AHCCCS
Arizona Health Care Cost Containment System

# AHCCCS Quality Strategy Evaluation
# CYE 2018 - CYE 2020

July 2021

## 1. Introduction

In accordance with Code of Federal Regulations 42 CFR 438.340 et. seq., the Arizona Health Care Cost Containment System (AHCCCS) Quality Strategy was first established in 2003. Since that time, it has been revised as appropriate to reflect innovative approaches to member care and continuous quality improvement efforts. AHCCCS' Quality Strategy is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. In addition, the Quality Strategy leads to the identification and documentation of issues related to those standards. It also encourages improvement through incentives, or when necessary, through regulatory actions.

The emphasis of AHCCCS' Quality Strategy has shifted from process measures to more comprehensive outcome-based measurement and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public comments. The Quality Strategy incorporates all required elements outlined in 42 CFR 438.340 and 42 CFR 457.1240(e).

The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy for the purpose of evaluating the effectiveness of the current AHCCCS Quality Strategy. Based on this evaluation, updates to the AHCCCS Quality Strategy are made, as appropriate, to address findings and identified areas of opportunity.

## 2. Population Management

One of the primary strategic goals of AHCCCS is to reduce system fragmentation and develop systems of care that are easy for members to navigate. Since 2013, and culminating in 2021, AHCCCS has been implementing a delivery system reform effort that allows members to access physical and behavioral health services through a single integrated delivery system model. This new integrated system is intended to treat all aspects of members' healthcare needs and encourages greater coordination between providers within the same network which can lead to better health outcomes for members.

The table below includes an enrollment summary for the following populations/lines of business:

- AHCCCS acute plans, inclusive of AHCCCS Complete Care (ACC) Managed Care Organizations (MCOs) and the Department of Child Safety Comprehensive Health Plan (DCS CHP) - formerly known as Comprehensive Medical and Dental Program (CMDP) prior to April 2021,
- Arizona Long Term Care System (ALTCS) Elderly and Physical Disabilities (EPD) and Developmental Disabilities (DD), and
- Regional Behavioral Health Authorities (RBHA) Serious Mental Illness (SMI).

Managed Care Organizations and Enrollment Summary

| Line of Business | Acronym | Sep 30, 2018 Enrollment | Sep 30, 2019 Enrollment | Sep 30, 2020 Enrollment |
|---|---|---|---|---|
| **AHCCCS Acute Plans** | **ACC and DCS CHP** | | | |
| **Arizona Complete Health - Complete Care Plan (CCP)** | AzCH | 192,352 | 204,510 | 221,400 |
| **Banner-University Family Care** | BUFC | 172,943 | 200,495 | 247,975 |
| **Care 1st Health Plan** | Care 1st | 184,548 | 172,622 | 181,694 |
| **Health Choice Arizona** | HCA | 227,556 | 200,180 | 206,563 |
| **Magellan Complete Care** | MCC | 174 | 14,722 | 41,651 |
| **Mercy Care** | MC | 353,108 | 327,341 | 356,368 |
| **UnitedHealthcare Community Plan** | UHCCP | 368,834 | 360,027 | 394,173 |
| **Department of Child Safety Comprehensive Health Plan** | DCS CHP | 13,186 | 13,385 | 13,493 |
| **Arizona Long Term Care (EPD and DD)** | **ALTCS** | | | |
| **Division of Developmental Disabilities** | DES/DDD | 32,688 | 34,404 | 35,986 |
| **Banner-University Family Care** | BUFC-LTC | 6,361 | 6,698 | 6,405 |
| **Mercy Care** | MC-LTC | 12,602 | 12,720 | 11,889 |
| **UnitedHealthcare Community Plan** | UHCCP-LTC | 8,990 | 9,736 | 9,178 |
| **Regional Behavioral Health Authority - SMI** | **RBHA** | | | |
| **Arizona Complete Health - CCP** | AzCH-RBHA | 13,395 | 13,402 | 13,902 |
| **Health Choice Arizona** | HCA-RBHA | 5,685 | 5,877 | 6,072 |
| **Mercy Care** | MC-RBHA | 21,867 | 22,691 | 24,913 |

The AHCCCS Population Statistics reports are made available on the AHCCCS website and include monthly enrollment data by MCO and county. The reports are utilized by internal and external stakeholders for statistical, planning, and decision making purposes.

### 3. AHCCCS Quality Strategy

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS. As part of its 2018 Quality Strategy, AHCCCS established the following quality goals and objectives:

**Quality Goal 1:** Improve the member's experience of care, including quality and satisfaction.

*Objectives:*

- Enrich member experience through an integrated approach to service delivery and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies, thereby increasing responsiveness and productivity,
- Enhance current performance measures, performance improvement projects (PIPs), and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs, and
- Drive the improvement of member-centered outcomes, using not only nationally recognized protocols, standards of care and benchmarks, but also the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows).

**Quality Goal 2:** Improve the health of AHCCCS populations.

*Objectives:*

- Increase member access to integrated care that meets the member's individual needs within their local community,
- Support innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services, and
- Build upon prevention and health maintenance efforts through targeted medical management:
    - Emphasizing disease and chronic care management,
    - Improving functionality in activities of daily living,
    - Planning patient care for the special needs population,
    - Identifying and sharing best practice, and
    - Expanding provider development of Centers of Excellence (COEs).

**Quality Goal 3:** Reduce the growth in healthcare costs and lower costs per person.

*Objectives:*

- Increase analytical capacity to make more informed clinical and policy making decisions, and
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
    - Strategic partnerships to improve access to health care services and affordable health care coverage,
    - Partnerships with sister government agencies, MCOs and providers to educate Arizonans on health issues,
    - Effective medical management of at-risk and vulnerable populations, and
    - Capacity building in rural and underserved areas to address both professional and paraprofessional shortages.

Activities and accomplishments related to these goals are highlighted within this Quality Strategy Evaluation.

## 4. Quality Strategy Evaluation

The Quality Strategy is reviewed at a minimum once every three years or as needed, based on significant program changes. The review process focuses on the previous three years, or less. The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy for the purpose of evaluating the effectiveness of the current AHCCCS Quality Strategy. Based on this evaluation, updates to the AHCCCS Quality Strategy are made, as appropriate, to address findings and identified areas of opportunity. The results of the Quality Strategy Evaluation, and any updates or revisions to the Quality Strategy, are submitted to the Centers for Medicare and Medicaid Services (CMS). In addition, all updates and revisions are posted on the AHCCCS website and made available in accordance with 42 CFR 438.340(d) and 42 CFR 457.1240(e).

### 4.1 Evaluation Methodology

The Quality Strategy is considered a companion document to the EQR Reports which encompass specific details of the assessment, results, and recommendations related to the goals and strategies found in this document. This information is used to assess the efficacy of currently stated goals and strategies, as well as provide a roadmap for potential changes and the development of new goals and strategies. Quality Strategy effectiveness, progress, and updates are also reported in the AHCCCS Section 1115 Waiver Quarterly Report. AHCCCS' quality assurance and monitoring activities occurring each quarter are described in this report and are summarized in the agency's annual report to CMS, as required in the State's Section 1115 Waiver.

In order to evaluate the Quality Strategy goals, AHCCCS:

- Conducted a review of the associated federal regulations to incorporate all required elements outlined in 42 CFR 438.340 and 42 CFR 457.1240(e),
- Reviewed AHCCCS-specific and MCO-specific improvement recommendations found within the EQR Reports, as well as reviewed the follow up activities conducted by each MCO,
- Conducted an analysis of operational review, performance measure, and PIP results,
- Analyzed provider performance as it relates to the AHCCCS Value Based Purchasing (VBP) initiatives,
- Analyzed network adequacy and appointment availability, and
- Conducted a review of AHCCCS' health information technology strategies.

AHCCCS will update its evaluation methodology, as needed, in the future to effectively analyze its Quality Strategy goals.

### 4.2 Evaluating the Quality Strategy Goals

During the Quality Strategy evaluation period (CYE 2018 - CYE 2020), AHCCCS conducted activities and implemented initiatives to achieve the CYE 2018 Quality Strategy goals and objectives, as outlined below.

#### *a. Quality Goal 1: Improve the member's experience of care, including quality and satisfaction*

- Transitioned from its use of internally established Minimum Performance Standards (MPS) to nationally recognized benchmarks inclusive of the National Committee for Quality Assurance (NCQA) Medicaid Mean [for NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures] and the CMS Medicaid Median (for CMS Core Set Only measures) beginning with CYE 2021. MCO performance will be compared to the national benchmarks for the associated measurement period, which serve as the performance target for each contractually required performance measure,

- Strategically aligned its statewide performance measures with the CMS Child and Adult Core Sets prior to implementation of mandatory child and behavioral health measure reporting. As a result, substantial updates were made to the performance measure sets found within the MCO contracts starting with CYE 2020,
- Continued its efforts to monitor and evaluate performance on current AHCCCS-mandated PIP indicators. In addition, AHCCCS identified and implemented new PIPs based on monitoring of performance measure data trends and EQRO improvement recommendations,
- The Office of Human Rights (OHR) eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The OHR has 2,504 individuals identified as requiring special assistance and provides direct advocacy via assignment to 702 members, and
- Received approval from CMS to begin the American Indian Medical Home (AIMH) initiative and, to date, AHCCCS has worked with tribal providers to establish seven AIMHs with nearly 25% of American Indian Health Program (AIHP) members empaneled.

***b. Quality Goal 2: Improve the health of AHCCCS populations***

- Reviewed and validated each MCO's progress towards compliance with minimum network requirements and standards,
- Received approval for a $300 million Targeted Investments Program (TIP), helping facilitate integration at approximately 500 provider sites across the state,
- Completed a rebase of the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology, better aligning inpatient reimbursement with current data,
- Implemented several strategies to combat the opioid epidemic, including overdose prevention through education and naloxone distribution, and increasing access to medication-assisted treatment through innovative approaches such as 24/7 access points providing opioid treatment services 24 hours a day, 7 days per week.
- Implemented a new reimbursement methodology for freestanding emergency departments, and
- Collaborated with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADC) [formerly known as the Department of Corrections (DOC)], and county justice partners resulting in over 6,000 incarcerated individuals becoming eligible for AHCCCS prior to release.

***c. Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person***

- Integrated new APMs in order to reduce costs and increase quality of care for members. Through VBP, AHCCCS is committing resources to leverage the State's successful managed care model to address inadequacies of the current health care delivery system such as fragmentation, and to continue to lead efforts to bend the health care cost curve to sustainable levels,
- Expanded access to Hepatitis C medication while lowering overall drug costs,
- Completed a request for information (RFI), held public meetings, and released the largest procurement in the history of Arizona for ACC,
- Implemented a new assessment policy and streamlined demographic reporting to reduce provider and member administrative burdens, and

- For the period of CYE 2018 through CYE 2020, the overall weighted average baseline capitation rate increase was 2.96 percent for lines of business included in the AHCCCS budget, which continues the overall trend for capitation rate growth of below 3 percent for the program.

***d. 2020 Year in Review***

The 2020 Year in Review document available on the AHCCCS website outlines various innovations in service delivery and technology as well as activities conducted in response to the COVID-19 Public Health Emergency (PHE). During CYE 2020, AHCCCS:

- Successfully transitioned more than 60 percent of AHCCCS employees to a virtual work environment, allowing the agency to consolidate two main campus buildings into one,
- Supported the work of the Governor's Abuse and Neglect Prevention Task Force through the October 1, 2020 implementation of minimum subcontract provisions aimed at preventing abuse, neglect, and exploitation,
- Launched the AHCCCS Provider Enrollment Portal (APEP), allowing providers to enroll with AHCCCS electronically any time of day,
- Implemented an Electronic Visit Verification system to verify member receipt of critical in-home services,
- Improved the timely processing of Medicaid applications to 94 percent for the non-Arizona Long Term Care System (ALTCS) applications and to 91 percent for ALTCS applications,
- Increased influenza vaccine rates by 10 percent to incentivize provider administration of the vaccine and partnered with health plans to offer managed care members a $10 gift card for receiving a flu shot,
- Added more than 3,000 members to American Indian Medical Homes, improving care coordination for members served in Indian Health Service (IHS) and 638 facilities,
- Created a Health Equity Committee to examine and understand health disparities that exist within the program and to develop strategies to ensure health equity for all AHCCCS members,
- Partnered with policy makers and hospitals to develop a new assessment, increasing payments to eligible hospitals by $800 million annually,
- Increased rates by an estimated $380 million for dental providers and practitioners, and
- Secured more than $37 million in grant funding to address the opioid epidemic, expand the State's suicide prevention work, and meet emergent needs related to the COVID-19 pandemic.

In response to the COVID-19 PHE, AHCCCS:

- Obtained permission to pursue more than 46 programmatic flexibilities from CMS. Key flexibilities implemented include:
    - Expanding the program's telehealth benefit to allow for a broader range of services to be provided electronically,
    - Expediting the provider enrollment process, and
    - Reimbursing parents for care offered to their minor children and allowing spouses offering paid care to be paid beyond the standard 40 hours per week limit.
- Offered provider financial relief:

- Made over $59 million in additional payments to nursing facilities, assisted living facilities, home and community based service providers, and critical access hospitals, and
- Advanced or accelerated more than $90 million in funding to hospitals, primary care providers, behavioral health outpatient providers, and justice clinic providers who participate in the agency's TIP and hospitals participating in the graduate medical education program.

### *e. Current AHCCCS Initiatives and Best Practices*

AHCCCS has several initiatives and best practices underway aimed at building a more cohesive and effective health care system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology, and working with private sector partners to further innovation to the greatest extent. Current AHCCCS initiatives include, but are not limited to:

- Increasing access to behavioral health services in schools,
- Electronic Visit Verification (EVV) to ensure timely service delivery for members,
- Emergency Triage, Treat, and Transport initiative designed to provide greater flexibility to ambulance care teams addressing emergency and non-emergency health care needs, and
- Leveraging telehealth services to better serve members and improve healthcare outcomes.

The AHCCCS Initiatives and Best Practices web page highlights ongoing initiatives with links to more detailed information and is updated as more information becomes available. Quality Initiatives specific to each contract year are included within the EQR Report located on the AHCCCS Health Plan Report Card web page.

### *f. Home and Community Based Services*

AHCCCS maintained a consistent trend of home and community based services member placements (considering increases in population) either plateauing or increasing as evidenced in CYE 2020 by a two percent decrease in institutional placements and the same increase of members residing in their own homes. Specifically, over a decade ago (2009) the proportion of members residing in their own homes was as low as 49 percent and has currently grown to 72 percent, while the proportion of the members residing in institutions declined from 31 percent (2009) to the current nine percent. The proportion of members residing in alternative residential settings remains stable at 19 percent. These placement rates are largely attributable to the service options and HCBS activities available, which demonstrates the program's commitment to advancing initiatives which result in the shift of placement for members to community-based placements.

### *g. System of Care Oversight*

The System of Care team is responsible for oversight of AHCCCS MCOs' adherence to contract and policy requirements to ensure services are delivered in line with the Arizona Vision (12 Principles and Adult Service Delivery System and 9 Guiding Principles), as well as the integration of physical and behavioral health services at the point of care. These oversight activities include monitoring of contract and policy requirements that ensure adequate, timely, and effective service delivery to aid members to achieve success in school/work, to live independently within their community, to avoid delinquency, and to achieve their vision of recovery.

Mercer Government Human Services Consulting (Mercer) conducts an annual quality service review (QSR) and conducts an annual evaluation of individuals with an SMI designation. The purpose of the

review is to identify strengths, service capacity and gaps in areas where members receive their services. The QSR includes an evaluation of nine targeted behavioral health services that includes the following: Case Management, Peer Support, Family Support, Supported Housing, Living Skills Training, Supported Employment, Crisis Services, Medication and Medication Services, and Assertive Community Treatment Services. Mercer conducts the QSR of the targeted services using a number of evaluation techniques.

- Peer Reviewers — Mercer contracted with two consumer-operated organizations to assist with completing project activities; primarily scheduling and conducting interviews and completing medical record review (MRR) tools for a sample of members with an SMI designation.
- Training — Mercer developed a two-week training curriculum to orient and educate peer support reviewers regarding relevant aspects of the project. The training included inter-rater reliability (IRR) testing to ensure consistent application of the review tools.
- Ongoing Support for Peer Reviewers — Mercer facilitated weekly meetings with the peer reviewer team to answer questions, follow up with concerns, and track the number of interviews and MRRs completed.
- Member Interviews — Peer reviewers contacted and interviewed a random sample of members to evaluate service needs and access to timeliness and satisfaction with the targeted services.
- MRRs — Peer reviewers conducted record reviews of the sample of members in order to assess individual assessments, individual service plans (ISPs), and progress notes utilizing a standard review tool.
- Data Analysis — Mercer conducted an analysis of data from the interviews and the MRR as well as service utilization data and other member demographics queried from the AHCCCS Client Information System (CIS).

### 4.3 External Quality Review

In accordance with 42 CFR 438.358, AHCCCS' External Quality Review Organization (EQRO) conducts an annual External Quality Review (EQR) that includes:

- Validation of performance measures,
- Validation of PIPs,
- A review conducted within the previous three-year period to determine compliance with the standards, and
- Validation of network adequacy.

AHCCCS contracted with an EQRO to conduct the mandatory activities for each MCO. The Annual EQR Technical Report (EQR Report) for each line of business outlines the findings of each mandatory activity, an analysis of the reported results, and recommendations to improve MCO performance.

As part of the Quality Strategy Evaluation process, the information presented within the EQR Reports is reviewed and utilized as a roadmap for the Quality Strategy Evaluation to identify potential changes and develop new goals/strategies, as needed. The EQR Reports outline AHCCCS, line of business, and MCO-specific recommendations for improvement in key areas. AHCCCS reviews these recommendations annually and as part of the Quality Strategy evaluation process in order to identify Quality Strategy strengths and areas for improvement.

In response to the EQR Report recommendations, AHCCCS completed the following activities:

*a. Performance Measures*

MCOs that did not meet performance standards for the Contract Year Ending (CYE) 2018 performance measures (child and adult) were required to submit a corrective action plan (CAP) to AHCCCS outlining root causes, new or enhanced interventions implemented to improve performance, and the methods for monitoring progress toward performance goals. As part of the CAP, MCOs were required to conduct root cause analysis, as well as examine and report potential barriers.

Based on review and analysis of well-child performance measure rates, AHCCCS implemented a Back to Basics PIP with a baseline measurement year of CYE 2019. The goal of this PIP is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child and well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

*b. Performance Improvement Projects*

AHCCCS updated its PIP reporting templates to include additional requirements for MCOs to conduct and report root cause analysis activities/findings. As part of the AHCCCS-mandated and MCO self-selected PIP reporting, MCOs are required to conduct a root cause and barrier analysis, as well as implement interventions to promote improvement. AHCCCS reviews and provides feedback for each MCO PIP submission, noting items that do not meet AHCCCS requirements. MCOs are required to incorporate AHCCCS feedback in future PIP submissions or resubmit the PIP report, per AHCCCS direction.

In addition, AHCCCS provides individual MCO technical assistance sessions, as requested by the MCO or mandated by AHCCCS, to facilitate MCO compliance in meeting AHCCCS expectations as it pertains to performance measures, PIPs, and CAPs. AHCCCS conducted technical assistance sessions specific to PIPs with two MCOs. The technical assistance included information related to quality improvement topics such as process and outcome measures, use of quality improvement tools, and enhancing interventions in order to help remove barriers to successfully improving the PIP indicator rates.

*c. Operational Reviews*

AHCCCS utilizes Operational Reviews (ORs) to evaluate MCO operations and performance related to compliance with federal and state laws, rules and regulations, as well as AHCCCS contracts and policies. AHCCCS offers technical assistance sessions to MCOs for any findings in the OR that may be of concern. The MCO may request a technical assistance session or AHCCCS staff may offer it based on the outcomes of the OR. In addition, AHCCCS has a number of venues to share lessons learned with MCOs. Lessons learned are often discussed at each of the MCO's exit interviews following completion of the OR onsite process.

A summary of key findings, program strengths and opportunities for improvement, AHCCCS and MCO recommendations, and associated follow-up activities are included within the EQR Reports and made available on the AHCCCS Health Plan Report Card web page.

### 4.4 Responsibility for Quality Monitoring

Several AHCCCS divisions are responsible for the implementation and oversight of the Quality Strategy. Internal and external collaborations and partnerships are utilized to address specific initiatives and issues. The agency maintains the ultimate authority for overseeing the Quality Strategy implementation and direction, including evaluation of overall effectiveness and MCO adherence. AHCCCS is responsible for reporting Quality Strategy activities, findings, and actions to members, other stakeholders, MCOs, the

Governor, legislators, and CMS. To ensure transparency, AHCCCS posts the Quality Strategy and related reporting to its website.

In order to oversee the Quality Strategy implementation and evaluate its overall effectiveness, AHCCCS established two quality-focused committees:

***a. AHCCCS Quality Steering Committee***

In CYE 2019, AHCCCS established the Quality Steering Committee inclusive of the executive management team, representatives from the AHCCCS clinical teams, and agency project teams. This committee meets monthly to discuss quality metrics and quality improvement activities.

***b. AHCCCS Clinical Oversight Committee***

The AHCCCS Clinical Oversight Committee is required by Arizona State Statute and requires review of clinical data specific to agency initiatives and populations identified by the director, including data on behavioral health services for persons receiving behavioral health services. The meetings are held quarterly and include the executive management team and representatives from the AHCCCS teams. An annual report is submitted to the Governor, the President of the Senate, the Speaker of the House of Representatives, and other key legislative members outlining the topics reviewed by the clinical oversight review committee in the preceding year and any recommendations relating to quality performance metrics stemming from the committee's activities.

## 5. Performance Monitoring Results

The core of the Quality Strategy is rooted in improving and/or maintaining members' health status, as well as increasing the potential for resilience and functional health status for members with chronic conditions. AHCCCS uses a variety of modalities to drive quality through its delivery system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration.

As part of the agency's commitment to continuous quality improvement, AHCCCS developed a performance metric to monitor improvement of performance measure rates at the AHCCCS statewide level. AHCCCS also monitors and evaluates MCO and aggregate performance on current AHCCCS-mandated PIP indicators, and conducts member experience surveys to monitor improvement in the members' experience of care, including quality and satisfaction. Additionally, AHCCCS conducts ORs of each contracted MCO at least once every three years, utilizing the OR process to meet the requirements of the Medicaid managed care regulations (42 CFR 438.358), to determine the extent to which each MCO meets AHCCCS contractual and policy requirements, as well as additional federal and state requirements.

### 5.1 Performance Measure Transition

Throughout the Quality Strategy evaluation period, AHCCCS implemented numerous improvements in performance measure rate calculations, evaluation, and reporting. AHCCCS also initiated efforts to enhance its performance measure standards and alignment with national benchmarks. These efforts are intended to reduce AHCCCS and MCO burden, facilitate more timely data, and drive improvement in performance measure rates.

In CYE 2018, AHCCCS began evaluating select CMS Child and Adult Core Set performance measures at the AHCCCS statewide level. The statewide rate calculations included all AHCCCS managed care enrolled members meeting the associated measure's continuous enrollment criteria at the agency level, regardless of whether the member was continuously enrolled in a specific MCO or line of business.

AHCCCS expanded the number of measures that are calculated at the statewide level for the purposes of evaluating and monitoring system-wide performance, as well as aligning performance measure reporting with CMS expectations.

To improve the timeliness of data collection, calculation, and reporting, AHCCCS transitioned from utilizing EQRO-calculated rates to measure and report MCO-level data. Starting with its 2020 performance measures, AHCCCS will begin utilizing MCO-calculated performance measure rates that have undergone EQRO validation. Additionally, the measurement period was transitioned from CYE (reflective of October 1 through September 30) to calendar year (CY) (reflective of January 1 through December 31). Beginning with its CYE 2021 contract amendments, AHCCCS also transitioned from its use of internally established MPS to the use of national benchmark data (i.e., CMS Medicaid Median and NCQA HEDIS® Medicaid Mean) to evaluate statewide and MCO performance. To promote quality improvement, performance measure results will be compared with nationally recognized standards that account for national performance trends and changes in measure technical specifications.

### 5.2 Quality Dashboard

AHCCCS has developed a quality dashboard inclusive of a selected set of performance measures that are reported based on line of business. The dashboard offers greater transparency to AHCCCS system performance and is a key point of reference for stakeholders. The dashboard compares the line of business aggregate rate with the associated CMS Medicaid Median and quartile data for a prioritized group of measures selected through stakeholder feedback. Appendix A outlines the selected set of performance measures for each line of business included within the quality dashboard. AHCCCS intends to expand the list of selected performance measures as well as enhance the dashboard as future year performance measure data becomes available and additional stakeholder feedback is received. The Quality Dashboard is made available on the AHCCCS website.

### 5.3 Performance Measures

AHCCCS utilizes performance measures to monitor MCO compliance in meeting contractual requirements related to the delivery of care and services to members. AHCCCS performance measures are based on CMS Core Measure Sets, NCQA HEDIS® measures, and other resources, when appropriate. These performance measures are also an important element of AHCCCS' approach to transparency in health services and VBP. MCO performance is publicly reported on the AHCCCS website as well as via other means, such as the sharing of data with state agencies, other community organizations, and stakeholders.

AHCCCS also monitors statewide performance for CMS Core Set measures. Statewide data are utilized for CMS reporting, and the results are compared with previous year statewide performance. Appendix B provides the trending analysis conducted for CYE 2018 and CYE 2019 data. The statewide data are also compared with the CMS Scorecard and associated CMS Medicaid Median and reported as part of the agency Scorecard. AHCCCS developed the following metric to monitor and improve statewide performance for CMS Core Set measures included within the CMS Scorecard:

**Performance Measure Target:** To meet or exceed the CMS Scorecard Median from the associated measurement period.

**Performance Improvement Target:** To maintain or increase the percentage of measures meeting or exceeding the CMS Scorecard Median from the previous year's reporting set.

| Total Number of CMS Scorecard Measures Reported | Number of Measures that Meet or Exceed the CMS Median | Percent of Measures Meeting or Exceeding the CMS Median |
|---|---|---|
| 13 | 8 | 61.5% |

In CYE 2018, AHCCCS reported statewide data for 13 of the measures included within the CMS Scorecard. Of those 13 measures, eight met or exceeded the CMS Medicaid Median resulting in 61.5 percent of measures meeting or exceeding the CMS Scorecard Medicaid Median. As CYE 2018 is the baseline year for the performance metric, data trending and associated analysis is not available. It is anticipated that data trending and analysis will be included in future Quality Strategy Evaluation reports, following the publication of the Federal Fiscal Year (FFY) 2020 CMS Medicaid Median data.

*a. Strengths*

AHCCCS demonstrated strength in the Follow-Up After Hospitalization for Mental Illness - 7 Day (ages 18 and older) measure with the statewide rate 27.6 percentage points above the CMS Medicaid Median, and the Follow-Up After Hospitalization for Mental Illness - 7 Day (ages 6-17) measure with the statewide rate 21.7 percentage points above the CMS Medicaid Median. AHCCCS also demonstrated strength in the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total Initiation measure with the statewide rate 3.2 percentage points above the CMS Scorecard Medicaid Median.

*b. Opportunities*

AHCCCS identified opportunities for improvement in the Adolescent Well-Care Visits, Well-Child Visits in the First 15 Months of Life, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measures as performance for these measures was below the CMS Medicaid Median. As a result, AHCCCS implemented the Back to Basics PIP with a baseline measurement year of CYE 2019. The goal of this PIP is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

AHCCCS also identified an opportunity for improvement in the Use of Opioids at High Dosage in Persons without Cancer measure as performance for this measure was above the CMS Medicaid Median (lower rates indicate better performance). As a result, AHCCCS intends to include an opioid-related measure within future VBP initiatives.

### 5.4 CYE 2018 Performance Measure Analysis

As part of the Quality Strategy evaluation, AHCCCS conducted an analysis of the CYE 2018 data reported to CMS. This analysis compared the AHCCCS reported performance measure rate with the associated CMS Medicaid Median and evaluated performance by Core Set domain. AHCCCS identified 34.6 percent of all CMS Child Core Set measures and 47.1 percent of CMS Adult Core Set measures reported met or exceeded the CMS Medicaid Median.

*a. Strengths*

AHCCCS demonstrated strength in the following domains as 50 percent (or greater) of the measure rates reported met or exceeded the associated CMS Medicaid Median.

- CMS Child Core Set: Behavioral Health Care,

- CMS Child Core Set: Dental and Oral Health Services,
- CMS Adult Core Set: Care of Acute and Chronic Conditions, and
- CMS Adult Core Set: Behavioral Health Care.

AHCCCS demonstrated the strongest performance in the Behavioral Health Care domain for both CMS Child and Adult measures as 100 percent of the Child Core Set and 56.6 percent of the Adult Core Set measures reported exceeded the CMS Medicaid Median. While AHCCCS demonstrated strong performance in behavioral health measures, AHCCCS continues to monitor and promote initiatives to further advance behavioral health care for members.

#### *b. Opportunities*

AHCCCS identified the following domains as areas for improvement as less than 50 percent of the measure rates reported met or exceeded the associated CMS Medicaid Median.

- CMS Child Core Set: Primary Care Access and Preventive Care,
- CMS Child Core Set: Maternal and Perinatal Health,
- CMS Child Core Set: Care of Acute and Chronic Conditions,
- CMS Adult Core Set: Primary Care Access and Preventive Care, and
- CMS Adult Core Set: Maternal and Perinatal Health.

AHCCCS identified the greatest opportunity for improvement in the Primary Care Access and Preventive Care domain. To promote improvement for measures included within this domain, AHCCCS has implemented the Back to Basics PIP, Breast Cancer Screening PIP, and Preventive Screening PIP. In addition, AHCCCS required all MCOs to implement a CAP for measures that did not meet the MPS. While measures within this domain did not meet or exceed the CMS Medicaid Median in CYE 2018, AHCCCS has noted improvement in the draft CYE 2019 performance measure rates when compared to CYE 2018.

### 5.5 Childhood and Adolescent Immunization Reports

Since 1993, AHCCCS has regularly measured the immunization status of children 24-months of age. AHCCCS publishes a report that evaluates the performance of MCOs, individually and overall, in accordance with state law (A.R.S. section 36-2904), which requires a biennial status of 24-month immunization completion rates for children served by AHCCCS. AHCCCS also measures the number of enrolled adolescents who received immunizations recommended by the Centers of Disease Control and Prevention (CDC) by 13 years of age and publishes a biennial report that evaluates adolescent immunization compliance for each MCO, individually and overall.

As AHCCCS has historically utilized the hybrid methodology to derive the Childhood Immunization Status and Immunizations for Adolescents measure rates, these performance measure rates were only available biennially; however, with the transition to MCO calculated rates that are validated by AHCCCS' EQRO, AHCCCS anticipates the ability to monitor this data more frequently. The most current Childhood Immunizations and Adolescent Immunizations reports are made publicly available on the AHCCCS Quality & Performance Improvement web page. These reports provide additional information related to the results, analysis, and associated MCO recommendations for improvement.

### 5.6 Form CMS-416

Annually, AHCCCS calculates and reports Form CMS-416 data for its Medicaid population utilizing the standardized methodology published by CMS. Additionally, AHCCCS calculates Form CMS-416 data for its

Children's Health Insurance Program (CHIP) population (i.e., KidsCare) to monitor Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and dental services.

AHCCCS participated in the CMS Form CMS-416 Transformed Medicaid Statistical Information System (T-MSIS) Replication Pilot, comparing and identifying variations within the Federal Fiscal Year (FFY) 2018 Form CMS-416 report generated by CMS with that submitted by the State. While states meeting specified standards for T-MSIS and T-MSIS Analytic Files (TAF) data quality and completeness had the option to allow CMS to generate its FFY 2020 Form CMS-416 reporting, AHCCCS elected to submit a state-generated report.

AHCCCS analyzes the aggregate CMS-416 data on an annual basis by conducting significance testing, evaluating the percent of change, and assessing the relative percent of change from the prior year's reporting.

Form CMS-416 Performance Summary Trends

| Form CMS-416 | CYE 2018 Rate | CYE 2019 Rate | CYE 2020 Rate[1] | CYE 2018 to CYE 2019 Relative Change | CYE 2019 to CYE 2020 Relative Change |
|---|---|---|---|---|---|
| **Title XIX Aggregate** | | | | | |
| **EPSDT Participation** | 50.8% | 51.0% | 43.2% | 0.4% | -15.3% |
| **Total Eligibles Receiving Preventive Dental Services** | 47.9% | 48.6% | 42.0% | 1.5% | -13.6% |
| **Total Eligibles Receiving Any Dental Services** | 48.9% | 49.5% | 43.6% | 1.2% | -11.9% |
| **Title XXI Aggregate** | | | | | |
| **EPSDT Participation** | 68.1% | 66.5% | 52.4% | -2.3% | -21.2% |
| **Total Eligibles Receiving Preventive Dental Services** | 52.5% | 53.8% | 45.6% | 2.5% | -15.2% |
| **Total Eligibles Receiving Any Dental Services** | 55.1% | 56.4% | 48.5% | 2.4% | -14.0% |

[1] *AHCCCS calculates and reports this measure in alignment with Form CMS-416 timelines. As a result, CYE 2020 data were available and included within this evaluation.*

Following this analysis, AHCCCS may require MCOs to implement interventions/activities (i.e., CAPs) or participate in mandatory workgroup activities when statistically significant declines in the Medicaid and/or KidsCare aggregate rates are identified. As part of the analysis activities conducted for CYE 2019 data, AHCCCS identified a 1.6 percentage point decrease in the KidsCare aggregate EPSDT Participation rate and a negative 2.3 percent relative percent change. To promote improvement in children and adolescents receiving well-child/well-care visits, AHCCCS implemented the Back to Basics PIP for the ACC/KidsCare, DCS CHP, and ALTCS DD MCOs with a baseline measurement year of CYE 2019.

Prior to the COVID-19 PHE, Form CMS-416 rates demonstrated improvement for both the Medicaid (Title XIX) and KidsCare (Title XXI) populations with the exception of EPSDT Participation for the KidsCare population. Based on analysis of the CYE 2020 data, the COVID-19 PHE negatively impacted the Form CMS-416 rates, most notably for EPSDT Participation.

### 5.7 Member Experience Surveys

AHCCCS and its MCOs continuously strive to improve the member's experience of care, quality of care, and satisfaction. With this goal in mind, AHCCCS routinely conducts and evaluates standardized member experience surveys. AHCCCS utilizes the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey as well as the Home and Community Based Services (HCBS) CAHPS® Survey, as appropriate to the member population, to monitor and evaluate member experience and satisfaction.

Due to the COVID-19 PHE, AHCCCS delayed the administration of the 2020 CAHPS® Surveys for its ACC, KidsCare, DCS CHP, and the RBHA-SMI integrated populations; however, AHCCCS initiated its CAHPS® Survey administration for these populations in early 2021. CAHPS® Survey results are made available within the Health Plan Report Card on the AHCCCS website. Additionally, the HCBS CAHPS® Survey Report is located on the AHCCCS website.

To promote improvement in member experience and satisfaction, MCOs are required to implement interventions/activities (i.e., CAPs) for survey results that achieve a three star rating or lower. MCOs may elect to conduct CAHPS® Surveys or internally developed member experience surveys to measure the effectiveness of interventions/activities and monitor improvement efforts. Beginning October 1, 2023, AHCCCS anticipates that MCOs will be required to conduct member experience surveys on an annual basis as part of the NCQA accreditation activities and requirements.

### 5.8 Performance Improvement Projects

AHCCCS mandates that MCOs participate in PIPs selected by AHCCCS as well as PIPs mandated by CMS. AHCCCS-mandated PIP topics are selected through analysis of internal and external data/trends and may include MCO input. Topics take into account the comprehensive aspects of member needs, care, and services for a broad spectrum of members, or a focused subset of the population, including those members with special health care needs, such as members receiving Long Term Care Services and Supports (LTSS).

AHCCCS may also mandate that a PIP be conducted by a MCO or group of MCOs, according to standardized methodology developed by AHCCCS. MCOs are also required to identify and implement additional PIPs based on self-identified opportunities for improvement, as supported by root cause analyses, external and internal data, surveillance of trends, or other information available to the MCO. AHCCCS-mandated PIP methodologies and final reports are made available on the AHCCCS Quality & Performance Improvement web page. Additional information related to AHCCCS-mandated PIP results can be found within the EQR Reports located on the AHCCCS Health Plan Report Card web page.

AHCCCS-Mandated Performance Improvement Projects

| PIP Topic | Applicable Line(s) of Business |
|---|---|
| E-Prescribing | RBHA (SMI Integrated) |
| Developmental Screening | ACC/Acute, DCS CHP, ALTCS DD |
| Back to Basics | ACC/KidsCare, DCS CHP, ALTCS DD |
| Breast Cancer Screening | ALTCS EPD |
| Preventive Screening | RBHA (SMI Integrated) |

### *a. E-Prescribing*

Population(s): RBHA-SMI Integrated

The purpose of this PIP was to increase the number of prescribers electronically prescribing prescriptions and to increase the percentage of prescriptions which are submitted electronically in order to improve patient safety. The goal was to demonstrate a statistically significant increase in the number of providers submitting electronic prescriptions and the number of electronic prescriptions submitted followed by sustained improvement for one year. As of CYE 2019, the RBHA-SMI integrated MCOs demonstrated significant and sustained improvement in the PIP indicators; as such, the project was closed. The E-Prescribing PIP Report, available on the AHCCCS website, provides the overall summary and analysis of the PIP indicator rates and improvement results.

E-Prescribing Performance Improvement Project

| E-Prescribing | CYE 2016 Rate | CYE 2018 Rate | CYE 2019 Rate | Year to Year Relative Change[1] | Statistical Significance[2] |
|---|---|---|---|---|---|
| **Aggregate** | | | | | |
| **Percent of Providers who Prescribed at Least One Prescription Electronically** | 58.9% | 69.8% | 82.9% | 40.7% | **P<0.001** |
| **Percent of Prescriptions Prescribed Electronically** | 54.3% | 67.5% | 76.6% | 41.0% | **P<0.001** |

[1] *Year to Year Change is reflective of the change in rate between CYE 2016 and CYE 2019.*

[2] *Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2016 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*

*CYE 2017 was reflective of the intervention year; as such, rates have not been included.*

*Note: the E-Prescribing PIP methodology varies from the Value Based E-Prescribing Initiative methodology; as such, there is variation in the reported rates.*

*b. Developmental Screening*

Population(s): ACC/Acute, DCS CHP, and ALTCS DD

The purpose of this PIP is to increase the number of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. The goal is to demonstrate a statistically significant increase in the number and percent of children receiving a developmental screening followed by sustained improvement for one consecutive year. The Developmental Screening Interim Report, available on the AHCCCS website, outlines the PIP indicator rates and associated analysis for remeasurement year one.

Developmental Screening Performance Improvement Project

| Developmental Screening | CYE 2016 Rate | CYE 2018 Rate | CYE 2019 Rate[1] | Year to Year Relative Change[2] | Statistical Significance[3] |
|---|---|---|---|---|---|
| **ACC (Acute)** | | | | | |
| **Percentage of Members Screened in the 12 Months Preceding their First Birthday** | 21.1% | 27.1% | 29.8% | 41.2% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their Second Birthday** | 27.5% | 34.1% | 40.1% | 45.8% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their Third Birthday** | 23.1% | 29.3% | 34.6% | 49.8% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their First, Second, and Third Birthday** | 23.6% | 29.9% | 34.4% | 45.8% | **P<0.001** |
| **DCS CHP** | | | | | |
| **Percentage of Members Screened in the 12 Months Preceding their First Birthday** | 23.8% | 31.1% | 39.5% | 66.0% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their Second Birthday** | 36.2% | 48.6% | 51.7% | 42.8% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their Third Birthday** | 29.0% | 33.5% | 43.0% | 48.3% | **P<0.001** |

| | | | | | |
|---|---|---|---|---|---|
| **Percentage of Members Screened in the 12 Months Preceding their First, Second, and Third Birthday** | 30.0% | 37.7% | 44.5% | 48.3% | **P<0.001** |
| **ALTCS DD** | | | | | |
| **Percentage of Members Screened in the 12 Months Preceding their First Birthday[4]** | N/A | N/A | N/A | N/A | N/A |
| **Percentage of Members Screened in the 12 Months Preceding their Second Birthday** | 24.4% | 31.3% | 29.9% | 22.5% | P=0.320 |
| **Percentage of Members Screened in the 12 Months Preceding their Third Birthday** | 25.1% | 22.3% | 23.8% | -5.2% | P=0.742 |
| **Percentage of Members Screened in the 12 Months Preceding their First, Second, and Third Birthday** | 24.9% | 25.1% | 25.8% | 3.6% | P=0.768 |
| **Aggregate** | | | | | |
| **Percentage of Members Screened in the 12 Months Preceding their First Birthday** | 21.1% | 27.1% | 30.0% | 42.2% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their Second Birthday** | 27.5% | 34.0% | 40.3% | 46.5% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their Third Birthday** | 23.1% | 29.2% | 34.7% | 50.2% | **P<0.001** |
| **Percentage of Members Screened in the 12 Months Preceding their First, Second, and Third Birthday** | 23.6% | 29.9% | 34.5% | 46.2% | **P<0.001** |

*The CYE 2016 and CYE 2018 ACC/Acute Aggregate rates are inclusive of the DCS CHP population.*
*CYE 2017 was reflective of the intervention year; as such, rates have not been included.*
*[1] CYE 2019 rates are reflective of draft rates.*
*[2] Year to Year Change is reflective of the change in rate between CYE 2016 and CYE 2019.*
*[3] Significance levels (p values) noted in the table demonstrate whether the differences in performance between CYE 2016 and CYE 2019 were statistically significant. The threshold for a result being considered statistically significant*

*is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.*
[4] *Rates are not reported for the ALTCS DD population.*

### 5.9 Newly Implemented Performance Improvement Projects

In addition, AHCCCS has implemented the additional PIPs outlined below beginning with CYE 2019 (October 1, 2018 to September 30, 2019):

#### *a. Back to Basics*

Population(s): ACC/KidsCare, ALTCS DD, and DCS CHP

The purpose of this PIP is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits. The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

Back to Basics Performance Improvement Project

| Back to Basics | CYE 2019 Rate[1] | CYE 2022 Rate | CYE 2023 Rate | Year to Year Change[2] |
|---|---|---|---|---|
| **ACC/KidsCare** | | | | |
| **Well-Child Visits: 15 Month Rate** | 64.1% | Rate Pending | Rate Pending | Not Available |
| **Child and Adolescent Well-Care Visits** | 49.9% | Rate Pending | Rate Pending | Not Available |
| **Annual Dental Visits** | 60.1% | Rate Pending | Rate Pending | Not Available |
| **DCS CHP** | | | | |
| **Well-Child Visits: 15 Month Rate** | N/A | Rate Pending | Rate Pending | Not Available |
| **Child and Adolescent Well-Care Visits** | 72.6% | Rate Pending | Rate Pending | Not Available |
| **Annual Dental Visits** | 74.7% | Rate Pending | Rate Pending | Not Available |
| **ALTCS DD** | | | | |
| **Well-Child Visits: 15 Month Rate** | N/A | Rate Pending | Rate Pending | Not Available |
| **Child and Adolescent Well-Care Visits** | 50.7% | Rate Pending | Rate Pending | Not Available |
| **Annual Dental Visits** | 52.7% | Rate Pending | Rate Pending | Not Available |
| **Aggregate** | | | | |
| **Well-Child Visits: 15 Month Rate** | 64.1% | Rate Pending | Rate Pending | Not Available |
| **Child and Adolescent Well-Care Visits** | 50.1% | Rate Pending | Rate Pending | Not Available |
| **Annual Dental Visits** | 60.0% | Rate Pending | Rate Pending | Not Available |

[1] *CYE 2019 rates are reflective of draft rates.*
[2] *Year to Year Change is not available.*

#### *b. Breast Cancer Screening*

Population(s): ALTCS EPD

The purpose of this PIP is to increase the number and percent of breast cancer screenings. The goal is to demonstrate a statistically significant increase in breast cancer screenings, followed by sustained improvement for one consecutive year.

Breast Cancer Screening Performance Improvement Project

| Breast Cancer Screening | CYE 2019 Rate[1] | CYE 2022 Rate | CYE 2023 Rate | Year to Year Change[2] |
|---|---|---|---|---|
| **Aggregate** | | | | |
| **Breast Cancer Screening** | 36.5% | Rate Pending | Rate Pending | Not Available |

[1] *CYE 2019 rates are reflective of draft rates.*
[2] *Year to Year Change is not available.*

### *c. Preventive Screening*

Population(s): RBHA-SMI Integrated

The purpose of this PIP is to increase the number and percent of breast cancer and cervical cancer screenings. The goal is to demonstrate a statistically significant increase in breast cancer screenings and cervical cancer screenings, followed by sustained improvement for one consecutive year.

Preventive Screening Performance Improvement Project

| Preventive Screening | CYE 2019 Rate[1] | CYE 2022 Rate | CYE 2023 Rate | Year to Year Change[2] |
|---|---|---|---|---|
| **Aggregate** | | | | |
| **Breast Cancer Screening** | 36.9% | Rate Pending | Rate Pending | Not Available |
| **Cervical Cancer Screening** | 43.2% | Rate Pending | Rate Pending | Not Available |

[1] *CYE 2019 rates are reflective of draft rates.*
[2] *Year to Year Change is not available.*

## 5.10 Operational Review

In CYE 2019, AHCCCS conducted a comprehensive OR inclusive of 12 standard areas for each ALTCS EPD MCO. Each standard area was inclusive of standards designed to measure each MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Case Management: 21 standards
- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 14 standards
- General Administration: 3 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 16 standards

- Medical Management: 27 standards
- Member Information: 10 standards
- Quality Management: 22 standards
- Reinsurance: 4 standards
- Third-Party Liability: 8 standards

In CYE 2019, AHCCCS also conducted a comprehensive OR inclusive of 11 standard areas for the DCS CHP MCO. Each standard area was inclusive of standards designed to measure the MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 10 standards
- General Administration: 3 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 14 standards
- Medical Management: 24 standards
- Member Information: 8 standards
- Quality Management: 18 standards
- Reinsurance: 4 standards
- Third-Party Liability: 7 standards

Upon completion of an OR, MCOs are required to submit CAPs in any area receiving a score of less than 95 percent. AHCCCS expects the majority of these CAPs to be implemented and closed within six months of AHCCCS' acceptance of the CAP. MCOs are required to submit a CAP update along with documentation demonstrating compliance to close each CAP. Appendix C provides a summary of the CYE 2019 OR compliance and associated CAPs.

AHCCCS scheduled ORs for the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) and RBHA MCOs during CYE 2020; however, due to the COVID-19 PHE, these reviews were put on hold. Additional information related to the OR findings and corrective actions can be found within the EQR Reports located on the AHCCCS Health Plan Report Card web page.

In CYE 2018, AHCCCS conducted a comprehensive Readiness Review process for each ACC MCO in preparation for the CYE 2019 ACC contract implementation. The Readiness Review process included assessing the ACC MCOs' readiness to perform and maintain compliance based upon an in depth review of the following areas:

- Administration staffing and staff training,
- Policy development/revision,
- Delivery systems,

- Provider and member communication,
- Grievance and appeals process,
- Corporate compliance program/program integrity,
- Provider network development and management,
- Care coordination and member transition procedures,
- Behavioral health service provision,
- Utilization review processes,
- Quality management and improvement,
- Financial reporting and monitoring,
- Financial solvency,
- Claims and provider support,
- Encounter systems testing,
- Management information systems including enrollment data, and
- Member services and outreach.

ACC MCOs were required to submit monthly overviews detailing their progress in addressing each of the individual evaluation elements, including reporting of risks, gaps in network and care, and strategies for remediation of identified issues. AHCCCS closely monitored ACC MCO readiness to ensure a successful implementation.

### 5.11 Administrative Actions

In the event a MCO fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose an administrative action. Administrative actions may include issuance of any or all of the following: Notice of Concern, Notice to Cure (NTC), a mandate for a CAP, and sanctions. With few exceptions, the AHCCCS Compliance Committee evaluates recommendations for proposed sanctions and determines the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee may also review administrative actions that do not include a sanction, such as a Notice of Concern, NTC, or requirement of a CAP. Information related to Administrative Actions is made available on the AHCCCS website. Appendix D outlines the administrative actions issued to MCOs from CYE 2018 through CYE 2020.

## 6. Network Adequacy

AHCCCS regularly receives reports from MCOs on compliance for network standards and follows up with MCOs on areas for improvement, as necessary. Additional information related to network adequacy findings are included within the EQR Reports located on the AHCCCS Health Plan Report Card web page.

AHCCCS provides general oversight of MCO network sufficiency through several committees. Data on MCO performance is presented in AHCCCS' Quality Management Committee, as well as the cross-agency Access to Care Committee. Individual performance issues are discussed in the quarterly Operations Oversight Committee.

#### *a. Appointment Availability*

Each quarter, MCOs submit an Appointment Availability report outlining their method for monitoring their provider network against appointment standards. The report consists of several matrices recording the number and percent of providers who have appointments available for members requiring specific services. As seen in the example below, MCOs submit the number of provider contacts and the number of providers that met and did not meet the required appointment availability.

Specialist and Dental Provider Appointment Availability (CYE 2019 Quarter 4 Example)

| PROVIDER REPORT | | URGENT | | | | ROUTINE CARE | | | |
|---|---|---|---|---|---|---|---|---|---|
| PROVIDER TYPE | | SURVEYS | PASS | FAIL | COMPLIANCE PERCENTAGE | SURVEYS | PASS | FAIL | COMPLIANCE PERCENTAGE |
| PCP | New | 1553 | 1448 | 105 | 93.24% | 1553 | 1530 | 23 | 98.52% |
| | Established | 1553 | 1457 | 96 | 93.82% | 1553 | 1548 | 5 | 99.68% |
| Specialist | New | 2081 | 2024 | 57 | 97.26% | 2081 | 2070 | 11 | 99.47% |
| | Established | 2081 | 2033 | 48 | 97.69% | 2081 | 2071 | 10 | 99.52% |
| Dental | New | 656 | 654 | 2 | 99.70% | 656 | 651 | 5 | 99.24% |
| | Established | 656 | 654 | 2 | 99.70% | 656 | 651 | 5 | 99.24% |

In addition to Primary Care Physicians (PCPs), specialists, and dental providers, MCOs submit information on available appointments for maternity care providers, behavioral health providers, and providers who serve members in legal custody of the State's foster care agency or adopted children.

MCOs adopt various methods for collecting this data, but have to declare the method and sampling methodology in their submissions. MCOs are also required to review these results in their annual network planning process by comparing their performance under these standards to the previous year and conducting an analysis of the sufficiency of their networks if there was a decrease in available appointments.

***b. Time and Distance***

AHCCCS requires MCOs to submit a completed Minimum Network Requirement Verification Report each quarter. The report describes the MCO's compliance with time and distance requirements for up to 13 provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. Since CYE 2019, AHCCCS has validated the Verification Report submissions by conducting an independent time and distance analysis of the health plan's compliance. The MCOs' analysis is validated through a contract with AHCCCS' EQRO. AHCCCS shares the results of this validation, along with the data AHCCCS provided to its EQRO and a file of non-contracted, AHCCCS-registered providers with the MCOs to assist them in researching discrepancies in the validated results, and in building their networks.

AHCCCS' EQRO also generates an annual report illustrating the performance of all MCOs serving each of Arizona's 15 counties for the ACC, ALTCS EPD, and RBHA lines of business. Additionally, AHCCCS' EQRO calculates the performance of two MCOs providing acute and behavioral health services for the State's ALTCS DD program. As seen in the example below, the annual report allows AHCCCS to compare MCO compliance over time with network time and distance requirements. AHCCCS requires that an MCO's network ensure at least 90 percent of their members live within the time and distances outlined in AHCCCS policy.

Based upon this reporting, AHCCCS identified areas for improvement and has worked with the MCOs to address their network deficiencies. While in most counties, like in Mohave County, MCOs meet or exceed AHCCCS network standards, the process has found room for improvement. For example, one major deficiency appears for MCOs serving the ACC population in Apache County and, to a lesser extent, Coconino County. These MCOs have difficulty meeting time and distance requirements for pharmacies and pediatric dentists. As noted above, AHCCCS shares lists of non-contracted, AHCCCS-registered pharmacies and dentists to assist in network expansion. Further, MCOs also must address these gaps and their steps to close them in deliverable submissions and their annual network planning. Additionally, AHCCCS reached out to both ACC MCOs serving these counties to address compliance. However, network expansion to address the deficiencies is complicated by the extremely rural nature of significant parts of these counties, and the lack of available pharmacies and dentists, and does not consider the presence of IHS/Tribal 638 facilities providers that have been excluded from these time and distance calculations.

AHCCCS Contractor Operations Manual (ACOM) Policy 436 includes an exception process for MCOs to request an exception from any minimum network standard that cannot be met after all efforts are exhausted. AHCCCS will review certain criteria to determine if an exception will be allowed. These criteria include, but are not limited to the number of providers available in the area, provider willingness to contract with an MCO, the availability of IHS/638 facilities to serve the American Indian population, and the availability of alternate service delivery mechanisms. MCOs are then required to monitor member access to the services covered by the exception while the exception is in place. In CYE 2020, there were no exemptions in place.

## 7. Value Based Purchasing

AHCCCS is pursuing the implementation of long-term strategies that bend the cost curve while improving member health outcomes. A critical tool in achieving this strategic priority is VBP. The overall mission is to leverage the AHCCCS managed care model toward value-based health care systems where members' experience and population health are improved through:

- Aligned incentives with MCOs and provider partners, and
- A commitment to continuous quality improvement and learning.

VBP encompasses a variety of initiatives for payment reform, including APM, Differential Adjusted Payments (DAP), E-Prescribing, as well as Directed Payments.

### 7.1 Alternative Payment Model

#### *a. LAN-APM Target Requirements*

AHCCCS has established contractually required targets for MCOs to contract with providers at a selected percentage of overall medical spend under VBP/APM arrangements. Furthermore, AHCCCS has specified the sub-requirement for the proportion of those VBP/APM arrangements that must be under Health Care Payment Learning and Action Network (LAN)-APM Framework Categories 3 and 4. Each year AHCCCS increases its LAN-APM target requirements for MCOs. The tables below show the progression of increased targets by line of business since CYE 2016.

LAN-APM Percent of Overall Medical Spend Target

| Year | ACC | EPD/DSNP | CRS CYE 2018 | RBHA Int | RBHA Non | DDD Sub | DDD LTSS | CMDP Sub |
|---|---|---|---|---|---|---|---|---|
| CYE 2016 | 20% | 15% | 20% | 5% | N/A | N/A | N/A | N/A |
| CYE 2017 | 35% | 25% | 35% | 15% | N/A | N/A | N/A | N/A |
| CYE 2018 | 50% | 35% | 50% | 25% | 10% | 20% | 5% | N/A |
| CYE 2019 | 50% | 50% | N/A | 50% | 20% | 35% | 10% | N/A |
| CYE 2020 | 60% | 60% | N/A | 50% | 25% | 50% | 20% | 0% |
| CYE 2021 | 65% | 65% | N/A | 60% | 30% | 60% | 35% | 0% |
| CYE 2022 | 70% | 70% | N/A | 70% | 35% | 70% | 50% | 50% |
| CYE 2023 | 75% | 75% | N/A | 75% | 40%[1] | 75% | 60% | 60% |

[1] *RBHA Competitive Contract Expansion (CCE) anticipated to be effective October 1, 2022.*

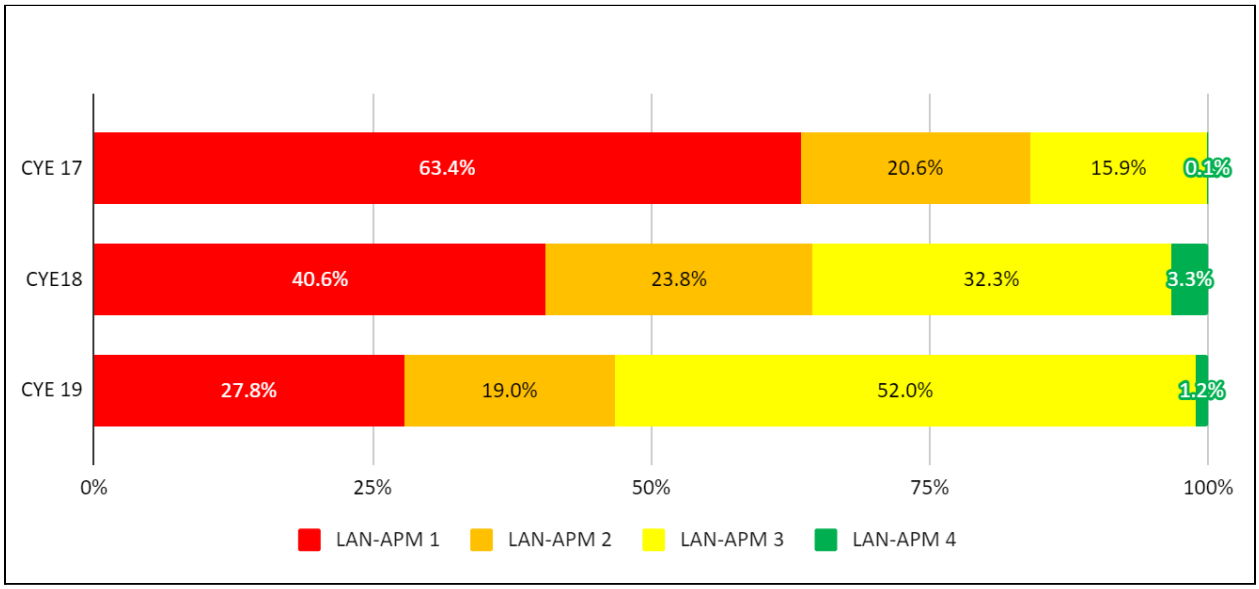
LAN-APM Category 3 & 4 Sub-Requirement Percent of LAN-APM Spend Target

| Year | ACC | EPD/DSNP | RBHA Int | RBHA Non | DDD Sub | DDD LTSS | CMDP Sub |
|---|---|---|---|---|---|---|---|
| CYE 2019 | 40% | 25% / 25% | 10% | 10% | 40% | 5% | N/A |
| CYE 2020 | 50% | 35% / 35% | 20% | 20% | 50% | 10% | 0% |
| CYE 2021 | 55% | 40% / 40% | 30% | 25% | 55% | 15% | 0% |
| CYE 2022 | 60% | 45% / 45% | 35% | 30% | 60% | 20% | 20% |
| CYE 2023 | 65% | 50% / 50% | 40%[1] | 35%[1] | 65% | 25% | 25% |

[1] *RBHA Competitive Contract Expansion (CCE) anticipated to be effective October 1, 2022.*

From CYE 2017 to CYE 2019, these contractual requirements have been successful in moving AHCCCS VBP efforts along the LAN-APM continuum. Over the last three years, there has been a significant increase in medical spend in VBP/APM arrangements (LAN Categories 2-4), from 36.6 percent to 71.6 percent, and an increase in the proportion of spend in LAN-APM Categories 3 or 4 from 16.0 percent to 52.6 percent, as shown in the graph below.

Progress Along LAN-APM Continuum




### *b. Performance Based Payments (PBP)*

Performance Based Payments (PBP) are payments from MCOs to providers for meeting certain quality measures that support LAN-APM initiatives. The purpose of PBP is to align incentives between the MCOs and providers to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality to achieve cost savings and improved outcomes. Care management, care coordination, case management, and infrastructure costs are excluded from PBP reimbursement.

By providing the PBP incentive, AHCCCS was able to drive the progression shown in the graph above into LAN Categories 2 and 3. MCOs used PBPs as a way to incentivize providers to enter into value-based contracts with additional funding available.

## 7.2 Differential Adjusted Payments (DAP)

AHCCCS utilizes DAP directed payments to provide a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The uniform percentage adjustment represents a positive increase to the AHCCCS Fee-For-Service (FFS) rates. The purpose of DAP is to distinguish providers which have committed to supporting designated actions that improve members' care experience, improve members' health, and reduce cost of care growth.

AHCCCS began DAP directed payments in CYE 2017 and over the past four years has expanded the program to over 12 provider types including, but not limited to: hospitals, IHS and 638 Tribally Owned and/or Operated Facilities, nursing facilities, and dental providers. AHCCCS posts an RFI outlining the potential DAP for the upcoming contract year. Stakeholders including providers and MCOs are able to comment and provide feedback on the proposed DAP as well as recommend new DAP for consideration. AHCCCS then, in a cross-divisional workgroup, reviews the comments and incorporates the feedback into its Preliminary DAP Public Notice, where stakeholders receive an additional chance to comment on proposed DAP before they are implemented for the next contract year. This process allows stakeholders to be involved in which DAP are implemented and/or retired each year.

Providers are measured on numerous performance measures specific to their provider type including, but not limited to:

- Number of AHCCCS registered integrated clinics,
- Number of providers registered in the Health Information Exchange (HIE), and
- Select performance measures, such as
    - Sepsis (SEP-1) - Hospital,
    - Pressure Ulcer - Long Term Hospital,
    - Pressure Ulcer - Inpatient Rehabilitation,
    - Dental Sealants for Children Ages 5-15,
    - Quality Reporting Program (IPFQR) - Psychiatric Hospitals,
    - Pressure Ulcers - Nursing Facility,
    - Urinary Tract Infection - Nursing Facility,
    - Electronic Prescriptions, and
    - Enrollees receiving Behavioral Health Services in an Integrated Clinic/Behavioral Health Outpatient Clinic.

| Registered Integrated Clinics | | | | |
|---|---|---|---|---|
| | **Baseline CYE 2017** | **Year One Results CYE 2018** | **Year Two Results CYE 2019** | **Year Three Results CYE 2020** |
| **Registered Integrated Clinics** | 79 | 104 | 140 | 179 |

Increasing the number of integrated clinics will help achieve AHCCCS' strategic goal to improve the member's experience of care. Prior to the DAP, AHCCCS had very few providers registered with AHCCCS under this provider type. By applying a DAP specific to the integrated clinic provider type, AHCCCS has encouraged more providers to move to this category and thus offer our members more choices of integrated providers.

| Registered and Active HIE Users | | | | |
|---|---|---|---|---|
| | **Baseline CYE 2017** | **Year One Results CYE 2018** | **Year Two Results CYE 2019** | **Year Three Results CYE 2020** |
| **Participants Registered in the HIE** | 350 | 492 | 631 | 736 |
| **HIE Registered Users** | 6,500 | 10,038 | 10,038 | 14,407 |
| **HIE Active Users** | 650 | 794 | 1,137 | 2,235 |

AHCCCS has seen a significant increase in HIE users over the last three years. Increasing the number of providers registered with the HIE, and increasing the number of active users among those providers, allows behavioral health providers insight into the physical health needs of their patients, and vice versa.

The selected performance measures outlined below were added to the DAP evaluation in CYE 2019.

| DAP Measures (CYE aligns with DAP Payment Year)[1] | | | | |
|---|---|---|---|---|
| | **Baseline CYE 2019** | **Year One Results CYE 2020** | **Year Two Results CYE 2021** | **Year Three Results CYE 2022** |
| **Sepsis (SEP-1) - Hospital** | N/A | 47% | 54% | 55% |
| **Pressure Ulcer - Long Term Hospital (Number of Hospital Qualified)** | N/A | 4 | 4 | 4 |
| **Pressure Ulcer - Inpatient Rehabilitation (Number of Hospitals Qualified)** | N/A | 5 | 6 | 7 |
| **Quality Reporting Program (IPFQR) - Psychiatric Hospitals (Number of Hospitals Qualified)** | 15 | 16 | 18 | 19 |
| **Pressure Ulcers - Nursing Facility** | N/A | 7.70% | 7.99%[2] | 8.31% |
| **Urinary Tract Infection - Nursing Facility** | 2.56% | 2.35% | 1.87% | 1.99% |

[1] Performance metrics for each year are based on criteria from the two years prior.
[2] Additional skin condition codes that satisfy the criteria of a pressure ulcer were added to the Percent of High-Risk Residents with Pressure Ulcers (Long Stay) measure with the changes to the 2018 version of the MDS-30-QM-USERS-MANUAL-v120. AHCCCS believes this is causing the increase in the percent of pressure ulcers in CYE 2019 and 2020.

### *a. Federally Qualified Health Centers (FQHC) DAP*

AHCCCS utilizes the FQHC DAP directed payment to provide a uniform percentage increase to FQHCs registered with AHCCCS who meet specific criteria established by AHCCCS. The uniform percentage adjustment represents a positive increase to the AHCCCS all-inclusive per visit Prospective Payment System (PPS) rates. The purpose of the FQHC DAP is to distinguish FQHC providers which have committed to supporting designated actions that improve members' care experience, improve members' health, and reduce cost of care growth.

Providers are measured on the following performance measures:

- Patients with Colorectal Cancer Screening (CMS130v5),

- Patients with Diabetes Hemoglobin A1c Poor Control > 9% or no Test during year (CMS122v5), and
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155v5).

| FQHC DAP Measures (CYE aligns with DAP Payment Year)[1] | | | | |
|---|---|---|---|---|
| | **Baseline CYE 2019** | **Year One Results CYE 2020** | **Year Two Results CYE 2021** | **Year Three Results CYE 2022** |
| **Patients with Colorectal Cancer Screening** | 37.4% | 39.8% | 37.4% | 33.1% |
| **Patients with Diabetes Hemoglobin A1C Poor Control > 9%** | 36.7% | 36.8% | 32.0% | 37.1% |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents** | 62.7% | 62.5% | 71.5% | 61.2% |

[1] Performance metrics for each year are based on the calendar year CMS Uniform Data System reports from two years prior.

The selected performance measures were added to the FQHC DAP evaluation in CYE 2019. AHCCCS anticipates that by focusing on outcome based performance metrics impacting both adults and children, quality of care and health are expected to increase; for example, improved management of diabetes should improve member outcomes, resulting in fewer emergency department and inpatient visits.

### 7.3 E-Prescribing (MCOs)

MCOs are required to increase their E-Prescribing rate of original prescriptions. The goal percentage is specific to each AHCCCS line of business. The table below shows that over the last three years, there has been a significant increase in E-Prescribing by the MCOs.

Value Based E-Prescribing Rates

| MCO | CYE 2018 | CYE 2019 | CYE 2020 |
|---|---|---|---|
| **ACC** | **62.3%** | **71.2%** | **79.9%** |
| **CARE1ST HEALTH PLAN** | 59.0% | 70.4% | 80.5% |
| **HEALTH CHOICE ARIZONA** | 62.9% | 70.3% | 79.6% |
| **AZ COMPLETE HEALTH CARE** | 60.2% | 74.2% | 82.2% |
| **MERCY CARE PLAN** | 55.8% | 66.3% | 74.8% |
| **UNITEDHEALTHCARE** | 66.4% | 76.6% | 84.4% |
| **BANNER UNIV FAMILY CARE** | 69.5% | 76.9% | 83.5% |
| **MAGELLAN COMPLETE CARE** | 0.0% | 64.0% | 74.0% |
| **DCS CHP** | **64.6%** | **47.3%** | **61.3%** |
| **DCS CHP**[1] | 64.6% | 47.3% | 61.3% |
| **ALTCS DD** | **66.3%** | **74.9%** | **83.2%** |
| **DES/DDD** | 66.3% | 74.9% | 83.2% |
| **ALTCS EPD** | **39.1%** | **48.7%** | **60.3%** |
| **MERCY CARE PLAN - LTC** | 39.7% | 49.9% | 60.8% |
| **UNITEDHEALTHCARE LTC** | 39.1% | 47.9% | 59.2% |
| **BANNER - UNIVERSITY LTC** | 38.4% | 48.2% | 60.9% |
| **RBHA** | **70.7%** | **78.1%** | **83.2%** |
| **HEALTH CHOICE ARIZONA** | 72.6% | 80.3% | 85.0% |
| **AZ COMPLETE HEALTH CARE** | 74.9% | 80.7% | 83.9% |
| **MERCY CARE PLAN** | 64.7% | 73.4% | 80.6% |

[1] *DCS CHP experienced encounter issues in CYE 2019; as such, a decrease in the E-Prescribing percentage for the CYE 2019 measurement period was noted. AHCCCS worked closely with the MCO to ensure all issues were resolved.*
*Note: the Value Based E-Prescribing Initiative methodology varies from the E-Prescribing PIP methodology; as such, there is variation in the reported rates.*

## 7.4 Directed Payments

### *a. Access to Professional Services Initiative (APSI)*

The Access to Professional Services Initiative (APSI) provides a uniform percentage increase to negotiated managed care contracted rates for eligible professional services delivered by network qualified practitioners for all five AHCCCS programs. AHCCCS monitors the impact of this payment arrangement on reducing the growth in healthcare costs and lowering costs per person using the following measures:

For all providers affiliated with any designated hospitals:

- All Cause Readmission (PCR-AD).

| All Cause Readmission (PCR-AD) (Lower is Better) | | | |
|---|---|---|---|
| | **Baseline CY 2017** | **Year One Results CY 2018** | **Year Two Results CY 2019** |
| **Banner Health** | 12.9% | 12.9% | 12.6% |
| **Dignity Health** | 15.3% | 15.1% | 15.2% |
| **Valleywise** | 8.0% | 7.9% | 8.6% |
| **Phoenix Children's Hospital** | 9.5% | 8.8% | 7.1% |
| **Tucson Medical Center** | 11.2% | 11.3% | 11.1% |

While AHCCCS has not observed any notable decreases during this time period, it has observed some specific improvements for Phoenix Children's Hospital.

For all providers, other than those affiliated with a free-standing children's hospital:

- Prev-10 – Preventative Care and Screening: Tobacco use: Screening and Cessation Intervention (PCPI), and
- Prev-12 – Preventative Care and Screening: Screening for Depression and Follow-Up Plan.

Preventive Care and Screening

| | **Prev-10 (Higher is Better)** | | | **Prev-12 (Higher is Better)** | | |
|---|---|---|---|---|---|---|
| **Provider** | **Baseline CY 2017** | **Year One Results CY 2018** | **Year Two Results CY 2019** | **Baseline CY 2017** | **Year One Results CY 2018** | **Year Two Results CY 2019** |
| **Banner Health** | 16.2% | 79.8% | 83.8% | 36.9% | 62.0% | 63.1% |
| **Dignity Health** | 83.8% | 88.1% | 92.9% | 39.5% | 64.4% | 42.7% |
| **Valleywise** | 85.4% | 84.2% | 86.4% | 67.3% | 65.1% | 71.9% |
| **Tucson Medical Center** | 94.7% | 96.8% | 95.5% | 58.1% | 62.4% | 57.9% |

Overall, AHCCCS has seen improvement on both of these measures for each of the providers. There has been some slight fluctuation, but every hospital is performing better than baseline for all measures, with the exception of Tucson Medical Center on the Prev-12 performance measure.

For all providers affiliated with a free-standing children's hospital:

- Childhood Immunization - Influenza Vaccination: Age <18, and
- Diabetes - Patient Education: Age <18.

Childhood Immunization and Diabetes Patient Education

| | Childhood Immunization (Higher is Better) | | | Diabetes - Patient Education (Higher is Better) | | |
|---|---|---|---|---|---|---|
| **Provider** | **Baseline CY 2017** | **Year One Results CY 2018** | **Year Two Results CY 2019** | **Baseline CY 2017** | **Year One Results CY 2018** | **Year Two Results CY 2019** |
| **Phoenix Children's Hospital** | 57.5% | 57.7% | 62.2% | 36.0% | 54.0% | 78.0% |

AHCCCS has seen improvement in both children's hospital measures over the past two years. Tracking and improving influenza vaccination rates ensures that patients receive low-cost preventive care services to avoid significant future health care costs (in this case the costs of contracting the flu and the associated complications that arise in a vulnerable population). Additionally, educating parents and children about Type 1 Diabetes will reduce the growth in health care costs and lower the costs per person by providing critical information to families about how to manage this illness. Proper management and health behaviors reduces the risk of costly and debilitating complications arising from the disease, and thereby lowers costs for the system.

### *b. Pediatric Services Initiative (PSI)*

The Pediatric Services Initiative (PSI) provides a uniform dollar increase to negotiated managed care contracted rates for inpatient and outpatient hospital services provided by freestanding children's hospitals with more than 100 licensed pediatric beds. Funding for this initiative comes from local funding partners, which is then matched with federal dollars.

PSI supports AHCCCS' goal to increase member access to integrated care that meets the member's individual needs within their local community. Freestanding children's hospitals meet a unique subspecialty need through pediatric specialties, and are critical to AHCCCS' ability to provide the full spectrum of care to its pediatric members.

Hospitals are measured on the following performance measures:

- Unplanned Readmissions,
- Antibiotic Stewardship – Indications for Antibiotic Use with Order, and
- Safe Transition Appointment.

PSI began in CYE 2020. At the time of writing this evaluation plan, AHCCCS had not yet obtained data regarding the selected performance measures.

### *c. Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII)*

The Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) is AHCCCS' newest directed payment initiative, authorized by Arizona Laws 2020, Chapter 46. HEALTHII will provide uniform

percentage increases for payments to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid managed care services.

By providing payments that cover a portion of Arizona hospitals' Medicaid program shortfall, AHCCCS anticipates the HEALTHII program will support the financial sustainability of hospitals that serve large proportions of Medicaid-covered individuals, including rural hospitals. This will, in turn, ensure a sufficient number of hospitals in each of the MCO's networks to provide timely access to services.

Over the longer term, it is also anticipated that these payments will support provider efforts to improve performance, resulting in higher quality services provided to Medicaid members.

Hospitals are measured on the following performance measures:

- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) Summary Star Rating,
- Hospital-Wide All-Cause Unplanned Readmission Measure (READM-30-HWR),
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18),
- Hospital Visits after Hospital Outpatient Surgery,
- Follow-up after Hospitalization for Mental Illness (FUH), and
- 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF).

HEALTHII began in CYE 2021. At the time of writing this evaluation plan, AHCCCS had not yet obtained information regarding the selected performance measures for the directed payment.

#### *d. Nursing Facilities Directed Payment*

AHCCCS uses the Nursing Facilities directed payment to provide a uniform dollar increase to AHCCCS FFS rates and ALTCS EPD MCO negotiated rates as lump sum payments to registered networks providers of nursing facility services.

This payment arrangement advances the goals and objectives of the AHCCCS Quality Strategy by 1) ensuring access to quality care and thus improving member experience of care, and 2) improving health outcomes.

Nursing facilities are measured on the following performance measures:

- Skilled Nursing Facility (SNF) Ownership Changes,
- Skilled Nursing Facility (SNF) Closures, and
- Percent of High-Risk Residents with Pressure Ulcers (Long-Stay).

| Skilled Nursing Facility (SNF) Ownership Changes/Closures | | | |
|---|---|---|---|
| | **Baseline CYE 2017** | **Year One Results CYE 2018** | **Year Two Results CYE 2019** |
| **Ownership Changes** | 35 | 12 | 7 |
| **Closures** | 0 | 0 | 2 |

AHCCCS has seen significant progress in reducing the number of ownership changes for nursing facilities. By reducing the number of ownership changes each year, members are able to receive a more stable, consistent level of care.

| Percent of High-Risk Residents with Pressure Ulcers (Long Stay) (Lower is Better) | | | |
|---|---|---|---|
| | **Baseline CYE 2017** | **Year One Results CYE 2018** | **Year Two Results CYE 2019** |
| **Average AHCCCS %** | 5.66% | 7.78% | 8.02% |
| **National Average** | 5.57% | 7.40% | 7.99% |

*Lower rates indicate better performance.*

Additional skin condition codes that satisfy the criteria of a pressure ulcer were added to the Percent of High-Risk Residents with Pressure Ulcers (Long Stay) measure with the changes to the 2018 version of the MDS-30-QM-USERS-MANUAL-v120. AHCCCS believes this is causing the increase in the percent of pressure ulcers in the CYE 2018 and 2019 data.

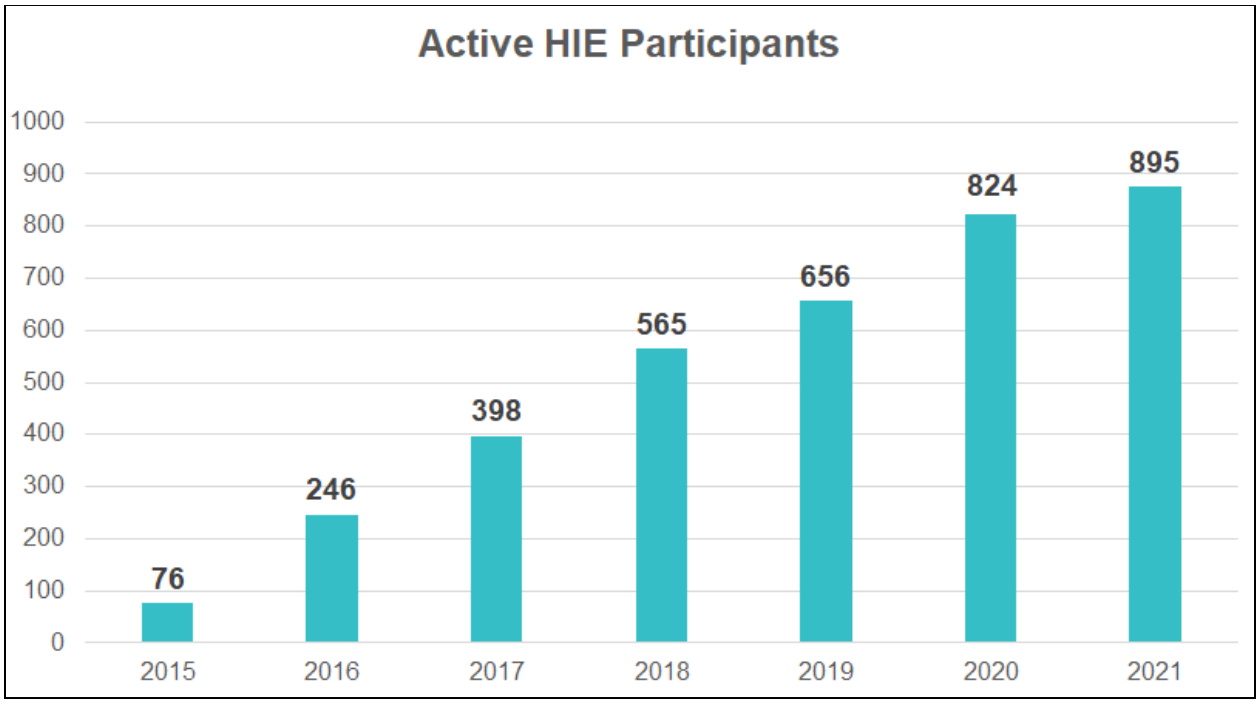
### 8. Health Information Technology

Since 2006, AHCCCS providers and MCOs have been supporting a single statewide HIE, now called Health Current. Health Current has become an integral part of AHCCCS' Quality Strategy and has grown to include 895 participating organizations representing laboratories, physical health and behavioral health providers, state agencies, 42 other HIEs, and other payers, such as Accountable Care Organizations and for-profit health plans. These organizations represent thousands of healthcare practitioners and delivery sites across Arizona.

In addition to supporting the HIE, AHCCCS covers all major forms of telehealth services, including telemedicine (real-time), asynchronous (store and forward), remote patient monitoring, and teledentistry. AHCCCS telehealth coverage and provider coding requirements, as well as additional telehealth resources, can be found on the AHCCCS Telehealth Services web page.

### 8.1 Health Information Exchange

HIE connects the electronic health record (EHR) systems of providers and clinicians allowing them to securely share patient information and better coordinate care. Health Current connects Arizona organizations, including first responders, hospitals, laboratories, and providers of community behavioral health, physical health, post-acute care, and hospice providers. As demonstrated in the table below, the number of active Health Current participants has been rapidly growing since 2015.




*Active HIE Participants as of April 2021, as provided by Health Current.*

Working collaboratively with each MCO, Health Current develops outreach and recruitment strategies to engage AHCCCS providers that have not yet joined the HIE. The number of new participants is set with each MCO at the start of each year and monitored on a month to month basis.

Health Current HIE Participants


*As of April 2021, as provided by Health Current.*

Growth in HIE participation facilitated the rapid implementation of COVID-19 services for the healthcare community in Arizona, as described below:

**Access to test results across a wide variety of healthcare providers in Arizona**
Health Current's growth in the number and types of healthcare organizations connecting with the HIE was a significant factor in Arizona's response to the PHE. Due to long-standing relationships with major health systems and one of Arizona's largest clinical lab providers (Sonora Quest), Health Current had almost immediate access to COVID-19 lab results delivered in the community as testing spread out across the state in the early days of the pandemic.

Within two weeks of Arizona Governor Ducey's emergency proclamation, Health Current launched real-time clinical lab results alerts to participating healthcare organizations who submitted lists of patients they wished to receive alerts on. Real-time alerts were scaled over the first month to include both positive and negative test results, as well as an option for receiving a batch report of COVID-19 tests across an entire list of patients. These alerts were shared by the HIE with all of the patient's treating providers, rather than just the provider that ordered or

conducted the test. This included hospitals, primary and specialty care, behavioral health facilities, emergency response providers, and others. Access to test results for COVID-19 allowed providers to both monitor virus status within their patient population as well as ensure the safety of staff by arranging personal protective equipment (PPE) for upcoming appointments with known positive patients or referring the appointment to a telehealth delivery platform. Subsequently Health Current developed a "dynamic" version of COVID-19 lab results specifically for hospital emergency departments that provided a real-time result at the time an individual registers at the emergency department's front desk.

Without Health Current's expanded connections with a wide variety of providers across healthcare sectors and around the state, far fewer providers would have had the option of receiving test results for the people they serve or the ability to protect staff from becoming infected.

**Visibility into the status of the pandemic among vulnerable Medicaid populations**
Over the past several years, Health Current has worked closely with AHCCCS on a variety of initiatives to ensure deep penetration of HIE use and connections among Medicaid providers. Health Current coordinated with each Medicaid health plan to obtain complete member lists and used these lists to run extract reports that profiled positive COVID-19 test status by health plan, as well as those positive Medicaid members with chronic conditions that placed them at greater risk of serious outcomes. AHCCCS used these reports and data to support care management and outreach programs for affected members.

**Using HIE technology to relieve hospital burden related to mandatory COVID-19 reporting**
A final area where Health Current maximized its extensive network of connections to support pandemic response in Arizona centered on relieving hospital burden associated with mandatory COVID-19 reporting requirements from the CDC. A key component of the daily CDC reporting is managing hospital bed capacity, including Intensive Care Unit (ICU) and staffed inpatient beds. Since April 2020, hospitals have been required to report total beds available and beds occupied by patients with COVID-19 or COVID-19-like symptoms. Health Current worked with the state's largest hospital systems and the Arizona Department of Health Services (ADHS) to develop a real-time reporting interface using electronic data already submitted to the HIE via admission, discharge, and transfer (ADT) alerts. Using the existing alert interface between hospitals and the HIE allowed Health Current to update the ADHS Central Registry database in real-time for the number of available and occupied beds. Health Current has continued to refine this technology-driven system to include other required reporting metrics such as ventilator supply and staffing using grant funds awarded to the HIE by the Office of the National Coordinator for Health Information Technology.

A year into the PHE, Health Current continues to identify new ways to utilize its technology and connections to support the Arizona healthcare community. With the recent passage of SB 1505, signed into law by Governor Ducey on April 9, 2021, Health Current is moving quickly to establish necessary connections to support the flow of COVID-19 immunization data to the HIE. As part of a package of the immunization services to be launched by early summer, Health Current will make available vaccine alerts, care coordination tools, and a COVID-19 Immunization Dashboard allowing health plans to better manage vaccine access and distribution for Medicaid members.

The table below reflects the increased use of the HIE via some of its operational metrics from 2016 to 2020. The HIE monitors these metrics as a way to demonstrate an increase in use of its HIE services and infrastructure.

Health Current Progress Review - Data Exchange & Utilization

| Activity | December 31, 2016 | December 31, 2020 | Percent Change |
|---|---|---|---|
| **Active Portal Users** | 359 | 2,202 | 513% |
| **Total Patients in the Master Patient Index (MPI)** | 7.6 M | 14.6 M | 92% |
| **Total Patients with Clinical Data** | 6.9 M | 12.9 M | 87% |
| **Patients Accessed via Portal Monthly** | 7.7 K | 779 K | 10,017% |
| **Health Level 7 V2 Transactions Received Monthly** | 9.8 M | 26.1 M | 166% |
| **Continuity of Care Documents Received Monthly** | 121 K | 2.1 M | 16,636% |
| **Alerts Received Monthly** | 51 K | 10.4 M | 20,292% |
| **Participating Acute Inpatient Discharges** | 83% | 97% | 17% |
| **Participating ED Visits** | 91% | 99% | 9% |

### 8.2 Telehealth

Prior to the COVID-19 PHE, AHCCCS broadened telehealth coverage beginning October 1, 2019.

- Asynchronous services were expanded to cover nine service categories (dermatology, radiology, ophthalmology, pathology, neurology, cardiology, behavioral health, infectious disease, and allergy/immunology),
- Synchronous (real-time) telemedicine services were broadened to allow for the coverage of AHCCCS covered services when the services could be reasonably provided via real-time telemedicine. Prior to October 1, 2019, synchronous telemedicine services were limited to 17 disciplines,
- Remote patient monitoring coverage was expanded; prior to October 1, 2019, it had been limited to only treatment of congestive heart failure,

- Place of Service (POS) categories were broadened, removing all restrictions for distant sites (where the provider is located), and broadening allowable originating sites (location of AHCCCS member) to include the home for many Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and revenue codes,
- Previous restrictions on provider types and facilities that could serve as the originating and distant sites were removed. As of October 1, 2019, the only remaining requirement was for the provider to be an AHCCCS registered provider,
- Previous restrictions that prohibited certain provider types from billing for telehealth services were removed. As of October 1, 2019, all provider types were permitted to bill for telehealth and available telephonic services, within the extent that their scope of practice, licensure, and standards of care allowed,
- Informed consent and confidentiality standards and requirements were aligned with statute and policy for in-person services,
- Expansion of billing guidance for FFS and IHS/638 providers was provided in the FFS and IHS/638 Provider Billing Manuals,
- MCOs retained their ability to manage their networks and leverage telehealth strategies as they deemed appropriate, and
- Established specific billing guidance for IHS/638 providers billing for telehealth and telephonic services.

During the COVID-19 PHE, AHCCCS added flexibilities for telehealth coverage to promote physical distancing and limit the spread of COVID-19, while also promoting access to health care; these flexibilities are posted in the AHCCCS COVID-19 FAQs on telehealth.

These flexibilities include:

- Expanding the set of covered CPT and HCPCS codes that could be performed via telehealth with over 150 additional covered codes added,
- Creating a temporary telephonic code set to remain active during the PHE,
- Creating the AHCCCS telehealth web page,
- Creating an online COVID-19 FAQs for providers, which includes a section specific to telehealth and telephonic services,
- Ensuring that rates for telehealth and telephonic services are not discounted when compared to rates for “in-person” services,
- Requiring MCOs to:
    - Reimburse at the same rate for services provided “in-person” and services provided via telehealth and/or telephonically, and
    - Cover all contracted services via telehealth modalities.
- Permitting FQHCs and Rural Health Clinics (RHCs) to bill for telehealth and telephonic services at the Prospective Payment System (PPS) rate, when the service is within the scope of the FQHC/RHC services; for services covered outside of the FQHC/RHC benefit, AHCCCS reimbursed telehealth and telephonic services provided by the FQHC/RHC at the AHCCCS FFS Rate, and

- Establishing specific billing guidance for IHS/638 providers billing for telehealth and telephonic services during the PHE.

Over the course of the PHE, the number of American Indian/Alaska Native (AI/AN) members who made use of telehealth and telephonic services, as indicated by claims data collected, increased five-fold between February 2020 and April 2020. As the PHE has persisted, claims data has indicated a continued utilization increase of four-fold since February 2020. There has been a three-fold increase in the submission of telehealth claims, and a four-fold increase in the submission of telephonic claims to AHCCCS in the same timeframe.

AHCCCS has committed to an extension of telehealth and telephonic flexibilities through at least September of 2021 and to provide public information regarding which telehealth and telephonic flexibilities will remain in place after the PHE ends. Given this data, demonstrating current telehealth and telephonic usage by providers, and given Arizona's unique member population and geographic (rural) areas, AHCCCS looks to continue reviewing its telehealth and telephonic service policies to continue as a nationwide leader in its utilization.

## 9. Conclusion

Improving and/or maintaining members' health status, as well as increasing the potential for resilience and functional health status for members with chronic conditions, is at the core of the Quality Strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration, as well as through its strong partnerships with MCOs and stakeholders. AHCCCS is a leader among the nation's Medicaid programs, operating a high-quality, cost-effective program with an average per enrollee, per year expense of only $7,008 compared with the national average of $8,057 in CYE 2019.

Through the ongoing evaluation of AHCCCS' Quality Strategy goals, initiatives, and improvement efforts, AHCCCS identified an additional Quality Strategy goal intended to further advance its data quality. In order to enhance data system and performance measure reporting capabilities, AHCCCS intends to evaluate current data system infrastructure as well as identify system and process limitations impacting performance measure reporting and analysis. As part of this new goal, AHCCCS also intends to leverage various data sources to produce comprehensive and reliable data through collaboration with external stakeholders to facilitate access to supplemental data sources and explore means for collecting and reporting performance measure data utilizing EHR methodologies. The establishment of this new Quality Strategy goal will enhance AHCCCS' ability to drive continuous delivery system performance, including advanced data analytics and disparity analyses.

Engagement and feedback from stakeholders, oversight and collaboration with MCOs, and performance monitoring promotes AHCCCS' culture of continuous quality improvement and drives improved member satisfaction and outcomes. Keeping a member-centered focus, AHCCCS will continue to collaborate with its partners to advance innovative ideas that drive continuous improvement.

## Appendix A: Quality Dashboard Performance Measures

| Line of Business/ Population | Performance Measure |
|---|---|
| **ACC/Acute** | Adolescent Well-Care Visits |
| | Breast Cancer Screening |
| | Developmental Screening in the First Three Years of Life |
| | Well-Child Visits in the First 15 Months of Life |
| | Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life |
| **DCS CHP** | Adolescent Well-Care Visits |
| | Developmental Screening in the First Three Years of Life |
| | Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life |
| **ALTCS DD** | Adolescent Well-Care Visits |
| | Breast Cancer Screening |
| | Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life |
| **ALTCS EPD** | Breast Cancer Screening |
| | Follow-Up After Hospitalization for Mental Illness (7 Days) - Ages 18-64 |
| | Follow-Up After Hospitalization for Mental Illness (30 Days) - Ages 18-64 |
| **General Mental Health/ Substance Use (GMH/SU)** | Follow-Up After Emergency Department Visit for Mental Illness (7 Days) |
| | Follow-Up After Emergency Department Visit for Mental Illness (30 Days) |
| | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 Days) |
| | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 Days) |
| | Follow-Up After Hospitalization for Mental Illness (7 Days) - Ages 18-64 |
| | Follow-Up After Hospitalization for Mental Illness (30 Days) - Ages 18-64 |
| | Follow-Up After Hospitalization for Mental Illness (7 Days) - Ages 6-17 |

| | |
|---|---|
| | Follow-Up After Hospitalization for Mental Illness (30 Days) - Ages 6-17 |
| | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics |
| | Metabolic Monitoring for Children and Adolescents on Antipsychotics |
| **SMI Integrated** | Breast Cancer Screening |
| | Follow-Up After Emergency Department Visit for Mental Illness (7 Days) |
| | Follow-Up After Emergency Department Visit for Mental Illness (30 Days) |
| | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 Days) |
| | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 Days) |
| | Follow-Up After Hospitalization for Mental Illness (7 Days) - Ages 18-64 |
| | Follow-Up After Hospitalization for Mental Illness (30 Days) - Ages 18-64 |
| **Statewide** | Adolescent Well-Care Visits |
| | Follow-Up After Hospitalization for Mental Illness (7 Days) - Ages 18-64 |
| | Follow-Up After Hospitalization for Mental Illness (30 Days) - Ages 18-64 |
| | Follow-Up After Hospitalization for Mental Illness (7 Days) - Ages 6-17 |
| | Follow-Up After Hospitalization for Mental Illness (30 Days) - Ages 6-17 |
| | Well-Child Visits in the First 15 Months of Life |
| | Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life |

## Appendix B: Statewide Performance Measure Trending

| Performance Measure | CYE 2018 Rate | CYE 2019 Rate | Year to Year Relative Change | Performance Target Met[1] |
|---|---|---|---|---|
| **Adolescent Well-Care Visits (AWC)** | 41.5% | 42.9% | 3.4% | Yes |
| **Diabetes Short-Term Complications Admission Rate (PQI 01)[2]** | 15.1 | 14.0 | -7.3% | Yes |
| **Follow-Up After Hospitalization for Mental Illness: Ages 18 & Older (FUH-AD) – 7 Day** | 54.0% | 51.6% | -4.4% | No |
| **Follow-Up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) – 7 Day** | 69.5% | 67.1% | -3.5% | No |
| **Follow-Up After Hospitalization for Mental Illness: Ages 18 & Older (FUH-AD) – 30 Day** | 71.4% | 70.0% | -2.0% | No |
| **Follow-Up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) – 30 Day** | 85.8% | 85.1% | -0.8% | No |
| **Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET) - Total Initiation** | 45.2% | 45.1% | -0.2% | No |
| **Use of Opioids at High Dosage in Persons Without Cancer (OHD)[2]** | 12.7% | 11.1% | -12.6% | Yes |
| **Well-Child Visits in the First 15 Months of Life (W15)** | 61.6% | 63.6% | 3.2% | Yes |
| **Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)** | 61.8% | 63.9% | 3.4% | Yes |

[1] The performance target is to improve performance from the previous measurement year.

[2] A lower rate indicates better performance.

## Appendix C: Summary of CYE 2019 Operational Review Compliance

| CYE 2019 Operational Review | BUFC LTC | | MC LTC | | UHCCP LTC | | DCS CHP | |
|---|---|---|---|---|---|---|---|---|
| **Standard Area** | **Score** | **CAPs** | **Score** | **CAPs** | **Score** | **CAPs** | **Score** | **CAPs** |
| **Case Management (CM)** | 93% | 7 | 82% | 12 | 89% | 8 | N/A | N/A |
| **Corporate Compliance (CC)** | 100% | 0 | 100% | 0 | 100% | 0 | 92% | 1 |
| **Claims and Information Systems (CIS)** | 99% | 1 | 98% | 1 | 98% | 1 | 91% | 3 |
| **Delivery Systems (DS)** | 87% | 4 | 89% | 4 | 90% | 2 | 95% | 2 |
| **General Administration (GA)** | 10% | 0 | 100% | 0 | 100% | 0 | 89% | 1 |
| **Grievance Systems (GS)** | 99% | 1 | 100% | 0 | 100% | 0 | 68% | 9 |
| **Adult, EPSDT, and Maternal Child Health (MCH)** | 72% | 11 | 93% | 4 | 75% | 8 | 76% | 9 |
| **Medical Management (MM)** | 94% | 6 | 94% | 5 | 90% | 8 | 85% | 9 |
| **Member Information (MI)** | 97% | 1 | 100% | 0 | 93% | 2 | 69% | 4 |
| **Quality Management (QM)** | 83% | 11 | 91% | 8 | 86% | 10 | 62% | 13 |
| **Reinsurance (RI)** | 100% | 0 | 100% | 0 | 100% | 0 | 100% | 0 |
| **Third-Party Liability (TPL)** | 100% | 0 | 87% | 1 | 100% | 0 | 86% | 1 |
| **Total Corrective Actions** | **42** | | **35** | | **39** | | **52** | |

## Appendix D: Administrative Actions

| MCO | CYE 2018 | CYE 2019 | CYE 2020 |
|---|---|---|---|
| **Acute/ACC Plans** | | | |
| **Health Net/Arizona Complete Health - CCP** | Sanction: Pended Encounters - $2,135.00 | Sanction: Pended Encounters - $3,130.00 | Sanction: Pended Encounters- $4,285.00 |
| | | Sanction: Claims System Issue - $125,000.00 | Sanction: Claims System Issue - $300,000.00 |
| **Banner University Family Care** | | Sanction: Pended Encounters- $507,735.00 | Sanction: Pended Encounters- $529,585.00 |
| | | | Sanction: Targeted Investment Payment Issue - $342,680.10 |
| **Care1st** | | Notice of Concern: PA Requirements for Behavioral Health Services | |
| | | Notice of Concern: Non-Emergency Transportation Provider Concerns | |
| | | Sanction: Pended Encounters- $880.00 | |
| **Health Choice** | Sanction: Pended Encounters- $116,360.00 | Sanction: Pended Encounters- $1,745.00 | Sanction: Pended Encounters- $7,125.00 |
| | Sanction: Equity Distribution Issue - $125,000.00 | | |
| | Sanction: Data Accuracy Issue - $50,000.00 | | |
| **UnitedHealthcare** | | Notice of Concern: Non-Emergency Transportation Provider Concerns | |
| **Mercy Care** | Sanction: Pended Encounters- $11,710.00 | Sanction: Incorrect Encounter Submissions- $136,000.00 | Sanction: Pended Encounters- $20,705.00 |
| | | Sanction: Pended Encounters- $86,070.00 | |
| | | Sanction: Telephone Performance Issues- $50,000.00 | |

| | | | |
|---|---|---|---|
| **Magellan** | | Sanction: DSNP Issue - $75,000.00 | |

| MCO | CYE 2018 | CYE 2019 | CYE 2020 |
|---|---|---|---|
| **ALTCS Plans** | | | |
| **Banner University Family Care** | Sanction: Pended Encounters- $12,880.00 | Sanction: Pending Encounters- $31,595.00 | Sanction: Pended Encounters- $61,030.00 |
| **UnitedHealthcare** | None | None | None |
| **Mercy Care** | Sanction: Pended Encounters- $7,105.00 | Sanction: Pended Encounters- $18,990.00 | Sanction: Pended Encounters- $470.00 |
| **DES/DDD** | | Corrective Action: HAB C Services | |
| | | Notice to Cure: Quality Management Program Concerns | |
| | | Notice to Cure: Failure to Utilize HCPCS and Standard Claims Forms | |
| | | Notice to Cure: Augmentative and Alternative Communication Devices | |

| MCO | CYE 2018 | CYE 2019 | CYE 2020 |
|---|---|---|---|
| **RBHA Plans** | | | |
| **Cenpatico Integrated Care/Arizona Complete Health - CCP** | Sanction: Pended Encounters - $9,445.00 | Sanction: Pended Encounters - $4,175.00 | |
| **Health Choice Integrated Care/Health Choice** | Sanction: Pended Encounters- $12,800.00 | Sanction: Pended Encounters- $4,730.00 | |
| **Mercy Maricopa Integrated Care/Mercy Care** | Notice of Concern: Claims Processing Timeliness | Corrective Action: Arnold vs Sarn Requirements | |
| | Sanction: Pended Encounters- $37,325.00 | Sanction: Pended Encounters- $72.200.00 | |

## Appendix E: Time and Distance Reporting Example

**Percentage of Members within Minimum Time and Distance Requirements in Mohave County for ACC MCOs**

| | MCO 1 | | | | MCO 2 | | | |
|---|---|---|---|---|---|---|---|---|
| **Minimum Network Requirement** | **CYE 2019 Q4** | **CYE 2020 Q1** | **CYE 2020 Q2** | **CYE 2020 Q3** | **CYE 2019 Q4** | **CYE 2020 Q1** | **CYE 2020 Q2** | **CYE 2020 Q3** |
| **Behavioral Health Outpatient and Integrated Clinic, Adult** | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99.9% |
| **Behavioral Health Outpatient and Integrated Clinic, Pediatric** | 100% | 99.9% | 100% | 99.9% | 100% | 100% | 100% | 99.9% |
| **Cardiologist, Adult** | 99.8% | 99.8% | 99.8% | 99.8% | 99.9% | 99.9% | 99.9% | 99.9% |
| **Cardiologist, Pediatric** | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Dentist, Pediatric** | 95.8% | 96.2% | 96.1% | 96.4% | 98.1% | 98.1% | 98.3% | 98.1% |
| **Hospital** | 99.9% | 99.9% | 99.9% | 99.9% | 100% | 100% | 100% | 100% |
| **Obstetrics/ Gynecology (OB/GYN)** | 100% | 99.9% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Pharmacy** | 97.9% | 97.8% | 98.9% | 99% | 97.7% | 97.8% | 99% | 98.8% |
| **PCP, Adult** | 98.1% | 98.1% | 98.5% | 98.6% | 99.4% | 99.3% | 99.1% | 99.6% |
| **PCP, Pediatric** | 97.4% | 97.1% | 97.6% | 98% | 98.1% | 98.2% | 97.8% | 98.8% |

*Cells highlighted in yellow identify where AHCCCS' EQRO validation differs from the Contractor-reported results but still comply with AHCCCS' time and distance standards.*

## Works Cited

Institute for Healthcare Improvement. 2021. “IHI Triple Aim Initiative.” http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx/.