

Arizona Health Care Cost Containment System



**Contract Year Ending 2019
External Quality Review Annual Report**

for

**AHCCCS Complete Care and
Comprehensive Medical and Dental
Program**

July 2020



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Overview of the Contract Year Ending (CYE) 2019 External Review

The Code of Federal Regulations (CFR) at 42 CFR §438.3641¹⁻¹ requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide.

According to 42 CFR, Part 438 Subpart E, External Quality Review, §438.358(b) and (c), the three mandatory activities for each MCO, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) are:

- Validation of performance improvement projects (PIPs).
- Validation of performance measures (PMs) required in accordance with §438.330(b)(2).
- A review conducted within the previous three-year period to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Subpart D of §438.

For contracts starting on or after July 1, 2018, and no later than one year from the issuance of the revised external quality review (EQR) protocol, according to requirements set forth in §438.68, the Centers for Medicare & Medicaid Services (CMS) has established validation of MCO, PIHP, or PAHP network adequacy as a mandatory activity.

In accordance with the 42 CFR §438.358(a), the state; its agent that is not an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]); or an EQRO may perform the mandatory and optional EQR-related activities.

As permitted by CMS and incorporated under federal regulation at 42 CFR Part 438, Arizona Health Care Cost Containment System (AHCCCS) elected to retain responsibility for performing the four EQR mandatory activities described in 42 CFR §438.358 (b). AHCCCS prepared Contractor-specific reports of findings related to each of the activities, and, as applicable, required Contractors to prepare and submit their proposed corrective action plans (CAPs) to AHCCCS for review and approval.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG) as its CMS-required EQRO to prepare this annual EQR technical report. This report presents AHCCCS' findings from conducting each activity as well as HSAG's analysis and assessment of the reported results for each Contractor's performance and, as applicable, recommendations to improve Contractors' performance.

¹⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 88/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR §438.364 Medicaid Program; External Quality Review, Final Rule.

HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR §438.354. HSAG has extensive experience and expertise in both conducting the mandatory activities and in analyzing information obtained from AHCCCS' reviews of the activities. Accordingly, HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to care and services that AHCCCS' Contractors provide.

To meet the requirements set forth in 42 CFR §438.364, as the EQRO, HSAG used information obtained from AHCCCS to prepare and provide a detailed annual technical report. The report summarizes findings on the quality of, timeliness of, and access to healthcare services, and includes the following:

- A description of the manner in which the data from all activities conducted were aggregated and analyzed.
- For each EQR-related activity conducted:
 - Objectives.
 - Technical method of data collection and analysis.
 - Description of the data obtained.
 - Conclusions drawn from the data.
- An assessment of each Contractor's strengths and weaknesses.
- Recommendations for improving the quality of care furnished by each Contractor including how the State can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.
- Methodologically appropriate comparative information about all Contractors (described in §438.310[c][2]), consistent with guidance included in the EQR protocols.
- An assessment of the degree to which each Contractor has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

HSAG has prepared the annual technical report for AHCCCS for 15 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

This executive summary includes an overview of AHCCCS' EQR activities as provided to HSAG and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the AHCCCS Contractors in complying with the AHCCCS contract requirements and the applicable federal 42 CFR §438 requirements for each activity. In addition, this executive summary includes an assessment of each Contractor's strengths and weaknesses related to the quality and timeliness of, and access to, healthcare services and HSAG's recommendations for improving the quality of services.

Additional sections of this annual EQR technical report include the following:

- Introduction to the Annual Technical Report: An introduction to the annual technical report, including a description of the EQR mandatory activities.

- Overview of the Arizona Health Care Cost Containment System: An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' strategic plan with key accomplishments for CYE 2019, AHCCCS' quality strategy, and waivers and legislative changes impacting AHCCCS' Medicaid programs.
- Quality Initiatives: An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those that are specific to the AHCCCS Complete Care (ACC) program for CYE 2019.
- Contractor Best and Emerging Practices: An overview of the Contractors' best and emerging practices for CYE 2019.
- Network Adequacy Update: A presentation of results for the network adequacy validation (NAV) and analysis conducted in CYE 2019 and HSAG's associated findings.
- Organizational Assessment and Structure Performance: A presentation of results for the Contractor-specific operational review (OR) conducted in CYE 2019 and HSAG's associated findings and recommendations.

Please see Appendix A for an overview of the AHCCCS methodology for the operational review activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements.

Appendix B includes the network adequacy validation study methodology and ACC Contractor results by quarter and county. Appendix C includes the complete text of AHCCCS' CYE 2019 Network Adequacy Report.

Contractors Reviewed

During the CYE 2019 review cycle, AHCCCS contracted with the Contractors¹⁻² listed below to provide services to members enrolled in the AHCCCS Complete Care (ACC) and Comprehensive Medical and Dental Program Medicaid managed care programs. Associated abbreviations are included.

- Arizona Complete Health – AHCCCS Complete Care (AzCH-ACC)
- Banner University Family Care – AHCCCS Complete Care (BUFC-ACC)
- Care1st of Arizona – AHCCCS Complete Care (Care1st-ACC)
- Magellan Complete Care – AHCCCS Complete Care (MCC-ACC)
- Mercy Care – AHCCCS Complete Care (MC-ACC)
- Steward Health Choice Arizona – AHCCCS Complete Care (SHCA-ACC)
- UnitedHealthcare Community Plan – AHCCCS Complete Care (UHCCP-ACC)
- Comprehensive Medical and Dental Program (CMDP)

¹⁻² Note: Title 42 CFR §438.2 defines “managed care organization (MCO),” in part, as “an entity that has or is seeking to qualify for a comprehensive risk contract.” CMS designates all AHCCCS Contractors as MCOs. Unless citing Title 42 CFR, this report will refer to AHCCCS' MCOs as Contractors.

Findings, Conclusions, and Recommendations About the Quality of, Timeliness of, and Access to Care

The following section provides a high-level summary of HSAG's findings and conclusions about the quality of, timeliness of, and access to care provided to AHCCCS members.

Network Adequacy Validation

Each quarter, each ACC Contractor submits its contracted network and its internal assessment of compliance with the applicable standards to AHCCCS. HSAG's analysis of network adequacy considered compliance with 11 AHCCCS-established time/distance standards for specific provider types and populations applicable to the ACC Contractors. Quarterly analytic results were assembled for the October 1, 2018, through June 30, 2019, measurement period for all beneficiary coverage areas for each ACC Contractor.

HSAG's quarterly network adequacy validation (NAV) determined that the ACC Contractors' provider networks generally met AHCCCS' minimum time/distance network requirements. Each ACC Contractor met the minimum network standards in all counties during all quarters for the following provider types: Cardiologist, Pediatric; Obstetrics/Gynecology (OB/GYN); and PCP, Adult. Additionally, one ACC Contractor, MC-ACC, met all applicable minimum network standards in its three covered counties during each quarter. Refer to Appendix B for the complete study methodology and ACC Contractor results by quarter and county. Refer to Appendix C for the complete text of AHCCCS' CYE 2019 Network Adequacy Report.

Organizational Assessment and Structure Standards

An OR was conducted in CYE 2019 for one Contractor (CMDP). The strongest performance was in the Reinsurance (RI) standard areas, wherein CMDP received 100 percent standard area scores and no CAPs. Additionally, CMDP met the 95 percent threshold for the Delivery Systems (DS) standard area. Standard areas requiring the fewest CAPs were Corporate Compliance (CC), General Administration (GA), and Third-Party Liability (TPL) with one CAP required for each. Standard areas with greatest opportunity for improvement based on the number of CAPs required were Quality Management (QM), Grievance Systems (GS), Adult, Early and Periodic Screening, Diagnostic and Treatment and Maternal Child Health (MCH), and Medical Management (MM). For all standard areas except two, CMDP scored below the 95 percent threshold.

Performance Measures and Performance Improvement Projects

For more information on the CYE 2018 performance measures and PIPs, please refer to the CYE 2019 Acute, Comprehensive Medical and Dental Program (CMDP), Children's Rehabilitative Services (CRS) and RBHA Report which details activities conducted in CYE 2018.

2. Introduction to the Annual Technical Report

Description of EQR Activities

Mandatory Activities

As permitted by CMS within federal regulation and described in Section 1—Executive Summary, AHCCCS retained the functions associated with the three CMS mandatory activities for its Contractors:

- Validate Contractor PIPs—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- Summary and findings of Contractor’s performance in complying with the AHCCCS’ contract requirements and the federal Medicaid managed care regulations—review performed by AHCCCS.

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for its Contractors and to prepare this CMS-required EQR annual report of findings and recommendations.

For contracts that started on or after July 1, 2018, and no later than one year from the issuance of the revised EQR protocol, according to requirements set forth in 42 CFR §438.68, CMS is requiring validation of MCO, PIHP, and PAHP network adequacy as applicable.

Optional Activities

AHCCCS’ EQRO contract with HSAG required HSAG to:

- Conduct quarterly validation of Contractors’ network adequacy.

AHCCCS’ EQRO contract with HSAG did not require HSAG to:

- Conduct any other CMS-defined optional activities (e.g., validating encounter data, conducting focused studies of healthcare quality, or assessing information systems capabilities).
- Analyze and report results, including providing conclusions and recommendations based on optional activities that AHCCCS conducted.

AHCCCS has numerous sophisticated processes for monitoring both the Contractors and its own performance in meeting all applicable federal and State requirements, its goals and internal objectives, and its policies and procedures. AHCCCS regularly prepares meaningful, detailed, and transparent reports documenting the results of its assessments. AHCCCS is transparent with performance results, posting to its website both provider performance reports and the required quarterly reports it submits to CMS. AHCCCS uses the information provided in the CMS-required EQR annual reports to honor its

commitment to transparency by posting final reports on its website. The EQR reports provide detailed information about the EQRO's independent assessment process; results obtained from the assessment; and, as applicable to its findings, recommendations for improvement. AHCCCS uses the information to assess the effectiveness of its current strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

Quality, Access, and Timeliness

CMS has identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains.

- **Quality**, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.²⁻¹
- **Access**, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements (“standards” for the purpose of this report) defined under §438.68 (Network Adequacy Standards) and §438.206 (Availability of Services). Under §438.206, availability of services means that each state must ensure that all services covered under the state’s plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that the MCO, PIHP, and PAHP provider networks for services covered in the contract meet the standards developed by the State in accordance with the network adequacy standards (§438.68). Any state that contracts with an MCO, PIHP, or PAHP to deliver Medicaid services is required by §438.68 to develop and enforce network adequacy standards.²⁻²
- **Timeliness**. Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of “timeliness” to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines “timeliness” relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”²⁻³ It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

²⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

²⁻² Ibid.

²⁻³ National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

3. Overview of the Arizona Health Care Cost Containment System (AHCCCS)

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 (Strategic Plan). The description of the Strategic Plan includes the four goals:

- AHCCCS must pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.
- AHCCCS must pursue continuous quality improvement.
- AHCCCS must reduce fragmentation driving toward an integrated healthcare system.
- AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations.

AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Research and Demonstration 1115 Waiver, which has allowed for the operation of an integrated managed care model. AHCCCS uses State, federal, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State's Medicaid members. AHCCCS has an allocated budget of approximately \$13.8 billion to administer its programs, which provides services for 1.9 million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. AHCCCS' Acute Care Program was incorporated from its inception in 1982. In 1988, AHCCCS added the ALTCS program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (E/PD) populations. ALTCS provides acute care, behavioral health services, LTC, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a residential setting. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona DES/DDD. The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 21.7 percent of the costs.

In October 1990, AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. The Children's Health Insurance Program (CHIP) was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill (SB) 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors. In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UnitedHealthcare Community Plan (UHCCP). This was done in order to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and

behavioral care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions and enrolled in the ALTCS program, other than in DDD, were fully integrated into their ALTCS Contractors' provided services, including all primary, specialty, long-term, and behavioral healthcare related to the members' CRS conditions.

Before the integration of services into a single health plan that began in April of 2014, a member with SMI had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute health plan; the behavioral health services through the Regional Behavioral Health Authority (RBHA) contracted through the Division of Behavioral Health Services (DBHS); the Medicare system, if the member was also eligible for Medicaid and Medicare; and Medicare Part D for medications. On April 1, 2014, approximately 17,000 members with a serious mental illness (SMI) residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Since October 1, 2015, AHCCCS has contracted with two additional integrated health plans to provide both physical and behavioral healthcare services for SMI members who do not reside in Maricopa County .

Contracts were awarded on March 13, 2017 to three MCOs throughout Arizona to administer Arizona's integrated long-term care system for individuals who are elderly and/or physically disabled, based on the bidder's proposed approaches for care and treatment of ALTCS individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g., use of health homes, electronic health records [EHRs], coordinated case management, and collaboration between behavioral and physical health). Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly regarding individuals who have been determined to have SMI. The newly awarded long-term care system contracts were implemented on October 1, 2017.

Effective October 1, 2018, AHCCCS implemented a delivery system reform that allows members to access physical and behavioral healthcare services through a single integrated delivery system model ACC with a choice of seven health plans. In addition, on October 1, 2018, service delivery was restructured into three geographic service areas (GSAs): North, Central, and South. Members continue to have a choice of health plans in their geographic service areas and to have access to a network of providers and the same array of covered services. RBHAs continue to provide specific crisis services and to serve members with SMI, children in foster care, and DES/DDD eligible members. American Indian members have the choice of enrolling in an ACC managed care plan or the American Indian Health Program (AIHP) and a Tribal RBHA when available. American Indian members have the same access to Indian Health Service (IHS) providers, Tribal 638 providers, and Urban Indian Health providers.

AHCCCS Waiver Amendment Requests and Legislative Updates

AHCCCS Works Waiver Amendment

Through the 1115 Waiver Amendment, AHCCCS received CMS approval to implement requirements for the community engagement program, titled “AHCCCS Works,” which is designed to provide low-income adults with the tools needed to gain and maintain meaningful employment, job training, education, or volunteer service experience.

The AHCCCS Works community engagement requirements will apply to able-bodied adults ages 19 to 49 who are not eligible for one of the following exemptions: pregnant women up to the 60th day of post-pregnancy; former Arizona foster youths up to age 26; members of a federally recognized tribe; individuals determined to have SMI; members with a disability recognized under federal law and individuals receiving long-term disability benefits; individuals who are medically frail or who have an acute medical condition; members who are in active treatment for a substance use disorder; full-time high school, college, and trade school students; survivors of domestic violence; individuals who are homeless; a designated caretaker of a child under the age of 18; a caregiver who is responsible for the care of an individual with a disability; and individuals who receive assistance through Supplemental Nutrition Assistance Program (SNAP), cash assistance, or unemployment insurance, or who participate in another AHCCCS-approved work program.

Members who are required to comply with AHCCCS Works requirements will participate in at least 80 hours of community engagement activities per month and report those hours by the 10th day of the following month. Engagement activities include: employment (including self-employment), less than full-time education, job or life skills training, job search activities, and community service. At the program start date, members will have a three-month period in which to become familiar with requirements and tools available to ensure their success. After that three-month period, members who do not complete at least 80 hours of community engagement in a month will be suspended from AHCCCS coverage for a two-month period, followed by automatic reinstatement.

Arizona has decided to postpone implementation of AHCCCS Works until further notice. This decision is informed by the evolving national landscape concerning Medicaid community engagement programs and ongoing litigation regarding this topic.

Prior Quarter Coverage Waiver Amendment

Through the 1115 Waiver Amendment, AHCCCS received CMS approval to limit retroactive coverage for some applicants to the beginning of the month in which the Medicaid application is filed, consistent with Arizona’s historical waiver authority prior to January 2014. Coverage for new Medicaid members will be retroactive to begin the first day of the month in which the Medicaid application is received. Women who are pregnant (up to 60 days postpartum) and children under age 19 are exempt from this

change and may still apply to receive retroactive coverage for the three months prior to the month of application. Changes to retroactive coverage were implemented on July 1, 2019.

AHCCCS Technical Correction Amendment

CMS approved Arizona's request for technical amendments to the language in the Special Terms and Conditions (STCs) to reflect the delivery system changes resulting from the ACC managed care contract award. CMS has issued the following technical corrections, in accordance with Arizona's request:

- Simplified language in Waiver Authority 1, Section II Program Overview, and Historical Context and STCs 26, 29(g), 46, and 72(c).
- Updated STCs 18 and 41 to detail that Arizona Acute Care Program (AACP) beneficiaries receive behavioral and physical healthcare through a single ACC plan.
- Updated STCs 27 and 43 to reflect that CRS beneficiaries receive behavioral and physical healthcare through a single ACC plan.
- Updated STC 42 to reflect how beneficiaries under the ALTCS receive physical, behavioral, and LTC services.
- Updated STC 61, 68, and 69 Table 8 to reflect accurate measures and targets language for the Targeted Investments (TI) Program.

Legislative Updates

The following are the legislative bills, provisions of the SFY budget package, assigned workgroups, and changes to professional scope of practice and reporting requirements that impacted AHCCCS.

- House Bill (HB) 2754/HB2747—Implements appropriations for the following state agencies and programs:
 - Eliminates a mandatory enrollment freeze on the KidsCare program due to declining federal funding participation and fully funds the program.
 - Creates a licensure type for secure behavioral health residential facilities.
 - Provides additional state funds for Graduate Medical Education.
 - Additional funding for LTC providers.
- SB 1296—Aligns the training and testing requirements for direct care workers with the training and testing requirements of assisted living caregivers, allowing for easier transitions for workers between in-home care and caregiving in an assisted living facility.
- SB 1450—Integrates physical and behavioral health under a single plan (the Comprehensive Medical and Dental Program) for foster children across the state.

The fiscal year (FY) 2020 budget package included the following:

- The amount of \$527,018,800 for Adult Expansion Services, which includes a decrease of \$36,059,100 for formula adjustments on federal matching.
- Total of \$9,990,000 for behavioral health services in schools.
- The amount of \$100,000 for a suicide prevention coordinator to assist school districts and charter schools in suicide prevention efforts.
- Incorporates a decrease of \$85,367,400 to transfer funding and administration of behavioral health services for people with developmental disabilities to the Department of Economic Security.
- The amount of \$3 million in General Medical Education funding in health professional shortage areas, as well as one-time funding of \$750,000 from the general fund to graduate medical education in community health centers to address healthcare provider shortages in northern Arizona.
- The reductions required by the Bipartisan Budget Act of 2018, which represents reductions in federal Disproportionate Share Hospital (DSH) funding by 31.7 percent in FY 2020 and by 63.4 percent in FY 2021, respectively. The DSH amount is now \$117.3 million.

Enacted legislation requires the following new reports:

- On or before January 31, 2022, AHCCCS shall complete a third-party study on the costs and effectiveness of secure behavioral health residential facilities for individuals with an SMI, taking into account the impacts on outcomes related to health, employment, and interactions with the criminal justice system.
- On or before January 2, 2020, requires AHCCCS to submit annual reports on the availability of inpatient psychiatric treatment both for adults and for children and adolescents who receive services from the RBHAs, that include the following:
 - The total number of inpatient psychiatric treatment beds available and the occupancy rate for those beds.
 - Expenditures on inpatient psychiatric treatment.
 - The total number of individuals in this state who are sent out of state for inpatient psychiatric treatment.
 - The prevalence of psychiatric boarding or holding psychiatric patients in emergency rooms for at least 24 hours before transferring the patients to a psychiatric facility.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The strategic plan identifies AHCCCS' mission, vision, and the agency's core values:³⁻¹

³⁻¹ AHCCCS Strategic Plan State Fiscal Years 2018-2023 Available at:
https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf Accessed on: October 29, 2018.

- AHCCCS Vision: Shaping tomorrow’s managed healthcare...from today’s experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality healthcare to those in need.
- Core Values:
 - Passion: Good health is a fundamental need of everyone. This belief drives us, inspires and energizes our work.
 - Community: Healthcare is fundamentally local. We consult with, are culturally sensitive to, and respond to the unique needs of each community we serve.
 - Quality: Quality begins as a personal commitment to continual and rigorous improvement, self-examination, and change based on proper data and quality improvement practices.
 - Respect: Each person with whom we interact deserves our respect. We value ideas for change, and we learn from others.
 - Accountability: We are personally responsible for our actions and understand the trust our government has placed on us. We plan and forecast as accurately as possible. Solid performance standards measure the integrity of our work. We tell the truth and keep our promises.
 - Innovation: We embrace change, but accept that not all innovation works as planned. We learn from experience.
 - Teamwork: Our mission requires good communication among interdependent areas inside and outside the agency. Internally, we team up within and across divisions. Externally, we partner with different customers as appropriate.
 - Leadership: We lead primarily in two ways: by setting the standards by which other programs can be judged and by developing and nurturing our own future leaders.

The strategic plan offers four overarching goals:

1. Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.

- Increase use of alternative payment models and AHCCCS fee schedule differentiation for all lines of business.
- Reduce administrative burden on providers while expanding access to care.
- Successfully implement program integrity strategies.
- Modernize 1115 Waiver to provide new flexibilities to the State.

2. Pursue continuous quality improvement.

- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care coordination initiatives to improve health outcomes.
- Develop comprehensive strategies to curb opioid abuse and dependency.

3. Reduce fragmentation driving toward an integrated sustainable healthcare system.

- Establish a system of integrated plans and support provider integration to better serve all AHCCCS members.
- Leverage integrated Health Information Exchange (HIE) to improve outcomes and reduce costs.
- Improve access for individuals transitioning out of the justice system.

4. Maintain core organizational capacity, infrastructure, and workforce planning that effectively serves AHCCCS operations.

- Promote activities that support employee engagement and retention and successful succession planning.
- Strengthen system-wide security and compliance with privacy regulations.
- Continue implementation of the Arizona Management System.

Key Accomplishments for AHCCCS

Following are key accomplishments highlighted by AHCCCS in the AHCCCS Strategic Plan, SFYs 2018–2023:

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding.
- AHCCCS successfully awarded the ALTCS request for proposal (RFP) and transitioned over 9,000 members on October 1, 2017.
- The ALTCS program began implementing a new eligibility system in November 2017.
- The Office of Human Rights eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The Office of Human Rights has 2,504 individuals identified as requiring special assistance and provides direct advocacy via assignment to 702 members.
- AHCCCS implemented a new assessment policy and streamlined demographic reporting to reduce provider and member administrative burdens.
- AHCCCS received approval from CMS to begin the American Indian Medical Home program and has begun the process of implementation.
- AHCCCS received approval for a \$300 million Targeted Investments Program, helping facilitate integration at approximately 500 provider sites across the state.
- AHCCCS established new value-based purchasing (VBP) strategies for nursing facilities (NFs) and providers who utilize e-prescriptions.
- AHCCCS completed a rebase of the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology, better aligning inpatient reimbursement with current data.

- AHCCCS Leadership Academy was established, providing an opportunity annually for 30 staff to broaden perspective about the Agency’s mission, explore key issues within healthcare, better understand the healthcare delivery system, and build personal networks.
- AHCCCS expanded access to Hepatitis C medication while lowering overall drug costs.
- AHCCCS implemented several strategies to combat the opioid epidemic, including implementing seven-day opioid-naïve fills.
- Cross-agency collaboration between AHCCCS, Arizona Department of Corrections (ADC), and county justice partners resulted in more than six thousand incarcerated individuals having AHCCCS coverage immediately upon their release from incarceration.
- The number of HIE providers increased from 250 to 350.
- AHCCCS increased the funding for physicians who are affiliated with graduate medical education by \$40 million.
- AHCCCS implemented a new reimbursement methodology for freestanding emergency departments.
- AHCCCS Office of the Inspector General completed a review by CMS; the results were positive.
- AHCCCS transitioned approximately 130,000 acute members as part of the closures of Phoenix Health Plan and Maricopa Health Plan.
- AHCCCS began registering board-certified behavior analyst (BCBA) providers.
- AHCCCS held four quarterly tribal consultations, which saw the largest turnout in AHCCCS history.
- AHCCCS completed a request for information (RFI), held public meetings, and released the largest procurement in the history of Arizona for AHCCCS Complete Care.
- AHCCCS participated in the Repeal and Replace discussions and published timely analysis of proposed legislation.
- For CYE 2018, the overall weighted average capitation rate increase was 2.9 percent, which continues the overall trend for capitation rate growth of below 3 percent for the program.
- AHCCCS continued to have overall employee engagement scores that far exceeded the statewide average.

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency quality strategy must include all of the following:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.

- The State’s goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.
- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.
- A description of the State’s transition of care policy.
- The State’s plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.
- Appropriate use of intermediate sanctions for MCOs.
- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.
- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.
- Information relating to non-duplication of EQR activities.
- The State’s definition of “significant change” related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

AHCCCS has had a formal quality assessment and performance improvement (QAPI) plan in place since 1994 and AHCCCS’ Quality Strategy was first established in 2003. Since that time, AHCCCS has revised the Quality Strategy to reflect AHCCCS’ innovative approaches to member care and continuous quality improvement efforts. The AHCCCS quality strategy was set for revision in CYE 2017. However, due to the introduction of proposed changes to the managed care regulations, AHCCCS elected to delay this revision until final publication was posted by CMS. AHCCCS has established an internal workgroup to head the expansive revisions that incorporate AHCCCS goals and initiatives, Contractor oversight, and the new requirements found within the managed care regulations. The revised Quality Strategy draft was completed, submitted to CMS for review and approval, and posted to the AHCCCS website on July 1, 2018.

AHCCCS’ Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. AHCCCS designed the Quality Strategy to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. AHCCCS’ Quality Strategy identifies, and documents issues related to those standards and encourages improvement through incentives or, when necessary, through regulatory action.

The Quality Strategy aligns with AHCCCS’ mission and vision and the Strategic Plan, all of which outline overarching goals that provide direction for SFY 2018–2023. The Quality Strategy outlines AHCCCS’ commitment to transparency, stakeholder engagement, and the provision of quality care and

services to members. Since 2003, the emphasis of AHCCCS' Quality Strategy has shifted from process measures to more comprehensive outcomes-based measurement and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status, providing focus on resilience and functional health of members with chronic conditions.

4. Quality Initiatives

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving quality of systems, care, and services. The draft July 1, 2018, Quality Strategy, Assessment and Performance Improvement Report (Quality Strategy); the 2018–2023 strategic plan, and the quarterly quality assurance/monitoring activity reports provided compelling evidence of AHCCCS’ vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services, as well as improve member health outcomes.

Quality Initiative Selection and Initiation

AHCCCS has established an objective, systematic process for identifying priority areas for improvement and selecting new performance measures and PIPs. This process involves a review of data from both internal and external sources, while also taking into account factors such as the prevalence of a particular condition and population affected, the resources required by both AHCCCS and Contractors to conduct studies and impact improvement, and whether the areas are current priorities of CMS or State leadership and/or can be combined with existing initiatives. AHCCCS also seeks Contractor input in prioritizing areas for improvement.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- Identified priority areas for improvement.
- Established realistic, outcome-based performance measures.
- Identified, collected, and assessed relevant data.
- Provided incentives for excellence and imposed financial sanctions for poor performance.
- Shared best practices with and provided technical assistance to the Contractors.
- Included relevant, associated requirements in its contracts.
- Regularly monitored and evaluated Contractor compliance and performance.
- Maintained an information system that supported initial and ongoing operations and review of AHCCCS’ quality strategy.
- Conducted frequent evaluation of the initiatives’ progress and results.

Systemwide Quality Initiatives/Collaboratives

Administrative Simplification and the Integrated Model Update

On October 1, 2018, AHCCCS offered fully integrated AHCCCS Complete Care (ACC) contracts to manage behavioral health and physical health services to children (including children with CRS eligible

conditions) and adult AHCCCS members not determined to have a serious mental illness (SMI). AHCCCS also proposed to preserve the RBHAs as a choice option and to provide a mechanism for affiliated Contractors to hold a single contract with AHCCCS for non-ALTCS members.

AHCCCS Complete Care

AHCCCS states that healthcare is most effective and efficient when it treats the patient holistically. Since its inception in 1982 and under the leadership of several directors, AHCCCS has worked to integrate physical and behavioral healthcare service delivery. AHCCCS has found that evidenced-based studies demonstrate mental health and physical health are dependent on each other and that optimal care includes that link. AHCCCS also stated that studies demonstrate the significant cost-savings resulting from integrating care.

Prior to October 1, 2018, most of the 1.8 million AHCCCS members in Arizona were enrolled in at least two managed care health plans—one for physical healthcare services and a second for behavioral healthcare services.

Throughout 2017 and 2018, AHCCCS worked to further this strategic goal of healthcare integration. In March 2018, AHCCCS took a large step toward this goal by awarding integrated managed care contracts to seven AHCCCS Complete Care (ACC) health plans. The seven ACC plans throughout the state will manage a network, provide all covered physical and behavioral health services, and be the only Medicaid payer to the ACC providers. The ACC plans will also provide services for members with CRS conditions. These CRS members had been restricted to a single plan and now have a choice of all ACC health plans offered in their service area.

Success was achieved through a committed team of AHCCCS staff throughout the agency that over the last two years achieved all of the following:

- Obtained stakeholder feedback.
- Conducted community forums.
- Issued and scored a request for proposal.
- Awarded ACC plan contracts without protest.
- Worked with ACC plans to ensure system and plan readiness to serve members.
- Undertook significant information system changes to ensure that members were enrolled correctly for integrated services and ACC plans and that providers had access to information by October 1, 2018.
- Made comprehensive policy and contractual changes as well as provided ongoing communication and education to the community, members, and staff.

The results of the October 1 implementation and transition of members to ACC plans have been incredibly successful. From the contract awards that were not protested, to the health plan and agency system transition on October 1, the reports have been positive.

With the implementation of ACC, more than 1.5 million AHCCCS members now have a single health plan for physical and behavioral healthcare services. A single health plan will be easier for members and providers to navigate, with one network and a single payer. One health plan can streamline care coordination at the health plan and provider levels and work to improve the member's whole health.

Executive Order 2016-06—Prescription of Opioids

On October 24, 2016, the Governor of Arizona, Douglas Ducey, signed Executive Order 2016-06 to address the opioid crisis affecting the nation and, in particular, the state of Arizona. In this order, the Governor indicated that Arizona has the ninth highest rate of opioid deaths in the nation, and that approximately 404 people in the state died of prescribed opioid overdoses in 2015. The State presented alarming statistics showing that during 2013 enough prescription pain medications were dispensed to medicate every adult in Arizona around the clock for two weeks.

The order authorized AHCCCS and the Arizona Department of Administration (ADOA) to adopt policies and rules that impose limitations to initial prescriptions of opioids for no more than seven days and initial and subsequent prescriptions to minors for the same period (seven days), except in cases of cancer and other chronic disease or traumatic injury.

As part of this initiative, the Governor also established the Arizona Substance Abuse Task Force to act as a coalition of leading experts, providers and members, and other community representatives. According to the Governor, this task force will provide recommendations on a variety of substance abuse-related issues, including access to treatment, evidence-based practices, neonatal abstinence syndrome, and medically assisted treatment best practices.

The overarching goal of this initiative is to reduce the prevalence of opioid use disorders (OUDs) and opioid-related overdose deaths. The initiative approach includes developing and supporting state, regional, and local-level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency. Strategies include:

- Increasing access to naloxone through community-based education and distribution as well as a co-prescribing campaign for individuals receiving opioid prescriptions exceeding morphine-equivalent daily doses and receiving combinations of opioids and benzodiazepines.
- Increasing access to and participation and retention in medication-assisted treatment (MAT).
- Reducing the number of opioid-naïve members unnecessarily started on opioid treatment.
- Promoting best practices and improving care process models for chronic pain and high-risk members.

The Medication Assisted Treatment—Prescription Drug Opioid Addiction Program (MAT-PDOA) grant, awarded to AHCCCS in September 2016, aims to target states having the highest rates of primary treatment admission for heroin and opioids. The primary goal of AHCCCS' MAT-PDOA program is focused toward engaging individuals diagnosed with OUD and involved with the criminal justice

system. Specifically, the intention is to focus on outreaching and screening individuals within four months of their release date to engage them in medication-assisted treatment (MAT) and provide care coordination as they reenter the community. The project also seeks to improve access to MAT services for these individuals by improving infrastructure and collaboration among criminal justice entities and opioid treatment programs (OTPs). Additionally, the project will expand infrastructure and build capacity for State, regional, and local collaborators to implement integrated strength-based treatment planning, screening, and assessment for co-occurring disorders for the target population by increasing participation in MAT services.

To date the MAT-PDOA program has enrolled 168 participants into the program to receive services. Among those enrolled, program outcomes include reductions in crimes committed, nights spent in jail, and drug-related arrests. The program has also produced an increase in gainful employment as well as increased housing acquisition and treatment retention. MAT-PDOA providers have expanded collaboration and engagement efforts with correctional facilities, re-entry centers, parole and probation departments, and drug courts. The program has also expanded services to the Graham County correctional facilities and drug court to assist an area that has been heavily impacted by the opioid epidemic and which, among other counties, has one of the highest overdose rates.

To expand training and education, AHCCCS will host two free MAT symposiums, in Mohave and Graham County, in efforts to display clinically effective prevention and treatment strategies to best serve those impacted by the opioid epidemic. Topics will also include current State initiatives being implemented to combat this rapidly emerging crisis. The content of the symposiums is designed for MAT providers, substance use disorder treatment providers, physical health providers, harm reduction organizations, justice system partners, and interested community members.

The Opioid State Targeted Response (STR) grant will enhance community-based prevention activities and treatment activities—to include offering 24/7 access to care points in “hotspot” areas throughout the state—increasing the availability of peer supports, providing additional care coordination efforts among high-risk and priority populations, and adding recovery supports.

During 2019, the following efforts supporting this initiative were made:

- Arizona opened six 24/7 centers of excellence (COEs) for opioid treatment on demand during year one. The COE is an opioid treatment program in a designated “hotspot” that expanded its hours to be open for intakes around the clock and for warm handoff navigation care post-intake. Arizona has also opened four medication units in rural Arizona to make MAT more accessible among those communities. In addition, Arizona has added 1,045 certified Drug Addiction Treatment Act (DATA)-waivered practitioners. As of June 30, 2019, more than 17,700 individuals have been connected to OUD treatment through the STR and State Opioid Response (SOR) grants.
- AHCCCS launched a concentrated effort through the STR grant to increase peer support utilization for individuals with OUD. Through the STR grant, additional peer support navigators have been hired in identified hotspots in Arizona; and efforts to include peer support navigation in COEs, jails, EDs, and for first responders at the scene in hotspot areas have increased. Through STR funding, Arizona has launched a real-time auto-dispatch model with the Phoenix Fire Department (PFD);

when PFD receives an opioid-related call, a peer support staff member from the 24/7 OTP clinic in Phoenix is also dispatched to arrive on the scene to help navigate individuals to resources. Arizona has also launched its first law enforcement “pre-booking” model in Tucson. Peers are called on scene to provide navigation to the 24/7 OTP as a mechanism for an alternative to incarceration. As of June 30, 2019, over 20,830 individuals have received peer support and recovery services through the STR and SOR grants.

- A total of 125,347 Naloxone kits have been distributed, resulting in 14,908 reported reversals.

Targeted Investments Program

On January 18, 2017, CMS approved Arizona’s request to implement the TI Program to support the State’s ongoing efforts to integrate the healthcare delivery system for AHCCCS members. The TI Program is AHCCCS’ strategy to provide financial incentives to participating AHCCCS providers to develop systems for integrated care. The TI Program will make nearly \$300 million available over five years to Arizona providers who assist AHCCCS in promoting the integration of physical and behavioral healthcare, increasing efficiencies in care delivery and improving health outcomes.

Pursuant to 42 CFR §438.6(c), the TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing healthcare delivery systems that improve care coordination and drive better health and financial outcomes. The TI projects will support children and adults with behavioral health needs (including children with or at risk for Autism Spectrum Disorder (ASD) and children engaged in the child welfare system) as well as individuals transitioning from incarceration who are AHCCCS eligible. The TI Program is expected to:

- Reduce fragmentation for both acute and behavioral health programs.
- Increase efficiency in service delivery for behavioral health members.
- Improve health outcomes for the affected populations.

As part of the AHCCCS TI Program initiative, use of the Early Childhood Service Intensity Instrument (ECSII), an incentive-based requirement, was adopted by the providers who volunteered to participate in the program for use with children birth to 5 years of age. The ECSII is a screening tool designed to examine risk and protective factors in the environment of infants and toddlers through the use of six major domains: quality of the relationship between child and caregiver; caregiving environment; developmental, emotional, or functional status of the child; and degree of safety within the child’s environment. Domain scores are used to help both the formal and informal systems of care that surround the child to coordinate services based on intensity of need.

The ECSII tool was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and is designed to identify intensity of services needed to improve early intervention outcomes for at-risk infants and toddlers. The tool promotes a collaborative and integrated approach among the various systems working on behalf of the child (behavioral and physical health, educational, foster care system, and State agencies). The ECSII is based on a child-centered, family, and team-driven

approach. It is expected to identify the need for behavioral health intervention sooner than what may otherwise be possible, and to thereby improve outcomes.

To satisfy specific requirements for the TI Program ECSII, providers were required to document the practice's policies and procedures for use of the ECSII, and to attest that the results of the ECSII were in the electronic medical record. By September 30, 2019, providers were required to attest that the practice performed the ECSII 85 percent of the time and incorporated service intensity recommendations into the integrated treatment plan.

The following are highlights of the TI Program implementation activities conducted by AHCCCS during CYE 2019:

- Enhanced the reporting system for TI Program participants to submit attestations of milestone completion and to upload documents for validation.
- Collaborated with Health Current, Arizona's HIE, to onboard TI Program participants in order to ensure that they are able to receive admission, discharge, and transfer (ADT) alerts from the HIE, and to send EHR core data to the HIE.
- Developed resources to support TI participants' work to meet program objectives, including a video of participant experience/success.
- Enabled implementation of a Peer/Family training curriculum to meet a TI milestone for co-located justice clinics that requires training of peer and family support staff members. The TI Program partnered with Maricopa Integrated Health System to develop the first phase of the Peer/Family training curriculum, which is being used to train individuals providing Peer/Family services to justice-involved individuals who are served by the TI co-located justice sites.
- Consulted with the Arizona Department of Child Safety on development of provider participant milestone requirements related to children in foster care.
- Developed and implemented multiple communication avenues for participants and stakeholders, including a detailed and regularly updated TI webpage, direct email, a dedicated TI email address, and social media posts.
- Made numerous presentations on the TI Program to a range of internal and external stakeholders, explaining the integration and whole person care goals and objectives of the TI Program.
- Established an ongoing dialogue between AHCCCS and its MCOs to facilitate alignment between the TI Program guidance on enhanced provider-level integration and the MCOs' provider network integration initiatives, including regular meetings between AHCCCS and MCO medical directors.
- Toured and evaluated the program's following co-located justice sites: Community Health Associates Tucson, Terros, Spectrum, Southwest Behavioral, and Valleywise Health (formerly Maricopa Integrated Health System).
- Instituted participant focus groups to solicit input and feedback on year 3 milestone requirements and potential year 4 performance measure milestones.
- Teamed with Arizona State University to develop a Quality Improvement Collaborative for program participants that provides timely and actionable performance metric information and a performance

management system to share best practices and disseminate the practical content needed to enhance program participants' milestone achievement.

- Submitted a Sustainability Plan on March 29, 2019, pursuant to Arizona's 1115 waiver demonstration STC 67. This Sustainability Plan was approved by CMS on August 12, 2019.

American Indian Health Plan Integration

In addition to the implementation of integrated managed care plans with ACC, AHCCCS has worked throughout the last year to integrate physical and behavioral healthcare and services throughout the state for members with CRS conditions who choose to enroll in AIHP.

Eligible American Indians currently have a choice of using managed care or the AHCCCS fee-for-service program, AIHP.

Prior to October 1, 2018, most members enrolled in AIHP were also enrolled in a RBHA or Tribal Regional Behavioral Health Authority (TRBHA) for behavioral health services.

As of October 1, 2018, American Indian members have the choice of integrated care: AIHP or an ACC health plan. AIHP members will also be able to choose care coordination through a TRBHA (when available).

Quality Strategy

During CYE 2018, an internal workgroup was established to lead the most recent overhaul of the AHCCCS Quality Strategy. The Quality Strategy supports the mission and vision of AHCCCS and is aligned with AHCCCS' Strategic Plan, which outlines overarching goals that guide AHCCCS' direction for SFY 2018–2023. The report outlines AHCCCS' commitment to transparency, stakeholder engagement, and ultimately a commitment to the provision of quality care and services to those served through Arizona's Medicaid managed care and fee-for-service system.

Arizona Management System (AMS)

Arizona Governor Doug Ducey has deployed a professional, results-driven management system to transform the way agencies think and do business. AHCCCS has fully embraced this system and is committed to tracking and improving performance daily. Across the agency, AHCCCS employees now meet regularly around huddle boards (approximately 110 across the agency) where staff can monitor performance and hold themselves accountable for results. Leaders routinely observe how the work is completed and assist staff in identifying waste and developing problem-solving skills. AHCCCS continues to gather data and work toward delivering results for the people of Arizona.

Suicide Prevention Plan

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15–29-year-olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4 percent of all deaths worldwide, making it the fifth leading cause of death in 2012.

In Arizona, suicide is a primary public health concern that touches urban and rural communities including people of all ages and backgrounds.

- Among children ages 10–14 in Arizona, suicide is the leading cause of death.
- On average, a suicide occurs every seven hours in Arizona.
- Arizona ranks 12th in the nation for deaths by suicide.
- A total of 1,310 Arizonans died by suicide in 2016—the youngest was 9 years old.
- Among American Indians or Alaskan Natives, the median age of death by suicide is 27 years old (compared to age 51 among Caucasians).

Governor Ducey issued a proclamation declaring September Suicide Prevention Awareness Month in Arizona, encouraging citizens to take part in addressing suicide in communities.

As a member of the Arizona Suicide Prevention Coalition, AHCCCS collaborates with State agencies, organizations, healthcare plans, lawmakers, and other partners to create a community-based plan to end suicide in our state.

Learning Community

AHCCCS developed a “Learning Community” for AHCCCS staff, where SMEs present on issues of topical interest. One such session was a review of the children’s system of care. The session reviewed the topic from an historical perspective and considered how it has been modified in response to recent litigation for behavioral health services for children. The session also explored the impact to the new ACC plans as outlined in the contract. The audience was provided tools to use in reviewing contractual deliverables associated with behavioral health services for children. As part of its commitment to quality improvement, AHCCCS reviews the feedback provided by the attendees to improve future presentations to ensure that the material is pertinent and germane to the mission of the clinical departments.

System Improvements

AHCCCS hosts various meetings to continue to direct system improvements:

- Monthly collaborative meetings with the Department of Children’s Services/Comprehensive Medical and Dental Program (DCS/CMDP) to continue efforts to improve service delivery for children in the foster care system and to ensure availability of medically necessary services.
- Quarterly contractor meetings including DCS/CMDP, to review deliverable submissions and foster care data and to discuss system successes and improvements.
- Quarterly cross-divisional operational team meetings to further enhance service delivery efforts.

Through these meetings, various system improvements have been identified:

- Resource Packet—the frequently asked questions (FAQs) document has been expanded and renamed. It now includes more FAQs, information, and resources for foster, kinship, and adoptive parents related to available physical and behavioral health services.
- Behavioral health and crisis services flyers for foster and kinship that are updated annually.

AHCCCS developed a specific policy (AHCCCS Contractor Operations Manual [ACOM] 449), which outlines specific requirements for behavioral health services for children within custody of the Department of Child Safety and for adopted children.

AHCCCS created a quarterly dashboard to track and trend utilization for children in foster care; this dashboard is posted on the AHCCCS foster care webpage.

Long-Acting Reversible Contraceptives (LARCs)

AHCCCS implemented the LARC initiative to allow for LARC devices to be reimbursed outside of regular hospital payment. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their six-week post-partum office visits.

Summary of Activities Designed to Enhance the Medical Record Review Process

AHCCCS has initiated a statewide workgroup designed to develop a consistent behavioral health chart review tool. The tool will be designed to:

- Meet the CFR and State statutory requirements.
- Operate according to AHCCCS contractual guidelines.
- Provide consistency across the state with regard to clinical behavioral health practice.
- Allow for consistency of results in chart analysis and review.
- Allow for data comparisons across geographic service areas using consistent measurement of required chart elements.

Data Stewardship Committee

In November 2018, AHCCCS selected a data governance manager, and one of the first objectives for the manager was to work with divisions to identify the key data owners across the agency and form the Data Stewardship Committee. The committee was formed in August 2019 and meets once a quarter to review progress of any workgroups, data governance monitoring reports, definition approval, and open data discussion. Members of the committee include subject matter experts from all the divisions that work with agency reporting and data, as well as with management. The committee's goals for CYE 2020 will be to implement the charter and policies to create a solid foundation for upcoming data governance projects such as the data dictionary.

Notable accomplishments of the Data Stewardship Committee during CYE 2019 include:

- Implemented training modules for the agency to expand the agency's knowledge about data governance and stewardship. These trainings were completed by the agency's employees, with the exception of Contractors and temporary staff, and are now required for new employees.
- Started a monthly reporting newsletter to share knowledge, updates, and other important data topics with data users to improve quality and foster open communication.
- Formed workgroups to start working on data governance initiatives for the agency, such as the business glossary and data dictionary, that will standardize definitions and fields to prevent inaccurate results in reports since everyone at the agency will have the same definitions.
- Created a new data request form to help users request data with more business detail along with maintaining quality for the analyst by requiring certain checklist items be done before the report can be sent to the user.
- Implemented change control for report development so all required documentation and quality checks are verified as completed by the report analyst before a request can be closed.

Electronic Visit Verification

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), also known as the 21st Century Cures Act, in order to prevent a reduction in the Federal Medical Assistance Percentage (FMAP), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) and for in-home skilled nursing services (home health). After receiving approval from CMS, AHCCCS is scheduled to implement EVV on January 1, 2021.

The EVV system must, at a minimum, electronically verify the:

- Type of service performed
- Individual receiving the service
- Date of the service

- Location of service delivery
- Individual providing the service
- Time the service begins and ends

AHCCCS (in partnership with the MCOs) is using EVV to help ensure, track and monitor timely service delivery and access to care for members, as well as using EVV to help reduce provider administrative burden associated with scheduling and hard copy timesheet processing.

More information on AHCCCS' EVV initiative can be found on the AHCCCS website (<http://www.azahcccs.gov/EVV>).

Other Systemwide Quality Initiatives/Collaboratives

During the reporting period, AHCCCS participated in the following systemwide quality initiatives. (Note: This is not an all-inclusive list.)

- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update:* AHCCCS is revising the Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age guidance document to ensure that the most recent research on appropriate prescribing is provided to providers, children, and families. AHCCCS is also updating tools that provide best practice strategies related to infants and toddlers—including psychotropic prescribing, early childhood mental health intervention, and trauma-informed care. The document content focuses on the most current prescribing practices and psychotherapeutic approaches for use during early childhood, with the recommendation that psychotherapeutic approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention. To further ensure realization of the treatment recommendations within these tools, AHCCCS has begun a statewide Birth to Five initiative to address the unique needs of infants and toddlers. Additionally, AHCCCS is collaborating with CMDP for their Birth to Five learning collaborative.
- *Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on ASD:* In February 2016, the ASD Advisory Committee (appointed by the Office of the Arizona Governor in spring 2015) published a report of recommendations to strengthen the healthcare system's ability to respond to the needs of AHCCCS members with or at-risk for ASD, including those with co-morbid diagnoses. During 2017, two COEs opened in Maricopa County. ACC, the new contract for AHCCCS and the Contractors, is addressing the recommendation to integrate care for acute members. In addition, AHCCCS is developing a behavioral intervention policy that addresses this issue.
- *Summary of Activities Designed to Enhance the Monitoring of Physical Health Providers:* Arizona Association of Health Plans (AZAHP), comprised of all AHCCCS Contractors for Medicaid business except CMDP and the Arizona Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), offers a single point of contact for the Contractors and promotes consistency across the system. AZAHP works closely with AHCCCS discussing Contractor concerns, barriers,

and challenges Contractors are asked to undertake. It also provides valuable feedback for consideration as the direct link to the care and services being provided. AHCCCS utilizes the AzAHP to provide stakeholder insight and to collaborate and promote new initiatives. AHCCCS has collaborated with AzAHP to provide consistent monitoring of physical health providers. This collaboration has historically allowed for uniform statewide review of primary care practitioners including internists, family practices, and obstetricians. AHCCCS began discussions with AzAHP regarding capacity to also monitor behavioral health providers throughout Arizona. Utilizing AzAHP as a monitoring agent facilitates consistency in quality monitoring and reduces burden on practitioners because AzAHP serves as the single reviewing entity for multiple MCOs. AHCCCS is currently combining this effort with the development of a consistent tool during meetings conducted with the RBHAs during 2017 and early 2018.

- AHCCCS Quarterly Contractors' Quality Management/Maternal and Child Health Meeting: To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor's Quality Management/Maternal and Child Health Meeting.
- Clinical Integration: The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and Maternal and Child Health/EPSTD units, added a second behavioral health coordinator to support efforts for the entire clinical team. The addition of a behavioral health coordinator enhances the ability for clinical considerations, service delivery, and program and contract development—to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional staff with behavioral health expertise from within its workforce.

Within the QM, Quality Improvement, and Maternal and Child Health/EPSTD units, other activities designed to enhance integration have involved utilization of performance and quality measurement activities that provide a greater focus on specific aspects of integrated care. Highlights include:

- Required tracking of performance on the frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.
- Tracking performance on prenatal and postpartum timeliness of care, with supplemental training provided to contracted health plan staff relative to physical and behavioral health aspects of perinatal mood disorders.
- Implementation of regular community-based meetings open to AHCCCS membership—with focus on enhancing member and stakeholder involvement and investment in performance as well as on enhancing quality improvement activities for physical and behavioral healthcare.
- Involvement of Stakeholders and Community SMEs: Throughout 2017, AHCCCS continually involved stakeholders and community SMEs as members of AHCCCS committees, quality meetings, policy workgroups, and advisory councils. SMEs provided technical assistance, guidance, and advisement related to various areas and issues (e.g., special needs populations, consumer advocacy, ASD, early intervention, trauma-informed care, behavioral health system best practices, integrated care).
- Medical Director Meetings: AHCCCS involves medical directors from Contractors in quarterly meetings. These meetings are designed to inform medical directors of changes in policy, regulation, billing practices, and current or future system updates. Additionally, these quarterly medical director

meetings are designed to provide information on best practices in medical, behavioral care, and/or prescribing practices.

- ADHS Bureau of the U.S. Department of Agriculture (USDA) Nutrition Programs: AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from Contractor education to Women, Infants, and Children (WIC) promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.
- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzEIP), Arizona’s IDEA Part C program, is administered by the Division of Developmental Disabilities. Maternal and Child Health staff in the Clinical Quality Management unit at AHCCCS work with AzEIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzEIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. As an ongoing effort to promote care coordination and system clarification the Maternal and Child Health/EPSTD manager undertook extensive efforts to create detailed flow charts that outline the process from multiple points of entry and across many different MCO types and member conditions. These flow charts have been promoted at several stakeholder groups, with collaborative feedback. Once the charts undergo a final review, these tools will be made available on the AHCCCS website.
- The Arizona Partnership for Immunization (TAPI): Maternal Child Health staff attend on-going TAPI Steering Committee meetings and subcommittee meetings concerning community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI’s Provider Awareness and Adult and Community Awareness committees continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents, and the community at large. In addition to the website, TAPI provides vaccination handouts. TAPI has a teen vaccination campaign (Tdap, meningococcal and human papillomavirus [HPV] vaccines) that involves provider education as well as parent and teen outreach. Protect Me with 3, a parent-focused campaign, reminds parents that their children still need them to protect them and to help with healthy decisions. Take Control, a teen campaign, addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.
- Health Current (formerly Arizona Health-e Connection): Health Current, a non-profit organization, is a health information exchange organization (HIO) and is the single statewide HIE. Health Current currently has 500 unique participants, which include hospitals, accountable care organizations, health plans, behavioral health providers, laboratories, ambulatory practices, long-term care providers, and more. (For a complete list of participants, Health Current maintains a count on their website: <https://healthcurrent.org/hie/the-network-participants/>). To improve care coordination, AHCCCS requires all managed care Contractors to join the HIE. Health Current electronically shares hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member’s home HIE if that member seeks care outside his or her Arizona or “home” HIE.

AHCCCS providers from across multiple programs (e.g. ACC, TI, and Differential Adjusted Payments/Value Based Payments) have been recruited and the number of total HIE participants from October 2018 to September 2019 has risen from 538 organizations to 649 organizations (a 21 percent increase). Of the total participants, 75 percent are AHCCCS registered providers.

- **ADHS Bureau of Tobacco and Chronic Disease:** In collaboration with ADHS, AHCCCS monitors the utilization of and access to smoking cessation drugs and nicotine replacement therapy programs. AHCCCS members are encouraged to participate in ADHS' Tobacco Education and Prevention Partnership (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.
- **Medicare and Medicaid Alignment for Duals:** Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 64,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact on plan alignment related to dual-eligible members. The study compared national data for dual-eligible members enrolled in traditional Medicare fee-for-service to data for aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmissions rate.
- **Early Reach-In:** Contractors are required to participate in the criminal justice system "reach-in" care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff's office; Correctional Health Services; and Arizona Department of Corrections (DOC), including community supervision and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend member eligibility upon incarceration rather than terminating coverage. Upon the member's release, the member's suspension of AHCCCS eligibility is lifted, allowing for immediate care coordination activities. Using the 834 data file to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of MAT-eligible members. The Contractors, with the criminal justice partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointments, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.
- **Foster Care Initiative:** AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through CMDP and RBHAs. Adoptive children are typically AHCCCS eligible and enroll in an ACC health plan like any Medicaid-eligible

child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care.

- Behavioral Health Learning Opportunities: With the advent of administrative simplification, AHCCCS recognized the need to provide learning opportunities for staff lacking behavioral healthcare experience and expertise due to previous historical hiring requirements for medically trained personnel. AHCCCS offers formal meetings as well as informal workshops, and lunch-hour trainings to ensure that staff had ample opportunities to increase behavioral health system knowledge. Internal behavioral health SMEs, licensed behavioral health practitioners, and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma-informed care, perinatal mood disorders, and adult system-of-care processes for individuals with general mental health needs and SMI.

QM is providing additional behavioral health “Lunch and Learn” trainings for QM and QOC staff especially, with attendance open to other departments based on department need. Topics include the following:

- Regulatory requirements for individuals designated as having an SMI versus having general mental health and/or substance use needs (GMH/SU)
 - Grant-based housing for individuals with SMI
 - Short-term behavioral health residential services
 - Crisis process and requirements
 - Diagnostic categories and symptoms
 - Best-practice and evidence-based clinical approaches for adults and children
 - Mental health awareness
 - AHCCCS Waiver process
 - Meeting the needs of members with developmental disabilities and behavioral health challenges
 - Coordination of benefits (e.g., AHCCCS, Medicare, commercial coverage)
- Workforce Development: Beginning October 1, 2018, AHCCCS instituted a requirement for Contractors to hire a Workforce Development Administrator, maintain a Workforce Development Operation, and as a part of the Network Development and Management Plan, to develop an annual Workforce Development (WFD) Plan. The WFD requirements have been adopted formally into policy in the AHCCCS Contractors Operations Manual, Policy 407, and the scope of the WFD requirements has expanded. Contractors spanning all lines of business are required to maintain an operational infrastructure for workforce policy management. The requirement addresses the Contractors’ capacity to collect data, assess workforce development needs of the subcontracted provider network, develop a Workforce Development Plan, and monitor provider adherence to AHCCCS workforce requirements and to directly assist providers with workforce issues if needed. Each Contractor’s WFD plan must incorporate required elements such as forecasts of workforce capacity and competency needs, and must identify strategic goals and implement initiatives to address those needs. The flexibility built into the planning process affords Contractors the opportunity to develop a plan responsive to membership and network needs. The Contractors also have the opportunity to jointly develop priorities that address common areas of need. For example, the Contractors’ Workforce Development personnel are working in collaboration with AHCCCS’

Workforce Development Administrator and the provider industry to create a competency-based training system. This multi-level system consists of a standardized approach to developing curricula for new employee orientation as well as basic, specialized, and advanced job-specific training programs. This virtual training system model is housed within a single learning management system (LMS) provided by Relias Learning. All ACC and RBHA Contractors share a portion of the cost to fund a contract for the LMS services provided by Relias Learning.

AHCCCS Complete Care Quality Initiatives/Collaboratives

During the reporting period, AHCCCS participated in the following quality initiatives. (Note: This is not an all-inclusive list.)

- **Arizona Head Start Association:** The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The meetings are attended by families participating in the Head Start program along with AHCCCS staff members and the AHCCCS Contractor Maternal and Child Health and EPSDT coordinators.
- **Arizona Perinatal Trust (APT):** The APT oversees voluntary certification of hospitals for the appropriate level of perinatal care according to established guidelines and conducts site visits for initial certification and recertification. AHCCCS covers over 50 percent of the births in Arizona; therefore, the site reviews provide AHCCCS with a better assessment of the hospitals that provide care to pregnant women and newborns, from normal labor and delivery to neonatal intensive care. Details of the site visit review are kept confidential; however, site visit reviews do allow opportunities for collaboration among healthcare professionals to learn about innovative practices that hospitals have implemented as well as sharing of best practices, policies, and guidelines. AHCCCS continues to support APT and participate in site visits regularly.
- **ADHS Immunization Program and Vaccine for Children (VFC) Program:** Ongoing collaboration with ADHS helps ensure efficient and effective administration and oversight of the federal VFC program. The VFC program representatives provide education to Contractors, regular notification to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State Immunization Information System (ASIIS), an immunization registry that can capture immunization data on individuals within the state. Staff also provide monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 Promoting Interoperability (previously meaningful use [MU]) public health requirements.

5. Contractor Best and Emerging Practices

The following are the best practices as reported by the Contractors to AHCCCS.

Arizona Complete Health – AHCCCS Complete Care (AzCH-ACC)

- **Provider Assistance: Healthcare Gap Geography Mapping:** AzCH created a geography map (geo-map) that highlights geographical areas with concentrations of healthcare gaps in an effort to target member outreach, improve service delivery and effectively evaluate the served population needs. The location-driven report is utilized by providers and AzCH to focus outreach efforts and interventions, and improve member outcomes. AzCH has utilized geo-mapping to pinpoint specific ZIP Codes to focus interventions, such as mammogram events, health fairs, and mailing campaigns. The geo-map allows network providers to focus their efforts and coordinate member-facing initiatives in collaboration with the health plan.
- **Member Outreach—Promotoras:** AzCH collaborated with the Promotoras group in an effort to effectively outreach members with healthcare gaps. The Promotoras are community health workers who conduct on-site visits to educate members about needed health screenings, tests, and available community resources. The collaboration is intended to increase member outreach and reduce healthcare gaps for both adults and children by utilizing community health workers. AzCH reported that all childhood and adolescent immunization measures have seen significant improvement in CY 2019.
- **EPSDT Member Reassignment:** During Quarter 2 of calendar year (CY) 2019, AzCH began monitoring EPSDT provider groups with large member assignment panels and historically low annual wellness claim submissions. AzCH's goal is to increase positive member outcomes by ensuring the member is assigned a provider who will engage them in care. Based on the EPSDT provider group monitoring, provider on-site visits were completed, and it was discovered that members are assigned to practitioners that are not engaging or may have recently left the group practice. As a result, all EPSDT providers are monitored for claims submission via the EPSDT Dashboard. If a discrepancy is noted, the team will complete a site visit in order to conduct a root cause and reassign the members to a provider that will engage the members.

Banner University Family Care – AHCCCS Complete Care (BUFC-ACC)

- **Diabetes Hemoglobin A1c (HbA1c) Control:** In CYE 2019, BUFC worked to get the HbA1c testing to the minimum performance standard (MPS) of 86 percent. The strategies included coordinating with Sonora Quest to track and monitor HbA1c tests and values and to conduct outreach to those members without a test on record or those with HbA1c values greater than 9 percent. BUFC case managers assist members with high HbA1c levels (greater than 9 percent) by following up with providers and care givers so that interventions can be done quickly to lower the HbA1c levels. When a member's HbA1c level is out of control and the member has only received one HbA1c test, a care

manager works to have the test done more often to ensure that the interventions are working and that the member is gaining control of his or her HbA1c level. This intervention continues until the HbA1c level is in appropriate range.

- Annual Dental Visits—2 through 20 years: The BUFC quality department calls and reminds parents of the importance of attending to their children’s dental needs, sends out reminder flyers, and ensures that all dental referrals are completed. In addition, BUFC partnered with the dental vendor (DentaQuest), who agreed to reach out to all high-volume providers, send them lists of children with no dental visit within the year, and request that they reach out and encourage these parents to get their children in for appointments. Additionally, the dental performance measure was included in the alternative payment model for all major providers.
- Breast Cancer Screening: BUFC sends regular mailings to members regarding the importance of mammography with the aim to increase the number of members receiving an annual mammogram. In addition, BUFC had a breast cancer member gift card campaign that appeared to have improved the measures at least slightly for this population. Further, BUFC has worked with several imaging clinics and a mobile mammogram vendor to reach rural and hard-to-reach populations.

Care1st of Arizona – AHCCCS Complete Care (Care1st-ACC)

- High-Touch Tailored Outreach to Pregnant Members: Immediately after identification of the pregnancy through a variety of means, Care1st employs tailored telephone counseling to educate the member and to ensure that she understands her benefits as well as important information related to accessing services. Tailored telephone counseling has been shown to improve adherence to obtaining services such as those related to colorectal cancer screening and cervical cancer screening. The maternal child health coordinator also has a protocol for identifying potential triggers for case management on the first call, including asking questions to identify potential depression and then referring the member to behavioral health care and/or substance use disorder services. A pregnant member receives personal calls during the third trimester, at delivery, and during the postpartum period—with staff members specializing in helping her navigate the delivery system at those important stages. The member also receives frequent contact from EPSDT specialists during the baby’s first two years.

Goals are assessed according to current specifications for Healthcare Effectiveness Data and Information Set (HEDIS[®])⁵⁻¹ measures and include the following interventions:

- Improve the rate of postpartum visits between 21 and 56 days after delivery.
 - Improve well visits in the first 15 months of life.
 - Maintain or improve immunization completion for seven childhood vaccines by 24 months.
- Pacify Mobile Application: Care1st is the first Arizona Contractor to use Pacify, an innovative application for smartphones that allows members in the late stages of pregnancy or up to one year after baby’s birth to call a certified lactation consultant, registered dietitian, or registered nurse for help and advice at any time of the day or night, seven days a week. Pacify is an evidenced-based

⁵⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

approach to improving health outcomes for new moms and babies: the U.S. Preventive Services Task Force recommends providing interventions during pregnancy and after birth to support breastfeeding, including professional support through home visits and telephone contact. The American Academy of Family Physicians also recommends providing interventions during pregnancy and after birth to support breastfeeding, and the National Association of Pediatric Nurse Practitioners endorses the optimization of infant breastfeeding and breastfeeding promotion as part of pediatric care. The Pacify application facilitates a “virtual visit” with a lactation consultant or dietitian by video call at the touch of one button on the application, while the connection to a registered nurse is voice only. A standard practice among these healthcare professionals is to refer callers back to their Care1st PCPs or children’s pediatricians for follow-up, to ensure continuity of care. Push notifications sent to the members’ phones also provide important health education and reminders, such as reminders for well-baby visits, and are tailored to each member’s delivery date or baby’s date of birth. Goals of the intervention include: a) improvements in infant healthcare costs for ED visits and hospital stays, as well as total medical cost savings, and b) improvement in the rate of well-child visits in the first 15 months of life.

- P360 Program: In CYE 2018, Care1st implemented a multifunctional process that brings together department staff members from quality improvement (QI), network management, and value-based partnerships, along with the Arizona senior medical director and the WellCare senior QI project manager, who lead the P360 initiative to review performance by its largest value-based provider groups. At these twice-monthly meetings, key performance measure rates and other grouped metrics are reviewed, as are the current number of care gaps needing closure in order to meet performance thresholds. Group-specific challenges or barriers to improvement are discussed with the input from frontline staff members who interface with these provider group directors and managers, and interventions to address those challenges and barriers are developed. For example, during CYE 2018, Care1st performed analysis and implemented interventions focused on recommendations for improved provider education on coding EPSDT services with sick visits and scheduling of family well visits on the same day.

When groups achieve high levels of performance or demonstrate significant improvement in their performance measure rates, a representative of the P360 team reaches out to identify any best practices that may be shared with similar provider types. A valuable tool used in evaluating provider practices and opportunities has been a WellCare proprietary document entitled, “Qualities of a Highly Engaged Physician Practice,” which lists 10 best practices for engaging with patients and eight best practices for engaging with the Contractor. These best practices were identified by WellCare based on evidence, and the document is shared with provider groups. The P360 collaborative process allows the Contractor to support its provider groups in the most effective way—making them partners rather than customers, and ensures a consistent approach to interfacing and messaging across departments. This approach is based on the tenet that, when payers focus on strengthening patient engagement and improving care coordination, ACOs and other providers with alternative payment models are likely to generate savings and greater patient satisfaction.

- Best Practice Playbook: WellCare (Care1st’s parent company), developed a “Best Practice Playbook” for Medicaid HEDIS measures that is updated quarterly. The goal is to provide details on standard practices, or initiatives and reports that should be utilized by every WellCare Medicaid

plan; best practices, which are considered “best in class” strategies and activities to improve performance; and pilots in one or more markets, which may not yet be proven to be a best practice. The playbook ensures that all WellCare Medicaid plans are able to benefit from shared experience, either at the enterprise (corporate) level or by individual plans, whose experience may be replicated in other states.

Each measure has a central point-of-contact for leadership and guidance on improvement activities and strategies, as well as quick links to shared sites containing reports, step action procedures, and other helpful information. An appendix of resources includes a health literacy tip sheet, a workflow for community events, and at-a-glance listing of measure owners at the corporate level.

Magellan Complete Care – AHCCCS Complete Care (MCC-ACC)

- **Integrated Team:** MCC-ACC of AZ utilized an integrated team for provider engagement. Key providers are identified, and site visits are made by the quality, peer recovery, and provider relations teams. This robust team allows for in-depth communication and educational opportunities with its key providers to ensure they are providing the needed care to MCC-ACC of AZ’s members.
- **Trended Call Data:** MCC-ACC of AZ trends the call data received from top providers and members. By trending these data, MCC-ACC of AZ is better able to understand the needs of both members and providers and adjust as needed.

The results of this trended data are brought to the Executive Management Committee monthly to review and make recommendations for improvements based on the feedback received from the calls.

- **Welltok Text Messaging to Members:** In July 2019, MCC-ACC contracted with Welltok, a vendor that utilizes a member engagement and communications platform, to send text messages to engage health plan members. MCC-ACC reports that low-income people send more than twice as many texts per day compared to those with higher incomes, and over 60 percent have used their phones to access health information, making texting (Short Message Service [SMS]) scalable and effective in engaging Medicaid beneficiaries. MCC-ACC also reported that SMS-based health programs provide interactive behavior change “nudges” at the right time, in the right place, providing unobtrusive, convenient, accessible ongoing support.

MCC-ACC states that messages are geared to help address gaps in care, and that messaging services fall into three categories that impact membership:

1. Health Programs
 - Interactive population health programs
 - Combine evidence-based curriculum with motivational interviewing, stages of change, and calls to action and resources
 - Developed with content partners
 - Proven impact
2. Campaign Library
 - Tailored campaigns on administrative and quality topics
 - Focused on health behavior and/or targeted cohort

- Access to content library with templates
- 3. Person-to-Person (which will be implemented in 2020)
 - Real-time or asynchronous messaging to individuals or groups
 - Administrative tools to support health management staff members to manage members, configure settings, and share members

Mercy Care – AHCCCS Complete Care (MC-ACC)

- **Policy Review:** In 2014, AHCCCS assigned a CAP to MC for noncompliance with timely review following an OR. As a result, MC established a best practice review process for all policies in accordance with regulatory, contract, and department requirements. The policy library holds policies (both active and retired) and desktops and workflows that are associated with the policies. The database sends out notifications to the policy owner prior to the annual review due date to review and collaborate with other departments and SMEs on updates to the policy and associated desktops. If applicable, automated emails are sent to the appropriate department informing it of the possible changes and/or possible additions to the member handbook or provider manual, prompting the department to conduct a review. Once the initial reviews are completed, the policy is reviewed by the policy review committee at the next scheduled meeting. Once the review process has been completed, and the chief medical officer (CMO) and the chief executive officer have conducted a final review, the policy is uploaded to the database.
- **Asthma Medication Ratio (AMR) Measure:** The NCQA HEDIS measure, *AMR*, evaluates adherence to asthma controller medications by members with persistent asthma. The measure is calculated at the member level by dividing the number of fills of asthma controller medications by the total number of asthma medications filled during the study period. MC reports that higher AMRs are associated with improved asthma control and decreased risk of emergency hospital care. MC set a goal of improving asthma-related QOC and decreasing the frequency of asthma exacerbations in members with an AMR less than 0.5 and a recent history of asthma exacerbations through member, case manager, and provider education provided by a clinical pharmacist.
- **Hospital Readmissions Reduction Program (HRRP):** HRRP focuses on coordinating care between providers, case managers, and pharmacy as members are discharged from the hospital. Eligible members are identified by a case management referral or by using the inpatient census report. MC reports that, when care transitions are not provided in a coordinated and seamless manner, members face significant challenges when discharged from the hospital, leaving members (particularly vulnerable members) at risk for negative health outcomes. With the HRRP, MC aims to reduce hospital readmission rates and it is intended to supplement established case management programs.
- **Pharmacy-Supported Comorbid Condition Management (PCCM) Program:** PCCM, a clinical program, focuses on coordinating care between members, case managers, and clinical pharmacists to improve medication-related outcomes in complex high-risk members through the completion of a thorough clinical medication review. Per the Centers for Disease Control and Prevention, as an individual's number of chronic conditions increases, their risk for premature death, hospitalization, and poorly coordinated care also increases. Further, approximately 71 percent of the total healthcare spending in the U.S. is associated with care for individuals with more than one chronic condition.

MC reports that approximately 61 percent of adult Medicaid enrollees have a chronic or disabling condition, and that a significant portion of these members suffer from multiple chronic conditions, leaving members vulnerable to poor health outcomes and substantial healthcare expenditure. MC identifies members with multiple chronic conditions either through the clinical pharmacist or through case management referrals.

- **Nursing facility (NF) Patient Discharges:** MC reports that it works with members so they can live in the least restrictive and most integrated setting that will meet their needs. MC further reports that many members prefer to live at home or in the community; research demonstrates that living at home has many benefits (including increased safety, independence and self-determination, strengthened social network and proximity to friends and family, increased comfort and convenience, and a decrease in expenditures for the payer) and aligns with AHCCCS' plans to increase the number of members living at home or in the community. Therefore, MC developed and implemented interventions so members would have ongoing funds and could discharge to their homes or a lower level of care. MC has identified its target population to include single, NF residents with discharge potential, and whom had zero cost-sharing and had been enrolled with Mercy Care for at least two weeks. Case managers discuss discharge plans with members in the cohort, raise their awareness of the possibility of unrealized funds, and provide them with information and resources to assist them in applying for and receiving income for which they are eligible.

Steward Health Choice Arizona – AHCCCS Complete Care (SHCA-ACC)

- **Performance Improvement Coordinator (PIC) Deployment and Gap Reports:** SHCA began deploying PICs to improve provider performance on selected measures. The PICs partner with provider practices and review, troubleshoot, and optimize office workflow, member outreach, and collection of supplemental data. PICs had begun office visits and workflow discussions with high volume providers. PICs also contact members directly with gaps in care and, for practices that allow PICs to access their electronic medical records, the PICs can book appointments directly and make notes to alert the practice of any care gaps for members with upcoming appointments. In upcoming months, a PICs will engage the behavioral health homes in the northern region to improve integration and performance on the behavioral health quality measures. The PICs' progress is tracked and monitored closely by SHCA leadership. PICs deliver gap reports to each engaged provider that list all of the members assigned to a provider and whether needed services have been received or scheduled. The PICs meet twice a week to discuss these barriers, develop best practice interventions with providers, and prioritize provider and member outreach based on the most recent quality measure performance. In the central region, a PIC will soon be dedicated to increasing care and collaboration with the behavioral health intake providers. Further, the SHCA Maternal Health and EPSDT team (MHT) continues its efforts to ensure timely and high-quality care for pregnant members and children. SHCA recently increased cooperation between the MHT team and the PIC team. The PIC team sends out member gap lists to all of the PIC-engaged providers that detail needed member gaps. These gap lists are now automatically send to the MHT team as well for additional follow up with members and providers, which allows the MHT team to better coordinate efforts to multiply this work rather than duplicate it.

- **Hi-Touch Transition of Care:** SHCA’s Transition of Care program utilizes a “high touch” approach and reaches out to the members while they are still inpatient to increase the successful contact rate. The objectives are to reduce readmissions, provide safe and seamless care transitions, increase customer experience, and reduce medical costs. Care management and assistance are provided to members via more frequent, direct contact from SHCA management staff members. In addition, SHCA has a Health Buddy program in which a member services representative makes similar outreach calls to members that are discharged from hospital settings. This serves to ensure that members receive appropriate follow-up and know where to go when they have questions about treatment or medications.

UnitedHealthcare Community Plan – AHCCCS Complete Care (UHCCP-ACC)

- **Immunization Gaps in Care, 13 and 14 Months:** UHCCP reported implementing a number of interventions to increase childhood immunization rates through the years; however, in CYE 2017, UHCCP was still below the AHCCCS MPS for the C diphtheria, tetanus, and acellular pertussis (DTaP), pneumococcal conjugate vaccine (PCV), and influenza immunizations for members under 2 years of age. As a result, UHCCP implemented additional interventions designed to improve the percentage of members who receive immunizations by 2 years of age. In addition to interventions already put into place, the following two interventions were implemented in the beginning of CYE 2019:
 1. Personalized member letters are sent to guardians of members at 13 months and 14 months of age who are non-compliant for their immunizations. The letters encourage guardians to schedule their member’s 15-month well-child visit and to address the missing immunizations. The letters provide the names of the member’s assigned PCP and also lists the immunizations the member is missing based upon data from the Arizona State Immunization Information System (ASIS).
 2. Monthly letters are sent to providers listing their assigned members 13 or 14 months of age that are missing one or more immunizations. The letters request the providers outreach those members and provide the child with the missing immunizations.
- **Missed Opportunities Report:** UHCCP recognizes the benefits of child and adolescent annual well-care visits, as indicated in the American Academy of Pediatrics’ (AAP’s) comprehensive health guidelines for well-child care. Benefits include: obtaining scheduled immunizations to prevent illness; ensuring the child reaches age-appropriate milestones physically and mentally; ongoing dialogue with the provider about the child’s growth and development; and creation of a strong, trustworthy relationship between the provider and parent. UHCCP has found that contracted providers who are doing well on child and adolescent well-care visit measures have implemented processes in their practices to incorporate annual well-care visits with sick visits. In an effort to increase well-care visit rates for children and adolescents, UHCCP is encouraging all providers to take the opportunity to turn sick visits into annual well-care visits whenever possible.

During monthly meetings between clinical practice consultants (CPCs) and providers, provider-specific “Missed Opportunities” reports are shared with the provider and/or staff members. The report identifies children and adolescent members in the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* or *Adolescent Well-Care Visits* measures that had one or more sick

visits with the provider, but have not had an annual well-care visit. The reports also include members' addresses and phone numbers so providers can utilize the report to outreach members. When sharing the "Missed Opportunities" report, the CPCs may also take the opportunity to engage in the following types of discussions with providers and/or staff members:

- CPCs may provide an overview of the two mentioned measures to providers and/or staff members if they are not familiar with the measures.
 - Talk about challenges associated with getting children and adolescents in for annual well-care visits.
 - Discuss how providers can turn sick/other visits into annual well-care visits and how they can use the visit as an opportunity to close these gaps.
 - Conversations about challenges practices may have with turning sick visits into well-care visits. CPCs may explain to providers that UHCCP-contracted providers who are doing well on getting these measures closed are doing so because they have managed to figure out a process of turning sick visits into annual wellness visits and have implemented it in their practices.
 - For providers who are not in an ACO or participating in the Community Plan Primary Care Physician Incentive (CP-PCPi) program, the CPCs may show them their missed opportunities and provide an explanation of the potential financial incentives associated with these measures with participation in the CP-PCPi program.
 - For providers participating in the CP-PCPi program, the CPCs may compare the report to the providers' scorecards to show how the missed opportunities translated into missed financial incentives.
 - For ACO providers, they may check their Value-Based Care (VBC) performance measures to see how these missed opportunities translate into dollars and cents.
 - The CPCs may ask providers that do not have a lot of members on the "Missed Opportunities" report and/or have high child and adolescent annual well-care visit measure rates, what they are doing to be successful in these measures.
- Well Child—Six Visits by 15 Months of Age: From CYE 2015 through CYE 2017, UHCCP's performance on the *Well-Child Visits in the First 15 Months of Life* measure was below the AHCCCS MPS. As a result, UHCCP implemented a series of interventions in CYE 2017 and CYE 2018 designed to improve the rate. As a result of a review of the interventions in 2018, the following were also implemented:
 1. Member-based:
 - A letter to guardians of members 13 and 14 months of age missing one or more immunizations, listing the missing immunizations and encouraging the guardian to schedule a well-child visit.
 - Live calls to guardians of 13-month-olds encouraging a well-child visit and to address missing immunizations.
 2. Provider-based:
 - Provider letter listing members 13 and 14 months of age in need of immunizations.
 - Provider letter listing 12-month-olds residing in "high-risk" locations for blood lead poisoning and to assist with scheduling a well-child visit.

Comprehensive Medical and Dental Program (CMDP)

- **Adolescent Well-Visit Engagement:** CMDP reported that NCQA collected and published national statistics showing a mean *Adolescent Well-Care Visit* measure rate of 53 percent for Medicaid populations in 2017, and that the mean for all Arizona Medicaid health plan participation in 2016 was 39.2 percent and the Arizona MPS of 41 percent. In the last quarter of 2018, CMDP reported receiving adolescent well-care visit claims for 65 percent of children in foster care between ages 12 and 17 years with continuous enrollment, well above both national and state reports. CMDP aims to have all adolescents in Arizona foster care, without a verified adolescent well-visit through CMDP claims data, receive an intervention to educate on preventive health literacy and improve well-visit participation.
- CMDP plans to increase adolescent well-care visit services engaged by current adolescent CMDP members through telephonic outreach to caregivers and adolescents. Further, CMDP expects the telephonic outreach to enhance caregiver and adolescent preventive health literacy by including educative information during the process. Research and observations made during the project will lead to enhancements to adolescent well-visit engagement and other member outreach activities conducted by CMDP.
- **Onboarding of New Members (Children into Care):** The onboarding of new members aims to provide customer service to the caregiver to assist with timely preventive medical and dental appointments for children in care. The service provided includes support in meeting the information and resource needs, so caregivers can navigate the health and DCS systems for optimal advocacy and engagement in the services required of DCS membership. During the caregiver outreach calls, CMDP onboarding unit (OBU) staff members assist with PCP and primary dental provider searches. Appointments with those providers can be set up through the OBU staff members as well. As a result, the rate of preventive care visits being accessed will increase, which CMDP reports is in alignment with the AAP healthcare standards for children and teens in foster care.
- **PCP Psychotropic Oversight Initiative:** PCPs may elect to treat CMDP youth for uncomplicated attention-deficit/hyperactivity disorder (ADHD), depression, or anxiety disorders. It is essential for PCPs to be aware that all CMDP youth have experienced trauma, which may result in severe behavioral symptoms. At times, behaviors that develop as a result of underlying trauma can cause diagnostic confusion and lead to inaccurate diagnoses including ADHD, depression, and/or anxiety disorders. Inaccurate diagnoses may result in unnecessary treatment and poor outcomes. For youth with a history of trauma, comprehensive treatment is essential and usually requires psychosocial interventions.
- CMDP reported that it is considered best practice for children less than 6 years of age that the use of psychosocial interventions be employed prior to the initiation of medication; therefore, CMDP requires that a prior authorization request be submitted to the pharmacy benefit management (PBM) for all members under the age of 6 years. The practice will allow for early and consistent care coordination between the providers, the child's custodial agency representative (DCS specialist), and the RBHA.

6. Network Adequacy Update

Beginning in CYE 2019, AHCCCS contracted its EQRO, HSAG, to support the validation and analysis of healthcare provider networks subcontracted to AHCCCS’ ACC Contractors.⁶⁻¹ HSAG’s analysis of network adequacy considers each ACC Contractor’s compliance with 11 AHCCCS-established time/distance standards for specific provider types and populations.⁶⁻²

Each quarter, each ACC Contractor submits its contracted network to AHCCCS along with its internal assessment of compliance with the applicable standards. This report presents quarterly analytic results for the October 1, 2018, through June 30, 2019, measurement period for all beneficiary coverage areas for each ACC Contractor.

In addition to the activities conducted by HSAG to validate the ACC Contractors’ compliance with time/distance standards, AHCCCS measures network adequacy through a number of other mechanisms, as outlined in Appendix C.

Table 6-1 presents the total AHCCCS ACC beneficiary enrollment for each county as of July 1, 2019 (i.e., the day after the end of the CYE 2019 Quarter 3 measurement period). The total numbers represent all Contractors with ACC beneficiaries residing in the county.

Table 6-1—AHCCCS’ ACC Beneficiary Enrollment by County, as of July 1, 2019

County	ACC Beneficiary Enrollment
Apache	6,116
Cochise	34,651
Coconino	20,046
Gila	10,585
Graham and Greenlee ⁶⁻³	10,567
La Paz	4,166
Maricopa	881,001
Mohave	57,665

⁶⁻¹ Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While CMS released updated EQR protocols in October 2019, a validation of network adequacy protocol has not yet been released as of the publication of this report. However, HSAG’s analysis of the Contractors’ time/distance results aligns with current federal regulations.

⁶⁻² The AHCCCS Contractors Operations Manual (ACOM), Section 436—Network Standards defines time/distance standards, as well as provider identification and beneficiaries’ county assignment criteria. Available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.

⁶⁻³ Due to Health Insurance Portability and Accountability Act (HIPAA) requirements, enrollment data reported for Graham and Greenlee counties have been combined.

County	ACC Beneficiary Enrollment
Navajo	20,090
Pima	228,164
Pinal	58,325
Santa Cruz	19,350
Yavapai	41,481
Yuma	73,622

Table 6-2 presents the counts of ACC Contractors’ provider locations identified for each time/distance network standard for CYE 2019 Quarter 3 (i.e., the April 1, 2019, through June 30, 2019, measurement period).

Table 6-2—Summary of ACC Provider Locations by Time/Distance Network Standard and Contractor, Quarter 3

Minimum Network Requirement	Count of AzCH-ACC Provider Locations	Count of BUFC-ACC Provider Locations	Count of Care1st-ACC Provider Locations	Count of Magellan-ACC Provider Locations	Count of MC-ACC Provider Locations	Count of SHCA-ACC Provider Locations	Count of UHCCP-ACC Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Adult	592	417	398	404	405	354	445
Behavioral Health Outpatient and Integrated Clinic, Pediatric	592	417	398	404	405	354	445
Behavioral Health Residential Facility (Only Maricopa and Pima Counties)	190	167	218	293	189	181	169
Cardiologist, Adult	1,596	1,393	1,226	335	1,700	1,464	2,090
Cardiologist, Pediatric	1,775	1,538	1,381	407	1,883	1,842	2,283
Dentist, Pediatric	1,551	2,166	2,059	1,620	472	1,863	1,494
Hospital	111	162	79	79	112	157	133
OB/GYN	1,515	1,388	1,459	365	2,226	2,156	3,783
Pharmacy	1,041	850	624	1,045	972	1,205	773
PCP, Adult	24,911	18,170	11,062	6,787	25,916	18,360	48,209
PCP, Pediatric	19,333	14,334	8,317	7,147	20,924	14,979	39,341

HSAG reviewed the ACC Contractors quarterly on 11 time/distance network standards applicable to the ACC line of business; each ACC Contractor may serve a different geographic region in Arizona. All ACC Contractors met the minimum time/distance network requirements in each quarter for the following standards:

- Cardiologist, Pediatric
- OB/GYN
- PCP, Adult

Additionally, the applicable ACC Contractors met all minimum time/distance network standards during all quarters in Cochise, Graham, Mohave, Santa Cruz, Yavapai, and Yuma counties.

Isolated data issues may have contributed to specific instances impacting ACC Contractors' compliance with time/distance standards. Specific examples include the following:

- AzCH-ACC's failure to meet the minimum time/distance standard for hospitals in Greenlee County occurred only during Quarter 1 and was determined to be the result of a data omission from the Contractor's Provider Affiliation Transmission (PAT) file.
- Magellan-ACC's failure to meet the minimum time/distance standards for Dentist, Pediatric, and Pharmacy was limited to Quarter 2 and resulted from an issue in Magellan-ACC's internal programming updates for the PAT file.
- Starting in Quarter 3, SHCA-ACC identified additional pharmacies in its network that were not considered in the Quarter 1 and Quarter 2 PAT data files, significantly increasing the number of pharmacies in its network and impacting SHCA-ACC's Quarter 3 time and distance compliance.

Based on the quarterly NAV results, MC-ACC met the minimum requirements in each quarter for all 11 network standards applicable to the ACC line of business. Additionally, UHCCP-ACC met all applicable network standards during Quarter 2 and Magellan-ACC met all applicable network standards during Quarter 3. Note that ACC coverage for Magellan-ACC and MC-ACC is limited to the Central Region (i.e., Gila, Maricopa, and Pinal counties), where provider networks are typically robust due to the Phoenix metropolitan area and key cities serving surrounding rural areas (e.g., Casa Grande, Florence, Globe, Maricopa, and Payson). Refer to Appendix B for results by ACC Contractor, quarter, and county.

More than one ACC Contractor failed to meet standards for at least one quarter and/or county, and ACC Contractors most commonly struggled to meet the following minimum time/distance network standards:

- Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County
- Behavioral Health Outpatient and Integrated Clinic, Pediatric in Apache County
- Dentist, Pediatric in Apache, Coconino, and La Paz counties
- Pharmacy in Apache County

Finally, all AHCCCS Contractors are required by state law to only contract with AHCCCS-registered providers. Saturation analyses considered the degree to which each ACC Contractor's provider networks reflect available AHCCCS-registered providers when the ACC Contractor was not in compliance with time/distance standards. Following each quarterly NAV, HSAG conducted saturation analyses specific to the ACC Contractor(s) and counties that failed to meet minimum network standards.

As part of the NAV implementation, AHCCCS developed a feedback process for ACC Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each ACC Contractor with a copy of HSAG's quarterly analysis of their network adequacy, the saturation analysis identifying AHCCCS registered providers that could improve their compliance with network standards, a file of provider addresses that could not be mapped under USPS CASS standards, and a copy of the PAT file that HSAG used to conduct the analysis. AHCCCS expected ACC Contractors to research instances in which the Contractor's ACOM 436 reporting and HSAG's validation lead to different conclusions regarding compliance with AHCCCS' standards. If an ACC Contractor determined that the differences resulted from its data processing errors, they were expected to make corrections for future PAT data and/or ACOM 436 submissions.

7. Organizational Assessment and Structure Performance

In accordance with 42 CFR §438.358, which describes activities related to EQR, a state Medicaid agency; its agent that is not an MCO, PIHP, PAHP, or PCCM entity; or an EQRO must conduct a review within the previous three-year period to determine the Contractor's compliance with state standards set forth in subpart D of 42 CFR §438 and the QAPI requirements described in 42 CFR §438.330. AHCCCS meets the requirement by conducting ORs of its Contractors' performance in complying with federal and AHCCCS' contract requirements, ensuring that it reviews each requirement at least once every three years.

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' compliance with federal and AHCCCS contractual requirements. As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the activities associated with the federal Medicaid managed care mandatory compliance reviews. In accordance with and satisfying the requirements of 42 CFR §438.364, AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

Conducting the Review

AHCCCS conducted a comprehensive OR for CMDP in CYE 2019. Details regarding the standard areas reviewed for CMDP are included in the findings.

For details on the review objectives, methodologies for conducting the review and for scoring, and criteria for requiring the Contractor to submit CAPs, please see Appendix A. Validation of Organizational Assessment and Structure Performance Methodology.

Standards

The CYE 2019 OR was organized into 11 standard areas. For CMDP, each standard area consists of several standards designed to measure the Contractor's performance and compliance. The following are the standard areas and number of standards involved in each standard area:

- Corporate Compliance (CC), five standards
- Claims and Information Systems (CIS), 10 standards
- Delivery Systems (DS), 10 applicable standards
- General Administration (GA), three standards
- Grievance Systems (GS), 17 applicable standards
- Adult, EPSDT, and Maternal Child Health (MCH), 14 applicable standards
- Medical Management (MM), 24 applicable standards

- Member Information (MI), 8 applicable standards
- Quality Management (QM), 18 applicable standards
- Reinsurance (RI), four standards
- Third-Party Liability (TPL), seven applicable standards

Contractor-Specific Results

For the CYE 2019 review cycle, AHCCCS conducted an OR for 11 standard areas in CYE 2019 for CMDP. CMDP’s results are presented below.

Comprehensive Medical and Dental Program (CMDP)

AHCCCS conducted an on-site review of CMDP from July 15, 2019, through July 17, 2019, and July 22, 2019. A copy of the draft version of the report was provided to the Contractor on August 28, 2019. CMDP was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the three-year review cycle, AHCCCS conducted a comprehensive OR considering 11 standard areas in CYE 2019. Table 7-1 presents the total number of standards; the standard area scores; and the total number, if any, of standards with required corrective actions for each standard area reviewed.

Table 7-1 presents compliance results for the 11 standard areas reviewed for the CMDP OR.

Table 7-1—Standard Areas and Compliance Scores for CMDP

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards with Required Corrective Actions
Corporate Compliance (5)	460/500	92%	1
Claims and Information Systems (10)	906/1,000	91%	3
Delivery Systems (10)	946/1,000	95%	2
General Administration (3)	267/300	89%	1
Grievance Systems (17)	1,157/1,700	68%	9
Adult, EPSDT, and Maternal Child Health (14)	1,058/1,400	76%	9
Medical Management (24)	2,047/2,400	85%	9

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards with Required Corrective Actions
Member Information (8)	625/800	78%	4
Quality Management (18)**	1,121/1,800	62%	12
Reinsurance (4)	400/400	100%	0
Third Party Liability (7)	600/700	86%	1

*Standard area scores, maximum possible scores, and standard area percentage scores were provided by AHCCCS.

**QM standard 3 was not scored; however, AHCCCS used the feedback from the interviews to assess overall program compliance (e.g., to supplement findings in other QM standards) as well as identify opportunities for improvement and/or best practices for the Contractor.

Strengths for CMDP

For this OR, AHCCCS reviewed a total of 11 standard areas. For two of those, CMDP achieved either full compliance or compliance. CMDP was fully compliant (100 percent compliance score) in the RI standard area. CMDP also demonstrated strong performance in the DS standard area, with a compliance score of 95 percent.

Although it did not meet full compliance, CMDP met the 95 percent threshold established by AHCCCS for the DS standard area, which included the following requirements: CMDP determines, monitors, and adjusts the number of members assigned to each PCP; and CMDP has a process for collecting, maintaining, updating, and reporting accurate demographic information on its provider network.

Opportunities for Improvement and Required Actions for CMDP

The results of the OR demonstrated opportunities for improvement as CMDP received 51 required corrective actions for 10 standard areas. CMDP was less than compliant in nine of the 11 standard areas reviewed (CC, CIS, GA, GS, MCH, MM, MI, QM, and TPL), and although having met compliance for one other standard area (DS), CMDP received required actions within this standard area.

For the CC standard area, CMDP did not adequately demonstrate that it collected information regarding ownership and control of any managing employees.

AHCCCS also found discrepancies in the CIS standard area related to applicable interest payments on all claims quick pay discounts to claims, and timely processes and payments on all overturned claim disputes.

For the GA standard area, AHCCCS determined that the documentation CMDP submitted did not clearly demonstrate that all policies/procedures are reviewed annually.

CMDP did not fully demonstrate compliance with all standards in the GS standard area. AHCCCS found the following issues related to requirements for:

- Time frame extensions.
- Continuation or reinstatement of benefits.
- Notices of appeal resolution.
- Authorization or provision of services as expeditiously as the member's condition requires.
- Recovery of the cost of services.
- Notification of member appeal rights.
- Time frame and notice requirements for hearing requests.
- Policies delineating the grievance system.

AHCCCS found several deficiencies in the MCH standard area, related to: EPSDT, women's preventive, and maternal and child programs and services; oral and dental services; inter-agency coordination; and perinatal and postpartum depression screenings. AHCCCS also found several discrepancies in the MM standard area involving requirements for the following:

- The concurrent review process
- Post-discharge follow-up appointments
- Inter-rater reliability (IRR) testing
- Drug utilization review
- Referrals to providers specialized in diagnosing autism
- Notices of adverse benefits determination
- Assignment to exclusive pharmacy and/or single prescribers
- Care management for opioid use disorders
- End-of-life care and advanced care planning

For the MI standard area, AHCCCS found deficiencies related to requirements for: training member service representatives to handle and track member inquiries and grievances, timely notices on terminated contract providers, member letter distribution, and training materials on the utilization of mapping services and/or applications.

CMDP received the lowest compliance score (62 percent) for the QM standard area. CMDP did not demonstrate adequate compliance with requirements related to the following:

- QOC processes, analyses, and monitoring
- QM and performance improvement program administration
- Policy reviews and revisions
- Peer reviews
- Credentialing, recredentialing, and provisional credentialing of providers
- Implementation of internal corrective actions

- Data collection
- Utilizing standard performance measures specific to QM/PI program activities
- Implementation of substance use and suicide interventions

Although AHCCCS did not score QM, element 3, AHCCCS required CMDP to complete action items related to contract, policy, and program requirements of the QM Program and work processes to support compliance that were not otherwise addressed in other QM elements.

AHCCCS noted for the TPL standard area, CMDP lacked documentation regarding member insurance updates. Although, overall, CMDP met compliance in the DS standard area, AHCCCS determined that CMDP's provider manual did not comply with all time frame and content requirements.

Recommendations for CMDP

Based on the results from the CYE 2019 OR, HSAG makes the following general recommendations to CMDP regarding ORs:

- CMDP should continue to conduct internal reviews of operational systems to identify barriers that affect compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations. In addition, CMDP should ensure that current policies and documents include adequate details of its processes.
- CMDP should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes and implement periodic assessments of those standards reviewed by AHCCCS for which CMDP was found deficient.
- CMDP should request technical assistance meetings with AHCCCS on areas of deficient knowledge and processes.

Appendix A. Validation of Organizational Assessment and Structure Performance Methodology

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.

Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR 438.364.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts formal reviews on a schedule that ensures it reviews all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.^{A-1}

AHCCCS' methodology for conducting the OR included the following:

- Reviewing activities that AHCCCS conducted to assess the Contractor's performance
- Reviewing documents and deliverables that the Contractor was required to submit to AHCCCS
- Conducting interviews with key Contractor administrative and program staff

^{A-1} Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf>. Accessed on: February 14, 2019.

AHCCCS conducted activities following the review that included documenting and compiling the results of the review, preparing the draft report of findings, and issuing the draft report to the Contractor for review and comment. In the report, each standard area and standard was individually listed with applicable performance designations based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standard areas.

AHCCCS' review team members included employees of the Division of Health Care Management (DHCM) in Medical and Case Management, Operations, Clinical Quality Management, and Finance and Reinsurance; the Division of Budget and Finance (DBF); Office of Administrative Legal Services; and Office of the Inspector General (OIG).

As needed throughout the preparation of this report, AHCCCS clarified any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this section of the EQR report.

Using the verified results that AHCCCS obtained from conducting the OR, HSAG organized and aggregated the performance data for each Contractor. HSAG then analyzed the data by performance category (e.g., Quality Management).

Based on its analysis, HSAG identified strengths and opportunities for improvement for each Contractor. When HSAG identified opportunities for improvement, HSAG also included the associated AHCCCS recommendations to further improve the quality and timeliness of, and access to, the care and services each Contractor provided to AHCCCS members.

Scoring Methodology

Each standard area consists of several standards designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured in the CYE 2019 OR. Within each standard are specific scoring detail criteria worth defined percentages of the standard's total possible score.

AHCCCS includes the percentages awarded for each scoring detail in the standard's total score. Using the sum of all applicable standard total scores, AHCCCS then develops an overall standard area score. In addition, a standard is scored *Not Applicable (N/A)* if it does not apply to the Contractor and/or no instances exist in which the requirement is applied.

Corrective Action Statements

As part of the AHCCCS methodology, each Contractor receives a report containing review findings. The Contractor has the opportunity to respond to AHCCCS concerning any disagreement related to the findings. AHCCCS reviews and responds to any Contractor disagreements based on review of the

Contractor information, and then revises the report if necessary. AHCCCS issues the final report to the Contractor, describing the findings, scores, and required CAPs.

Contractors must complete a CAP for any standard for which the total score is less than 95 percent. The report, based on the review and the findings, may contain one of the three following statements:

- *The Contractor must* This statement indicates a critical noncompliant area that must be corrected as soon as possible to comply with the AHCCCS contract.
- *The Contractor should* This statement indicates a noncompliant area that must be corrected to comply with the AHCCCS contract but is not critical to the day-to-day operation of the Contractor.
- *The Contractor should consider* This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.

Appendix B. Network Adequacy Validation Methodology and Detailed Results

HSAG used data supplied by AHCCCS to calculate the number and percent of ACC beneficiaries within a defined time or distance from 11 types of AHCCCS-defined providers. As Table B-1 describes, these time/distance standards vary by provider type and county, and some standards may not apply to every Contractor.

Table B-1—Time/Distance Network Standards for AHCCCS Contractors by Provider Type and Geography

Provider Type	Beneficiary Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
Behavioral Health Outpatient and Integrated Clinic, Adult	Beneficiaries aged 18 years and older	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 60 miles
Behavioral Health Outpatient and Integrated Clinic, Pediatric	Beneficiaries younger than 18 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 60 miles
Behavioral Health Residential Facility ¹	All beneficiaries	90 percent of beneficiaries within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult	Beneficiaries aged 21 years and older	90 percent of beneficiaries within 30 minutes or 20 miles	90 percent of beneficiaries within 75 minutes or 60 miles
Cardiologist, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 60 minutes or 45 miles	90 percent of beneficiaries within 110 minutes or 100 miles
Dentist, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles
Hospital	All beneficiaries	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 95 minutes or 85 miles
Obstetrics/Gynecology (OB/GYN)	Female beneficiaries aged 15 to 45 years	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 90 minutes or 75 miles
Pharmacy	All beneficiaries	90 percent of beneficiaries within 12 minutes or 8 miles	90 percent of beneficiaries within 40 minutes or 30 miles
PCP, Adult	Beneficiaries aged 21 years and older	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles
PCP, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles

1. Applies only to Maricopa and Pima counties.

Data Sources

For each quarterly measurement period, AHCCCS supplied HSAG with the following data files:

1. Prepaid Medical Management Information System (PMMIS) provider data—data files maintained by AHCCCS that list all AHCCCS-registered providers and their corresponding addresses.

2. AHCCCS beneficiary data—a data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data.
 - a. PMMIS data elements include the addresses and pertinent demographic information for AHCCCS beneficiaries.^{B-1}
 - b. CATS data elements identify AHCCCS beneficiaries that live in their own home, for calculation of the Nursing Facility time/distance standard applicable to the Arizona Long Term Care System - Elderly and Physically Disabled (ALTCS E/PD) line of business.
3. Provider Affiliation Transmission (PAT) file—a data file listing each Contractor’s contracted providers.
4. AHCCCS Contractor Operations Manual Policy 436 (ACOM 436) submission—a Microsoft (MS) Excel workbook with a tab listing the quarterly results for compliance with county-level time/distance standards.

Table B-2 shows the effective dates for the data files supplied to HSAG in each quarter.

Table B-2—Effective Dates for AHCCCS-Supplied Network Adequacy Data by Quarter and Data Type

Data Source	Quarter One	Quarter Two	Quarter Three
Measurement Period	October 1, 2018– December 31, 2018	January 1, 2019– March 31, 2019	April 1, 2019– June 30, 2019
PMMIS Providers	Data as of January 16, 2019	Data as of April 24, 2019	Data as of July 17, 2019
AHCCCS Beneficiaries	Active Enrollment as of January 1, 2019	Active Enrollment as of April 1, 2019	Active Enrollment as of July 1, 2019
Contractor-Specific PAT Providers	Submitted to AHCCCS in January 2019	Submitted to AHCCCS in April 2019	Submitted to AHCCCS in July 2019
Contractor-Specific ACOM 436 Submissions	Submitted to AHCCCS in January 2019	Submitted to AHCCCS in April 2019	Submitted to AHCCCS in July 2019

Study Indicators

The quarterly, Contractor-specific analysis of network adequacy includes study indicators from three analytic domains:

^{B-1} Prior to conducting analyses, HSAG assigned beneficiaries to counties consistent with AHCCCS’ ACOM 436 requirements, including county reassignments for beneficiaries residing in the following AHCCCS-specific ZIP codes, updated May 2019: beneficiaries residing in ZIP codes 85120, 85140, 85142, 85143, and 85190 are assigned to Maricopa County; beneficiaries residing in ZIP code 85135 are assigned to Gila County; and beneficiaries residing in ZIP codes 85542, 85192, and 85550 are assigned to Graham County.

1. **Time/Distance Calculation:** HSAG’s calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, line of business, and county, using beneficiary and PAT data.
 - Study indicators show the percent of beneficiaries assigned by AHCCCS to the specified county, with access to any provider serving the line of business within the time/distance standard.
2. **Time/Distance Validation:** Validation of each Contractor’s compliance with the time/distance standards, based on HSAG’s time/distance calculation results from #1 above.
 - Study indicators validate each Contractor’s reported compliance with each time/distance standard applicable to the line of business and county.
 - A score of “*met*” indicates that HSAG’s time/distance results show a percentage of beneficiaries at or above the time/distance standard.
 - A score of “*not met*” indicates that HSAG’s time/distance results show a percentage of beneficiaries below the time/distance standard.
 - The value “*NA*” identifies standards not applicable to the line of business and/or geography.
 - The value “*NR*” identifies standards for which no beneficiaries met the network requirement denominator for the line of business and geography; therefore, HSAG calculated no corresponding time/distance result.
 - An asterisk (*) identifies standards with fewer than five beneficiaries included in HSAG’s time/distance calculation results.
 - Study indicators also consider the degree to which HSAG’s time/distance results align with the time/distance values reported in each Contractor’s ACOM 436 submission.
 - Shaded cells in the Findings tables identify notable differences between each Contractor’s ACOM 436 time/distance calculation results and HSAG’s results.
3. **Provider Saturation Analysis:** HSAG’s assessment of the degree to which each Contractor’s provider network reflects available AHCCCS-contracted providers.
 - Study indicators include the number of AHCCCS-contracted providers not reflected in each Contractor’s quarterly PAT file for each applicable time/distance standard scored as “*not met*”.

Analytic Process

HSAG used the Quest Analytics Suite software, version 2019.1 (Quest) to geocode the PAT and PMMIS addresses for beneficiaries and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized beneficiary and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files.

HSAG assembled the geocoded beneficiary (PMMIS) and provider (PAT) addresses into datasets that were used with Quest to calculate the percentage of beneficiaries meeting the time/distance standards described in Table B-1. Quarterly county-specific time/distance calculations were conducted separately for each line of business and excluded less than 1 percent of beneficiaries and providers with addresses that could not be geocoded or were geocoded to non-neighboring states. HSAG’s time/distance

calculations considered the driving time/distance between a beneficiary and the nearest provider (i.e., the time or distance for the beneficiary to reach the provider using established roadways). Driving time calculations assumed 30 miles per hour (MPH) for Maricopa and Pima counties and 55 MPH for all other counties.

To assess the validity of each Contractor’s quarterly ACOM 436 submission, HSAG compared the time/distance results calculated from the PMMIS and PAT data against the quarterly ACOM 436 time/distance results submitted to AHCCCS by each Contractor.

Quarterly analyses reflect the following measurement periods:

- Quarter One: October 1, 2018–December 31, 2018
- Quarter Two: January 1, 2019–March 31, 2019
- Quarter Three: April 1, 2019–June 30, 2019

AHCCCS does not define the software or process by which each ACC Contractor calculates the quarterly ACOM 436 time/distance results. As described above, HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result from the Contractors’ use of different versions of Quest. Table B-3 describes each ACC Contractor’s self-reported methods for calculating the ACOM 436 results, as of January 2019.

Table B-3—AHCCCS Contractors’ ACOM 436 Calculation Methods

Contractor	ACOM 436 Calculation Method
AzCH-ACC	Uses Quest to calculate time/distance results based on driving distances.
BUFC-ACC	Uses Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).
Care1st-ACC	Uses Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).
Magellan-ACC	Uses Quest to calculate time/distance results based on driving distances.
MC-ACC	Uses Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).
SHCA-ACC	Uses ArcMap application within Esri ArcGIS Desktop software, as well as MS Excel to calculate time/distance results based on driving distance.
UHCCP-ACC	Uses GeoNetworks and Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).

AHCCCS beneficiaries may seek care from network providers practicing outside of the beneficiary’s county of residence. As such, HSAG considered all applicable providers within a line of business when calculating time/distance results.

The tables below present quarterly validation findings specific to the ACC line of business, with one results table for each of the following counties by region:

- Central Region: Gila, Maricopa, Pinal
- North Region: Apache, Coconino, Mohave, Navajo, Yavapai
- South Region: Cochise, Graham,^{B-2} Greenlee, La Paz, Pima, Santa Cruz, Yuma

Each county-specific table summarizes quarterly validation results containing the percent of beneficiaries meeting each time/distance standard by quarter and Contractor, with color-coding to identify whether the time/distance standard was “met” or “not met”. The value, “NA,” is shown for time/distance standards that do not apply to the county or ACC line of business. The value, “NR,” is shown for time/distance standards in which no beneficiaries met the network requirement denominator for the ACC line of business and county; therefore, HSAG calculated no corresponding time/distance result.

^{B-2} Graham County includes the 85542, 85192, and 85550 ZIP codes representing the San Carlos Tribal area; these ZIP codes are physically located in Gila or Pinal County.

Central Region: Gila, Maricopa, and Pinal Counties

Table B-4—ACC Time/Distance Validation Results for Gila County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC			Care1st-ACC			Magellan-ACC ^{B-3}			MC-ACC			Steward			UHCCP			
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	98.6	97.6	99.6	99.7	99.6	100.0	100.0	100.0	100.0	0.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	53.1
Hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	100.0	100.0	100.0	100.0	98.8	98.8	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

^{B-3} As a result of the validation process, Magellan-ACC indicated it reprogrammed its PAT file generation process for the Quarter 2 submission, and errors with the updated program resulted in the failure to include applicable providers in the PAT file, negatively affecting the Quarter 2 validation results.

Table B-5—ACC Time/Distance Validation Results for Maricopa County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC			Care1st-ACC			MCC-ACC ^{B-4}			MC-ACC			SHCA-ACC			UHCCP-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	95.7	98.1	98.2	98.4	98.6	98.7	98.3	98.9	98.8	92.4	98.4	98.9	97.2	97.3	97.2	98.3	98.3	98.7	93.6	98.4	98.5
Behavioral Health Outpatient and Integrated Clinic, Pediatric	95.6	98.4	98.4	98.7	98.8	98.8	98.7	99.1	99.1	92.0	98.5	98.8	97.3	97.3	97.2	98.6	98.6	99.0	93.7	98.4	98.6
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	98.7	99.0	99.0	98.5	98.8	98.9	98.9	99.0	99.0	28.0	99.0	99.3	99.0	99.1	99.1	97.3	98.1	98.1	98.5	98.7	98.5
Cardiologist, Adult	99.9	99.9	99.7	100.0	100.0	100.0	100.0	99.8	99.8	99.5	100.0	99.8	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	99.5	99.5	99.4	99.3	99.5	99.2	99.4	99.5	99.4	99.4	0.0	99.6	99.4	99.4	99.3	99.5	99.5	99.6	99.5	99.5	99.3
Hospital	99.9	99.9	99.9	99.9	99.8	99.8	99.8	99.8	99.8	99.9	99.9	99.9	99.9	99.9	99.9	100.0	100.0	99.9	99.9	99.9	99.9
Obstetrics/Gynecology (OB/GYN)	100.0	99.9	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	99.9	99.9	99.9	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.4	99.4	99.4	99.2	99.3	99.3	99.1	99.1	99.1	99.5	19.6	99.2	99.4	99.4	99.3	99.0	99.0	99.3	99.2	99.2	99.2
PCP, Adult	99.7	99.7	99.7	99.6	99.7	99.7	99.7	99.7	99.7	99.8	99.6	99.6	99.7	99.7	99.7	99.7	99.7	99.7	99.8	99.8	99.8
PCP, Pediatric	99.7	99.7	99.7	99.6	99.7	99.6	99.7	99.7	99.7	99.9	99.7	99.5	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.7

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

^{B-4} As a result of the validation process, MCC-ACC indicated it reprogrammed its PAT file generation process for the Quarter 2 submission, and errors with the updated program resulted in the failure to include applicable providers in the PAT file, negatively affecting the Quarter 2 validation results.

Table B-6—ACC Time/Distance Validation Results for Pinal County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC			Care1st-ACC			Magellan-ACC ^{B-5}			MC-ACC			SHCA-ACC			UHCCP-ACC			
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	98.7	0.0	99.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	81.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.


^{B-5} As a result of the validation process, Magellan-ACC indicated it reprogrammed its PAT file generation process for the Quarter 2 submission, and errors with the updated program resulted in the failure to include applicable providers in the PAT file, negatively affecting the Quarter 2 validation results.

North Region: Apache, Coconino, Mohave, Navajo, and Yavapai Counties

Table B-7—ACC Time/Distance Validation Results for Apache County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	Care1st-ACC			SHCA-ACC ^{B-6}		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	78.8	78.7	78.3	82.9	84.5	84.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	70.4	72.1	72.4	84.1	86.0	87.6
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	92.7	93.9	92.5	94.3	94.4	94.8
Cardiologist, Pediatric	99.6	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	66.8	69.2	65.4	83.3	83.4	83.5
Hospital	100.0	100.0	100.0	100.0	99.9	100.0
Obstetrics/Gynecology (OB/GYN)	97.1	97.3	96.3	100.0	100.0	100.0
Pharmacy	70.0	70.4	69.4	78.7	80.1	87.2
PCP, Adult	91.9	91.9	91.0	97.2	99.2	97.5
PCP, Pediatric	90.0	89.7	88.0	98.1	99.1	98.5

 Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

 Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.


NA indicates results are not applicable to the county.

^{B-6} In Quarter 3, SHCA-ACC identified additional pharmacies in its network that were not considered during Quarter 1 and Quarter 2, significantly increasing the number of pharmacies in its network and impacting the Contractor's time and distance compliance during Quarter 3.

Table B-8—ACC Time/Distance Validation Results for Coconino County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	Care1st-ACC			SHCA-ACC ^{B-7}		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	99.4	99.5	99.9	100.0	98.5	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	98.6	99.2	99.8	100.0	97.8	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	99.8	99.2	99.9	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	83.6	88.2	89.0	88.4	87.8	88.6
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	99.9	100.0	100.0	100.0
Pharmacy	90.7	90.7	90.7	84.7	84.6	89.0
PCP, Adult	96.0	96.5	99.4	99.2	99.5	99.7
PCP, Pediatric	92.4	92.5	92.5	98.7	95.0	98.4

 Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

 Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

^{B-7} In Quarter 3, SHCA-ACC identified additional pharmacies in its network that were not considered during Quarter 1 and Quarter 2, significantly increasing the number of pharmacies in its network and impacting the Contractor's time and distance compliance during Quarter 3.

Table B-9—ACC Time/Distance Validation Results for Mohave County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	Care1st-ACC			SHCA-ACC ^{B-8}		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	99.9	99.9	99.9	99.9	99.9	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	99.9	99.9	99.8	99.9	99.9	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	99.7	99.7	99.7	99.9	99.9	99.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	90.1	92.6	93.2	99.5	99.5	98.2
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	93.0	94.9	99.9	100.0	100.0	100.0
Pharmacy	95.1	95.4	95.6	93.6	93.7	95.2
PCP, Adult	97.3	97.6	97.9	99.9	99.9	99.2
PCP, Pediatric	92.6	93.1	93.9	99.9	99.9	98.1

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.


NA indicates results are not applicable to the county.

^{B-8} In Quarter 3, SHCA-ACC identified additional pharmacies in its network that were not considered during Quarter 1 and Quarter 2, significantly increasing the number of pharmacies in its network and impacting the Contractor's time and distance compliance during Quarter 3.

Table B-10—ACC Time/Distance Validation Results for Navajo County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	Care1st-ACC			SHCA-ACC ^{B-9}		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	96.5	96.8	98.6	98.9	96.7	98.7
Behavioral Health Outpatient and Integrated Clinic, Pediatric	94.4	94.8	98.1	98.9	96.7	98.8
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	97.7	99.5	99.3	99.8	99.1	98.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	96.7	96.1	97.5	97.7	98.2	98.5
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	99.7	100.0	99.8	100.0	100.0	100.0
Pharmacy	92.8	94.8	94.1	89.3	90.2	95.6
PCP, Adult	98.2	98.3	98.2	99.8	99.9	99.9
PCP, Pediatric	97.5	97.7	97.9	98.5	98.6	98.8

 Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

 Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

^{B-9} In Quarter 3, SHCA-ACC identified additional pharmacies in its network that were not considered during Quarter 1 and Quarter 2, significantly increasing the number of pharmacies in its network and impacting the Contractor's time and distance compliance during Quarter 3.

Table B-11—ACC Time/Distance Validation Results for Yavapai County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	Care1st-ACC			SHCA-ACC ^{B-10}		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	99.9	99.9	99.9	99.9	99.9	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	99.9	99.8	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	98.8	98.9	98.9	98.7	98.8	98.8
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	98.5	98.5	98.4	96.6	96.6	98.3
PCP, Adult	99.3	99.3	99.3	100.0	100.0	100.0
PCP, Pediatric	99.6	99.6	99.5	100.0	100.0	100.0

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

^{B-10} In Quarter 3, SHCA-ACC identified additional pharmacies in its network that were not considered during Quarter 1 and Quarter 2, significantly increasing the number of pharmacies in its network and impacting the Contractor's time and distance compliance during Quarter 3.

South Region: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties

Table B-12—ACC Time/Distance Validation Results for Cochise County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility <i>(Only Maricopa and Pima Counties)</i>	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	95.5	95.5	95.5	99.7	99.7	99.6
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.7	99.6	99.6	99.5	99.5	99.5
PCP, Adult	99.7	99.7	99.7	100.0	100.0	100.0
PCP, Pediatric	99.9	99.9	99.9	100.0	100.0	100.0

 Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

Table B-13—ACC Time/Distance Validation Results for Graham County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	99.6	99.8	99.9
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	99.5	99.7	99.8
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	98.7	98.2	98.6	96.3	96.6	95.9
Hospital	98.5	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.0	98.6	99.0	97.9	97.8	97.5
PCP, Adult	99.4	99.2	99.4	99.4	99.5	99.3
PCP, Pediatric	99.0	98.6	99.3	99.1	99.2	99.3


Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

Table B-14—ACC Time/Distance Validation Results for Greenlee County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC ^{B-11}			BUFC-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	99.8	99.8	99.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	62.6	98.7	100.0	100.0
Hospital	0.2	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.4	99.5	99.5	99.3	99.3	99.3
PCP, Adult	99.4	99.7	99.7	99.8	99.8	99.8
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

 Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

 Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

^{B-11} AzCH-ACC’s failure to meet the minimum time/distance standard for hospitals in Greenlee County during Quarter 1 was determined to be a result of a data omission from Contractor’s PAT file.

Table B-15—ACC Time/Distance Validation Results for La Paz County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	66.1	99.9	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	67.2	100.0	99.9	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	81.1	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	79.3	67.0	70.1	67.8	69.4	67.1
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	82.4	92.9	90.3	88.7	93.9	92.4
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.

Table B-16—ACC Time/Distance Validation Results for Pima County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC			UHCCP-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	95.7	97.6	99.3	96.6	97.3	97.3	97.2	96.8	95.3
Behavioral Health Outpatient and Integrated Clinic, Pediatric	96.1	98.0	99.5	96.7	97.4	97.5	97.3	97.0	95.5
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	94.2	94.2	93.9	94.6	94.6	94.5	89.3	91.6	92.1
Cardiologist, Adult	99.4	99.3	99.3	99.5	99.5	99.5	99.8	99.8	99.3
Cardiologist, Pediatric	99.9	99.7	99.7	99.9	99.9	100.0	100.0	100.0	100.0
Dentist, Pediatric	97.1	98.1	98.6	98.6	98.6	98.5	98.6	98.7	98.7
Hospital	99.4	99.6	99.7	99.7	99.7	99.6	99.5	99.4	99.5
Obstetrics/Gynecology (OB/GYN)	99.6	99.7	99.7	99.8	99.8	99.7	100.0	100.0	100.0
Pharmacy	98.4	98.4	98.4	98.4	98.5	98.4	98.1	98.2	98.2
PCP, Adult	99.8	99.8	99.8	99.9	99.9	99.9	99.9	99.9	99.9
PCP, Pediatric	99.7	99.7	99.7	99.9	99.8	99.8	99.9	99.8	99.8

 Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.


 Represents Contractor-reported results that do not meet the compliance standard based on HSAG’s results.

Table B-17—ACC Time/Distance Validation Results for Santa Cruz County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

NA indicates results are not applicable to the county.

Table B-18—ACC Time/Distance Validation Results for Yuma County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	AzCH-ACC			BUFC-ACC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	99.7	99.8	99.8	99.8	99.8	99.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	99.8	99.9	100.0	99.9	99.9	99.9
Behavioral Health Residential Facility (<i>Only Maricopa and Pima Counties</i>)	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	99.9	99.7	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	99.8	99.8	99.9	99.7	99.8	99.7
Hospital	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.7	99.7	99.7	99.7	99.7	99.7
PCP, Adult	99.7	99.7	99.8	99.8	99.7	99.7
PCP, Pediatric	99.8	99.8	99.9	99.8	99.8	99.8

Represents Contractor-reported results that differ from HSAG’s results and meet the compliance standard based on HSAG’s results.

NA indicates results are not applicable to the county.



**2019 AHCCCS NETWORK ADEQUACY
REPORT**

PREPARED BY

DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS





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Purpose

This report outlines the processes the Arizona Health Care Cost Containment System (AHCCCS) uses to ensure contracted Managed Care Organizations (health plans) and state agencies maintain adequate networks to serve Medicaid beneficiaries in Arizona.

The report is designed to address the requirements outlined as mandatory External Quality Review (EQR) activities under 42 CFR 438.358(b)(1)(iv), state monitoring of the availability and accessibility of services through network adequacy standards under 42 CFR 438.66(b)(11), and Arizona's review of the health plans' assurances of adequate capacity of services under 42 CFR 438.207(d).

In this report, AHCCCS describes its program, requirements for contracted health plans and authorized state agencies, the reporting used to ensure network adequacy, how the validity and accuracy of this reporting is ensured, and other work used to ensure Arizonan's have reasonable access to Medicaid services.

Based upon this program and the documentation, AHCCCS assures the Center for Medicare and Medicaid Services (CMS) that its contracted health plans meet the state's requirements for the availability of services as set forth in 42 CFR 438.68 and 438.206.

Program Description

Arizona currently operates under an 1115 Waiver, extended by CMS on September 30, 2016. The extension was approved for a five-year period from October 1, 2016 to September 30, 2021.

AHCCCS administers a wide variety of covered services through its Medicaid program. These services include acute care services, behavioral health services covering general mental health as well as crisis services, services for members determined to have a Serious Mental Illness (SMI), children in the state's foster care program, and long term care and support services for the state's aging and/or physically disabled population, including individuals with developmental disabilities.

For most members¹, services are administered through contracts with health plans, including contracts with two Arizona state agencies.

- **AHCCCS Complete Care (ACC) Contractors** provide integrated care addressing the physical and behavioral health needs for the majority of Title XIX/XXI eligible children and adults. AHCCCS contracts with seven ACC Contractors: Arizona Complete Health-Complete Care Plan, Banner University Family Care, Care1st Health Plan, Magellan Complete Care, Mercy Care, Health Choice of Arizona, and UnitedHealthcare Community Plan. Each ACC Contractor is assigned to serve one or more of three county-based Geographic Service Areas (GSAs).
- **Regional Behavioral Health Authority (RBHA) Contractors** provide integrated physical and behavioral health services to eligible members determined to have a Serious Mental Illness as well as comprehensive behavioral health services to individuals enrolled in CMDP, as outlined below. RBHA Contractors are also responsible for the provision of crisis services to all individuals, including but not limited to, crisis telephone services, mobile crisis teams and crisis stabilization services. AHCCCS contracts with three RBHA Contractors: Arizona Complete Health-Complete Care Plan, Mercy Care and Health Choice of Arizona. Each RBHA Contractor is assigned to serve one of three county-based GSAs.
- **Arizona Long Term Care System Elderly and Physically Disabled (ALTCS E/PD) Contractors** provide long term services and supports and acute physical and behavioral health services to eligible members who are Elderly and/or have a Physical Disability. AHCCCS Contracts with three ALTCS E/PD Contractors: Banner University Family Care, Mercy Care and UnitedHealthcare Community Plan. Each ALTCS E/PD Contractor is assigned to serve one or more three county-based GSAs.

¹ Arizona American Indian members meeting specific criteria may receive services through an MCO, or may choose to receive services through the state-administered fee for service program

- **Arizona Long Term Care System Arizona Department of Economic Security/Division of Developmental Disabilities (ALTCS/DDD)** is a contracted Arizona state agency responsible for providing long term services and supports and acute physical and behavioral health services to eligible members with Intellectual and/or Developmental Disabilities as outlined under Arizona state law. The ALTCS/DDD Contractor directly contracts with providers for long term care services and supports statewide, and subcontracts with two health plans who administer acute physical and behavioral health services to ALTCS/DDD members statewide.
- **Department of Child Safety/Comprehensive Medical and Dental Program (CMDP)** is a contracted Arizona state agency responsible for providing physical health services for children in the custody of the Department of Child Safety (DCS) as outlined under Arizona state law. Current Arizona law allows CMDP members to see any AHCCCS registered provider.

AHCCCS provides oversight of health plans through contracts, policies, and guidance documents.

AHCCCS Contracts are available on the AHCCCS website at the following link:

<https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html>

The AHCCCS Contractor Operations Manual (ACOM) provides information to health plans on their operational responsibilities and requirements under the AHCCCS program. The AHCCCS Medical Policy Manual (AMPM) provides information to health plans and providers regarding the services covered within the AHCCCS program. Both Policy Manuals are available on the AHCCCS website at the following link: <https://www.azahcccs.gov/Resources/GuidesManualsPolicies/>.

In addition, AHCCCS has developed several guidance documents that exist outside of these policies. The primary guidance document related to network adequacy is the AHCCCS Provider Affiliation Transmission (PAT) Manual, found at the Guides, Manuals and Policies page linked above.

Health plans demonstrate compliance with program requirements through the submission of required deliverables. These deliverables are identified in a table within each contract under a section called “Contractor Chart of Deliverables”. The chart defines each deliverable submission requirements, including due date and any associated policy and checklist.

If, as a result of AHCCCS’ review of the deliverable, or if for any other reason a health plan fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose and Administrative Action. Administrative Actions may include the issuance of any or all of the following: Notice of Concern, Notice to Cure, a mandated Corrective Action Plan, or financial sanction. AHCCCS also publishes issued Administrative Actions on its website at:

<https://www.azahcccs.gov/Resources/OversightOfHealthPlans/AdministrativeActions/>

Deliverables Demonstrating Network Adequacy

In order to demonstrate network adequacy, AHCCCS health plans submit a number of deliverables as outlined below:

Provider Network Development and Management Plan (Network Plan) – The Network Plan outlines the health plan’s process to develop, maintain, and monitor an adequate provider network which is supported by written agreements and is sufficient to provide access to all services under their contract. The Network Plan is submitted annually. Its purpose is to ensure sufficient provision of services to members by outlining network activity and performance in the preceding year, as well as proposing a comprehensive plan for the provision of services in the coming year.

The elements of the Network Plan are dictated by a checklist of mandatory elements outlined as part of ACOM Policy 415 (*See Attachment B ACOM 415 Network Plan Checklist*). The checklist is derived from federal and state law and regulations, policy, and AHCCCS initiatives, and is updated on a regular basis. Checklist elements that health plans must include in the Network Plan include, but are not limited to the following:

- A formal attestation of the health plan’s network adequacy,
- An evaluation of the previous contract year’s network plan,
- A description of the current status of the network by service type,
- A description of the health plan’s process for evaluating its network adequacy,
- An evaluation of the previous year’s compliance with AHCCCS network standards
- A review of services provided by out of network providers, and
- A description of the health plan’s approach to community-based providers.

AHCCCS performs a cross agency review by subject matter experts who review the Network Plans and provide feedback on areas within their areas of expertise. The feedback is collected and the Network Plan is either accepted or rejected, requiring resubmission until the Network Plan is accepted.

A key goal of the AHCCCS 2019 review process was to ensure the Network Plans balanced a descriptive outline of health plan’s network management processes with planning for the coming year. As a result, many Network Plans were required to be resubmitted to formally address planning priorities for the coming year, along with measurable goals to determine the Network Plan’s effectiveness.

The Provider Affiliation Transmission (PAT) File – The PAT file is a quarterly electronic submission outlining each health plan’s contracted provider network. The Pat file is used as a source of validating health plan compliance with minimum network requirements, to support review of material change submissions, and to assist in the research of network issues.

Minimum Network Requirements Verification – Each quarter, health plans² are required to submit a completed Minimum Network Requirement Verification Report (Verification Report). The requirements for this report are outlined in ACOM Policy 436. In the Verification Report health plans describe their compliance with minimum network requirements, including time and distance requirements (*See Attachment C ACOM 436 Verification Report*). These requirements identify thirteen provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards specific to all health plans, as well as some standards specific to RBHA and ALTCS E/PD health plans. Moreover, some standards are measured against specific member populations and the standards vary by county. These standards are identified in Table 1, below:

Table 1 - AHCCCS Minimum Time and Distance Standards

Provider Type	Beneficiary Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
1. Behavioral Health Outpatient and Integrated Clinic, Adult	Beneficiaries aged 18 years and older	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 60 miles
2. Behavioral Health Outpatient and Integrated Clinic, Pediatric	Beneficiaries younger than 18 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 60 miles
3. Behavioral Health Residential Facility <i>(Applies to Maricopa and Pima Counties Only)</i>	All beneficiaries	90 percent of beneficiaries within 15 minutes or 10 miles	Not Applicable
4. Cardiologist, Adult	Beneficiaries aged 21 years and older	90 percent of beneficiaries within 30 minutes or 20 miles	90 percent of beneficiaries within 75 minutes or 60 miles
5. Cardiologist, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 60 minutes or 45 miles	90 percent of beneficiaries within 110 minutes or 100 miles
6. Crisis Stabilization Facility <i>(Applies to RBHAs only)</i>	All beneficiaries	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 45 miles
7. Dentist, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles
8. Hospital	All beneficiaries	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 95 minutes or 85 miles
9. Nursing Facility <i>(Applies to ALTCS E/PD Plans Only)</i>	All beneficiaries currently residing in their own home	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 95 minutes or 85 miles
10. Obstetrics/Gynecology (OB/GYN)	Female beneficiaries aged 15 to 45 years	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 90 minutes or 75 miles
11. Pharmacy	All beneficiaries	90 percent of beneficiaries within 12 minutes or 8 miles	90 percent of beneficiaries within 40 minutes or 30 miles

² CMDP is exempted from this requirement as state law also allows members enrolled in CMDP to see any AHCCCS registered provider. This lack of a defined provider network prohibited this kind of network analysis for CMDP.

Provider Type	Beneficiary Population	Network Standard	
		Maricopa and Pima Counties	All Other Arizona Counties
12. PCP, Adult	Beneficiaries aged 21 years and older	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles
13. PCP, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles

AHCCCS validates the Verification Report submissions by conducting an independent time and distance analysis of the health plan’s compliance. This analysis is completed through a contract with Health Services Advisory Group (HSAG). Each quarter, AHCCCS provides HSAG with each health plan’s Verification Report submission, the health plan’s PAT file, the health plan’s enrolled membership and a file of all AHCCCS registered providers. For each health plan, HSAG produces a report comparing the Verification Report submissions with its validation.

The first validation report was generated using Quarter 1, 2019 data. In the early stage of this process, AHCCCS wanted to ensure any discrepancies found were not the result of different methods, or errors in reporting. As a result, AHCCCS provided information to assist the health plan plans research and address any identified discrepancies. AHCCCS provided the following information to the health plans:

- The health plan’s quarterly report completed by HSAG
- The list of the providers sent to HSAG for the analysis
- The list of addresses rejected by HSAG’s address matching software as not compliant with United State Postal Service standards

AHCCCS provided this information to the health plans with the expectation that they research the discrepancies, and identify and correct any reporting issues for future submissions.

After completion of the individual quarterly reports, HSAG also generated an annual validation report which is attached with this Network Adequacy Report (*See Attachment A HSAG Validation Report*).

After review of HSAG’s validation, AHCCCS identified a number of areas where health plans appear to struggle to meet the minimum network requirements. For example, the validation of both ACC contractors serving Apache County shows difficulty in meeting the time and distance requirements for Outpatient and Integrated Clinics, Pediatric Dentists, and Pharmacies. While, as previously indicated, AHCCCS is working in the initial stages to ensure the discrepancies are not the result of differences in methodology and data, AHCCCS has also been working with the health plans to identify out of network providers to address any identified network gaps. Further, Banner University Family Care’s ALTCS E/PD plan was out of compliance with seven of assisted living standards in ACOM Policy 436. AHCCCS required them to address these gaps, and Banner University Family Care has come into compliance with 3 of them, and is pursuing additional contracts to address the others.

The process of reviewing and validating the health plans' progress towards compliance with minimum network requirements is underscoring the relative lack of providers in some of Arizona's more rural counties. ACOM Policy 436 does include an exception process for health plans 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 a health plan, the availability of IHS/638 facilities³ to serve the American Indian population, and the availability of alternate service delivery mechanisms. Plans are then required to monitor member access to the services covered by the exception while the exception is in place. In 2019 there were no exemptions in place.

In addition to time and distance standards, AHCCCS has established a number of other minimum network requirements that define network access under this policy.

- ALTCS E/PD and ALTCS/DDD health plans report compliance with requirements for long term care facilities in specific areas of any county served. For example, an ALTCS E/PD health plan serving Coconino County must have one assisted living facility in Page and five additional facilities within the county boundary.
- All health plans report compliance with network requirements related to Multi-Specialty Interdisciplinary Clinics (MSICs).
- RBHA health plans report compliance with Mobile Behavioral Health Crisis Team response time requirements.

Appointment Availability Monitoring and Reporting – In order to evaluate the practical ability of members to find a timely appointment, AHCCCS has established minimum appointment availability requirements, outlined in ACOM Policy 417. Under this policy, AHCCCS establishes specific timeframes that members should expect to receive an appointment within a health plan's provider network. These timeframes are categorized by provider type and include varying degrees of need for appointments. Appointment availability standards monitor appointments with the following providers: primary care physicians (PCPs), specialists, dentists, maternity care providers, behavioral health providers, and providers prescribing psychotropic medications. A separate section in the Policy outlines appointment availability requirements specific to behavioral health appointments for members in legal custody of DCS.

Each quarter health plans submit the Appointment Availability report outlining their method for monitoring their provider network against appointment standards, as well as a matrix specifying audited provider compliance with standards (*See Attachment D ACOM 417 Template*). Provider compliance for PCPs, specialists and dentists is reported separately for new and established members, where a new member would be one who has not received services from the physician within the previous three years.

³ American Indian members are able to receive services from any IHS/638 facility regardless of contracted status with a health plan.

While AHCCCS has not established specific compliance percentages for meeting appointment availability standards, health plan performance is closely monitored and trended over time. AHCCCS addresses any significant changes in provider availability directly with the health plan when needed. Further, in their Network Plan, health plans must compare their performance in these standards to the previous year, and if there was a decrease in available appointments conduct an analysis of the sufficiency of their network.

Material Changes to the Provider Network – AHCCCS has established reporting requirements for when a significant change is made to a health plan’s provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires health plans to evaluate changes made to their provider network for materiality. A material change to provider network is defined as any change in the composition of or payments to the health plan’s provider network that would cause or is likely to cause more than five percent of its members in a GSA to change where they receive services, or any change impacting fewer than five percent of members but involves a provider or provider group who is the sole source of a service, or operates in an area with limited alternate sources.

When the health plan identifies a material change to provider network, it submits an assessment of the impact of the change, how the health plan will transition members, a communication plan regarding the change, and how the health plan will monitor the impact of the change after transition (*See Attachment E ACOM 439 Material Change Checklist*). After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status of transitioning members. In 2019, AHCCCS approved four Material changes from contracted health plans.

Provider Changes Due to Rates Reporting – Health plans must also identify when a provider leaves, or reduces services due to rates, regardless of whether the change is a material impact on the provider network. Specifically, ACOM Policy 415 includes an attachment where plans report the name, type, whether the provider is a PCP, the region served, and number of members assigned of any provider leaving the network, or reducing or diminishing their scope of services due to sufficiency of rates (*See Attachment F ACOM 415 Rates Template*). The health plan must also conduct an analysis to determine if the loss is a material change and requires more in-depth reporting under ACOM Policy 439.

AHCCCS uses this information to inform its rate setting, access to care reporting to CMS, and also evaluate the impact on provider networks of Arizona Statutory changes, such as the passage of a new minimum wage law impacting the salaries of health care workers.

Gap in Critical Services Reporting – AHCCCS has established reporting requirements for gaps in the provision of specific Home and Community Based (HCBS) services provided to ALTCS E/PD and ALTCS/DDD members. Under ACOM Policy 413, each quarter these health plans must report their ‘gap hours’, or the number of hours of scheduled Attendant Care, Personal Care, Homemaker and Respite care services that were not delivered to members without being replaced by another paid caregiver (*See Attachment G ACOM 413 Gap Reporting Template*). Plans also report the percent of gap hours compared to total authorized hours for these services. In 2019, AHCCCS health plans reported less than .05% of authorized hours were gap hours.

This reporting was instituted as a part of a settlement agreement for a class action lawsuit. While the lawsuit has since been dismissed, AHCCCS retains this report and continues to monitor it as a measure of member access to HCBS services deemed critical under the lawsuit. Starting in 2019, AHCCCS has been exploring replacing this reporting with an automated method through its planned Electronic Visit Verification program.

In addition to monitoring health plan network adequacy, AHCCCS has been required to produce various network reports to the Arizona State Legislature. In 2019, this consisted of a report on the number of Behavioral Health Residential Facility and Supportive Housing beds available to members determined to have a Serious Mental Illness.