.g., 30 case managers (CMs) speak 10 unique languages, 83% of CMs are women, 38% are people of color)**. These insights inform targeted interventions and quality improvement initiatives aimed at addressing identified gaps and promoting health equity.

We formed our local diversity, equity and inclusion council in 2021 to support our employees in connecting and sharing experiences, progressing in their learning journeys together and ensuring inclusion is woven into the fabric of our health plan. Dedicated space and efforts for employees to learn, grow and provide feedback supports our commitment to tackling health equity challenges faced by our members and our Arizona community.

Unique Approach to Meet Contract Requirements

Our unique approach to meet contract requirements begins with the member voice. For example, in building upon the HRSN requirements in our contract, we acted on feedback from our Member Advisory Council, which shared information on the lack of fresh fruit and vegetables in rural northern areas. We partnered with Manzanita Outreach, a community-based organization (CBO) to address the rural disparity. We remain committed to financially reinvesting into local Arizona CBOs, such as the Area Agency on Aging, providing resources, including free tablets for seniors to address social isolation and Duet: Partners In Health & Aging, which offers caregiver support programs for those impacted by Alzheimer's disease in Hispanic and LGBTQ+ communities.

Our contract management approach is proven, reliable and distinctive; it incorporates comprehensive and structured procedures for monitoring and compliance. Our commitment to the highest standards of ethics, integrity and compliance guarantees policies and procedures align with contract requirements. We consistently demonstrate our ability to effectively coordinate care, manage resources and deliver high-quality, accessible services to members. As we look to strengthening the ALTCS E/PD program, our approach will build on our core capabilities and include the following transformative commitments.

Reliability and performance: We are continuously committed to implementing comprehensive programs that prioritize consistent and dependable access to health care for our members while enhancing quality and lowering costs. **We will help stabilize the direct care worker (DCW) workforce by using data to maximize enhanced recruitment, training and retention support for 2,000 DCWs.** Critical to achieving this commitment is our **$500,000 grant to HCBS staffing agencies** to recruit and retain direct care workers.

Compassion: Compassion is integrated into every aspect of our service. By listening to and empathizing with our members' unique experiences, we provide tailored care and support. For instance, to address the challenges faced by caregivers, we are partnering with Careforth to deliver caregiver support and training to reduce burnout and improve care to members. In addition to suicide prevention trainings, such as QPR, and abuse/neglect prevention training, **we will train 100% of health plan staff in trauma-informed care**.

Advancing innovation: Through innovation, we make health care work for everyone, unlocking new possibilities, improving efficiency and staying at the forefront of progress to better serve our members. In 2021, we launched an Innovation Force for process improvements directly from our team members, including CMs, who submit ideas for review and mobilization. To date, more than 130 ideas have been submitted by more than 60 individuals. **Our innovative solutions will reduce disparities in engagement in behavioral health services for members in rural counties by 15% over life of the contract.**

Member empowerment: We encourage and uplift our members, empowering them to play an active role in their communities, while making sure their independence and perspectives are valued and respected. Our award-winning Member Empowerment (***me****) team, begun in 2010, embeds this core capability throughout our ALTCS E/PD program by helping members reach their goals and is recognized by the Medicaid Health Plans of America as a best practice. **UnitedHealthcare will enhance social connectedness and reduce loneliness by 10% over the life of the contract.**

Prioritizing health equity: Anchored in our vision is our committment to deliver equitable care to reduce health disparities and improve health outcomes individually and systemically. By using data insights and engaging with local organizations, we advance access to equitable programs. **We will use the closed-loop referral system to screen and refer, as needed, all members for HRSN twice per year, at minimum.** This system-level investment builds upon our one-on-one, person-centered case management experience that identifies and closes gaps in care to address inequities.

Members are the heart and soul of our ALTCS E/PD program, and our ability to serve and meet their needs is grounded in our core capabilities of reliability and performance, compassion, prioritizing health equity, advancing innovation and member empowerment. We will meet and exceed the contract requirements and the expectations of AHCCCS while continuing our partnership with members, providers and AHCCCS for years to come.

B2 Cite Contracts

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
1.	Arizona Physicians IPA, Inc. Contract Number: H0321-004	UnitedHealthcare® Dual Complete® ONE	Arizona
Description: Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) that offers healthy food, utilities, over-the-counter items, dental, vision, fitness, transportation, pest control, hearing aids, podiatry, chiropractor, home-delivered meals and more | **Geographic coverage:** Aligned with UnitedHealthcare's ALTCS E/PD geographical presence in Central GSA and North GSA | **Population served:** Full dual eligible members with ALTCS E/PD coverage | **Enrollment:** As of August 2023, 4,960 members | **Integration status:** Integrated physical and BH | **Years in program:** Eight years; contract origination date Jan. 1, 2015 | **Current contract status:** Active through Dec. 31, 2023; renewed until Dec. 31, 2024			

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
2.	UnitedHealthcare Community Plan of Ohio, Inc. Contract Number: 2531-001	MyCare Ohio (Medicare-Medicaid Plan [MMP])	Ohio
Description: Population size and demographics similar to ALTCS E/PD population; earned NCQA Medicaid Health Plan Accreditation and Health Equity Accreditation | **Geographic coverage:** Three geographic regions (Northeast, East Central, Northeast Central), encompassing 12 counties | **Population served:** Dual eligible age 18 or older | **Enrollment:** As of August 2023, 28,634 members, all of which are MMP | **Integration status:** Contract and program has full physical, BH and LTSS, including benefits, case management, care planning, service delivery and operations | **Years in program:** Nine years; contract origination date May 1, 2014 | **Current contract status:** Active through Dec. 31, 2023 | **Carve-in services:** Standard Medicare and Medicaid benefits, BH, HCBS and LTSS | **Carve-out services:** None			

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
3	UnitedHealthcare Plan of the River Valley, Inc. Contract Number: State "Edison" Record ID: 40181	TennCare	Tennessee
Description: Population size and demographics similar to ALTCS E/PD population; has affiliated FIDE SNP; earned NCQA Medicaid Health Plan Accreditation, Health Equity Accreditation and LTSS Distinction | **Geographic coverage:** Statewide | **Population served:** CHIP, LTC, TANF and I/DD | **Enrollment:** As of August 2023, 531,329 members, of which 7,746 are LTSS | **Integration status:** Contract and program has full physical, BH and LTSS, including benefits, case management, care planning, service delivery and operations | **Years in program:** 29 years; contract origination date Jan. 1, 1994 | **Current contract status:** Active through Dec. 31, 2023 | **Carve-in services:** Standard Medicaid benefits, I/DD, HCBS and LTSS | **Carve-out services:** Dental and pharmacy			

B4 ALTCS E/PD Case Management Best Practices

Since 1989, UnitedHealthcare has supported the ALTCS E/PD program's evolution through development and implementation of innovative case management best practices, promoting member dignity, independence, individuality, privacy and self-determination. Our case managers (CMs) leverage our more than 30 years of Arizona experience and national long-term care (LTC) expertise — informed by serving over 335,000 LTC eligibles — and incorporate evidence-based strategies to create and deploy equitable, member-driven best practices so our members can achieve independent, safe and fulfilling lives in the location they choose.

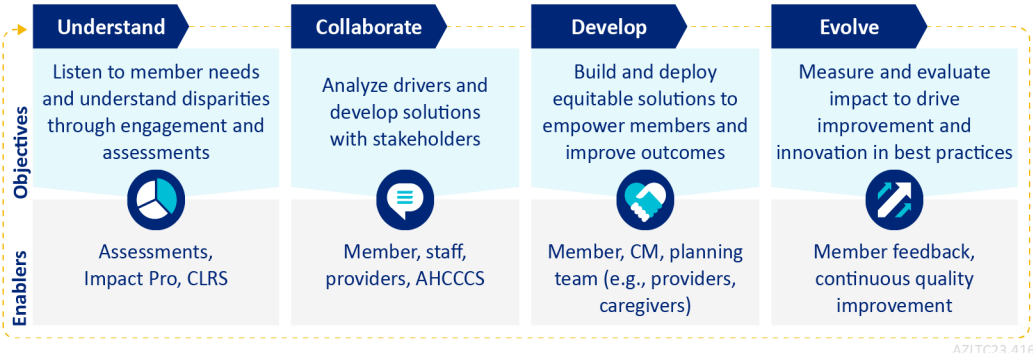


Figure 1. CM Best Practice Development and Implementation Process. Serving members with complex conditions involves understanding their needs and delivering equitable solutions to achieve their goals.

Our process to develop and implement case management best practices, as shown in Figure 1, begins by **understanding** what members need to achieve their goals. In **collaboration** with members, their families, stakeholders and experts, we **develop** best practices to validate effectiveness, creating tools and training for deployment. We continuously **evolve** our best practices using outcome data and member feedback (e.g., Member Advisory Council [MAC], CAHPS®) to confirm the approach is supporting member voice and choice, improving outcomes and promoting equitable care, adjusting whenever needed.

Prioritizing Health Equity

We are incorporating additional questions to capture race, ethnicity and language (REL) data in our member assessment to augment REL data from AHCCCS. Aggregating data in a single location facilitates CM assignments and allows our clinical leadership to tailor delivery of equitable care.

For example, in 2010, we developed our award-winning ***me**** program, **recognized and recommended by the Medicaid Health Plans of America as a best practice**. By listening to our members, we determined an empowerment culture was essential to facilitate development of member-driven goals, built on an individual's strengths. Through collaboration with CMs, we developed a goal-setting process that looks beyond clinical data in an assessment and supports members in creating personal goals as part of their person-centered service plan (PCSP). The development of the ***me**** program became an effective driver for CMs to empower members in the assessment process. Over time, we have evolved the program based on member feedback. We created a dedicated resource team, composed of CMs who support other CMs in identifying local resources (e.g., volunteer and social engagement opportunities, education), to help members meet their goals and connect with their community.

Decrease Duplication of Effort and Enhance Coordination of Care

We reduce duplication and enhance care coordination primarily through two best practices — (1) ensuring CMs serve as a single point of contact for the care team, while guaranteeing every CM has experience with people with behavioral health (BH) diagnoses, including serious mental illness (SMI), and (2) sharing data to enable timely access to information. A member's UnitedHealthcare CM is their single point of contact. The CM collaborates with the member and is supported by the member's planning team (e.g., PCP, BH providers, family members, caregivers, government agencies, community-based organizations [CBOs]). Because we require all CMs to have at least two years of SMI experience, members benefit from the additional expertise in screenings, referrals and coordination for BH care needs. Further, as member needs change (e.g., SMI designation), they receive continuous care and support from their current CM without unnecessary transition due to CM SMI experience.

The CM, as the coordinator of the member's care, clearly communicates the member's goals with their planning team, including providers, to confirm services are in alignment with goals, enhancing coordination of care and ensuring the

member receives timely, integrated physical, BH and social supports. CMs share data to reduce duplication, collaborating with providers to confirm providers are communicating required information for members receiving BH services. We share PCSPs and completed assessments with providers, as permitted by the member, to confirm a shared understanding of the member's goals and known health-related social needs (HRSN). We monitor data sharing between providers through our routine CM member chart review and through oversight by our BH coordinator.

Our integrated clinical care management system consolidates data from multiple sources (e.g., claims, health information exchange [HIE], members). Integrating data in a single location for case management and medical management promotes timely delivery of care, reduced duplication and enhanced coordination, leading to improved outcomes for our members. For example, for the 55% of our E/PD members enrolled in our Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), the CM has access to Medicare authorizations and claims in our system. Using available data, the CM coordinates the member's benefits across Medicaid and Medicare. ensuring all members of the team are aware and avoiding providing unnecessary services.

Assist Members Before and Throughout Transitions

We deploy case management best practices to reduce transition risk and offer comprehensive, integrated, person-centered care for all transitions. In accordance with Section I, Exhibit G, Transition Requirements, we deploy case management best practices to support E/PD program expansion, including:

- Using our Initial Adherence Report to monitor completion of member assessments within contractually required time periods while honoring all existing authorizations for new members, minimizing any interruptions or delays in service delivery
- Evaluating each member's transition using comprehensive data analysis and reporting, across clinical and operational areas, to confirm members have timely and convenient access to needed services (e.g., analyzing state data files, reviewing prescription fill data, monitoring claims denials, evaluating PCSP activity)

Successful Arizona Transitions

We have a history of successful large-scale transitions of all types. Our ALTCS experience includes expanding to four southern counties and Yavapai County, transitioning over 3,000 members in 2011. We also transitioned 1,400 Capstone DDD members in the North in 2011 and 1,300 members from Bridgeway when they exited the market in 2017. Additionally, we transitioned over 23,000 members for the Children's Rehabilitative Services program in 2013 and over 65,000 members from Maricopa Integrated Health System in 2017.

In the following table, we offer examples of additional member transition best practices.

Transition Type	Transition Approach CM Best Practice
New ALTCS Members	▪ Assign bilingual CM if member has preferred language to reflect member's cultural and linguistic needs ▪ Assign licensed CM (LCSW/RN) for newly enrolled members in an inpatient setting to reduce length of stay ▪ Pair a licensed behavioral health professional (BHP) with a CM for members with SMI to offer expertise and facilitate collaboration with RBHAs
Fee-for-Service for Tribal Members	▪ Use long-standing relationships to telephonically engage Tribal ALTCS CMs, before the member's transition, to discuss potential barriers, needs (e.g., transportation, electricity source, water availability, heating source) and available resources, supporting a safe and effective transition to or from their Tribal community
Acute Settings	▪ Create real-time alerts in our integrated clinical care management system, using data from Arizona's HIE, to initiate reach-in discharge planning, with licensed staff working with the hospital and meeting the member in person when barriers to discharge are identified or for members with complex issues ▪ Assess members post-hospitalization within 48 hours, exceeding contract requirements of 72 hours, to address member needs and meaningfully reduce risk of a subsequent adverse event
Nursing Facility to Community	▪ Connect members with Ability360's reintegration peer support program, offering mentoring from someone with shared reintegration experience and connections to engage in programs addressing social isolation ▪ Assess caregiver needs using Careforth, our caregiver support program, before and throughout the member's community transition, to support a safe transition and empowering natural supports
Transition Age Youth (TAY)	▪ Work with members ages 16 to 24, using dedicated pediatric CMs who are supported by our medical director, on a PCSP process focused on adulthood and independence (e.g., education, housing, employment) ▪ Partner with centers for independent living and centers of excellence on resources for youths with disabilities (e.g., Ability360's Building Bridges program, which pairs TAY members with peer support)

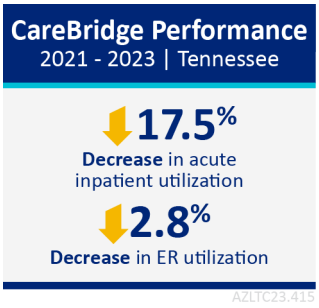
Transition Type	Transition Approach CM Best Practice
Justice System	▪ Coordinate services upon release, including medical, BH, pharmacy and HRSN care (e.g., transportation, housing), supported by our justice-focused community health worker who collaborates with the CM

Improve Member Engagement

Our member engagement best practices focus on CM-facilitated member empowerment, with specialized teams who uniquely understand member needs and alternative ways for members to engage in their care. To promote engagement, staff are trained in motivational interviewing; diversity, equity and inclusion; trauma-informed care; and strengths-based case management (SBCM). An evidence-based approach, SBCM focuses on identifying and mobilizing member strengths, resources and resiliencies, rather than solely addressing their problems or deficits. By adopting an empowering, collaborative and person-centered stance, members recognize their potential, set and prioritize goals and develop their self-efficacy and problem-solving skills. Our CMs use these strategies to connect with members and increase engagement, as evidenced by a 12% improvement from 2021 to 2022 (86% to 98%) in identifying person-centered goals in member PCSPs based on record review audits.

We have developed best practices to assist with understanding the diverse backgrounds and experiences of our members, leading to empathetic listening and improved member engagement. Our veteran navigator team comprises an LTC member, who is a veteran serving as a peer advisor, and CMs with military service experience and training by the Arizona Coalition for Military Families. This approach **better equips our CMs to support the unique needs of veterans**. In addition, we have a **well-established Diversity, Equity and Inclusion Council**, led by Arizona LTC staff, including CMs, that provides support, education and coaching to the health plan and CMs on topics that include recognizing and addressing health disparities and inequities in Arizona.

We offer members alternative ways to engage with their CM, family, community and the health care system using technology best practices. CMs use video communication, based on member preference, for additional check-ins between required planning meetings (e.g., every 90 or 180 days, change in condition or placement) and to increase participation of planning team members unable to attend meetings in person. CMs assist members in obtaining technology (e.g., internet, cell phones) through resources like Assurance Wireless and Cyber Seniors, a phone-based tech support line. We host technology workshops at local community senior centers to bridge the technology knowledge gap for seniors through training. Members can use tools such as CareBridge, which provides our high-risk home and community-based members a simplified tablet with year-round 24-hour access to advanced practice clinicians, physicians (e.g., medical, BH) and geriatricians. Members press the “red button” and are engaged with a CareBridge team member. Using this technology and care solution is a best practice to help address urgent care needs in real time (e.g., medication refills, DME, monitoring vitals, addressing HRSN) and direct members to appropriate care settings.



Coordination of Social and Community Support Services

Our case management best practices to coordinate social and community support services include facilitating early identification of HRSN, monitoring connection to community supports through closed-loop referral tools and deploying a comprehensive housing program to support members in safely remaining in their communities.

To identify social needs, we assess members for HRSN at multiple points along their health care journey and use any member engagement as an opportunity to determine potential gaps in resources. Our members voice their needs, as CMs guide them through HRSN questions included in our Standardized Assessment Tool. Further, we use HRSN assessments completed by our partners, such as DispatchHealth, Spectrum Healthcare and HouseCalls, from screenings they conduct during in-home visits to further identify unmet member HRSN.

For all member record reviews completed in 2022, **96% of member needs were met** and gaps closed, including HRSNs.

AZLTC23.447

Upon identification of HRSN, we collaborate with members to make referrals, monitoring service delivery and validating member satisfaction. Our integrated closed-loop referral system (CLRS), UnitedHealthcare Community Connector, connects members to needed services and supports, delivering data on completed referrals to our integrated clinical care management system. We enhance CBO connection in Community Connector using data. For example, in Maricopa County, between 2021 and 2023, 8% of ICD-10 Z codes submitted on claims for LTC members indicated a problem related to psychosocial needs. Understanding our membership and the potential for loneliness, we use this information to identify and connect members to CBO partners, such as the Area Agency on Aging, that can specifically address our members' needs, including social isolation. Community Connector will integrate seamlessly with the state's CLRS, CommunityCares, upon implementation. We will continue collaborating on the development and adoption of CommunityCares, contributing our experience and best practices in connecting members to needed social supports and coordinating with CBOs.

For members with housing needs, we offer specialized support, including identifying housing solutions, monitoring housing waitlists and coordinating needed home and community-based services (HCBS). Our designated housing specialist conducts technical assistance calls to address CM questions, offers CM coaching and fosters partnerships with providers and CBOs. Our housing specialist **provided assistance to 128 LTC members over the last three years**, demonstrating the success of our program.

Identify, Manage and Track Outcomes for Members with Complex Needs

Our complex care management program serves members with complex or comorbid conditions. We use data-driven best practices and sophisticated tools to identify members who require additional support quickly and effectively, deploy integrated care coordination to support condition management and track outcomes to confirm delivery of comprehensive, equitable care.

We analyze data to keep members healthy, safe and stable in their preferred settings by understanding rising clinical risk, at both an individual member and population health level. Our predictive modeling system, Impact Pro®, is central to how we identify, manage and monitor outcomes. Impact Pro offers the following features:

- Builds the comorbidity of health conditions (i.e., medical and behavioral) and influenceable factors, like HRSN (e.g., housing insecurity, literacy concerns), into the member's risk score
- Considers BH risks and physical health comorbidities during population risk analysis, promoting holistic assessment and delivery of care
- Analyzes service utilization patterns and characteristics so we can identify members with BH conditions, including members with co-occurring mood and substance use disorders
- Produces customized reports for cohorts (e.g., under age 18) and certain diagnoses, allowing us to target interventions for a given group
- Allows us to study the impact of our interventions at a population and member level to understand whether we are producing positive outcomes, such as reduction in inpatient and emergency expense and make improvements where possible

We implemented the best practice to assess members who have a rising risk for nursing facility placement. Our proprietary algorithm examines member patterns of utilization, such as ER visits for falls, unfilled medications and repeat hospitalizations or diagnoses. Identified members receive targeted engagement and intervention to support stabilization, resulting in our ability to **maintain 78% of our members in a community setting**. Our local best practice was successfully expanded to Tennessee and Ohio, resulting in 97% of members identified as at risk for skilled nursing facility placement in 2023 to remain in a community setting.

Our care managers coordinate closely with the assigned CMs so we do not duplicate services, efforts or activities, making sure authorized care aligns with the member's PCSP. In 2022, our E/PD members engaged in complex care management and disease management saw decreases in ER (18% and 65%, respectively) and inpatient (83% and 55%, respectively) utilization.

High Needs Case Management Identification and Support for Members and Their Families

As a best practice, we provide members under age 21 a high needs pediatric CM, even though it is not required by our contract. To support the complex needs of members and their families, we provide quarterly enhanced training from internal and external experts on topics specific to programs, resources and issues most relevant to our pediatric population (e.g., WIC, Head Start, Arizona Early Intervention Program, addressing respite needs for parents). In addition, members under age 21 receive an annual review by our licensed BHP, including a Child and Adolescent Level of Care (CALOCUS) assessment for members aged 6 to 17. Using this review and other assessment data, the BHP supports pediatric CMs to monitor the effectiveness of each member's services and validate whether formal and informal supports and rehabilitative services are meeting the member's needs. Any concerns or issues are reviewed with our LTC medical director and BH coordinator and discussed with the Child Family Team to evaluate for PCSP changes.

We monitor PCSPs using our Service Plan Equity Dashboard, a tool that tracks service allocation by several demographic categories, as a best practice to identify issues with equitable distribution of care. Our case management leadership team reviews trends and identifies potential barriers, gaps and system level interventions. Through this process, **we found members under age 21 are 51% more likely to underutilize HCBS than members aged 21 and up**, likely due to additional resources offered in school settings and through families providing informal caregiver supports. To support families of members under age 21, our CMs discuss options, including accessing respite services, becoming a paid caregiver and engaging with Careforth, which offers people with pediatric expertise as caregiver mentors. Using assessments to collect data, Careforth develops coaching plans, which are tailored to each caregiver's needs, sharing information with both caregivers and members' CMs to seamlessly coordinate care.

Monitor Case Manager Performance at the Individual and System Levels

Our team deploys best practices to confirm we are meeting the needs of our members, leveraging several actionable reports and conducting direct CM oversight and observation. Our approach provides a comprehensive overview of case management operations at both the individual CM and system levels, allowing for opportunities to coach CMs or implement new best practices to better serve members:

- **Case Management Clinical Intervention and Adherence Report:** Creates reports that provide data and insights on individual CM performance, adherence to program requirements and identification of member risk with the potential for clinical interventions.
- **Initial Adherence Assessment Report:** Tracks completion of the initial assessment for members, regardless of placement, compared to enrollment date, allowing for proactive monitoring. The report is used by CM supervisors who identify barriers to timely member assessments and support CMs in meeting assessment timing requirements.
- **Participation Report:** Provides data to indicate CM engagement following their initial assessment, confirms member satisfaction with services received and addresses barriers for accessing services included in the PCSP.
- **Member Record Review Tool:** Evaluates CM compliance for over 40 AHCCCS standards, including PCSP performance. Based on results, CMs receive individualized coaching and education. Aggregate trends identify opportunities for improved resources and for training for all CMs supporting the E/PD program.
- **Inter-Rater Reliability:** Evaluates consistency in practice guideline application for member assessments and service authorizations, measuring consistency across PCSP, UAT and HCBS Needs Tool. CMs with compliance less than 95% participate in remediation activities (e.g., one-on-one coaching, re-training, continual reassessment).
- **Directly Engaging With and Observing Case Management Staff:** Conducts evaluations through weekly one-on-one meetings, direct observation of the CM's interactions and feedback from members to evaluate quality of member engagement, adherence to program interventions, opportunities for additional training and areas for growth.

B5 Person-Centered Service Planning

Members lead their person-centered service plan (PCSP) process at UnitedHealthcare. We ensure our case managers (CMs) support members with dignity, respect and inclusion, promoting equitable care. A member's PCSP is driven by their goals and is developed in alignment with NCQA's Long-Term Services and Supports (LTSS) Distinction standards, awarded to us in June 2023. Our 34 years of experience serving members in the ALTCS E/PD program allow us to effectively support members in meeting their goals and achieving improved outcomes through the PCSP process, validating they receive quality, cost-effective care in the safest, least restrictive setting of their choice.

The ALTCS Guiding Principles, Adult Service Delivery System Nine Guiding Principles, Arizona Vision for Children Twelve Principles and Employment First Guiding Principles set the foundation for how we engage members in the PCSP process and train CMs to promote inclusion, member choice and empowerment. During PCSP development, members receive person-centered, trauma-informed, culturally sensitive and responsive support from their CM and planning team. Using Person-First Language and AHCCCS' tools (e.g., Discovery), CMs guide members through the PCSP process, as shown in Figure 1.

Figure 1. Approach to Person-Centered Service Planning. Members are at the center of our PCSP process, supported by their CM and planning team, to develop and achieve their goals.

Active Engagement with ALTCS Members

Active engagement relies on building trust, so members are heard and supported in their decision making. We foster opportunities for members to drive development of their PCSP, including creating goals, identifying providers and residing safely in the setting of their choice. We accomplish active engagement with members in the following ways:

Align CM relationships to member preferences: Our goal is to accommodate member preferences regarding CM assignment. We assign CMs who live in the same communities as our members and incorporate known member cultural preferences in CM assignment to facilitate more authentic member engagement in the PCSP process. We use information in the enrollment file to determine if members have specific language needs. Further, we refine CM assignment to reflect an individual's preference and cultural needs. For example, CMs use their initial engagement with members to determine if they or their families would benefit from a bilingual CM to improve the member's experience, enhance communication and promote active engagement. We accomplish these connections by monitoring member preferences, which informs our CM hiring process. We have a diverse workforce, including 30 CMs who speak 10 different languages. In addition, **83% of our CMs are women and 38% are people of color**, which reflects our membership who are 60% female and 32% who do not report as white, allowing us to make CM assignments in alignment with member needs and preferences.

Provide members flexibility in how, when and with whom they engage: CMs are flexible and work with members and their families to complete timely assessments in a manner directed by the member. Our assessment process is customizable, helping members to determine when and how they engage (e.g., day of the week, time of the day, telephonic, video, in person). Members determine who participates on their planning team, promoting supported engagement from family, caregivers and providers. In addition to defined assessment timelines for outreach, CMs connect with members routinely to validate their engagement and satisfaction with their PCSP (e.g., to follow up on changes in services, after critical events, to discuss action items). We regularly audit member engagement with their PCSP to understand how we can increase engagement.

Listen to members: CMs are trained in active listening (included in our initial and ongoing training program), reiterating what they hear and confirming the member's voice is driving the PCSP. We use nonverbal and observational cues during in-person interactions to connect and engage with members, as demonstrated in the following member story.

Connecting with Members to Promote Engagement in the PCSP Process

A member in Yavapai County was participating in a PCSP assessment but not highly engaged, offering only brief responses. Noticing the large book collection in the home, the CM asked the member about their interest in reading, making a connection on a topic important to the member. The member shared their love of reading, which was impacted by their vision issues. The CM connected the member with their local library so they could access large-print books on their tablet to remove the barrier of vision impairment. The CM's effort resulted in a deeper connection with the member, improved quality of life and increased engagement in the PCSP process.

Inclusion of All Aspects of Quality of Life

Once members are engaged, CMs further foster connection and collaboration so members feel comfortable sharing what they need and want to achieve quality home life, daily life and health. Our Standardized Assessment explores areas, including the member's medical and behavioral health (BH) needs, cognitive and functional status and health-related social needs (HRSN) to inform the development of the PCSP. Based on the responses, the assessment tailors to their individual needs by exploring various aspects of life (e.g., home safety, social isolation, nutritional support) when developing a comprehensive PCSP. For example, the assessment includes depression and anxiety screenings, which could result in additional evaluation for BH needs. Further, we use discussion questions related to advance directives and end-of-life care, prompting members to share and document their preferences with their CM, family, physicians and the Arizona Health Directives Registry.

Case managers use AHCCCS tools to further engage members and their families in a conversation on quality of life. For example, ALTCS Discovery Tools identify aspects of members' lives that bring them joy and drive individualized goal planning by determining what is most important to and for members. With the 4+1 Tool, members are prompted through questions to identify what they have done in pursuit of their goals and what else needs to occur to achieve their goals, supporting members in identifying next steps and solutions in collaboration with their CM.

Informal caregivers are critical to supporting members in maintaining their quality of life and have access to Careforth, which offers a wide range of caregiver supports. Careforth offers coaches with diverse expertise (e.g., social work, BH, pediatric, dementia care) who conduct initial and ongoing assessments of caregivers to determine their needed level of support. We average 30 new caregivers a month enrolling in this program and **85% of caregivers engaged with Careforth would recommend the program** to another caregiver. We offer additional resources to caregivers through partnerships with organizations such as Duet: Partners In Health & Aging, which provides support to Spanish-speaking caregivers statewide, and the Alzheimer's Association.

Consistency with Individual Needs and Wishes

Member voice and choice is central to all aspects of the PCSP process, emphasizing dignity, independence and individuality. Our ***me**** program, recognized by the Medicaid Health Plans of America as a national Medicaid Plan Best Practice, aims to inspire members to think creatively about their goals. The program encourages members to build on their personal strengths, resulting in goals representing their needs and wishes. After development, we provide members help in meeting their goals through our ***me**** resource team, composed of case management staff who serve as subject matter experts on community resources. They are responsible for identifying topic-specific resources to support members in achieving their individual goals (e.g., housing needs, continuing education programs, employment options, volunteer opportunities, transportation supports).

Addressing Member Needs and Wishes

From 2021 to 2022, our performance on the CAHPS survey on Choosing Services that Matter to You improved by 14%. In 2022, with 84.2% of members reporting, all services important to them are included in their PCSP and CMs understood what was important to the member. Our improvement demonstrates commitment to identifying and meeting member needs in alignment with their preferences.

For example, the team established partnerships with local community-based organizations (CBOs) (e.g., Feed My Starving Children, Humane Society) to match members to volunteer organizations aligned with their interests and to address loneliness and social isolation. For members in our Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), we coordinate transportation to activities and senior centers, including volunteering, through our enhanced NEMT benefit of 200 trips per year.

Promotion of Access to Services in Home and Community-Based Settings

Supporting Members to Stay in Their Home and Community

In Arizona, 78% of our E/PD members receive HCBS, exceeding the state average for E/PD of 76% and demonstrating our commitment to a PCSP experience grounded in self-determination, dignity, member choice, safety and supported decision making.

We support members in directing where they want to live, from whom they receive care and how they access services, using community-based and informal supports, whenever possible. Collaborating with members and their planning team, CMs thoroughly assess the level of support members need to safely maintain their independence at home, using the state's HCBS Needs Tool (HNT) and Uniform Assessment Tool (UAT). In 2023, 98% of our E/PD members identified as at risk for facility placement remained in the community with CM, formal and informal supports.

Using assessment responses and feedback from members, development of the PCSP accounts for the level of care and appropriate amount and type of authorized services needed to meet member needs. Through our closed-loop referral process, we receive information about members' engagement, which prompts CM follow-up to confirm needs are met. Our CMs ask members to identify their preferred providers and care delivery methods, using our broad and expansive provider network, including primary care and BH providers who deliver in-home services or offer telehealth capabilities. Our partnerships enable members to access care where they live, including:

- **DispatchHealth** offers on-demand urgent, acute, in-home care using their ER diversion model. The mobile care team includes an advanced practice provider and emergency medical technician, with access to an ER physician. In-home treatment includes diagnostics, lab services and prescribing or administering medications.
- **CareBridge**, implemented for E/PD members in August 2023, offers members and their families a year-round 24-hour virtual care option to connect to a doctor or nurse practitioner for immediate health concerns. CareBridge supports physical and BH needs and assists with HRSN identification and referral.
- **Spectrum Healthcare**, a statewide integrated provider, offers our members Anywhere Care, which bring services like primary care, therapy, psychiatry and point-of-care testing to members in their home.

Our housing program offers services and supports so members who choose can stay in their homes or move back into their community from a facility setting. We have a dedicated housing specialist who supports our members and their CMs on housing-related needs (e.g., identifying housing solutions, voucher availability, monitoring housing waitlists). For members at risk of homelessness, the housing specialist uses expansive knowledge of tenant rights and local housing resources to partner with CMs to keep members in their homes. For members transitioning from a nursing facility to the community, the housing specialist works with CMs and our LTC medical director to address barriers to home or community living identified through the PCSP process, including facilitating access to the ALTCS Community Transition Fund benefit for security deposits, furnishings or other items needed to establish a home.

Partnership in Action

For ALTCS members engaged with Dispatch,

57.3% **were diverted from the ER.**

In Tennessee, members engaged with Carebridge had a

50% **reduction in wait times to access DME.**

Based on survey results in Arizona,

92% **of patients were seen within 48 hours of calling Spectrum.**

AZLTC23.448

Achievement of High-Quality, Equitable and Cost-Effective Person-Centered Care

When developing and monitoring PCSPs, we routinely evaluate, adjusting the PCSP to achieve cost-effective care while maintaining alignment with member goals and high-quality care delivery.

We use objective data (e.g. CAHPS®, NCQA LTSS Core Measure Set, HEDIS®) to evaluate whether the PCSP ensures high-quality care. In 2022, **our plan rated 92.71% for the Comprehensive Assessment and Update measure**, with compliance rates on both the core and supplemental elements. The measure evaluates the percentage of LTSS members who have documentation of a comprehensive assessment that includes core elements (e.g., activities of daily living, medications) and supplemental elements (e.g., hearing, vision, speech needs). Our HEDIS results for Breast Cancer Screening, Antidepressant Medication Management and Plan All-cause Readmission exceed the Quality Compass 95th percentiles.

Member Satisfaction with PCSP Care

In 2022, 91.9% of members indicated, via the CAHPS survey, personal assistance, BH and homemaking staff were timely to appointments or communicated scheduling changes, worked the full time allotted and offered personal privacy when needed, demonstrating the quality of HCBS care we deliver to our members.

To date in 2023, our reviews have resulted in **no members with over**

100% CES.

AZLTC23.465

Case management leadership use the Cost Effective Study (CES) percentage to evaluate monthly both cost-effective and equitable distribution of care. For members with low utilization (CES<10%), CMs work with supervisors, collaborating with the planning team, to evaluate current needs to determine if additional services are required. For example, members receiving home-delivered meals are evaluated to identify potential barriers to other services, such as language, access or cultural needs. Members with a high utilization (CES>80%) are identified, so the planning team can help identify informal and community supports to maintain cost-effective care.

We use the CES review to determine drivers of underutilization, such as availability of services (e.g., type, location, availability of direct care workers [DCWs]) or HRSN. Utilization based on demographic factors (e.g., geography, level of education) is monitored to determine equity of utilization and allows us to act. For example, members in rural areas are more likely to have a CES under 10%. **Based on provider feedback, we used community reinvestment funds to support provider partners in purchasing training licenses needed for online training to reduce travel burden for potential DCWs.** Further, in a recent disparity evaluation, we learned HCBS utilization by Tribal members in Maricopa County is 76% lower than for other members with similar needs. Tribal members' families provide informal care due to the lack of interest of having non-Tribal agency caregivers and, for cultural reasons, do not want to be paid as a caregiver. Our Tribal coordinator conducts provider education efforts to increase agency recruitment of Native American individuals as paid caregivers.

Monitoring and Evaluation of CM and Member Experience

The values and principles of person-centered thinking, planning and practice include self-determination, family and close relationships and inclusion. While we have innovative data capabilities, we believe there is no substitute for direct member and community feedback. Therefore, we monitor and evaluate our CM experience, PCSP process and member experience using a combination of quantitative data and direct feedback, including Net Promoter Score (NPS) surveys; feedback from our Member Advisory Council, members, community partners and providers; monitoring of calls to member services; our NCQA chart audit report; CM PSCP reviews; and HCBS-specific CAHPS survey results. Informed by data, we identify opportunities to improve care delivery and CM performance that enable members' choice, inclusion and personal goal achievement. Through the CAHPS survey results and other feedback, we learned members with wheelchairs in rural areas experienced transportation concerns. In response, we developed a transportation escalation pathway pilot to assist members in real time when a member called about a late, missing or inadequate transport. MTBA, our NEMT provider, used an established communication pathway for immediate resolution and tracking of concerns. Within the pilot's first three months, MTBA identified a gap and added two wheelchair-accessible vehicles in Mohave County and one in Yavapai County in direct response to member needs, increasing satisfaction, as well as interaction with family and community inclusion.

B6 Performance Data and Metrics Collected

NCQA recently recognized our excellence in using data to drive performance metrics, including data gathered in partnership with members, by awarding UnitedHealthcare its Medicaid Health Plan Accreditation and Long-Term Services & Supports Distinction. This recognition is the result of decades of commitment in collecting and using data to inform innovative initiatives for continued advancement of our program and to improve our service for members.

Types of Data Collected, Monitored and Analyzed to Improve Outcomes and Initiatives

We have a dedicated analytics team that collects data and reports findings as part of our Continuous Quality Improvement (CQI), Population Health Management (PHM) and Quality Management and Performance Improvement (QMPI) programs and initiatives.

Data Collected to Monitor and Analyze Performance Metrics

As shown in Figure 1, our comprehensive approach to data collection, monitoring and analysis enables data-driven decisions promoting equitable person-centered care. At defined intervals and for each operational area (e.g., grievances and appeals, case management), we collect quantitative and qualitative data and insights to understand members' needs and evaluate our performance. To understand and address disparities, we analyze and compare data with membership characteristics such as condition prevalence, utilization patterns, race, ethnicity, language and urban and rural factors. We analyze medical, behavioral health (BH) and health-related social needs (HRSN) data to understand performance drivers and develop targeted solutions to drive continuous improvement. Our Strategic Management Analytic Reporting Tool (SMART) data warehouse consolidates data (e.g., claims, member, provider, authorizations, subcontractor) from internal and external sources (e.g., AHCCCS blind spot data) to support ongoing performance monitoring and predictive modeling. Along with data ingested, housed in and mined from SMART, we collect, record and use information from direct interactions with members, caregivers and providers in our integrated clinical platform.

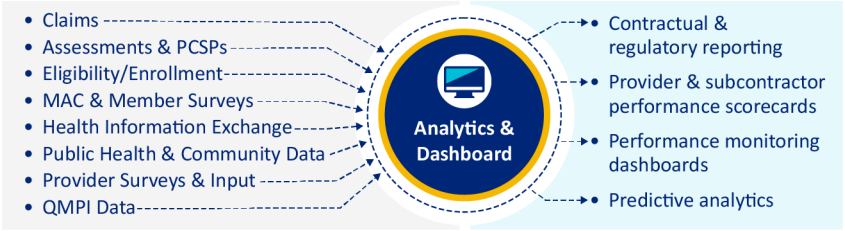


Figure 1. Comprehensive Data Integration. We use data from many sources to improve member health outcomes and our performance.

On a daily, weekly and ongoing basis, functional area leads review dashboards and reports, including our comprehensive Health Plan Scorecard, to monitor outcomes data and Key Performance Metrics (KPMs), such as HEDIS® measures, electronic visit verification and network adequacy. If performance gaps arise, the area lead provides an in-depth root-cause analysis and action plan to address the gaps. These items are documented in a scorecard our leadership reviews monthly to confirm the gap is addressed and the KPM meets or exceeds goals.

Improved Access to SDOH Services

93% ↑ *Members Whose Providers Filed Z Code Claims (2021-2022)*

When providers use Z codes to bill, we can capture and better understand members' health and social needs to develop targeted interventions, like our Manzanita Outreach partnership.

AZLTC23.421

Data Collected in Partnership with Members

To honor member voice and choice, we gather feedback from surveys and direct contact with members, their families and caregivers. We use this feedback and insight to tailor our supports, prioritize equitable person-centered care, improve member satisfaction and enhance safety and quality of care across the services members receive. We collect member-, population- and system-level data to improve care delivery and services, staying mindful that data represent a person. The following table shows key data collected in partnership with members to improve outcomes and satisfaction.

Type of Data	Description
Member Advisory Council (MAC)	We actively recruit a representative sample of members from across geographic service areas (GSAs) to collect diverse insights and perspectives, which we use to improve equitable access to care and the member experience**. For example, we identified an HRSN gap regarding food insecurity in the North GSA. To address this need, we partnered with Manzanita Outreach to provide locally sourced produce to home-bound seniors.**

Type of Data	Description
Quality of Care (QOC)	We collect and analyze member-reported QOC concerns and act immediately to confirm member safety and support improved member health outcomes. **For example, a member at an assisted living facility (ALF) reported staff abuse to their case manager (CM) (i.e., a case of immediate jeopardy). Our QOC team promptly notified AHCCCS and coordinated efforts with medical directors, CM management and ALF network providers to relocate all members to another facility.**
Member Services	Our person-centered, integrated Advocate4Me call center team is staffed with advocates trained to assist members with sensitivity to cultural differences and special needs. They screen members for unmet BH, physical health, pharmacy and HRSN. **In the first half of 2023, of those with an identified unmet HRSN and interested in receiving additional services, 96% accepted referrals to local resources.**
CAHPS®	Monitoring CAHPS data provides valuable insights into member experience and satisfaction and helps us identify opportunities to improve CM and member engagement. **For example, we identified a disparity in member satisfaction with transportation services in the North GSA. In response, we created an action plan with our transportation vendor, adding three more wheelchair accessible vans to improve service.**
Case Management	Assessment, person-centered service plan (PCSP), coordination and outcomes data our CMs collect are recorded in our integrated clinical platform for ongoing analysis and monitoring. **Figure 2 shows the impact of our CQI activities that improved how CMs collect data in partnership with members.**

Processes Used to Inform and Initiate Performance Improvement Activities

Using advanced data analytics and tools, we identify trends and prioritize opportunities and resources to make informed decisions on performance improvement initiatives, actions and accountability. These tools identify ways to improve outcomes generally, but also address disparities in outcomes across populations. To assess our intervention effectiveness and adjust current initiatives, we adhere to Plan-Do-Study-Act (PDSA) methods and member-centered strategies. When we identify a process improvement opportunity, we create a hypothesis pertaining to a process improvement that might lead to a better outcome. After mapping the process and making the changes, we study the results. Our technologies, tools and partnerships are integral to the PDSA CQI activities, facilitating data capture, documentation, monitoring and collaboration; and confirming measured improvements originated from accurate, comprehensive data and diverse perspectives. These include:

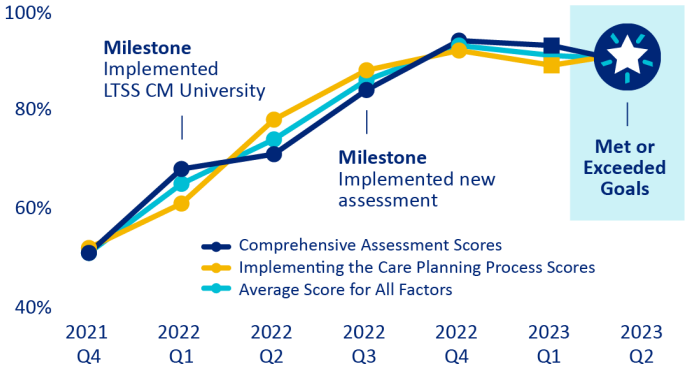


Figure 2. Process Improvement Impact. We used CQI methods to drive improvements in CM processes.

- **Reporting Tools**: We use a comprehensive suite of tools, including those described herein, to identify trends, facilitate data-driven decision making and track outcomes. Our Quality Solutions Platform provides extensive operational data and reporting for HEDIS and CMS core measures and submeasures, including member-level detail used for race and ethnicity stratifications and performance reporting.
- **Monitoring Technologies**: Our data management systems (e.g., SMART data warehouse) and business intelligence tools (e.g., Talend, Crystal SAP, Tableau) facilitate collection, analysis, tracking, trending, sharing and reporting.
- **Partnerships**: Our partnerships improve the member and provider experience through community involvement. For example, we have partnered with the American Heart Association (AHA) since 2020 to develop and provide training in English and Spanish to community health workers (CHWs) whom we sponsor to attend. The AHA's Conozca Su Corazón (Know Your Heart) training focuses on CHWs serving predominantly Black, American Indian or Hispanic communities with opportunities for continuing education units and ongoing support. To date, the AHA has **conducted 10 training sessions for 488 CHWs, including 276 Spanish-speaking CHWs**.

Processes Used for Member- and Population-Specific Data Analysis

To identify and quantify disparities, we analyze data by select variables, such as gender, race, ethnicity, language, social risk factors, GSA, county and applicable member designations. We apply CQI methods to improve provision of culturally and linguistically appropriate services to mitigate or eliminate barriers or disparities. To confirm data is as complete and

accurate as possible, we collect critical data elements from the health information exchange, case and care managers, AHCCCS, claims and other sources. We conduct root-cause analysis to further understand barriers to meeting established goals, starting at baseline and thereafter with each remeasurement. Based on aggregate and subpopulation analyses and evidence-based guidelines, we implement targeted interventions focused on improving health and equity.

For example, through subpopulation analysis of cervical cancer screening measure data, we found a need to reduce a disparity for Black or African American members. We conducted a literature review and root-cause analysis to identify barriers (e.g., lack of trust of health plans, lack of representation in educational materials) and implemented strategies to reduce them (e.g., tailoring education materials culturally relevant for Black or African American members). **These efforts drove a statistically significant improvement for Black or African American members from measurement year 2020 to 2022 (from 48.8% to 51.8%).**

MCO Decision-Making Processes

The Quality Management Committee (QMC) is one of our key local decision-making bodies with oversight and input from senior leaders, medical directors and operational leads. Chaired by our chief medical officer, our QMC coordinates, implements and integrates CQI activities for members enrolled in the E/PD program. The QMC recommends policy decisions, reviews provider engagement in QMPI programs, institutes actions and confirms follow-ups. Our QMC oversees our MAC, Provider Advisory Committee, Medical Technology Assessment Committee, Healthcare Quality Utilization Management Committee and Service Quality Improvement Subcommittee (SQIS). It verifies that our vendor relationship owners host and lead Joint Operating Committee meetings with subcontractors to evaluate their performance and make decisions regarding subcontractor process improvement opportunities. Using KPMs and data collected in partnership with members, each committee has a critical role in sharing information, improving member health outcomes and informing program initiatives. For example, based on CAHPS results analysis, in April 2023, we developed and deployed a value-based purchasing (VBP) pilot incentive for two of our Accountable Care Organizations. The pilot focuses on improving the member experience, as measured by the Rating of Personal Doctor and Getting Care Quickly CAHPS questions.

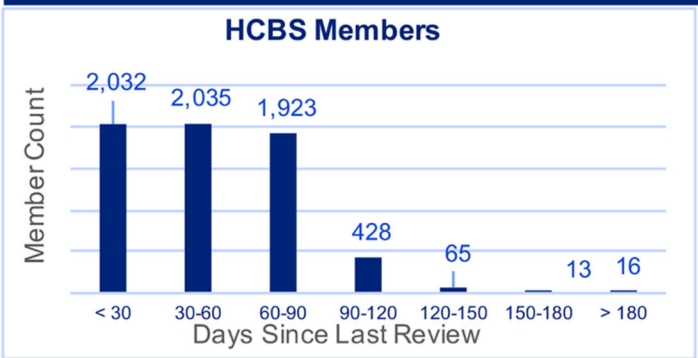
Sample Reports Demonstrating Our Comprehensive Monitoring and Analysis Processes

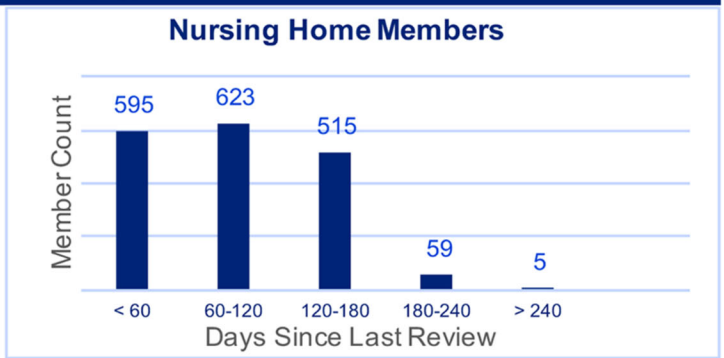
The samples herein are a small portion of the data we collect, analyze, monitor and transform into action to improve member health outcomes, case management activities and augment our CQI, PHM and QMPI initiatives.

Why the Data Matters	Data Sources	Monitoring and Analysis Processes
Sample Report 1 of 3: Case Management Clinical Intervention and Adherence Report		
We use the data to ensure each member receives quality and timely services in the right setting and to monitor CM compliance with contract requirements.	Case management data in our integrated clinical care management system and the Client Assessment and Tracking System (CATS)	Our CM leadership team reviews the report monthly for targeted CM intervention. They use the data to identify members with potential clinical intervention needs (e.g., BH case review, review of LTSS services), CM coaching and systemic training or process improvement opportunities.
Sample Report 2 of 3: Hotspotting		
Hotspotting is a multifaceted, dynamic, on-demand tool for identifying members needing intervention, evidence-based care or supports to address health-related social needs or inappropriate utilization.	Claims, 834 enrollment files, additional AHCCCS-supplied data (e.g., DUGless, blind spot), case and care management enrollment, predictive risk stratification data	Data are refreshed monthly, and local leadership monitors trends and health outcomes over time to identify members for targeted intervention. We can zoom in or out at program, population and member levels to inform initiatives for improved member health outcomes and reduced health disparities. Users select from a menu of conditions and social factors with list or heat map views to implement resolutions.
Sample Report 3 of 3: Repeat Caller Dashboard		
Repeat calling within a brief timeframe or with the same question or concern indicate that a member, caregiver or provider may need additional assistance, or it may indicate training needs.	Call center operations performance data	Data are refreshed daily with a three-day lag. Supervisors drill down to member, advocate or call type to pinpoint call repetition cause and to address the issue according to identified scenarios. In addition, we review call drivers, key metrics and member survey data (e.g., Net Promoter Scores) during monthly operations and SQIS meetings.

Sample Report 1 of 3: **Case Management Clinical Intervention and Adherence Report**

Timeliness of Review



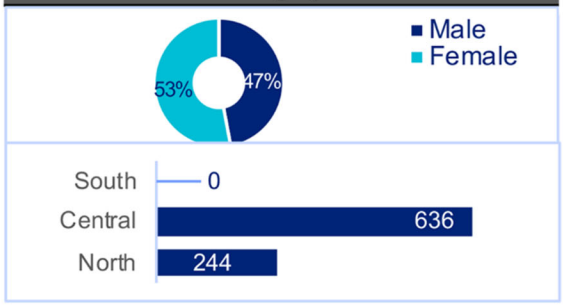


Members Needing Service Review Based on CES

Member Counts

CES %	Possible Interpretation	Count of Members	Action Needed
>100%	Over Utilizer	1	Schedule Case Review for Members on Tab E
80-100%	Super Utilizer: At Risk of moving to Nursing Facility	113	Schedule Case Review for Members on Tab F
<10%	Under Utilizer: Posible Care Gap	763	Schedule Case Review for Members on Tab G

Demographics



BH Assessment

BH Need	# Members	Member List
Psychotropic Medications Only	4,203	Tab A
BH Placement or Services Only	97	Tab B
BH Placement or Services with Medication	947	Tab C
Children under 21 with no BH needs	104	Tab D

*Members identified in the following member lists need to be checked for up to date BH review by case manager and licensed behavioral health professional.

Case Manager Operations Summary

	Baseline	Individual
	Average for all CMs	LAST NAME/FIRST NAME
Caseload	42	43
Cases Needing Timeliness Review	3	1
Cases Needing BH Review	25	21
Cases Needing HCBS Review	5	16
Percentage of Cases Needing Action	70%	79%

*Select a Case Manager from the dropdown list

Figure 3. The Right Setting and Services. Screenshots depict KPMs we monitor to verify quality care and appropriate type and quantity of services.

Sample Report 2 of 3: **Hotspotting**

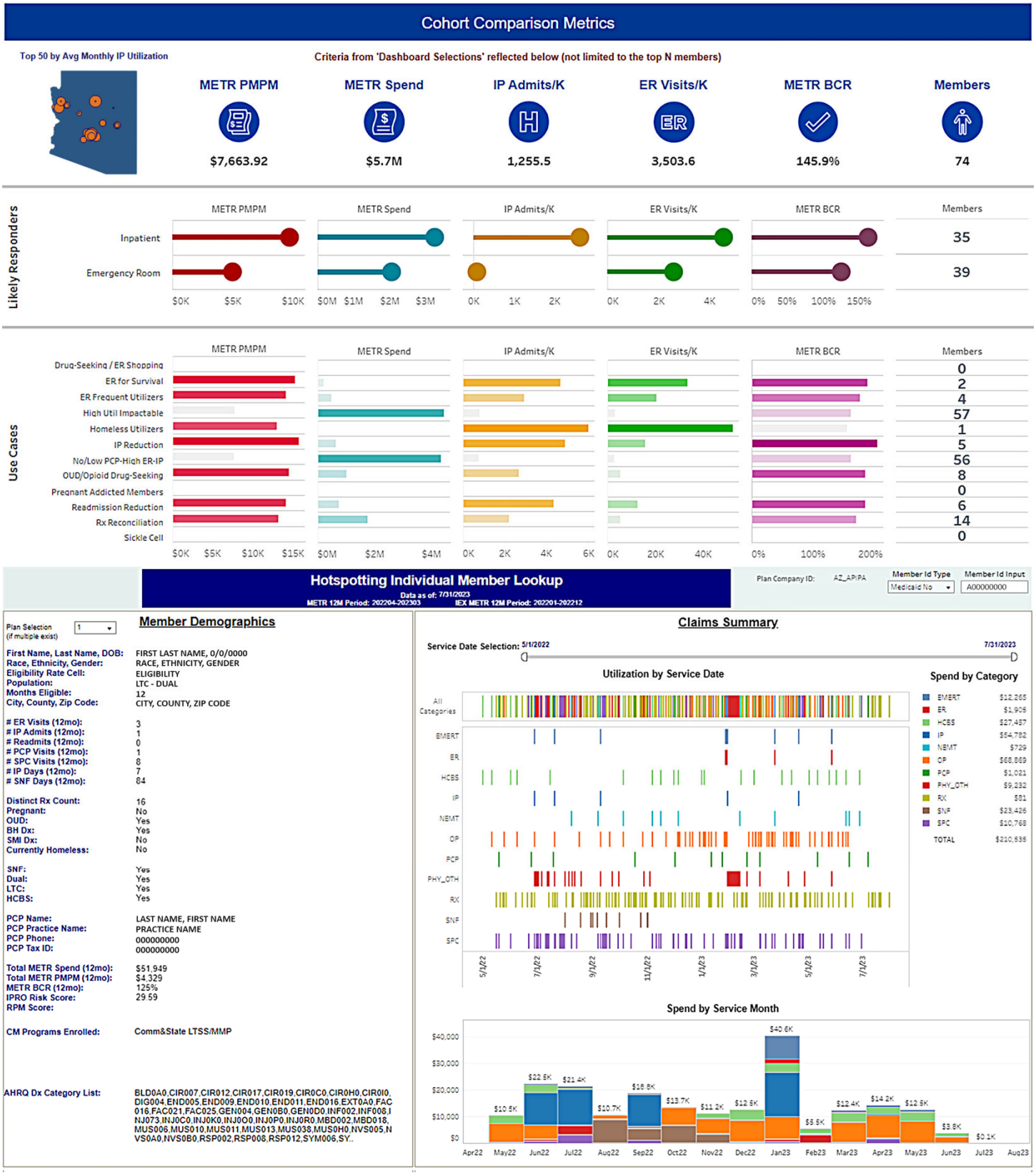


Figure 4. Hotspotting Tool. Two screenshots from the same tool depict population and member drill-down capabilities in near real time for targeted interventions.

Sample Report 3 of 3: **Repeat Caller Dashboard**

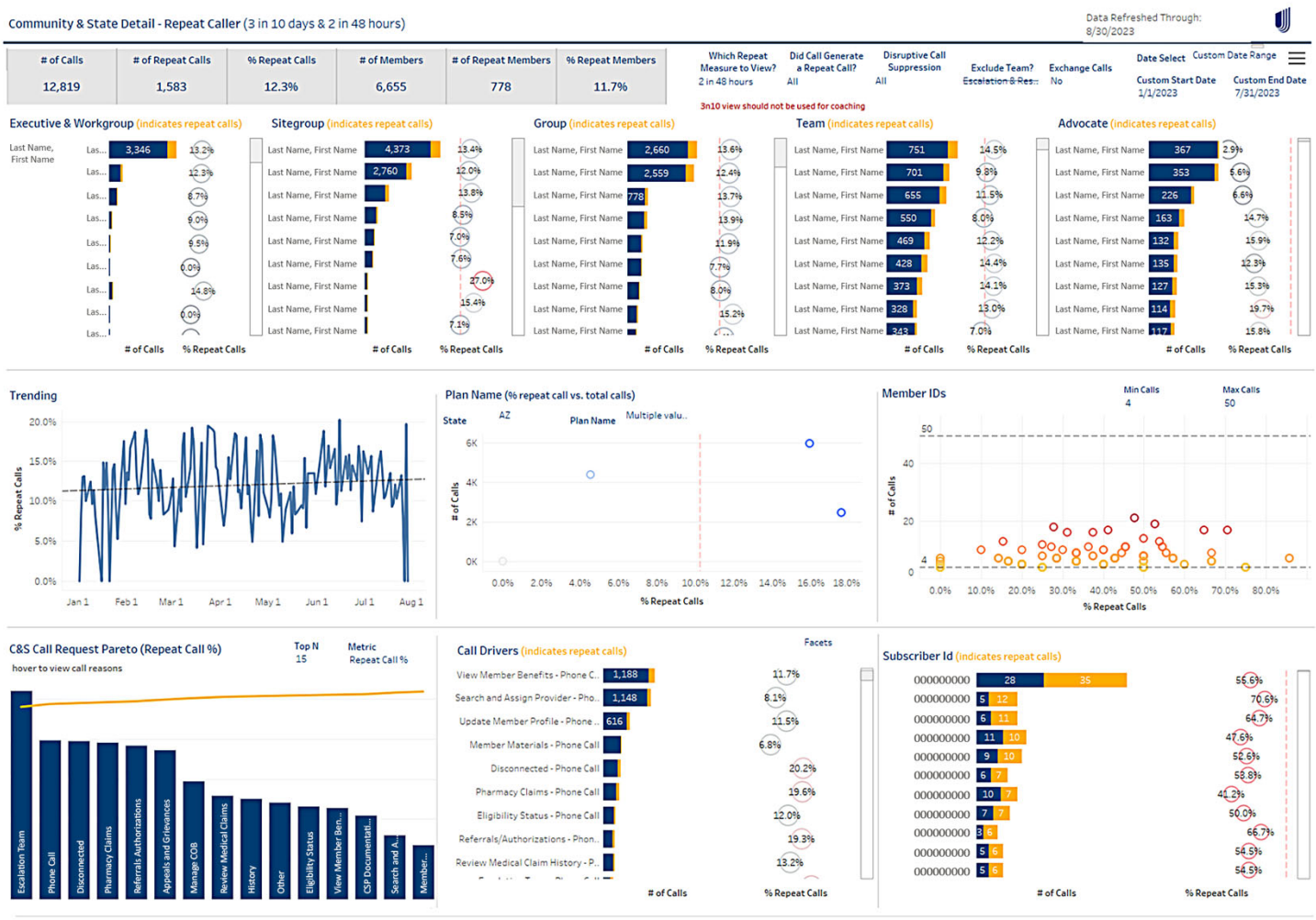


Figure 5. Repeat Caller Dashboard. Quickly identifying repeat callers enables us to ensure members receive appropriate support and services.

B7 Network Development Strategy

UnitedHealthcare has a network that ensures members receive timely, high-quality, safe, equitable and effective care. Our consistent, data-driven approach draws input from members, caregivers, providers and key community stakeholders, guiding our actions and development of both traditional and innovative solutions to address provider shortages in rural areas. To maintain, adapt and evolve a comprehensive and diverse network, we employ the following strategies:

- **Listening to Members and Providers:** We listen to member and caregiver feedback through our Member Advisory Council (MAC), member feedback to case managers, call center trends and member surveys. We value our provider relationships and incorporate feedback via multiple methods and sources, including provider forums, meetings with provider advocates and our issue resolution process, disputes, call center trends and provider surveys.
- **Evaluating Our Network:** We continuously monitor our network for quality, access and gaps to make sure members can access care. We use planning tools like Quest Cloud analysis, Zelis Network 360®, state file review and competitive analysis. Our network team meets regularly with health plan leadership and our workforce development administrator to address network enhancements and workforce opportunities.
- **Recruiting, Contracting and Credentialing Providers:** We promote retention by recruiting providers with the right credentials, experience, knowledge and passion to serve our members. We conduct contract negotiations and considerations are made based on multiple factors, including geographical needs, accessibility to services, quality and reputation of the provider, and the needs of our culturally and linguistically diverse membership. We have established mechanisms for confirming the quality of our network, including through our credentialing process, ongoing monitoring, provider education and value-based purchasing (VBP) arrangements.

In an ever-changing provider landscape, our core strategies drive continuous development efforts, addressing each challenge, including known HCBS provider shortages and skilled nursing facility (SNF) gaps in rural areas, to provide equitable, holistic, local care options.

Methods to Build Home and Community-Based Providers in Rural Areas

Application of these intentional processes of listening, evaluating, recruiting and monitoring led to a clear recognition of how the COVID-19 public health emergency placed added stress on the preexisting HCBS workforce shortage. Acknowledging and proactively seeking to understand such impacts directly influences our methods and approaches to reveal disparities and better support the current and future needs of all our members. Through our social determinants of health (SDOH) dashboard that tracks members' health-related social needs (HRSN) and other data monitoring, we understand the socioeconomic and geographic variables that drive inequities in access to care for those living in urban and rural portions of our state, and we actively work with stakeholders to raise awareness and identify local solutions. Rural members have higher trends in inpatient and emergency room (ER) utilization and lower PCP and behavioral health utilization than their urban counterparts. For example, members in Yavapai County saw ER utilization grow by 26% from 2021 to 2022, while in Maricopa County, ER utilization grew by 4% in the same time period. Our HCBS and in-home investments and partnerships aim to lessen health disparities like these for our rural members.

To build upon the capacity of HCBS providers in rural areas, we are supporting them through:

- **VBP Contracts:** We offer a range of provider VBP models, supported by tools, data and multidisciplinary teams, designed to incentivize improvement of targeted quality measures and member experience, while lowering costs. **Our Health Equity Program incentive (HEPi) model, which offers an additional provider bonus for select stratified HEDIS® measures, is designed to reduce quality of care disparities identified for marginalized or at-risk populations.**

- **HCBS Workforce Investments:** We are making a **$500,000 grant to HCBS staffing agencies**, including Prileo Home Care, Consumer Direct Care Network Arizona, and Ability360 to recruit and retain 2,000 Direct Care Workers (DCWs) and made a **$99,000 grant to Consumer Direct Care Network Arizona** to hire a workforce development specialist, expand training and online resources, offer CPR classes and to provide fingerprint clearance cards for DCWs.

- **Healthcare Hub:** We actively promote the Healthcare Hub (an interactive centralized online resource for health care career seekers) via social media, provider communications and training and via one-on-one provider interactions. We also post our open positions through Healthcare Hub to actively recruit staff.

To help members receive care, we connect members with providers in their home to increase timely access to care and reduce the burden on HCBS services. This helps members experience more independence and choice in their care while reducing the need for transportation.

- **CareBridge Partnership:** CareBridge's physician-led interdisciplinary care team provides critical clinical support for HCBS members, including virtual care 24 hours a day, seven days a week. The CareBridge predictive risk model identifies higher needs for rural members, demonstrated by rural members being 52% of targeted members enrolled despite only being 27.5% of our membership.
- **In-Home Primary Care:** We have identified and continue to recruit in-home primary care services throughout the North and Central geographic service areas (GSAs), and these services will be available in the South GSA for go-live.
- **Spectrum Anywhere Care:** Spectrum's Anywhere Care offers mobile, home and community-based whole-person, integrated and multidisciplinary health care. Anywhere Care specialists are trained to assess SDOH for members.

Supporting informal caregivers fills gaps in rural workforce shortages. We support caregivers and reduce strain on workforce capacity through:

- **Duet: Partners In Health & Aging:** This organization focuses on supporting family caregivers, especially those caring for family with Alzheimer's disease or dementia. Alzheimer's disease is expected to increase in Arizona by 33.3% from 2020 to 2025, much higher than the national average, and Hispanic Americans are 1.5 times more likely to develop Alzheimer's than white Americans. To address this disparity, **we have invested $99,000 over three years to improve access to caregiver support groups and peer support resources for Hispanic families** across the state.

- **Careforth:** Careforth is a market leader in the caregiver space offering coaches with diverse expertise who engage, empower, educate and support informal caregivers.

Addressing Institutional Capacity in Rural Areas

Our approach to building institutional capacity in rural areas includes maximizing the available beds by continuing to support members choice to live at home and a tactical framework with identified SNFs to maximize their revenue, staffing and existing infrastructure. We begin with an assessment of SNFs in rural areas by reviewing capacity, CMS Star ratings and their willingness to partner and possibly diversify. Together, we develop a strategic plan, including services needed in the area and techniques to maximize revenue streams (such as improving CMS Star ratings and Medicaid VBP). Our SNF support will also include technical assistance in understanding the drivers of quality ratings and additional licensing requirements needed for diversification of services, such as home health, adult daycare and other methods of service delivery. To support resource development, we will provide assistance in creating a quality improvement plan for areas of opportunity with the SNF CMS Star ratings and provide grants for infrastructure improvements to expand services, such as converting space for new services and support staff development, including recruiting, training and retention. Evaluation will include improvements in capacity, new services and Star ratings. For those interested partners, we will initiate an SNF VBP for quality improvement as measured by Star ratings leading to increased revenue from Medicaid and Medicare.

We actively address adequacy and capacity for SNFs. As new facilities are added, we outreach for contracting and share the support UnitedHealthcare can offer. To empower members to reach their care goals, we help them stay in their homes or return home when they are able, and we actively assist members transitioning from SNFs back home, maximizing SNF capacity. We monitor and evaluate member placement data to increase the percentage of members residing in their home with the goal being to return members to home or locate other housing options. We have a reintegration specialist who supports the CM preparing members for discharge back into their community. We are contracted with multiple providers to purchase items using community transition funds to address the financial hardship and social barriers members experience after living in an SNF setting for an extended period. The reintegration specialist assists in accessing, using and tracking the use of these funds. We have been able to meet the needs of all members transitioning to community settings.

Assisting Skilled Nursing Facilities Expanding into Community-Based Care

As we address institutional capacity in rural areas, we have partnered with SNFs to help them expand into community-based care. Navigating the licensing requirements to expand into community-based care can be a challenge, and we guide SNFs through this process. We have assisted four SNFs with the development of specialized behavioral health units and developed an assisted living alternative for members with behavioral health needs. Most recently, we supported two SNFs in Yavapai and Navajo counties with expanding their services into community-based care. We supported their efforts to convert a wing in the SNF into an assisted living facility (ALF). This met the needs for higher demand for ALF options in rural counties and supported a SNF, as nursing facility censuses have decreased since the pandemic. These arrangements have helped SNFs support appropriate member care and enabled our rural-based members to live closer to their families. We are connecting with SNFs in other states, like Ohio, who have successfully moved into community-based care to determine best practices, share lessons learned during Joint Operating Committees and connect them with Arizona providers.

Maximizing Available Resources

Improving access to health care services by maximizing all the available resources for members and providers in rural areas is a priority. Together, we are improving health equity, outcomes and reducing disparities by building in new capacity and care access. Innovative partnerships help providers maximize available resources, gain data insights and receive advanced coordination support resulting in high-quality care for our members. To support providers, we collaborate with the partners, such as:

- **MD Ally:** We have committed to a pilot with MD Ally designed to divert avoidable ambulance and ER use for non-emergent events via direct integration with fire department 911 dispatch centers, using clinical pathways to connect members in near real time using telehealth with emergency trained physicians.
- **AristaMD:** In collaboration with AHCCCS and once a new provider type is available, we are ready to launch E-Consult Services (AMPM Chapter 300, Policy 320-I) with AristaMD. This service will be available across our network, and rural PCPs will especially benefit. It provides an additional option for holistic, local care to individuals with complex illness through a peer-to-peer e-consultation with a network of more than 70 specialists.
- **SNF at Home Pilot:** In October 2023, we are executing a SNF at Home pilot with home health agency Patient Care Advocates designed to increase member voice and choice, by safely providing effective SNF level of care in the least restrictive, most cost-effective setting. Based on lessons learned, we will replicate this model in partnership with SNFs to further expand their services and resources to home-based settings.

As we expand the HCBS provider network and SNFs' services, especially in rural areas, we are committed to comprehensive programs that prioritize communication, training and collaboration with providers to ease their administrative burden. For example, our provider advocate model builds strong relationships with HCBS providers and SNFs through in-person visits, online training and telephonic support. Provider advocates support providers with education, claims and billing support and electronic visit verification (EVV) training. Further, we monitor and engage providers of all types and sizes with education, including trainings on implicit bias and cultural competency.

Three-Year Action Plan

As an incumbent, we have a well-established network and a trusted program to build upon. In the following table, we have outlined our action steps and measurable outcomes for the first three years of the contract.

Action Steps	Measurable Outcomes
Contract Year Ending (CYE): 2025 ▪ Network, quality and case management teams to conduct listening sessions with multiple SNF and HCBS providers and their associations (e.g., Elderly and Physically Disabled Providers Alliance, Arizona In-Home Care Association) and members, families and caregivers during MAC meetings ▪ Clinical, financial, network teams and health plan leadership to: - Analyze member data, such as EVV and provider utilization, single case agreements and grievance and appeals to identify gaps in HCBS and SNF network	**CYE: 2025** ▪ Quarterly listening sessions with providers and their associations ▪ Quarterly listening sessions with MACs ▪ Identify at least one SNF to expand services ▪ Introduce at least one provider to the HCBS and SNF VBP models ▪ Identify at least two SNFs to introduce SNF at Home care model

Action Steps	Measurable Outcomes
- Identify SNFs we can support in transitioning available space for community-based services, such as assisted living or adult daycare - Create and expand telehealth capacity in general and at SNFs, including kiosk for rural areas - Identify geographic expansion opportunities for SNFs - Identify participating providers for HCBS VBP programs and work with AHCCCS on EVV reporting to support VBP programs - Identify SNFs to introduce SNF at Home - Evaluate Health Equity Program Incentive (HEPi) performance ▪ Network, health plan leadership and other key stakeholders: - Evaluate performance (CareBridge, SNF at Home, MD Ally, AristaMD) - Ongoing evaluation of network adequacy, including new network in South GSA	▪ Establish baseline for measuring cost and quality outcomes for CareBridge ▪ Compliance with contract requirements for network adequacy in new GSA
CYE: 2026 ▪ Clinical, financial, network teams and health plan leadership to: - Identify licenses needed for SNFs to expand into community-based care programs and assist with license or development costs for expansions - Evaluate provider performance in HCBS VBP program - Assist additional providers in establishing SNF at Home - Consider further expansion of HEPi contracts with providers ▪ Network, health plan leadership and key stakeholders to: - Support MD Ally in expanding services to more urban and rural areas by facilitating relationships with local fire departments - Continue to educate providers on AristaMD, especially in rural areas	**CYE: 2026** ▪ Measurable increase in number of providers delivering new services from baseline (e.g., in-home PCP, adult daycare) ▪ Grants provided to SNFs for licensing or development costs ▪ Establish baseline for measuring quality outcomes for HCBS VBP program ▪ Improvement of 1% to 2% from baseline in quality outcomes and cost for CareBridge ▪ Significant increase in utilization of new programs (e.g., AristaMD, MD Ally) from baseline ▪ Double number of providers participating with HEPi program from baseline
CYE: 2027 ▪ Clinical, financial, network teams and health plan leadership to: - Assist with license or development costs for SNF partners expanding into community-based care - Support SNF partners with implementation of community-based care - Evaluate performance of SNF at Home and consider further expansion opportunities of SNF at Home model with more providers - Share outcomes of SNF at Home and community-based expansions with providers, associations and other key stakeholders - Evaluate HEPi program and adjust program as needed - Network, health plan leadership and other key stakeholders evaluate MD Ally expansion programs	**CYE: 2027** ▪ Continued increase in number of providers delivering new services from CYE 2026 ▪ Grants provided to SNFs for licensing or development costs ▪ Increase of 3% to 5% in quality outcomes attributed to HCBS VBP program from baseline ▪ Improvement of 1% to 2% from CYE 2026 for quality outcomes and cost for CareBridge ▪ Evaluate HEPi program outcomes with goal of improving disparities by 5% for specific stratified HEDIS measures

B8 Workforce Development Strategy

UnitedHealthcare's commitment to continuing to grow a strong Arizona workforce is reflected at the highest level in our organization. In 2022, the United Health Foundation **committed $100 million nationally over 10 years to create opportunities for 10,000 underrepresented and diverse clinical professionals**. In year one, nine Arizonans received scholarships through this funding with more local workers to benefit over the next decade. We are making a **$500,000 grant to local home- and community-based services (HCBS) staffing agencies Prileo Home Care, Consumer Direct Care Network Arizona and Ability360**. This local funding will help our partners recruit and retain **up to 2,000 Direct Care Workers (DCWs)**.

Our Workforce Development Philosophy

Our workforce development (WFD) philosophy aligns with the Arizona Workforce Development Alliance's (AWFDA's) five C's: building providers' capability, capacity, connectivity, culture and commitment. By analyzing data and soliciting feedback from all stakeholders — including members, DCWs, our own employees, primary care and specialty providers, community-based organizations (CBOs) and AHCCCS — our WFD actions align to the five C's:

- **Capability:** We build workforce skills through timely and accessible training. Our partnership with Consumer Direct Care Network Arizona expands statewide training access and online WFD resources for DCWs. Easier access to empowering professional development tools helps workers expand their capabilities.
- **Capacity:** We actively partner with AHCCCS to grow a sufficient workforce to meet future needs. To address provider recruitment and career pathway challenges, we promote the Healthcare Hub — an interactive, centralized online resource for health care career seekers. We use social media, provider communications and trainings as promotion tools. We also post our open positions through Healthcare Hub to actively recruit staff.
- **Connectivity:** We foster connectivity to promote better WFD outcomes. Our DCW Transportation Program, which provides support to workers with transportation barriers so they may complete their scheduled visits, helps ensure member access to care, member satisfaction and health outcomes.
- **Culture:** Our WFD efforts promote equitable, culturally aligned and integrated health care. Our Direct Care Referral Program uses bidirectional data sharing with DCW agencies to provide detail regarding members' service needs and preferences. We develop and sponsor initiatives such as our Tribal Internship Program offered in collaboration with Native Health in Phoenix. This program recruits, trains, employs and empowers new Tribal health care workers to serve our communities — improving access to equitable and culturally focused care for Tribal members.
- **Commitment:** Through our Optum Health Education free continuing education platform, Arizona providers completed 5,082 courses from 2021 through 2022 earning 5,540 CEUs. Topics we offer include Supporting Resiliency in Older Adults: A Focus on Life's Purpose and Driving Health Equity through Technology. All providers have access to this free education platform.

Using Data to Inform the Monitoring and Efficacy of Workforce Development Strategies

We continuously use data insights to inform our WFD strategy and monitor the efficacy of WFD partnerships. This drives our WFD philosophy and ensures alignment with ACOM 407 and ACOM 407 Attachment A. As an active AWFDA member, we apply the most current data insights to WFD initiatives. These include:

- **Arizona Healthcare Workforce Goals and Metrics Assessment (AHWGMA):** This reporting tool captures provider trends from all counties in the state and focuses on workforce capacity and recruitment.
- **Healthcare Network Employee Questionnaire (HNEQ):** This questionnaire includes responses from more than 16,000 health care workers and covers key metrics like demographics, salary ranges, satisfaction, challenges and workforce training needs.
- **Arizona Provider Workforce Database:** We are pleased to support the development of this new, innovative AHCCCS-driven WFD database. Working in partnership with Bill Kennard at the Administrator Office of Healthcare Workforce Development, our workforce development administrator (WFDA) is proud to co-chair the joint MCO collaborative that is helping to build and implement this database. The tool will combine existing data such as the AHWGMA and HNEQ with electronic visit verification (EVV), Bureau of Labor Statistics, MCO and

other data — empowering providers and other key stakeholders to make informed WFD decisions to align with members' needs.

UnitedHealthcare also leverages provider and member survey data, health disparities data, state and census analytics and provider performance data to inform WFD initiatives. **To align WFD efforts to our own health equity initiatives, we analyze data from our proprietary social determinants of health (SDOH) insights dashboard**, built from member-reported health-related social needs (HRSN) and provider Z code data (which tracks the social, economic and environmental determinants known to affect health-related outcomes). SDOH insights drive many of the partnerships described throughout our proposal. We are also building our own WFD analytics dashboard to inform and monitor WFD initiatives. We have successfully used similar dashboards in other states like Tennessee (see Figure 1) and Ohio. Using this tool, we are developing Arizona's WFD dashboard prototype. Dashboards provide teams with data to drive initiatives, including enhancing capacity and new provider supports.

Workforce Development Outcomes

Our WFD outcomes are supported through strategic local partnerships and investments deployed based on data and stakeholder feedback. Our WFD community partnerships expand local workforces driving increased access to equitable care. In addition to our **commitment to recruiting and retaining up to 2,000 DCWs through grant funding,** other key partnerships and outcomes include:

South Mountain Community College (SMCC) Internship Program: To complement AHCCCS WFD efforts, we are working with SMCC to fund 32 paid internships over the next four years. Based on data and recommendations from the AHWGMA, we know that caregivers between the ages of 18 and 24 are underrepresented in the workforce. This partnership will sustain paid internships and promote the caregiver and behavioral health fields to college-age students.

Duet: Partners In Health & Aging: The Alzheimer's Association cites that Hispanics are 1.5 times more likely to develop Alzheimer's disease in America compared to whites. We know from community listening that our members and their families need more Spanish-language support. Our Duet CBO partnership expands the awareness of and participation in caregiver support groups and wraparound services for Spanish-speaking caregivers. Unpaid caregivers are vital to empowering loved ones to live at home, resulting in less DCW demand. We are working with providers and influential Promotoras to educate the community about Duet's programs, especially for members with Alzheimer's disease or dementia. This partnership lifts and supports our community of Hispanic and Spanish-speaking members and their caregivers.

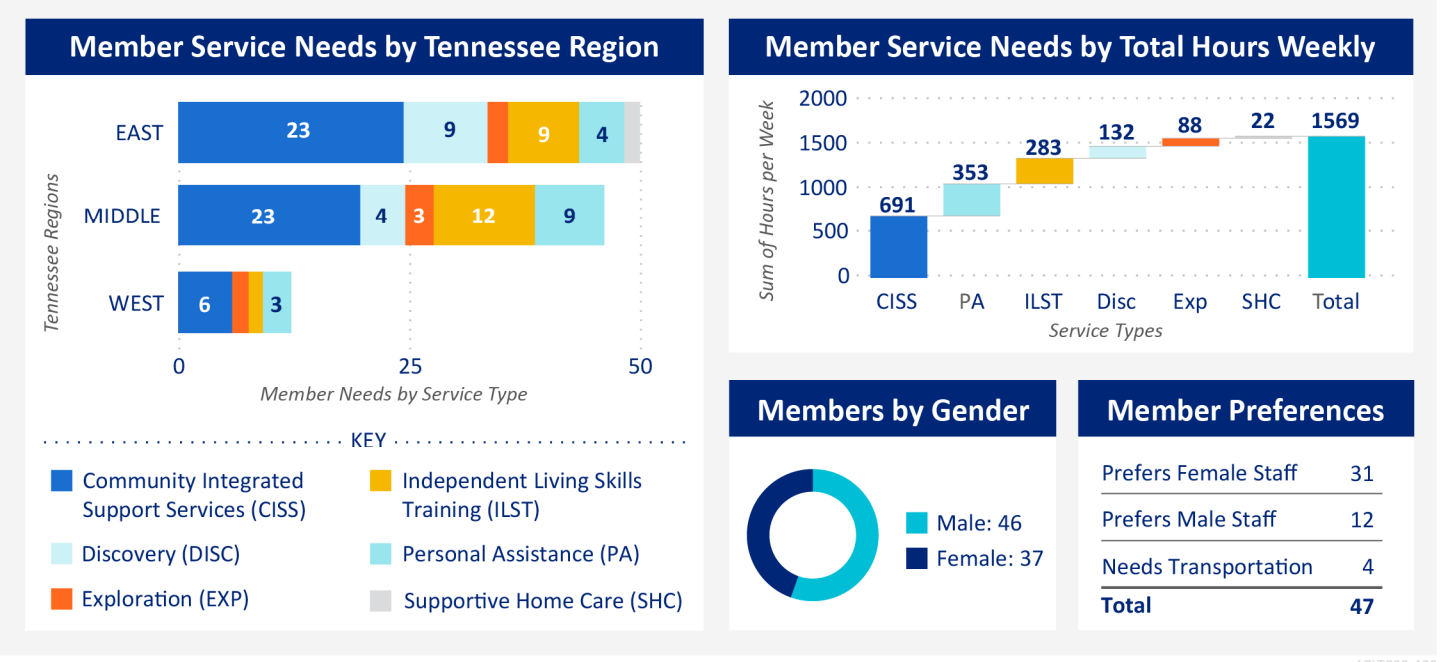


Figure 1. State of Tennessee Workforce Development Reporting. Dashboards help us analyze data that drive initiatives to improve workforce capacity. We will implement a similar report to support providers in Arizona.

Native Health Tribal internships: In the Phoenix metro area, we have worked with Native Health since 2019, sponsoring multiple paid Tribal internships at the local FQHC. Through this partnership, each intern receives funding, supervision from our collective leaders, and through our Tribal coordinator, extensive career coaching. By the end of 2023, we expect to have nine internship graduates. We chose Native Health for partnership because of its reach in Tribal communities and commitment to providing the best health care for urban AI/ANs and other members who experience barriers to equitable health services.

Native Health Partnership Helps Tribal Interns Become Active Workers

Our partnership with Native Health resulted in two interns not only completing their training, but going on to become Native Health employees, demonstrating how our WFD initiatives can improve health equity and access.

Assisting and Incentivizing Providers to Improve Workforce Monitoring

We are proud to be actively engaged in AWFDA to help build on the outstanding tools and partnerships the alliance has developed. Following are examples of approaches we offer that further assist and incentivize providers to develop, empower and monitor the LTSS workforce. Our partnership with Consumer Direct Care Network Arizona, an organization committed to providing quality in-home care, is enabled by monitoring data to understand the efficacy of various innovative pilots. **Through our recent $99,000 grant, Consumer Direct was able to hire a WFD leader whose focus is recruitment and retention,** two of the biggest challenges we know providers face statewide based on AHWGMA data. The grant also drives the expansion of Consumer Direct's learning management systems, CPR trainings and DCW fingerprint clearance. We jointly review performance metrics to understand grant efficacy. Metrics include new DCWs hired, retention statistics, CPR trainings and Learning Management System trainings. In early 2023, we also launched the Direct Care Services Referral program. This program's goal is to promote member choice and empower DCW agencies to better forecast staffing and service needs. This program is powered by bidirectional data sharing, including data regarding member preferences for caregiver language and gender, members' interests and requested service types. We are encouraged that in only a few months, we have successfully staffed more than 260 DCW referrals for members using this forecasting program.

Assisting Providers with Post-training Coaching and Supervision

Along with AWFDA, we are engaged partners in assisting providers with post-training coaching, skills development and applying what is learned to improving members' experiences and outcomes. Beyond meeting ACOM 407 requirements, our WFDA's goal is to exceed training, coaching and supervision requirements, including participating in monthly and quarterly abuse and neglect meetings such as the Training and Prevention Task Force, Arizona Sexual Violence and I/DD Response Collaborative and the trauma-informed care workgroup. Our WFDA collaborates with other MCOs' Cultural and WFD Administrators on provider trainings that address cultural competence, such as CC200 LGBTQIA+ Clinical Care. Our WFDA also facilitates technical assistance for providers by promoting an EVV Hard Edit Interactive Guide among other resources. At the core of the E/PD program's success are the DCWs who support members in their homes and at assisted living facilities. We use many capabilities to support DCWs and other providers in better understanding their training needs, talents and strengths, all of which are tied to improving member experiences.

For example, CAHPS® data shows which workforce skills are being well-used and where gaps may exist. The WFDA identifies CAHPS deficiencies and, working in partnership with our Network Management and Quality Improvement teams, uses that data to address skills development gaps. The WFDA shares this work with our Workforce Development Operations (WFDO) for support and assistance in strategic planning.

Additionally, we will offer providers access to a new, tablet-based electronic self-evaluation tool to assess their skills after participating in DCW and long-term care trainings. The tool will be based on state prescribed DCW curricula and self-evaluation forms available in the *DCW Skills Workbook Evaluator Guide* and empowers DCW agencies to discern strengths and skills development needs in real time. Skills addressed include sanitation, aiding with activities of daily living, providing effective and culturally competent communication and member safety. Using one

electronic training and evaluation tool makes it easier for providers to engage in skills evaluation, learn from results and share results with our team for additional support.

Dedicated staff will conduct in-person provider audits to observe direct skills application and offer real-time coaching and supervision. We will track and trend audit results, share them with providers and use them to guide provider training and member advocacy programming. Results will help identify individual and systemic service barriers and empower providers and our team to address them. We are also incorporating member experience and outcomes questions in conjunction with Heightened Scrutiny and other provider audits to assess provider training efficacy. Our Quality team will incorporate results as part of ongoing provider training. Through an innovative incentive partnership, we are also enhancing our nonemergency medical transportation (NEMT) services. Working with Medical Transportation Brokerage of Arizona (MTBA), our NEMT vendor, **we are offering incentives for drivers to complete cultural competency training**. Democratizing and incentivizing education promotes workforce commitment and builds capacity.

As an example of how we collaborate to improve the member and provider experience, our Tennessee health plan shared best practices around the use of EVV data to identify workforce challenges and provider recruitment opportunities, including how EVV data can drive real-time outreach triggers to providers to close gaps in the workforce. We are in the process of implementing a version of the tool Tennessee uses to internally monitor these opportunities in Arizona.

Integrating Workforce Development into Operations

Our WFDO, led by our chief executive officer (CEO) and chief operating officer (COO), collaborates with the WFDA and leaders throughout our organization. The WFDO ties WFD objectives to operations through ongoing meetings and initiatives that actively include operations teams. We explore WFD initiatives at CEO leadership meetings and our WFDA meets with operations leaders. The WFDA integrates activities into provider network management, medical management, quality improvement and the work of our member- and provider-facing staff. WFD integration efforts have led to successful initiatives, including:

- **Personal Care Attendant (PCA) Value-Based Purchasing (VBP):** We historically deployed an HCBS VBP designed to incentivize DCWs working with members to close HEDIS® gaps in care, but equipping DCWs with real-time data to understand members' open gaps in care and tracking outcomes was challenging. Through our current work in Tennessee, EVV-enabled real-time gap information can now be shared while a DCW is working in the member's home. This enables timely interventions and the opportunity to reward DCWs. We are committed to working with AHCCCS to improve EVV data sharing capabilities driving improved member outcomes and enabling EVV supported VBP programs.
- **Bringing State Training to Our Staff:** Our WFDA shared work we have been leading regarding Child and Family Team (CFT) training. Though CFT training is not required for our own staff, our WFDO recognized the value in the knowledge our team would gain by participating in CFT training. Our WFDA provided AHCCCS-approved CFT training to 62 of our team members, including psychiatry leadership staff.

B9 Providing Timely Access and Monitoring Outcomes

Since the inception of the ALTCS E/PD program, we have supported members with complex needs, helping them navigate structural and health-related social needs (HRSN) and the resources that contribute to equitable whole person care. With more than three decades of ALTCS E/PD experience, UnitedHealthcare has developed effective strategies that facilitate timely access to services and supports, improving health equity and access to care. These include:

- Effective, culturally competent case management solutions that address individual members' barriers to care — from transportation to personal safety to employment to housing concerns
- Well-established provider network allowing members to receive care where and when they prefer
- Accredited quality programs that monitor equitable service delivery and outcomes, incentivize for quality
- Effective partnerships with community-based organizations (CBOs) to address HRSN, services and supports

Nationally, UnitedHealthcare has 19 plans (including in Ohio and Tennessee) that have earned NCQA's Health Equity Accreditation, an acknowledged best practice for improving cultural responsiveness. This underscores our commitment to provide quality services and use effective systems to monitor disparity-related outcomes. **We are in the process of seeking Health Equity Accreditation in Arizona to complement our NCQA Medicaid Health Plan Accreditation and LTSS Distinction.** To advance health equity and improve access to care, we continuously monitor member and provider outcomes using an array of tools (e.g., Hotspotting, Population Insights dashboards and others described herein) that provide quantitative and qualitative insights. These tools help our teams identify systemic and trending barriers to care. To assess the efficacy of our solutions and adjust initiatives to improve outcomes, we adhere to Plan-Do-Study-Act (PDSA) methods with members' voices and choices being central to our efforts.

Supporting Members in Rural Communities

We address barriers to equitable, quality care in rural communities through data-driven strategies that improve timeliness and verify adequate reach. For example, our 2022 program data shows that E/PD members living in rural areas have higher ER utilization (686 vs. 448 ER visits per 1,000), lower PCP visits (1,512 vs. 1,828 visits per 1,000) and lower behavioral health (BH) utilization (2,513 vs. 4,341 visits per 1,000) than members living in urban communities. One way we address these disparities to improve rural members' routine and specialty access to care is by applying targeted solutions to promote telehealth services and the technical supports needed to access telehealth. Key solutions include, but are not limited to, the following:

Common Barriers	Solutions and Outcomes
Technology Comfort and Access	Our Device Support program educates members on the services we offer through Cyber Seniors, a multi-language, phone-based technical support line that helps members troubleshoot devices. We facilitate in-person technology training at senior centers, Member Advisory Council meetings and with individual members. To address technology access issues, case managers (CMs) connect members to resources like Assurance Wireless, which provides no-cost smartphones with unlimited data and minutes.
In-Home Medical and BH Care, Services and Supports for Members at High Risk	Our partnership with CareBridge offers members access to its Member Support program. This program provides virtual in-home medical, BH and social support coordination for members with high-risk conditions. Support is accessible at any time, day or night. In Tennessee, members engaged in CareBridge saw a 2.8% decrease in ER visits per 1,000 and a 17.5% decrease in inpatient admissions per 1,000 from 2021 to 2023. In Arizona, early engagement results show 52% of CareBridge-engaged members live in rural communities (compared to less than 28% of our E/PD membership), reflecting the importance of the CareBridge partnership in increasing our rural members' access to care. We partner with Spectrum Anywhere Care. Spectrum's team provides in-home supports to address members' health care needs and their HRSN, with 92% of Spectrum's patients indicating they were seen within 48 hours. This increases timely access to care and helps reduce avoidable urgent care and ER visits.
Member and PCP Access to Specialty Care Integration	We will continue to support providers, especially PCPs, in rural areas through our best practice contract with AristaMD and concurrent AHCCCS collaboration to develop a new provider type to support it. AristaMD will connect providers to specialists via on-demand eConsults in over 70 different specialties. Access to eConsults will especially help rural providers and members via increased access to specialty care, which can be delivered in more than 70% of routine cases through a PCP with a specialist's guidance.

We empower individual members who live in rural communities to share their needs with us during their person-centered service planning meetings. Serving as member advocates, CMs help facilitate access to services like utility assistance resources, housing, technology and transportation.

Natural Disasters: Helping Arizonans in Crisis

Natural disasters present our North GSA rural members, their families and our local staff with ongoing access challenges (e.g., poor air quality from wildfire smoke, flood water impacts to transportation). Navajo, Apache and Yavapai counties are most often affected. Our CMs are quick to respond when we learn of disasters, volunteering locally and calling 100% of affected members, ALFs and SNFs to check that all are safe and have disaster plans secured. Living in the same communities as members, CMs have trusted relationships and are familiar with local needs and resources. We coordinate supply delivery, check in with facilities and conduct in-person assessments. When evacuation is necessary, CMs assist members and their family with securing safe relocation. During disasters, we flex our prior authorization and pharmacy protocols to ease access, and we work with our transportation vendor on any needed urgent transport.

Supporting Tribal Members

We respect the sovereignty of Arizona Tribes, their dedication to reducing health inequities (such as BH and substance use disorder [SUD] conditions, which disproportionally affect Tribal members) and their commitment to improving care for AI/AN members. We support members living on and off reservations and understand our Tribal members have choices when accessing health care, including Tribal ALTCS when living on the reservation, MCO enrollment preferences when applicable, and other covered benefits through Indian Health Services, Tribal 638s, Urban Indian Facilities (I/T/Us) and traditional healers. We acknowledge our role is to support AI/AN members in accessing timely care in their preferred delivery system and to ease continuity of care during transitions to improve health outcomes. Approaches to supporting Tribal members are rooted in our best practices of listening to those we serve while demonstrating cultural respect and humility.

We have the staff, expertise and infrastructure in place to continue to serve the members of Arizona's 22 federally recognized American Indian Tribal Nations, including our 260 Tribal members currently receiving LTSS. Our experienced and visible full-time staff, including **our Tribal coordinator and RN clinical Tribal coordinator (CTC), work statewide with AHCCCS, Tribal members, Tribal communities, providers and stakeholders.**

Our Tribal coordinator and CTC understand the cultural perspectives, beliefs, values and practices of the Tribal communities we serve and lead the integration of these into timely provision of and access to health care services. Our Tribal coordinator leads our Tribal Relations program. He founded, leads and manages the MCO Tribal Collaborative, a joint forum that provides a space where Arizona MCOs can collectively listen to Tribal members, respond to their needs and vice versa.

Listening to Tribal Voices

To learn about the needs of Tribal communities, we surveyed more than 100 Tribal representatives, providers and stakeholders. The survey feedback reflected a desire for telehealth education. In response, we delivered tailored telehealth resources like our Telehealth Best Practices Interactive Course and User Guide.

In October 2022, our Tribal coordinator received a request from Apache Behavioral Health Services (ABHS) for assistance accessing Narcan (Naloxone) so their staff can have an emergency supply on hand while working in the field. Our Tribal coordinator worked with our pharmacy director and Sonoran Prevention Works to provide ABHS with ample supplies and training on correct medication administration, thus improving Tribal members' access to SUD care. When members living at home or in a facility need Tribal advocacy and support, our Tribal CTC joins our CMs during on-site visits. This advocacy elevates members' voices and empowers Tribal members across transitions of care, accessing LTSS, coordination across payers and more.

To promote a companywide culture of humility, respect and responsiveness, **all UnitedHealthcare staff participate in annual Tribal cultural competency training.** By listening to understand Tribal members' individual experiences, we empower our E/PD members' voices and choices so they may remain active and engaged in their communities and Tribe

(if desired). Member-specific, self-determined interdisciplinary clinical and HRSN resources are part of the person-centered service plan (PCSP) for all Tribal members. For example, to help a member who desired to reconnect to Navajo culture after a transition in care, our CM assisted with placement at Winslow Campus of Care (Winslow). Winslow has a large Navajo/Diné population and a traditional healer who visits weekly. Since transitioning to Winslow, the member reconnected with his uncle who is a traditional healer and started training with him to reorient himself to his culture.

We are equally committed to fostering the best practices of cultural humility, respect and responsiveness among network providers. To increase providers' cultural competency, **we crafted an Indigenous Tribal Cultural Competency Awareness training** that we shared with all AHCCCS providers via Relias. **Since April 2022, this training has been completed 141 times.** We are continuing support for Tribal members with SUD in partnership with White Bison, Inc., a nonprofit dedicated to providing culturally based healing to the next seven generations of Indigenous People. In 2019, **we facilitated a series of two White Bison Wellbriety Circles and 12-Step Training Programs** for 15 attendees from Tribal 638s, Tribal Regional BH Authorities, I/T/Us and contracted providers. We will sponsor an additional 15 attendees in 2024. Our successful Tribal internship program, offered in partnership with Native Health, promotes timely access to care for Tribal members by helping develop a larger and more diverse Tribal workforce. **By the end of 2023, we expect to have nine Tribal internship graduates,** two of which have successfully been hired at Native Health. We recognize this as a best practice and are actively recruiting additional Tribal providers for the program.

Supporting Members in Need of Community Resources

2023 FIDE SNP Valuable Benefits:

- Total of 200 non-medical transportation trips (e.g., community center, library)
- UnitedHealthcare UCard® provides $3,180 annually for healthy groceries, utilities (including internet) and over-the-counter products

We integrate members' individual HRSN into ongoing case management via the PCSP to drive timely access to community resources. We share AHCCCS' vision for a statewide closed-loop referral system (CLRS) that will empower all stakeholders to monitor community resources and referrals. We have our own CLRS and use it to serve members in need of community resources. Our CLRS, UnitedHealthcare Community Connector, will integrate seamlessly with CommunityCares once implementation is complete. We use blended individual and community data from UnitedHealthcare Community Connector to identify, address and monitor HRSN, access to care, network development and health disparities. We will use the state's CLRS in a similar way and continue to support its promotion and integration. Our Social Determinants of Health (SDOH) Insights dashboard is another tool that integrates data from many sources (e.g., CLRS, providers, members, assessments) and empowers program monitoring. It powers outcomes reports we use to monitor and improve community referral outcomes, trends in HRSN and loop closures by member race, ethnicity, gender, age, language and geography. Our network provider Z code data shows, for example, that among our E/PD members, food insecurity and social isolation are the two most prevalent HRSN. We have partnerships in place to address these two most prevalent HRSN.

Addressing Food Insecurity

Food insecurity is a significant issue statewide, with 12 counties having a food insecurity score higher than the national average (12.0%). We deploy strategic investments, support local programs, forge CBO partnerships and offer mobile food pantry support to increase access to healthy food. Over the past five years, **UnitedHealthcare has donated more than $1.5 million to address food insecurity statewide**. Our investments support local community efforts, larger infrastructure efforts, all five regional Arizona food banks and nearly 1,000 food pantries and agencies. Our Manzanita Outreach partnership in Northern Arizona addresses both food insecurity and social isolation; offers food delivery for home-bound older adults with fresh, locally grown fruits and vegetables from nearby farms (a need we heard directly from members); and provides a Phone Pals service that includes outbound wellness checks for home-bound older adults receiving home food deliveries. **Our $80,000 investment allows Manzanita Outreach to expand from 300 to 500 food box deliveries per month for the next two years.** The program also aims to advance health equity by improving access to culturally relevant foods. We recognize this as a best practice and are recruiting similar organizations in other rural counties. Manzanita Outreach is collaborating with local farmers to source products like heritage chiles, tomatillos and corn and aims to expand the availability of recipe cards in both English and Spanish. Similarly, we partnered with Interfaith Community Services in Pima County to provide education and awareness sessions (e.g., Mental Health First Aid, Honoring Our Lives) while distributing food via our mobile food pantry.

Addressing Social Isolation

Four of five counties in the North GSA — all except Coconino — have an Algorex social isolation score higher than the state (2.8) and national average (2.9). Through listening to understand and empathizing with members' individual experiences, we provide support to help members set self-directed goals that address social isolation and confirm equitable care. In addition to educating members about the statewide Solari Warm Line, we are partnering with HOPE, Inc. (HOPE), a peer-run organization to offer a closed-loop referral process for members facing social isolation. After receiving a referral, HOPE's credentialed peer support specialist makes outbound calls to members experiencing social isolation or depression, reviewing individual's HRSN to address members' needs. Additionally, we provided a **$300,000 investment to the Area Agency on Aging to provide 256 adult-friendly tablets** to give older adults better access to technology and community event information, reduce social isolation and increase connection to family and friends.

Meet Coach Carol

A Member Empowerment and Community Access Success Story

Our member Carol lives independently in Winslow. Prior to the COVID-19 pandemic, she was active and mobile using her wheelchair, visiting with neighbors and attending the local high school's basketball games.

During the pandemic Carol withdrew from her regular activities and told her CM she "felt disconnected." When vaccinations became available, Carol let her CM know she felt safer and was ready to resume activities.

During a PCSP meeting, Carol shared how much she loves sports and missed her days playing college basketball prior to her injury. Carol and her CM developed a goal for Carol to volunteer as a city coach for the local league. Carol's CM assisted her in completing the volunteer coaching application and connected her with the city's basketball program. Upon becoming a coach, Carol was so excited she recruited her grandchildren for her team. Carol's CM attended games to show support. Carol said, "becoming a coach [is] the best thing that could ever happen."

AZLTC23.396

Supporting Members in Need of Peer and/or Family Support Services

Peer and family supports empower members and their families, increase access to care and reduce health care costs. In 2021, we partnered with Gellert Health to develop and launch an Intensive Peer Support program. The program connects members to self-directed resources to regain independence, overcome barriers and reintegrate into communities. Based on the program's demonstrated success, we expanded this best practice program in 2023 to include E/PD members. Since 2021, we have seen a 10% increase in E/PD member peer and family support utilization and a 6% increase in contracted providers who offer peer and/or family support services. We are continuing to grow peer supports and utilization — tracking outcomes no less than quarterly. Our Office of Individual and Family Affairs team offers credentialed peer support training, including training supporting Tribal, veteran and long-term care-engaged members, which was initially piloted with our Member Advisory Council (MAC). This is a program differentiator and helps address members' needs for a diverse, knowledgeable peer panel. We are also partnering with HOPE to expand their peer support reach to our North GSA E/PD members. HOPE's peer and family support specialists, described earlier, help E/PD members who have limited mobility reduce feelings of isolation and connect with an array of BH and SUD supports.

From 2021-2022, our Intensive Peer Support Program with Gellert Health resulted in:

40%	66%	83%
reduction in **medical** costs	**reduction** in **ER** costs	**reduction** in **inpatient** costs

AZLTC23.417

UnitedHealthcare is dedicated to meeting and honoring our commitments to be the partner of choice to the communities and people we serve.

B10 Compliance Review

As an Incumbent E/PD Contractor, UnitedHealthcare Community Plan is not required to provide a submission for Requirement B10. We understand that AHCCCS will utilize the AHCCCS Calendar Year (CY) 23 ALTCS E/PD Operational Review (OR) for this requirement.

B11 D-SNP STAR Rating

	MEDICARE PLAN NAME	MEDICARE CONTRACT NUMBER	CORRESPONDING CONTRACT FROM B2	TYPE OF PLAN (FIDE/DSNP; SNP; MEDICARE ADVANTAGE)	STAR RATING
1.	UnitedHealthcare® Dual Complete® ONE; UnitedHealthcare Dual Complete® LP	H0321	YH18-0001 YH19-0001 CTR047021	FIDE SNP/HIDE SNP	4

B12 Oral Presentation Information

In accordance with RFP Section H, Paragraph 19, Contents of Offeror's Proposal, Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan) is submitting resumes for the following individuals who will participate in oral presentations:

- Jean Kalbacher – Chief Executive Officer
- Stephen D. Chakmakian, D.O. – Chief Medical Officer
- Heidi Kemmer – Chief Operating Officer
- Francine Pechnik – Executive Director, Long-Term Care
- Toby Hall – Vice President, Quality Management
- Della Wood – Behavioral Health Coordinator

Jean Kalbacher, CPA

Chief Executive Officer

Overview

Health plan executive with over 20 years of business and health care industry leadership experience. Served as chief financial officer and chief executive officer at large health care companies in Arizona. Extensive experience in key health plan roles, including executive management, business development, operations, systems, network development and management, accounting and finance. Tenure with employer-sponsored, Medicare and Medicaid health plans across multiple states provides a thorough understanding of the expectations and requirements for success in health care, including an understanding of current and future needs of providers, members and other customers as health care continues to transform and evolve.

Education

- Bachelor of Arts Degree – Accounting and Management, Fort Lewis College, Durango, Colorado

Licensure and Credentials

- Certified Public Accountant, State of Arizona
- Board Member AzAHP, Home Matters to AZ Fund, Brighter Way Dental
- Finance Committee Board member: Arizona Health-e Connections/Health Current and Medicaid Health Plans of America (past)

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Phoenix, Arizona**
Timeframe:	May 2008 – Present
Role and Responsibilities:	**Chief Executive Officer – UnitedHealthcare Community Plan – Phoenix, Arizona (June 2020 – present)** ▪ Oversee $4.2 billion revenue, 620,000 members (Medicaid, I/DD, LTSS, D-SNP, IFP) ▪ Create an overall vision for the leadership team to navigate a rapidly changing industry and use innovation to capture opportunities for growth and improvement ▪ Develop and execute state-specific strategies to drive sustainable and profitable growth while setting the strategic direction and decision-making for RFP bid processes to drive business growth ▪ Drive industry-leading customer service and satisfaction levels as measured in Net Promoter Scores ▪ Build, develop, improve, influence and expand relationships with state regulators, community-based organizations and providers/provider networks within Arizona ▪ Manage multiple levers of health plan operations and financial stability (e.g., rate advocacy, member retention, utilization management, Star performance and Medicaid Quality) **Chief Financial Officer, Central and West Regions – UnitedHealthcare Community & State (May 2014 – June 2020)** ▪ Managed $13.6 billion in revenue for 1.8 million members annually in UnitedHealthcare Medicaid MCOs in eight states, including Arizona (Medicaid, I/DD, LTSS, MMP, D-SNP) ▪ Developed, supported and achieved strategic business goals, including annual rate advocacy, VBC agreements, quality metrics, medical and administration cost management for all regional Medicaid states

- Provided executive leadership for merger and acquisition purchases and divestiture, including health plan assimilation and wind-down
- Mentored and managed chief financial officers within UnitedHealth Group's organization, including mentoring and talent development for shared services finance leaders
- Served as member of the board of directors for UnitedHealthcare Community Plan of New Mexico, UnitedHealthcare Community Plan of California, Arizona Physicians IPA, Inc., UnitedHealthcare Integrated Services and UnitedHealthcare Community Plan of Ohio
- Served as Audit Committee member for AmeriChoice Corporation and UnitedHealthcare Community Plan of Texas

Chief Financial Officer (September 2013 – May 2014)

- Served as chief financial officer for UnitedHealthcare employer-sponsored programs responsible for $3.8 billion revenue covering 1.7 million members across six western states (small group, large group and public sector clients)

Chief Financial Officer (May 2008 – September 2013)

- Served as chief financial officer for UnitedHealthcare employer-sponsored programs in Arizona, Idaho and Utah; responsible for $1.1 billion revenue covering 570,000 members (small group, large group and public sector clients)
- Developed and supported strategic business initiatives relating to affordability, product, pricing, sales, medical trend and network for commercial lines of business, local leadership of social responsibility team and culture panel.
- Served as chief financial officer for UnitedHealthcare employer-sponsored plans in Arizona, California, Utah and Washington and on the PacifiCare of Arizona board of directors

Employer:	**Schaller Anderson Inc., an Aetna Company – Phoenix, Arizona**
Timeframe:	August 2004 – May 2008
Role and Responsibilities:	**Senior Director, Corporate Financial Planning and Analysis (January 2007 – May 2008)** ▪ Managed staff responsible for weekly provider check runs for eight health plans, including SAS 70 audit, 1099 reporting, system conversion and upgrade, testing, implementation and third party liability (TPL) recoveries ▪ Prepared of budgets/forecasts for eight management entities for multiple lines of business with revenues of $700 million, and over 2,000 full-time employees (FTEs) nationwide **Controller and Director of Managed Health Plans (August 2004 – January 2007)** ▪ Managed staff responsible for weekly provider check runs for eight health plans, including SAS 70 audit, 1099 reporting, system conversion and upgrade, testing, implementation and TPL recoveries ▪ Responsible for accounting and finance functions for company owned 100,000 member Medicaid health plan located in Delaware, including GAAP financial statements, quarterly board reporting, IBNR/claim reserve projections, budget and forecast preparation and analysis

Employer:	**PacifiCare of Arizona – Phoenix, Arizona**
Timeframe:	1995 – August 2004
Role and Responsibilities:	**Manager, Financial Planning and Analysis (May 2003 – August 2004)** ▪ Managed staff of professional financial analysts ▪ Prepared and reviewed budgets and forecasts, including membership, revenue, health care costs and general expenses for two regions for multiple products and lines of business ▪ Completed close analysis comparing actuals to both forecasts and budgets, including membership, revenue, health care costs and general expenses for two regions for multiple products and lines of business **Accounting, Capitation and Provider Informatics Manager (1998 – May 2003)** ▪ Managed staff of professional accountants and numerous interdepartmental projects as well as staff responsible for configuration of provider demographics, contract pricing and related projects ▪ Managed internal finance operational audit team related to system configuration and claims payment ▪ Approved and analyzed PCP and specialist provider capitations for payment, journal entries and account reconciliation **Accountant I, II and Senior Accountant (1995 – 1998)** ▪ Served as finance division team lead for claims, eligibility and revenue platform conversion (Note: FHP HealthCare was acquired by PacifiCare of Arizona during this time)

Stephen D. Chakmakian, D.O.

Chief Medical Officer

Overview

Board-certified in Family Medicine with more than 25 years of experience, including direct patient care, coaching and supervision of mid-level clinicians and diverse executive clinical administrative leadership. Background includes direct family medicine practice in Phoenix serving a diverse multigenerational urban population with preventive and complex integrated health and social needs. Medical administrative roles and leadership experience include managed care credentialing and peer review committee appointments, medical policy and utilization review guideline research and development and serving in pharmacy and medical director roles. Over the past 12 years, serving as chief medical officer for Medicaid and Medicare Advantage Dual Special Needs plans serving at-risk populations with complex integrated health care and socioeconomic needs. Demonstrates excellent communication, interpersonal and problem-solving skills. Builds trust, consensus, promotes innovation, change and teamwork. Adept at refining managed care strategies, integrating delivery systems and developing innovative, effective, sustainable quality and utilization management programs. Confirms ethical, principled approaches to decision-making to implement consistent, equitable and diverse population health strategies and solutions.

Licensure and Credentials

- Registered Doctor of Osteopathy with State of Arizona: Active license number 3521
- American Board of Family Medicine: Initial certification July 14, 2000; Recertified August 3, 2007 and July 20, 2020

Education

- Family Practice Residency, St. Joseph's Hospital and Medical Center Phoenix, Arizona
- Doctor of Osteopathic Medicine, Midwestern University, Chicago College of Osteopathic Medicine, Downers Grove, Illinois
- Bachelor of Arts – Biology, University of San Diego

Professional and Community Affiliations

- Arizona Board of Osteopathic Medical Examiners, unrestricted license, January 31, 2000, through December 31, 2024
- American Academy of Family Practice Board Certified, July 14, 2000 through February 28, 2030
- Arizona Osteopathic Medical Association member since 2012
- American Academy of Family Physicians member since 2020

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Phoenix, Arizona**
Timeframe:	January 2011 – Present
Role and Responsibilities:	Chief Medical Officer ▪ Oversee health plan clinical and quality operations for over 600,000 members across four Medicaid managed care programs, including Individuals with Intellectual and Developmental Disabilities, Elderly and Physically Disabled persons, Medicare Advantage Dual Special Needs (D-SNP) members and Arizona Complete Care ▪ Verify consistent adherence to regulatory and contractual requirements ▪ Actively oversee and manage all quality management, quality improvement and medical management programs ▪ Expand clinical partnerships and innovation initiatives across Arizona ▪ Implement and oversee all accountable care programs, including value-based contracting with accountable care partner organizations and other health care providers to improve member outcomes and improve cost effectiveness

- Received three UnitedHealth Group Innovation awards
- Received Innovation Leadership Shadow award for pursing unique and effective health care initiatives

Employer:	**Health Choice Arizona/Health Choice Generations – Phoenix, Arizona**
Timeframe:	November 2001 – November 2010
Role and Responsibilities:	Chief Medical Officer (September 2006 – November 2010) ▪ Oversaw utilization management programs, enhancing data collection, quality control and affordability ▪ Contributed to a successful D-SNP health plan start-up ▪ Implemented and managed Health Choice Generations Medicare Advantage health plan serving dual Medicare and Medicaid eligible members ▪ Steered health service and quality programs through plan membership expansion from 34,000 to over 220,000 lives across 10 Arizona counties Medical Director (March 2004 – September 2006) ▪ Redesigned health plan clinical department policies and procedures to enhance efficiency and quality ▪ Implemented process improvements that increased scalability while reducing costs associated with the provider credentialing program ▪ Request for proposal development, issuance, and selection processes for new vendor partners, including Radiology Benefits Management Associate Medical Director (November 2001 – February 2004) ▪ Developed medical and dental clinical coverage criteria to confirm consistent high-quality evidence-based care standards ▪ Managed Pharmacy & Therapeutics programs along with cost-effective preferred drug lists, including utilization and safety controls

Employer:	**IASIS Healthcare – Phoenix, Arizona**
Timeframe:	September 2000 – February 2004
Role and Responsibilities:	Family Practice Physician ▪ Managed The Centre Clinics family practice offices that IASIS Healthcare owned and operated which served more than 5,000 diverse, inner-city populations having employer-sponsored, Medicaid or Medicare coverage ▪ Served as a dedicated board-certified Family Practice Physician within a full-spectrum ambulatory care clinic and urgent care center within a central Phoenix metropolitan health center ▪ Provided direct clinical supervision, education and training for certified Physician Assistant and certified Family Nurse Practitioner ▪ Conducted inpatient admissions and on-call care for the clinic and St. Luke's Hospital Emergency Department

Heidi S. Kemmer, FACHE

Chief Operating Officer

Overview

Seasoned managed care executive with over 30 years of experience in the industry holding a number of positions in network contracting, provider services, operations management and health plan leadership. Proven experience across multiple functions at a local, regional and national level.

Education

- Master of Business Administration, University of Iowa, Iowa City, Iowa
- Master of Arts – Hospital and Health Administration, University of Iowa, Iowa City, Iowa
- Bachelor of Arts – Health Care Administration, Wichita State University, Wichita, Kansas

Professional Memberships or Community Affiliations

- Fellow of the American College of Healthcare Executives (FACHE)

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Phoenix, Arizona**
Timeframe:	February 2006 – Present
Role and Responsibilities:	**Chief Operating Officer – UnitedHealthcare Community Plan – Phoenix, Arizona** **(April 2020 – present)** ▪ Oversee key operations, including claims, enrollment, provider and member call centers, appeals and grievances, reporting, vendor relations and network administration. ▪ Develop and execute on strategies for the health plan to meet and exceed member, provider, state and regulatory requirements ▪ Support, develop and validate compliance with operations policies, procedures and regulations ▪ Review, manage and drive operations efficiency, quality and financial performance ▪ Set business direction, develop, implement and oversee operational models to meet business requirements ▪ Own end-to-end process improvement, including definition of need, project plans, status updates, reporting and achieving results **West Region Director – UnitedHealthcare Community & State** **(February 2015 – April 2020)** ▪ Oversaw operations performance and regulatory change management for UnitedHealthcare Medicaid MCOs (known as Community & State) in the west region, including Arizona **National Director – UnitedHealthcare Community & State** **(February 2006 – February 2015)** ▪ Served as Community & State national director for provider experience and in executive leadership roles with UnitedHealthcare's Medicaid MCO in Tennessee

Employer:	**John Deere Health – Knoxville, Tennessee**
Timeframe:	February 1994 – February 2006
Role and Responsibilities:	Area Manager and Regional Contract Manager ▪ Promoted several times over the course of employment, with increasing responsibilities and accountabilities for the company's operational excellence ▪ As Area Manager, oversaw day-to-day operations of a growing HMO with a variety of product lines, including Medicaid, Medicare Risk and Commercial; accountable for enrollment, financial, network and medical management goals in defined service area ▪ As Regional Contract Manager, managed all hospital and ancillary contracts in Southeast Region, including financial analysis, provider negotiations and network building and maintenance

Francine Pechnik

Executive Director, Long-Term Care

Overview

Accomplished leader and health plan executive with 34 years of long-term care case management experience – specific to ALTCS programs. Served in leadership and managerial roles overseeing clinical and operations staff who serve ALTCS members. Extensive experience in key health plan roles, including business development, operations oversight and finance. Oversees the day-to-day operations of our ALTCS E/PD program.

Education

- Bachelor of Science – Education, University of Connecticut, Storrs, CT

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Phoenix, Arizona**
Timeframe:	September 2005 – Present
Role and Responsibilities:	**Executive Director, Long-Term Care (November 2019 – present)** ▪ Accountable to AHCCCS for compliance with requirements and obligations of the ALTCS E/PD contract ▪ Responsible for the management of health plan clinical operations ▪ Develop, translate and execute strategies or functional and operational objectives for the long-term care line of business, including programs impacting consumers ▪ Responsible for planning and directing operational policies, objectives, and initiatives, including day-to-day site operations, management leadership internal and external to organization ▪ Accountable for financial and non-financial results (budgets and actuals) ▪ Develop policies and procedures for operational processes to optimize performance and in compliance with established standards and regulations ▪ Provide leadership to and is accountable for the performance and results through multiple layers of management and senior level professional staff ▪ Direct others to resolve complex or unusual business problems that affect major functions or disciplines ▪ Project management and implementation, staff management **Vice President, LTC and ALTCS Case Management Administrator (March 2006 – November 2019)** ▪ Oversaw implementation, maintenance and monitoring of operational processes specific to case management programs ▪ Responsible for formalized review of case management service delivery for Medicare and ALTCS Medicaid membership ▪ Monitored access to effective treatment modalities that meet member needs and comply with standards of care and appropriate state and federal regulations ▪ Managed timely reporting to government agencies such as AHCCCS, ADHS, CMS and other regulatory agencies ▪ Directed a system of monitoring progress to meet the goal of participating in initiatives focused toward increasing the number of members living in a home community setting ▪ Monitored training and ongoing professional development of case management staff to meet department business goals, confirming key staff are knowledgeable

concerning state regulations and contractual requirements for their area of responsibility

- Developed, implemented and evaluated a case management work plan submitted to AHCCCS for approval on an annual basis
- Responsible to develop, implement and evaluate the annual Advisory Council Plan that included conducting quarterly meetings in counties across Arizona
- Developed and maintained case management policies and procedures to comply with regulatory standards and adhere to program goals and objectives
- Implemented and maintained systems and procedures necessary to effectively control and monitor case management performance
- Served as regional liaison with other departments to coordinate workflow processes and implementation plans (e.g., claims, medical policy, contracting)

Case Management Manager, LTC (September 2005 – March 2006)

- Developed clear goals and objectives for performance management and effectively communicated accountability
- Identified areas of strength and concerns and developed specific goals to improve performance and established systems for tracking performance
- Managed the utilization program as a result of day-to-day management
- Created a collaborative management environment, enhancing the integration and communication between departments
- Validated standardized execution of workflow processes, such as authorizations and non-certifications, and analyzed outcomes of standardized audits for continuous quality improvement purposes
- Participated in development and execution of educational programs for staff development and training
- Evaluated metrics in addition to developing action plans to address variance from standards
- Participated in development of department policies and procedures

Employer:	**Maricopa County Long Term Care Plan – Phoenix, Arizona**
Timeframe:	June 1989 – September 2005
Role and Responsibilities:	ALTCS Case Management Administrator ▪ Served in case manager, case management manager and ALTCS Administrator roles for the ALTCS program ▪ During tenure, promoted three times to roles with increasing case management oversight accountability and responsibility

Toby Hall, M.A., CPHQ

Vice President, Quality Management

Overview

Ambitious, creative and supportive health care professional with a proven track record of successful HEDIS® reviews for Medicare and NCQA Accreditation of Marketplace and Medicaid plans. Extensive experience in Medicaid for behavioral health as both a provider and health plan employee. Highly experienced at building of quality management (QM) department for new lines of business. Strong supporter of colleagues and staff in times of challenge with projects, giving them the guidance and courage to continue.

Education

- Master of Arts – Psychology, Pepperdine University, Malibu, California
- Bachelor of Arts – Psychology, California State University, Northridge, California

Credentials

- Certified Professional in Healthcare Quality (CPHQ) since April 2011

Community Affiliations

- Member of the National Association of Healthcare Quality (NAHQ) since 2020

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Phoenix, Arizona**
Timeframe:	June 2018 – Present
Role and Responsibilities:	Vice President, Quality Management ▪ Provides strategic leadership and direction for the quality improvement and management programs ▪ Works within local and matrixed relationships to lead and develop the overall quality strategy for the plan, verifying the quality program is proactive, continuously improves, applies to Arizona programs and includes QM, regulatory adherence and quality improvement ▪ Provides strategic insight and direction to health plan executive leadership to align with a changing health care landscape as it applies to quality ▪ Develops and maintains strong relationships with state regulators, providing leadership input to expand and support provider engagement and advocacy at the state level ▪ Coordinates across multiple functional areas, including but not limited to clinical services, provider engagement, member experience, benefit design, compliance, network services, behavioral health services and pharmacy services as needed to support quality outcomes ▪ Worked to improve D-SNP Star Rating from 3.5 to 4 stars in 2020

Employer:	**Community Bridges, Inc. – Tucson, Arizona**
Timeframe:	January 2018 – June 2018
Role and Responsibilities:	Director of Southern Arizona Operations ▪ Supervised four operations and nursing administrators with responsibility for approximately 100 staff, including front line staff and nurses

- Oversight and direction of crisis and inpatient detox centers in southern Arizona. Other responsibilities included budget, strategy and operations day-to-day, including crucial interactions with Regional Behavioral Health Authorities (RBHAs), health plans and the public

Employer:	**University of Arizona Health Network/Banner Health – Tucson, Arizona**
Timeframe:	December 2013 – January 2018
Role and Responsibilities:	Director of Quality Management (January 2017 – January 2018) ▪ Oversight, vision and direction of QM department with three lines of business (Medicare, Medicaid, ALTCS) ▪ Supervised four managers with responsibility for 25 staff, including nurses and outreach call staff ▪ Directed Quality of Care team for site review, quality of care concerns and responses to AHCCCS ▪ Developed and achieved minimum performance standards actions on Corrective Action Plans ▪ Prepared required QM, HEDIS® and ALTCS measures reports Senior Quality Manager, Medicare (February 2015 – January 2017) ▪ Oversaw quality processes and reports related to providers and members ▪ Supervised staff in areas of member and provider outreach, member and provider education ▪ Oversaw yearly HEDIS® review with nurses and staff, including reporting and submitting data to Medicare ▪ Developed Star Rating activities to improve ratings and member care Clinical Quality Improvement Manager (December 2013 – February 2015) ▪ Developed Quality Improvement processes and program for Medical Management ▪ Coordinated NCQA Accreditation activities for Marketplace health plan submission ▪ Achieved initial NCQA Accreditation for Marketplace health plan through collaborative efforts and teams throughout the system with key leadership responsibility

Employer:	**Arizona's Children Association – Tucson, Arizona**
Timeframe:	February 2012 – November 2013
Role and Responsibilities:	Director of Quality Improvement/Compliance Officer ▪ Oversaw agency's Quality Improvement, Continuous Quality Improvement (CQI) and outcome activities and staff ▪ Successfully developed a QM plan for child welfare area of organization with buy in from key stakeholders on benefits ▪ Administered and managed the Medical Records Department statewide ▪ Supervised four CQI staff for both behavioral health and child welfare activities

Della Wood, LBSW

Behavioral Health Coordinator

Overview

Licensed social worker with over 20 years of experience in long-term case management and care services. Experience includes working in nursing homes, ALTCS case management, including behavioral health and 12 years' experience in case management leadership. Currently serve as behavioral health coordinator for long-term care membership. Responsible for monitoring the provision of behavioral health services and verifying compliance with contract standards.

Education

- Bachelor of Social Work, Arizona State University, Tempe, Arizona

Licensure

- Licensed Baccalaureate Social Worker; License number LBSW-13807

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Phoenix, Arizona**
Timeframe:	July 2005 – Present
Role and Responsibilities:	**Director of Case Management (March 2021 – present)** ▪ Monitor provision of behavioral health services and compliance to AHCCCS and contractual standards for our long-term care membership, including coordination of care between physical and behavioral health providers and out-of-state placements ▪ Collaborate with stakeholders to improve member access to behavioral health services ▪ Coordinating and consulting with medical directors ▪ Directing specialized behavioral health management and case management staff with primary caseloads of members with serious mental illness (SMI) or cognitive impairment who are unable to live in traditional long-term care settings or require extensive wrap around behavioral health services ▪ Indirectly supervising, educating and training all case management staff at time of orientation and ongoing **Behavioral Health Case Management Manager/Case Manager (July 2005 – March 2021)** ▪ Supervised specialized behavioral health case management staff with primary caseloads of members with SMI or cognitive impairment unable to live in traditional long-term care settings or requiring extensive wrap around behavioral health services ▪ Reviewed and approved individualized service care plans to make sure members with SMI or cognitive impairment received the least restrictive but appropriate behavioral health services and placement ▪ Coordinated the court ordered treatment process and reporting for Central and North GSAs

Employer:	**Maricopa Long Term Care Plan – Phoenix, Arizona**
Timeframe:	May 2005 – July 2005
Role and Responsibilities:	Case Manager ▪ Assessed member medical needs through assessment process involving provider, member and family; in HCBS, assisted living or nursing home settings ▪ Developed patient centered individualized service plans based on member needs and goals through proactive collaboration and communication with members, families and providers ▪ Implemented, facilitated and coordinated services to meet member needs in a timely manner ▪ Modified, evaluated and monitored services and outcomes for continuing quality of care and services and member progress toward personal goals

Employer:	**Evergreen Healthcare Center – Mesa, Arizona**
Timeframe:	August 2003 – April 2005
Role and Responsibilities:	Social Services and Case Management Director ▪ Advocated for residents by educating staff on resident rights, dignity and abuse. ▪ Investigated abuse allegations as facility abuse officer ▪ Provided ongoing assessment and documentation in conjunction with individualized care planning to meet residents' mood and behavior needs ▪ Coordinated community reintegration and services upon discharge ▪ Led behavior management committee and resident care plan meetings ▪ Participated in CQI, on weight loss committees and facility management team

Part C

Addressing Barriers to Entry for the Direct Care Workforce

Direct care workers play a critical role in meeting the day-to-day needs of our ALTCS members. Improving recruitment, training and retention of the direct care workforce is essential to the strength of the ALTCS system of care. We are collaborating with Consumer Direct, a direct care agency statewide in Arizona, to increase the availability of job-skills training and cover the cost of fingerprinting and CPR training for 200 direct care workers.

Empowering Independence

United Healthcare

C1

Agreement Accepting Capitation Rates

UnitedHealthcare has collaborated with Valle del Sol Community Health to create a new mobile unit that advances access to care for families and reduces disparities in Arizona. Nearly 2,000 people have received health services including primary care, immunizations and screenings for behavioral health.

Empowering Independence

United Healthcare

C1 Agreement to Accept Capitation Rates

As indicated in RFP No. YH24-0001, Section H, subsection 20:

"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."

I, Jean Kalbacher, Chief Executive Officer of Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan), understand that the actuarially sound capitation rates will be calculated by AHCCCS prior to October 1, 2024. UnitedHealthcare Community Plan will accept these capitation rates developed by AHCCCS for the contract.

No moral or religious objections were submitted by UnitedHealthcare Community Plan as part of the RFP.

This document satisfies the submission of a signed agreement accepting capitation rates per RFP Section H, Instructions to Offerors.

Jean Kalbacher, Chief Executive Officer

September 21, 2023

Date

C2

Administrative Cost Component Bid

Our Diversity Equity and Inclusion Council is dedicated to eliminating disparities and educating our teams about the barriers that impact our members at a systemic level and in each individual's lived experiences. The efforts of our council foster an inclusive mindset that extends to our members, partners and more.

Empowering Independence

United Healthcare

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	$ 6.11	$ 2,151,766	$ 6.43	$ 2,276,562	$ 6.76	$ 2,404,847	$ 7.09	$ 2,536,709	$ 7.44	$ 2,658,916
Occupancy	$ 0.04	$ 2,818	$ 0.04	$ 2,981	$ 0.05	$ 3,149	$ 0.05	$ 3,322	$ 0.05	$ 3,482
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management/Care Coordination	$ 11.88	$ 1,157,876	$ 12.81	$ 1,225,029	$ 13.75	$ 1,294,060	$ 14.71	$ 1,365,016	$ 15.69	$ 1,430,776
Professional and Outside Services	$ 19.38	$ 568,858	$ 21.24	$ 626,735	$ 23.15	$ 686,283	$ 25.09	$ 747,547	$ 27.07	$ 806,528
Office Supplies and Equipment	$ 0.71	$ 47,212	$ 0.75	$ 49,950	$ 0.79	$ 52,765	$ 0.83	$ 55,658	$ 0.87	$ 58,340
Travel	$ 0.01	$ 817	$ 0.01	$ 864	$ 0.01	$ 913	$ 0.01	$ 963	$ 0.02	$ 1,010
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 1.68	$ 110,825	$ 1.77	$ 117,253	$ 1.86	$ 123,860	$ 1.95	$ 130,652	$ 2.04	$ 136,946
Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Expense	$ 0.73	$ 48,313	$ 0.77	$ 51,115	$ 0.81	$ 53,995	$ 0.85	$ 56,956	$ 0.89	$ 59,700
Pharmacy Benefit Manager Expenses	$ 2.99	$ 105,459	$ 2.99	$ 130,177	$ 2.99	$ 155,626	$ 2.99	$ 181,825	$ 2.99	$ 207,752
Fraud Reduction Expenses	$ 0.39	$ 25,549	$ 0.41	$ 27,030	$ 0.43	$ 28,553	$ 0.45	$ 30,119	$ 0.47	$ 31,570
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -
Health Care Quality Improvement	$ 30.28	$ 888,898	$ 31.03	$ 915,566	$ 31.80	$ 942,926	$ 32.59	$ 970,996	$ 33.39	$ 994,806
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.03	$ 2,212	$ 0.04	$ 2,340	$ 0.04	$ 2,472	$ 0.04	$ 2,608	$ 0.04	$ 2,733
Interpretation/Translation Services	$ 0.17	$ -	$ 0.18	$ -	$ 0.19	$ -	$ 0.20	$ -	$ 0.21	$ -
Other Administrative Expenses [2]	$ 1.02	$ 67,485	$ 1.08	$ 71,399	$ 1.13	$ 75,423	$ 1.19	$ 79,558	$ 1.24	$ 83,391
Total Admin Costs	$ 81.09	$ 5,178,088	$ 85.20	$ 5,497,003	$ 89.41	$ 5,824,873	$ 93.69	$ 6,161,927	$ 98.05	$ 6,475,948

Member Months Assumed in Bid		17,500		17,588		17,675		17,764		17,853

Footnotes:

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

AHCCCS
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	$ 6.11	$ 2,151,766	$ 6.43	$ 2,276,562	$ 6.76	$ 2,404,847	$ 7.09	$ 2,536,709	$ 7.44	$ 2,658,916
Occupancy	$ 0.04	$ 2,818	$ 0.04	$ 2,981	$ 0.05	$ 3,149	$ 0.05	$ 3,322	$ 0.05	$ 3,482
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management/Care Coordination	$ 11.88	$ 1,157,876	$ 12.81	$ 1,225,029	$ 13.75	$ 1,294,060	$ 14.71	$ 1,365,016	$ 15.69	$ 1,430,776
Professional and Outside Services	$ 19.38	$ 568,858	$ 21.24	$ 626,735	$ 23.15	$ 686,283	$ 25.09	$ 747,547	$ 27.07	$ 806,528
Office Supplies and Equipment	$ 0.71	$ 47,212	$ 0.75	$ 49,950	$ 0.79	$ 52,765	$ 0.83	$ 55,658	$ 0.87	$ 58,340
Travel	$ 0.01	$ 817	$ 0.01	$ 864	$ 0.01	$ 913	$ 0.01	$ 963	$ 0.02	$ 1,010
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 1.68	$ 110,825	$ 1.77	$ 117,253	$ 1.86	$ 123,860	$ 1.95	$ 130,652	$ 2.04	$ 136,946
Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Expense	$ 0.73	$ 48,313	$ 0.77	$ 51,115	$ 0.81	$ 53,995	$ 0.85	$ 56,956	$ 0.89	$ 59,700
Pharmacy Benefit Manager Expenses	$ 2.99	$ 105,459	$ 2.99	$ 130,177	$ 2.99	$ 155,626	$ 2.99	$ 181,825	$ 2.99	$ 207,752
Fraud Reduction Expenses	$ 0.39	$ 25,549	$ 0.41	$ 27,030	$ 0.43	$ 28,553	$ 0.45	$ 30,119	$ 0.47	$ 31,570
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -
Health Care Quality Improvement	$ 30.28	$ 888,898	$ 31.04	$ 915,566	$ 31.80	$ 942,926	$ 32.59	$ 970,996	$ 33.39	$ 994,806
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.03	$ 2,212	$ 0.04	$ 2,340	$ 0.04	$ 2,472	$ 0.04	$ 2,608	$ 0.04	$ 2,733
Interpretation/Translation Services	$ 0.17	$ -	$ 0.18	$ -	$ 0.19	$ -	$ 0.20	$ -	$ 0.21	$ -
Other Administrative Expenses [2]	$ 1.02	$ 67,485	$ 1.08	$ 71,399	$ 1.13	$ 75,423	$ 1.19	$ 79,558	$ 1.24	$ 83,391
Total Admin Costs	$ 81.09	$ 5,178,088	$ 85.20	$ 5,497,003	$ 89.40	$ 5,824,873	$ 93.69	$ 6,161,927	$ 98.06	$ 6,475,948

Member Months Assumed in Bid		52,500		52,763		53,026		53,291		53,558

Footnotes:

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

AHCCCS
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	$ 6.11	$ 2,151,766	$ 6.43	$ 2,276,562	$ 6.76	$ 2,404,847	$ 7.09	$ 2,536,709	$ 7.44	$ 2,658,916
Occupancy	$ 0.04	$ 2,818	$ 0.04	$ 2,981	$ 0.05	$ 3,149	$ 0.05	$ 3,322	$ 0.05	$ 3,482
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management/Care Coordination	$ 11.88	$ 1,157,876	$ 12.81	$ 1,225,029	$ 13.75	$ 1,294,060	$ 14.71	$ 1,365,016	$ 15.69	$ 1,430,776
Professional and Outside Services	$ 19.38	$ 568,858	$ 21.24	$ 626,735	$ 23.15	$ 686,283	$ 25.09	$ 747,547	$ 27.07	$ 806,528
Office Supplies and Equipment	$ 0.71	$ 47,212	$ 0.75	$ 49,950	$ 0.79	$ 52,765	$ 0.83	$ 55,658	$ 0.87	$ 58,340
Travel	$ 0.01	$ 817	$ 0.01	$ 864	$ 0.01	$ 913	$ 0.01	$ 963	$ 0.02	$ 1,010
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 1.68	$ 110,825	$ 1.77	$ 117,253	$ 1.86	$ 123,860	$ 1.95	$ 130,652	$ 2.04	$ 136,946
Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Expense	$ 0.73	$ 48,313	$ 0.77	$ 51,115	$ 0.81	$ 53,995	$ 0.85	$ 56,956	$ 0.89	$ 59,700
Pharmacy Benefit Manager Expenses	$ 2.99	$ 105,459	$ 2.99	$ 130,177	$ 2.99	$ 155,626	$ 2.99	$ 181,825	$ 2.99	$ 207,752
Fraud Reduction Expenses	$ 0.39	$ 25,549	$ 0.41	$ 27,030	$ 0.43	$ 28,553	$ 0.45	$ 30,119	$ 0.47	$ 31,570
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -
Health Care Quality Improvement	$ 30.28	$ 888,898	$ 31.04	$ 915,566	$ 31.80	$ 942,926	$ 32.59	$ 970,996	$ 33.39	$ 994,806
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.03	$ 2,212	$ 0.04	$ 2,340	$ 0.04	$ 2,472	$ 0.04	$ 2,608	$ 0.04	$ 2,733
Interpretation/Translation Services	$ 0.17	$ -	$ 0.18	$ -	$ 0.19	$ -	$ 0.20	$ -	$ 0.21	$ -
Other Administrative Expenses [2]	$ 1.02	$ 67,485	$ 1.08	$ 71,399	$ 1.13	$ 75,423	$ 1.19	$ 79,558	$ 1.24	$ 83,391
Total Admin Costs	$ 81.09	$ 5,178,088	$ 85.20	$ 5,497,003	$ 89.40	$ 5,824,873	$ 93.69	$ 6,161,927	$ 98.06	$ 6,475,948

Member Months Assumed in Bid		87,500		87,938		88,377		88,819		89,263

Footnotes:

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

AHCCCS
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	$ 6.11	$ 2,151,766	$ 6.43	$ 2,276,562	$ 6.76	$ 2,404,847	$ 7.09	$ 2,536,709	$ 7.44	$ 2,658,916
Occupancy	$ 0.04	$ 2,818	$ 0.04	$ 2,981	$ 0.05	$ 3,149	$ 0.05	$ 3,322	$ 0.05	$ 3,482
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management/Care Coordination	$ 11.88	$ 1,157,876	$ 12.81	$ 1,225,029	$ 13.75	$ 1,294,060	$ 14.71	$ 1,365,016	$ 15.69	$ 1,430,776
Professional and Outside Services	$ 19.38	$ 568,858	$ 21.25	$ 626,735	$ 23.15	$ 686,283	$ 25.09	$ 747,547	$ 27.07	$ 806,528
Office Supplies and Equipment	$ 0.71	$ 47,212	$ 0.75	$ 49,950	$ 0.79	$ 52,765	$ 0.83	$ 55,658	$ 0.87	$ 58,340
Travel	$ 0.01	$ 817	$ 0.01	$ 864	$ 0.01	$ 913	$ 0.01	$ 963	$ 0.02	$ 1,010
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 1.68	$ 110,825	$ 1.77	$ 117,253	$ 1.86	$ 123,860	$ 1.95	$ 130,652	$ 2.04	$ 136,946
Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Expense	$ 0.73	$ 48,313	$ 0.77	$ 51,115	$ 0.81	$ 53,995	$ 0.85	$ 56,956	$ 0.89	$ 59,700
Pharmacy Benefit Manager Expenses	$ 2.99	$ 105,459	$ 2.99	$ 130,177	$ 2.99	$ 155,626	$ 2.99	$ 181,825	$ 2.99	$ 207,752
Fraud Reduction Expenses	$ 0.39	$ 25,549	$ 0.41	$ 27,030	$ 0.43	$ 28,553	$ 0.45	$ 30,119	$ 0.47	$ 31,570
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -
Health Care Quality Improvement	$ 30.28	$ 888,898	$ 31.04	$ 915,566	$ 31.80	$ 942,926	$ 32.59	$ 970,996	$ 33.39	$ 994,806
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.03	$ 2,212	$ 0.04	$ 2,340	$ 0.04	$ 2,472	$ 0.04	$ 2,608	$ 0.04	$ 2,733
Interpretation/Translation Services	$ 0.17	$ -	$ 0.18	$ -	$ 0.19	$ -	$ 0.20	$ -	$ 0.21	$ -
Other Administrative Expenses [2]	$ 1.02	$ 67,485	$ 1.08	$ 71,399	$ 1.13	$ 75,423	$ 1.19	$ 79,558	$ 1.24	$ 83,391
Total Admin Costs	$ 81.09	$ 5,178,088	$ 85.20	$ 5,497,003	$ 89.40	$ 5,824,873	$ 93.69	$ 6,161,927	$ 98.06	$ 6,475,948

Member Months Assumed in Bid		117,413		118,001		118,593		119,187		119,187

Footnotes:

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

AHCCCS
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	$ 6.11	$ 2,151,766	$ 6.43	$ 2,276,562	$ 6.76	$ 2,404,847	$ 7.09	$ 2,536,709	$ 7.44	$ 2,658,916
Occupancy	$ 0.04	$ 2,818	$ 0.04	$ 2,981	$ 0.05	$ 3,149	$ 0.05	$ 3,322	$ 0.05	$ 3,482
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management/Care Coordination	$ 11.88	$ 1,157,876	$ 12.81	$ 1,225,029	$ 13.75	$ 1,294,060	$ 14.71	$ 1,365,016	$ 15.69	$ 1,430,776
Professional and Outside Services	$ 19.38	$ 568,858	$ 21.24	$ 626,735	$ 23.15	$ 686,283	$ 25.09	$ 747,547	$ 27.07	$ 806,528
Office Supplies and Equipment	$ 0.71	$ 47,212	$ 0.75	$ 49,950	$ 0.79	$ 52,765	$ 0.83	$ 55,658	$ 0.87	$ 58,340
Travel	$ 0.01	$ 817	$ 0.01	$ 864	$ 0.01	$ 913	$ 0.01	$ 963	$ 0.02	$ 1,010
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 1.68	$ 110,825	$ 1.77	$ 117,253	$ 1.86	$ 123,860	$ 1.95	$ 130,652	$ 2.04	$ 136,946
Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Expense	$ 0.73	$ 48,313	$ 0.77	$ 51,115	$ 0.81	$ 53,995	$ 0.85	$ 56,956	$ 0.89	$ 59,700
Pharmacy Benefit Manager Expenses	$ 2.99	$ 105,459	$ 2.99	$ 130,177	$ 2.99	$ 155,626	$ 2.99	$ 181,825	$ 2.99	$ 207,752
Fraud Reduction Expenses	$ 0.39	$ 25,549	$ 0.41	$ 27,030	$ 0.43	$ 28,553	$ 0.45	$ 30,119	$ 0.47	$ 31,570
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -
Health Care Quality Improvement	$ 30.28	$ 888,898	$ 31.04	$ 915,566	$ 31.80	$ 942,926	$ 32.59	$ 970,996	$ 33.39	$ 994,806
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.03	$ 2,212	$ 0.04	$ 2,340	$ 0.04	$ 2,472	$ 0.04	$ 2,608	$ 0.04	$ 2,733
Interpretation/Translation Services	$ 0.17	$ -	$ 0.18	$ -	$ 0.19	$ -	$ 0.20	$ -	$ 0.21	$ -
Other Administrative Expenses [2]	$ 1.02	$ 67,485	$ 1.08	$ 71,399	$ 1.13	$ 75,423	$ 1.19	$ 79,558	$ 1.24	$ 83,391
Total Admin Costs	$ 81.09	$ 5,178,088	$ 85.20	$ 5,497,003	$ 89.40	$ 5,824,873	$ 93.69	$ 6,161,927	$ 98.06	$ 6,475,948

Member Months Assumed in Bid		157,500		158,288		159,079		159,874		160,674

Footnotes:

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

AHCCCS
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	$ 6.11	$ 2,151,766	$ 6.43	$ 2,276,562	$ 6.76	$ 2,404,847	$ 7.09	$ 2,536,709	$ 7.44	$ 2,658,916
Occupancy	$ 0.04	$ 2,818	$ 0.04	$ 2,981	$ 0.05	$ 3,149	$ 0.05	$ 3,322	$ 0.05	$ 3,482
Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Care Management/Care Coordination	$ 11.88	$ 1,157,876	$ 12.80	$ 1,225,029	$ 13.75	$ 1,294,060	$ 14.71	$ 1,365,016	$ 15.69	$ 1,430,776
Professional and Outside Services	$ 19.38	$ 568,858	$ 21.23	$ 626,735	$ 23.15	$ 686,283	$ 25.09	$ 747,547	$ 27.07	$ 806,528
Office Supplies and Equipment	$ 0.71	$ 47,212	$ 0.75	$ 49,950	$ 0.79	$ 52,765	$ 0.83	$ 55,658	$ 0.87	$ 58,340
Travel	$ 0.01	$ 817	$ 0.01	$ 864	$ 0.01	$ 913	$ 0.01	$ 963	$ 0.02	$ 1,010
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bank Service Charge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 1.68	$ 110,825	$ 1.77	$ 117,253	$ 1.86	$ 123,860	$ 1.95	$ 130,652	$ 2.04	$ 136,946
Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Expense	$ 0.73	$ 48,313	$ 0.77	$ 51,115	$ 0.81	$ 53,995	$ 0.85	$ 56,956	$ 0.89	$ 59,700
Pharmacy Benefit Manager Expenses	$ 2.99	$ 105,459	$ 2.99	$ 130,177	$ 2.99	$ 155,626	$ 2.99	$ 181,825	$ 2.99	$ 207,752
Fraud Reduction Expenses	$ 0.39	$ 25,549	$ 0.41	$ 27,030	$ 0.43	$ 28,553	$ 0.45	$ 30,119	$ 0.47	$ 31,570
Third Party Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Sub Capitation Block Administrative	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -	$ 5.65	$ -
Health Care Quality Improvement	$ 30.28	$ 888,898	$ 31.02	$ 915,566	$ 31.80	$ 942,926	$ 32.59	$ 970,996	$ 33.39	$ 994,806
Program Integrity Fraud, Waste and Abuse Prevention Expenses	$ 0.03	$ 2,212	$ 0.04	$ 2,340	$ 0.04	$ 2,472	$ 0.04	$ 2,608	$ 0.04	$ 2,733
Interpretation/Translation Services	$ 0.17	$ -	$ 0.18	$ -	$ 0.19	$ -	$ 0.20	$ -	$ 0.21	$ -
Other Administrative Expenses [2]	$ 1.02	$ 67,485	$ 1.08	$ 71,399	$ 1.13	$ 75,423	$ 1.19	$ 79,558	$ 1.24	$ 83,391
Total Admin Costs	$ 81.09	$ 5,178,088	$ 85.16	$ 5,497,003	$ 89.40	$ 5,824,873	$ 93.69	$ 6,161,927	$ 98.06	$ 6,475,948

Member Months Assumed in Bid		200,000		201,111		202,005		203,015		204,030

Footnotes:

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

C3
Case Management Cost Component Bid

Eighty UnitedHealthcare volunteers worked together to pack 1,296 emergency food boxes and 900 supplemental food boxes for low income seniors at St. Mary's Food Bank. The event was part of the inaugural UnitedHealthcare Feeding America Volunteer Week.

Empowering Independence

United Healthcare

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

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)	$ 89,213	$ 89,213	$ 89,213	$ 96,350	$ 96,350	$ 96,350	$ 96,350	$ 96,350	$ 96,350	
Average Case Management Supervisor total compensation (includes ERE)	$ 144,225	$ 144,225	$ 144,225	$ 155,763	$ 155,763	$ 155,763	$ 155,763	$ 155,763	$ 155,763	
Average Case Management Administration Support Staff total compensation (includes ERE)	$ 138,492	$ 138,492	$ 138,492	$ 138,492	$ 138,492	$ 138,492	$ 138,492	$ 138,492	$ 138,492	
Maximum Members per Case Manager (Institutional) [2]	96.0	68.0	93.4	92.0	68.0	88.0	96.0	68.0	91.5	
Maximum Members per Case Manager (Acute Care Only) [2]	96.0	96.0	96.0	92.0	96.0	92.1	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	$ 3,069.77	$ 3,069.77	$ 3,069.77	$ 2,790.70	$ 2,790.70	$ 2,790.70	$ 3,069.77	$ 3,069.77	$ 3,069.77	
Average Case Managers per Supervisor	12	12	12	12	12	12	12	12	12	
Average Administrative Support Staff per Supervisor	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	
Calculations:										
Case Management Manager FTEs required	39.9	3.9	43.8	103.0	9.6	112.6	53.7	5.4	59.1	
Case Management Manager salary and ERE	$3,555,804	$347,898	$3,903,702	$9,926,607	$923,827	$10,850,434	$5,176,646	$516,548	$5,693,194	
Case Management Supervisor FTEs required	3.3	0.3	3.6	8.6	0.8	9.4	4.5	0.4	4.9	
Case Management Supervisor salary and ERE	$479,037	$46,869	$525,906	$1,337,311	$124,458	$1,461,769	$697,397	$69,589	$766,986	
Case Management Administration Support Staff FTEs	5.3	0.5	5.8	13.7	1.3	15.0	7.2	0.7	7.9	
Case Management Administration Support Staff salary and ERE	$735,993	$72,009	$808,002	$1,902,448	$177,053	$2,079,501	$992,112	$98,997	$1,091,109	
Travel Costs	$122,353	$11,971	$134,324	$287,516	$26,758	$314,274	$164,931	$16,458	$181,389	
Total Annual Case Management Cost	$4,893,188	$478,746	$5,371,934	$13,453,883	$1,252,096	$14,705,978	$7,031,086	$701,592	$7,732,678	
Total Case Management PMPM			**$189.30**			**$209.92**			**$207.02**	

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.

C4

Actuarial Certification

At a recent Arizona town hall sponsored by UnitedHealthcare, Nic Danger, an ALTCS member shared how his non-profit promotes wellness and independence by connecting people who have disabilities with engaging activities like camping and kayaking.

Empowering Independence

United Healthcare

C4 Actuarial Certification

Introduction and Limitations

The 2022-23 Medicaid Managed Care Rate Development Guide (2023 Guide) issued by CMS describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certification. This certification has been organized to follow the 2023 Guide to help facilitate the review of this rate certification by CMS and AHCCCS. The following certification covers Section 5 of the guide, Projected Non-Benefit Costs.

5. Projected Non-Benefit Cost Section

A. Rate Development Standards

i. Overview

The purpose of this document is to certify the non-benefit cost bid submission for UnitedHealthcare's response to Contract/RFP No. YH24-0001. In accordance with 42 CFR 438.5(e) the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the ALTCS managed care program. The methodology described was applied to each scenario of member month enrollment.

ii. PMPM versus percentage basis

The non-benefit cost was developed as a PMPM amount for each of the scenarios submitted. Each individual scenario bid stands alone.

B. Appropriate Documentation

i. Development of non-benefit costs

(a) Description of the data, assumptions and methodologies

Data

The primary data sources used in the development of the non-benefit costs are as follows:

- Historical non-benefit expense loads
- A detailed survey of internal functional areas based on contract requirements
- Non-benefit loads in comparable state Medicaid programs

Assumptions and methodology

In developing the non-benefit costs, we reviewed historical state specific managed care administrative costs loads for the ALTCS E/PD contract. For each scenario we considered the anticipated membership and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the ALTCS population. We surveyed internal functional areas to determine appropriate staffing and other needs related to the contract.

Historic non-benefit expense assumptions were utilized, adjusted for additional administrative requirements since the development of the historical expenses. We have compared this load to actual administrative costs in Contract Year Ending 2024 ALTC rates as well as administrative loads added to capitation rates in other comparable state Medicaid programs. Both of these comparisons lead us to believe that the non-benefit load rate developments are reasonable.

(b) Material changes

Considerations in development were given for programmatic and administrative requirement changes since the development of the historical administrative rates. Additionally, considerations were given for economies of scale and efficiencies gained through the integration of physical and behavioral health programs.

(c) Descriptions of other material adjustments

There were no other adjustments (material or non-material) to the projected non-benefit expenses bid in each scenario.

ii. Non-benefit costs, by cost category

(a) Administrative costs

Non-benefit costs were developed by geographic service area (GSA), utilizing historical applied non-benefit expenses and results of internal functional area survey. The non-benefit cost allowed was reviewed in aggregate by scenario, with anticipated further actuarially sound adjustments to be applied by AHCCCS. The resulting non-benefit costs by scenario are illustrated in the following table for Contract Year Ending 2025. Case Management costs were calculated by region using the mix provided.

Admin Component	MMs 0-34,999	MMs 35,000-69,999	MMs 70,000-104,999	MMs 105,000-139,999	MMs 140,000-174,999	MMs 175,000+
% of Admin PMPM that is variable	21.5%	45.1%	57.8%	64.8%	71.2%	75.8%
% of Admin PMPM that is fixed	78.5%	54.9%	42.2%	35.2%	28.8%	24.2%
Total Admin PMPM (All Admin Expenses)	$376.98	$179.72	$140.26	$125.19	$113.96	$106.98
Case Management PMPM – North	$189.30	$189.30	$189.30	$189.30	$189.30	$189.30
Case Management PMPM – Central	$209.92	$209.92	$209.92	$209.92	$209.92	$209.92
Case Management PMPM – South	$207.02	$207.02	$207.02	$207.02	$207.02	$207.02

(b) Taxes, licensing and regulatory fees and other assessments and fees

As indicated in the RFP, AHCCCS will include a provision for premium tax and any other applicable taxes, fees or assessments for this filing. UnitedHealthcare did not include any provisions for these fees.

(c) Contribution to reserves, risk margin and cost of capital

A provision for risk margin of 1.00% of the gross medical component for each scenario, consistent with guidance given in the RFP documents.

(d) Other material non-benefit costs

The required submission document, “Non Benefit Costs Bid Submission” includes a detailed admin break out section for each component (including case management) of the non-benefit cost submission.

iii. Historical administrative information

Historical administrative costs for Contract Year Ending 2022 were approximately $121.61 PMPM and case management costs were approximately $180.03. It should be noted that these administrative costs represent different geographical service area assumptions and contracts.

Actuarial Certification

I, James Johnson, Actuary at UnitedHealthcare and Member of the American Academy of Actuaries (MAAA) and a Fellow of the Society of Actuaries (FSA), am certifying that the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the ALTCS managed care program for the contract period. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established by the Actuarial Standards Board, specifically the guidance put forth in ASOP #49.

James Johnson, FSA, MAAA
Vice President, Actuarial Services

Part D

Addressing Food Insecurity and Social Isolation for Seniors in Yavapai County

Access to fresh, healthy foods can have a tremendous impact on health outcomes. We are teaming up with Manzanita Outreach to fund 12,000 home deliveries of fresh, healthy foods to home-bound seniors in Yavapai County. Manzanita Outreach partners with local farms to supply locally sourced fresh fruits and vegetables and provides a Phone Pals program where each home-bound senior receives a wellness call to address social isolation.

Empowering Independence

United Healthcare

D1
Intent to Provide Insurance

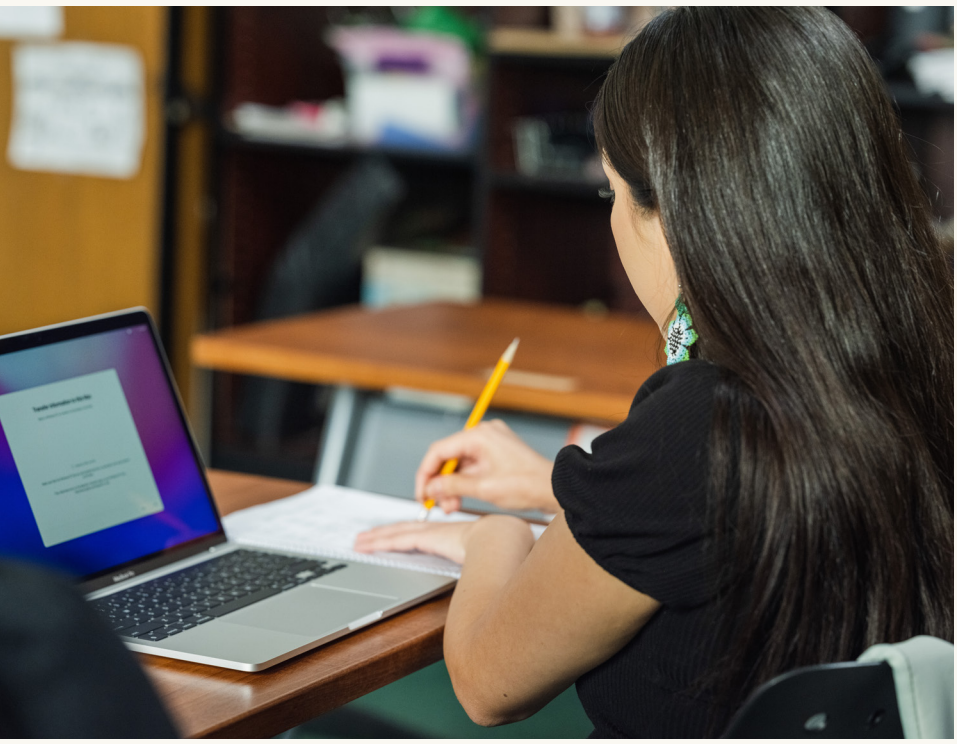
As part of our commitment to empowering our members to live the lives they choose with independence, we focus on activities and programs that enable our members to be more engaged in their communities. One example is an event where our members enjoyed fishing, water sports and boat rides.

D1 Intent to Provide Certificate of Insurance

Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan confirms that, if notified of contract award, we will submit to AHCCCS for review and acceptance the applicable certificates of insurance as required within this RFP document within 10 business days of such notification.

D2

Completed Section G: Disclosure of Information Instructions and Attestation



In support of the Community Health Workers, promotoras de salud and tribal community health representatives serving our communities, we provided scholarships for fourteen Community Health Workers to obtain voluntary certification through the Arizona Community Health Workers Association (AzCHOW).

Empowering Independence

United Healthcare

SECTION G - DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION

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

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

OFFEROR INSTRUCTIONS

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

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

4. Once all the above information has been submitted and entered into APEP and the Offeror has received confirmation that AHCCCS/Provider Enrollment has uploaded its completed RFP Exhibit I, the Offeror shall send confirmation of completion of all APEP information by September 15, 2023, ~~Once all information has been submitted, the Offeror shall send confirmation of completion of submittal (due no later than August 31, 2023 3:00 PM Arizona Time)~~ to **both** AHCCCS/DMPS dmpsproviderenrollmentunit@azahcccs.gov and AHCCCS/Procurement Email RFPYH24-0001@azahcccs.gov.

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

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

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

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

OFFEROR ATTESTATION

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

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

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

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

OFFEROR

OFFEROR NAME	DATE
Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan	September 11, 2023
PRINTED NAME AND TITLE OF INDIVIDUAL AUTHORIZED TO SIGN	**SIGNATURE OF INDIVIDUAL AUTHORIZED TO SIGN**
Jean Kalbacher, Chief Executive Officer	

CITY	STATE	ZIP	EMAIL ADDRESS	PHONE NUMBER
Phoenix	Arizona	85004	jean_kalbacher@uhc.com	(602) 255-8457

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

D3

Boycott of Israel Disclosure

We are proud to have earned Health Plan Accreditation and Long-Term Services & Supports Distinction from the National Committee for Quality Assurance (NCQA). NCQA recognizes health care organizations for meeting rigorous standards for consumer protection and quality improvement.

Empowering Independence

United Healthcare

EXHIBIT E: BOYCOTT OF ISRAEL DISCLOSURE

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

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

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

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

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

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

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

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

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

Signature of Individual Authorized to Sign	Jean Kalbacher, Chief Executive Officer Printed Name and Title
Phoenix Arizona City State	jean_kalbacher@uhc.com (602) 255-8457 Email Address Phone Number

D4
Moral or Religious Objections

Since the creation of ALTCS in 1989, we have been honored to serve long-term care members and to strengthen and modernize the system of care. Building on our 40-year partnership with AHCCCS, we will continue to advance health equity and improve the experiences and outcomes of those we serve.

Empowering Independence

United Healthcare

D4 Moral or Religious Objections

Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan does not restrict coverage for any services because of moral or religious objections, nor do we place any constraints on the coverage, reimbursement or delivery of services based upon moral or religious principles. We provide access to all Medicaid services covered under our contract with AHCCCS. All of our provider agreements contain a clause that allows the provider to refuse to provide any service they find objectionable because of moral or religious grounds. In that situation, we assist the member to access another provider who is willing to provide the service.

D5

State Only Pregnancy Terminations Agreement

During the COVID-19 pandemic, when many members were particularly isolated from their families, friends and communities, our case managers coordinated drive-through birthday parades. We were thrilled to celebrate members reaching exciting milestones in their lives – including one member who turned 104 years old.

Empowering Independence

United Healthcare

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 _Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan__ (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.**

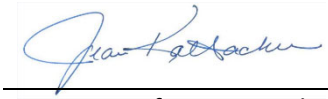
9. Termination – Availability of Funds: If, funds are not presently available to support the continuation of performance under this Contract beyond the current fiscal year, this Contract may be terminated at the end of the period for which funds are available. No legal liability on the part of AHCCCS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

Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan	
Offeror Name	Signature of Person Authorized to Sign
1 E. Washington Street, Suite 900	Jean Kalbacher
Address	Printed Name
Phoenix Arizona 85004	Chief Executive Officer
City State Zip	Title