Arizona Health Care Cost Containment System

Contract Year Ending 2021 External Quality Review Annual Technical Report

for

AHCCCS Complete Care (ACC) and Department of Child Safety Comprehensive Health Plan (DCS CHP)

April 2022

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Overview of the Contract Year Ending (CYE) 2021 External Review

The Code of Federal Regulations (CFR) at 42 CFR §438.364 [1-1] 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 and timeliness of, and access to healthcare services that the MCOs provide.

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

- Validation of performance measures required in accordance with §438.330(b)(2).
- Validation of performance improvement projects (PIPs).
- An operational review (OR) 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.
- Validation of network adequacy to comply with requirements set forth in §438.68.

For contracts effective 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, and PAHP network adequacy as a mandatory activity.

In accordance with the 42 CFR §438.358(a), the following entities may perform both mandatory and optional EQR-related activities: 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.

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 two of the four EQR mandatory activities described in 42 CFR §438.358 (b)—validation of PIPs and review of compliance with standards. 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.

[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.

This report presents:

- AHCCCS' findings from conducting each activity.
- HSAG's analysis and assessment of the reported results for each Contractor's performance.
- Recommendations to improve Contractors' performance, as applicable.

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 and 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 methodology for data collection and analysis.
  - Description of the data obtained.
  - Conclusions drawn from the data.
- An assessment of each Contractor's strengths and weaknesses (identified as opportunities for improvement within the remainder of this report).
- 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 and timeliness of, and access to healthcare services furnished to Medicaid members.
- Methodologically appropriate comparative information about all Contractors (described in §438.310[c][2]), consistent with the guidance included in the EQR protocols.
- An assessment of the degree to which each Contractor has effectively addressed 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 18 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 opportunities for improvement related to the

quality and timeliness of, and access to healthcare services as well as 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 2021, 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 specific to the AHCCCS Complete Care (ACC) program for CYE 2021.
- Contractor Best and Emerging Practices: An overview of the Contractors' best and emerging practices for CYE 2021.
- Performance Measure Results: A presentation of results for select performance measures for each Contractor, as well as HSAG's associated findings and recommendations for calendar year (CY)/measurement year (MY) 2020, as appropriate, to reflect the change in approach for performance measure calculations starting with CY 2020 (i.e., moving from CYE to CY measurement period).
- PIPs: A presentation of results for the *Back to Basics* PIP that was initiated CYE 2019.
- Organizational Assessment and Structure Performance: A review of organization review methodology and processes.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2]: A presentation of member survey findings.
- Network Adequacy Update: A presentation of results for the network adequacy validation (NAV) and analysis conducted in CYE 2021 and HSAG's associated findings.

Please see appendices A, B, and C for an overview of the AHCCCS methodology for the performance measure, PIP, and OR activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements. Appendix D includes CAHPS methodology. Appendix E includes the NAV study methodology and Contractor results by quarter and county. Appendix F includes the complete text of AHCCCS' CYE 2020 Network Adequacy Report.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Contractors Reviewed

During the CYE 2021 review cycle, AHCCCS contracted with the Contractors[1-3] listed in Table 1-1 to provide services to members enrolled in the ACC and Department of Child Safety Comprehensive Health Plan (DCS CHP) Medicaid managed care programs. Associated abbreviations are included.

Table 1-1—AHCCCS Contracted ACC Providers

ACC and DCS CHP Contracted Providers	
Contractor Name	**Contractor Abbreviation**
Arizona Complete Health – Complete Care Plan	AzCH-CCP ACC
Banner University Family Care	BUFC ACC
Care1st Health Plan	Care1st ACC
Molina Complete Care *Formerly Magellan Complete Care, this change became effective on July 1, 2021. For the purposes of this report, Molina Complete Care (MCC ACC) will be used.*	MCC ACC
Mercy Care	Mercy Care ACC
Health Choice Arizona	HCA ACC
UnitedHealthcare Community Plan	UHCCP ACC
Department of Child Safety Comprehensive Health Plan *Formerly Comprehensive Medical and Dental Program (CMDP), this change became effective on April 1, 2021. For the purposes of this report, Department of Child Safety Comprehensive Health Plan (DCS CHP) will be used.*	DCS CHP

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

The following section provides a high-level summary of HSAG's findings and conclusions about the quality and timeliness of, and access to care furnished to AHCCCS members across activities. For each Contractor reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the Contractor's performance, which can be found in sections 7–11 of this report.

[1-3] 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.

Performance Measures

CYE 2021 Performance Measure Validation

During CYE 2021, HSAG validated and reported Contractor performance for a set of CY 2020/MY 2020 performance measures related to providing quality, timely, and accessible care and services to AHCCCS members. The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by Contractors and to determine the extent to which performance measures reported by the Contractors follow state specifications and reporting requirements. According to the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,[1-4] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not an MCO, or an EQRO.

The following tables display the performance measure rates for measures that HSAG validated that could be compared to the National Committee for Quality Assurance's (NCQA's) Quality Compass® national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] MY 2020.[1-6] Contractor-specific performance measure results, including an assessment of strengths, opportunities for improvement, and recommendations, are included in Section 8, with additional performance measures (i.e., measures that could not be compared to NCQA Quality Compass national Medicaid HMO means) and findings from the CYE 2021 PMV activity included in Appendix A of this report.

Of note, some access to care challenges may have been the result of the coronavirus disease 2019 (COVID-19) public health emergency (PHE), as some in-person services were temporarily suspended.

ACC Aggregate Findings

Table 1-2 presents the MY 2020 aggregate performance measure results for the ACC Contractors. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green.

[1-4] The Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Dec 7, 2021.

[1-5] HEDIS® is a registered trademark of NCQA.

[1-6] Quality Compass® is a registered trademark of the NCQA.

Table 1-2—MY 2020 Aggregate Performance Measure Results for the ACC Program

Performance Measure	MY 2020 Performance
Maternal and Perinatal Health	
Prenatal and Postpartum Care	
Postpartum Care	64.6%
Behavioral Health Care	
Antidepressant Medication Management	
Effective Acute Phase Treatment	54.2%
Effective Continuation Phase Treatment	38.5%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	
7-Day Follow-Up—Total	17.7%
30-Day Follow-Up—Total	24.3%
Follow-Up After Emergency Department Visit for Mental Illness	
7-Day Follow-Up—Total	47.6%
30-Day Follow-Up—Total	58.0%
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total	43.6%
30-Day Follow-Up—Total	59.8%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	
Total Initiation of AOD—Total	46.8%
Total Engagement of AOD—Total	17.6%
Care of Acute and Chronic Conditions	
Comprehensive Diabetes Care	
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	45.8%
Pediatric Health	
Child and Adolescent Well-Care Visits	
Total	42.8%
Developmental Screening in the First Three Years of Life	
Total	35.4%
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.6%
Preventive Screening	
Breast Cancer Screening	
Total	49.5%
Cervical Cancer Screening	
Cervical Cancer Screening	49.3%

** A lower rate indicates better performance for this measure.*

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

ACC Aggregate Conclusions and Recommendations

Table 1-3 AHCCCS 2021 Aggregate Performance Measurement Strengths, Opportunities for Improvement, and Recommendations for the ACC Program

Performance Measurement
Program Strengths
1. In the Behavioral Health Care domain, all seven ACC Contractors and the ACC Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 for the following three measures: *Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total, Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total,* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total.*
2. In the Behavioral Health Care domain, six of seven (85.7 percent) ACC Contractors and the ACC Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 for the *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total—Total* measure rates.
3. In the Pediatric Health domain, five of seven (71.4 percent) ACC Contractors and the ACC Aggregate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate.
Program Opportunities for Improvement and Recommendations
1. In the Maternal and Perinatal Health domain, all seven ACC Contractors' performance measure rates for *Prenatal and Postpartum Care—Postpartum Care* fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that AHCCCS support the ACC Contractors in conducting a root cause analysis to determine why female members were not receiving timely postpartum care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Contractors should implement appropriate interventions to improve the performance related to access to postpartum care. The ACC Contractors should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for

Program Opportunities for Improvement and Recommendations
improved community outreach and education). Additionally, the ACC Contractors should also identify factors related to the COVID-19 PHE and how access to care was impacted.
2. In the Care of Acute and Chronic Conditions domain, performance measure rates for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* for five of seven (71.4 percent) ACC Contractors fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person primary care practitioner (PCP) appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AHCCCS support the ACC Contractors in conducting a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Contractors should implement appropriate interventions to improve the performance related to this chronic condition.
3. In the Pediatric Health domain, performance measures rate for *Child and Adolescent Well-Care Visits—Total* for five of seven (71.4 percent) ACC Contractors fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020, indicating that children and adolescents were not always accessing well-child/care visits with a PCP or obstetrics/gynecology (OB/GYN) practitioner. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[1-7] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AHCCCS support the ACC Contractors in conducting a root cause analysis to determine why children and adolescents were not always accessing well-child/care visits. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. The ACC Contractors should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service

[1-7] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%2015%20months%20of%20life. Accessed on: Jan 25, 2022.

Program Opportunities for Improvement and Recommendations
providers, or the need for community outreach and education). Upon identification of a root cause, the ACC Contractors should implement appropriate interventions to improve the performance related to access to care.
4. In the Preventive Screening domain, performance measure rates for *Breast Cancer Screening* for five of seven (71.4 percent) ACC Contractors and performance measure rates for *Cervical Cancer Screening* for six of seven (85.7 percent) ACC Contractors fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020, indicating that women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[1-8] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AHCCCS support the ACC Contractors in conducting a root cause analysis or focused study to determine why female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ACC Contractors should implement appropriate interventions to improve the performance related to preventive screenings.

DCS CHP Findings

Table 1-4 presents the MY 2020 aggregate performance measure results for DCS CHP. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded NCQA's Quality Compass national Medicaid HMO mean for HEDIS MY 2020.

Table 1-4—MY 2020 Performance Measure Results for the DCS CHP Program

Performance Measure	MY 2020 Performance
Pediatric Health	
Child and Adolescent Well-Care Visits	
Total	66.2%
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	53.9%

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

[1-8] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 25, 2022.

DCS CHP Conclusions and Recommendations

Table 1-5—AHCCCS 2021 Performance Measurement Strengths, Opportunities for Improvement, and Recommendations for the DCS CHP Program

Performance Measurement
Program Strengths
1. DCS CHP performed well on measures related to pediatric health, as measure rates for both measures, *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
Program Opportunities for Improvement and Recommendations
1. DCS CHP developed the necessary source code for reporting the AHCCCS HEDIS and CMS Core measures rather than using an NCQA certified measures vendor. Timely source code development and rate production was problematic for MY 2020, as two measures were unable to be developed or completed: *Asthma Medication Ratio* and *Contraceptive Care—All Women*. Source code for another two measures, *Ambulatory Care* and *Inpatient Utilization,* was not completed for the required age-group stratifications, and only results for the total eligible population were reported. Additional measures for which source code was developed subsequently received a Do Not Report (DNR) designation due to variances identified during final rate review. Recommendation: HSAG recommends that DCS CHP ensure the accuracy of the source codes its subcontracted health plan will use to generate the full AHCCCS measure list. The ability to routinely produce AHCCCS measures through its subcontracted health plan's accurate source code will allow DCS CHP to monitor and trend its performance as DCS CHP oversees and verifies rates produced by its subcontracted health plan.

Performance Improvement Projects (PIPs)

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ACC/KidsCare, DCS CHP (formerly CMDP), and Division of Developmental Disabilities (DDD) populations. Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits. The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits. CY 2020 served as an intervention year for this PIP; as the PIP is in the early stages of implementation, repeated measurements are not yet available. Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation.

Table 1-6 and Table 1-7 provide a high-level overview of AHCCCS PIP strengths, opportunities for improvement, and recommendations for CYE 2021. A summary of activities, including individual Contractor overviews and comparative analysis is provided in Section 7.

Table 1-6—AHCCCS 2021 PIP Strengths, Opportunities for Improvement, and Recommendations for the ACC Program

Performance Improvement Projects
Program Strengths
1. For CYE 2021, AHCCCS ensured that all Contractors had interventions in place that may lead to improvement in indicator outcomes. **[Quality, Access, and Timeliness]**
Program Opportunities for Improvement and Recommendations
Recommendation: CYE 2021 served as an intervention year for the *Back to Basics* PIP. HSAG recommends that AHCCCS continue to support the ACC Contractors in the implementation of interventions for the *Back to Basics* PIP. Specific opportunities for improvement and additional recommendations will be provided after the first remeasurement year (CYE 2022).

Table 1-7—AHCCCS 2021 PIP Strengths, Opportunities for Improvement, and Recommendations for the DCS CHP Program

Performance Improvement Projects
Program Strengths
1. For CYE 2021, AHCCCS ensured that all Contractors had interventions in place that may lead to improvement in indicator outcomes. **[Quality, Access, and Timeliness]**
Program Opportunities for Improvement and Recommendations
Recommendation: CYE 2021 served as an intervention year for the *Back to Basics* PIP. HSAG recommends that AHCCCS continue to support DCS CHP in the implementation of interventions for the *Back to Basics* PIP. Specific opportunities for improvement and additional recommendations will be provided after the first remeasurement year (CYE 2022).

Organizational Assessment and Structure Standards

AHCCCS postponed its OR activities at the onset of the COVID-19 PHE to allow the Contractors the ability to focus on ensuring members received appropriate care and services during the PHE, in part through supporting their provider networks. Similarly, CAP/CAP update submissions were postponed. AHCCCS resumed OR activities in June 2021. Information pertaining to operational reviews, including methodology, is included in Section 9.

Table 1-8—AHCCCS 2021 OR Strengths, Opportunities for Improvement, and Recommendations for the ACC Program

Operational Reviews
Program Strengths
Program strengths are not applicable, as ORs were postponed during CYE 2021.
Program Opportunities for Improvement and Recommendations
Program opportunities for improvement are not applicable, as ORs were postponed for CYE 2021. Recommendation: HSAG recommends that AHCCCS continue performing ORs with the ACC Contractors to ensure continuity with compliance.

DCS CHP was reviewed during the three-year cycle that started in CYE 2019. The findings of this Contractor's OR were included in the *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Complete Care and Comprehensive Medical and Dental Program (CMDP)*, July 2021. For DCS CHP, review of the OR CAPs was put on hold due to COVID-19. Review of the CAPs resumed in CYE 2021; however, final documentation was not available to include within this year's report.

Table 1-9—AHCCCS 2021 OR Strengths, Opportunities for Improvement, and Recommendations for the DCS CHP Program

Operational Reviews
Program Strengths
Program strengths are not applicable, as ORs were postponed during CYE 2021.
Program Opportunities for Improvement and Recommendations
Program opportunities for improvement are not applicable, as ORs were postponed for CYE 2021. Recommendation: HSAG recommends that AHCCCS continue supporting DCS CHP as it implements its CAP.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on members' experiences with their healthcare and health plan. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare and performed comparisons of the results to NCQA's Quality Compass Benchmark and Compare Quality Data to derive the overall member

experience ratings. Table 1-10 and Table 1-11 provide a high-level overview of the 2021 CAHPS Program strengths, opportunities for improvement, and recommendations.

Table 1-10—AHCCCS 2021 CAHPS Strengths, Opportunities for Improvement, and Recommendations for the ACC Program

CAHPS
Program Strengths
1. Member experience ratings for the ACC Program for *Rating of Specialist Seen Most Often* and *Coordination of Care for Children with Chronic Conditions* met or exceeded the 75th percentiles for the general child population and children with chronic conditions (CCC) population, respectively. **[Quality]**
Program Opportunities for Improvement and Recommendations
1. Member experience ratings for the ACC Program for *Customer Service* and *Coordination of Care* were below the 25th percentiles for the general child population. **[Quality]** Recommendation: HSAG recommends that the ACC Contractors explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving parents'/caretakers' overall experiences with customer service and coordination of care for child members.
2. Member experience ratings for the ACC Program for *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Coordination of Care*, *Access to Specialized Services*, *Family-Centered Care (FCC): Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information* were below the 25th percentiles for the CCC population. **[Quality, Access, and/or Timeliness]** Recommendation: HSAG recommends that the ACC Contractors explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, timeliness of care, and access to care for child members with chronic conditions.

Table 1-11—AHCCCS 2021 CAHPS Strengths, Opportunities for Improvement, and Recommendations for the DCS CHP Program

CAHPS
Program Strengths
1. DCS CHP's member experience ratings for *Getting Needed Care* met or exceeded the 75th percentile for the general child population. **[Access]**
Program Opportunities for Improvement and Recommendations
1. Member experience ratings for the ACC Program for *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*,

Program Opportunities for Improvement and Recommendations
Discussing Cessation Medications, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. **[Quality]** Recommendation: HSAG recommends that the ACC Contractors explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving members' overall experiences with their specialists and coordination of care for adult members. The ACC Contractors should provide training and resources to providers to improve their communication skills and promote smoking cessation with their adult members.
2. Member experience ratings for DCS CHP for *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care* were below the 25th percentiles for the general child population. **[Quality]** Recommendation: HSAG recommends that DCS CHP focus on improving parents'/caretakers' overall experiences with their child's specialist and the quality of care of their child's health plan, including a focus on customer service and coordination of care for child members.
3. Member experience ratings for DCS CHP for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Coordination of Care*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines* were below the 25th percentiles for the CCC population. **[Quality, Access, and/or Timeliness]** Recommendation: HSAG recommends that DCS CHP focus on improving parents'/caretakers' of child members with chronic conditions overall experiences with their child's specialist, and the quality of care of their child's health plan and healthcare, including a focus on access to care, timeliness of getting care, customer service, coordination of care, access to specialized services, personal doctors' knowledge of child members' healthcare, and access to prescription medicines for child members with chronic conditions.

Network Adequacy Validation (NAV)

Biannually, each ACC Contractor and DCS CHP subcontracted health plan submits its contracted network to AHCCCS along with its internal assessment of compliance with the applicable standards. HSAG's NAV considered compliance with up to 11 AHCCCS-established time/distance standards for specific provider types and populations applicable to the ACC Contractors and DCS CHP subcontracted health plan. HSAG assembled biannual analytical results for the CYE 2021 measurement period for all member coverage areas for each ACC Contractor and DCS CHP subcontracted health plan. Additionally, detailed time/distance results were presented to AHCCCS, each Contractor, and subcontracted health plan in an interactive Tableau dashboard filterable by line of business (LOB), Contractor, urbanicity, county, and provider category.

ACC

HSAG's biannual NAV determined that two ACC Contractors, Mercy Care ACC and UHCCP ACC, met all requirements for all standards across both quarters in their respective counties; also, all ACC Contractors met all minimum time/distance network standards during both quarters in Cochise, Graham, Mohave, Navajo, Pima, Santa Cruz, Yavapai, and Yuma counties. Additionally, all ACC Contractors met all the Behavioral Health Residential Facility, Cardiologist, Adult, Cardiologist, Pediatric, Hospital, and OB/GYN standards.

Two Contractors, MCC ACC and BUFC ACC, demonstrated Provider Affiliation Transmission (PAT) data issues, which impacted HSAG's time/distance results and the subsequent validation of the Contractors' AHCCCS Contractor Operations Manual (ACOM) 436 results.

Table 1-12—AHCCCS 2021 NAV Strengths, Opportunities for Improvement, and Recommendations for the ACC Program

Network Adequacy Validation
Program Strengths
1. The applicable ACC Contractors met all minimum time/distance network standards during all quarters in Cochise, Graham, Mohave, Navajo, Pima, Santa Cruz, Yavapai, and Yuma counties.
2. The ACC Contractors' performance consistently met the Behavioral Health Residential Facility; Cardiology, Adult and Pediatric; Hospital; and OB/GYN standards.
Program Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: HSAG recommends that AHCCCS support the ACC Contractors in continuing to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. Based on the quarterly NAV results, no ACC contractor met all requirements for all standards across all quarters and counties. Recommendation: HSAG recommends that AHCCCS support each ACC Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2021, Quarter 4, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors: • Behavioral health outpatient and integrated clinics for adults or children in Apache County • PCPs for adults or children in Apache County • Pediatric dentists in Apache, Coconino, Greenlee, and La Paz counties • Pharmacies in Apache and Coconino counties

DCS CHP

AHCCCS maintains a contract with DCS CHP to provide physical health, dental, and behavioral health services. Beginning with CYE 2021, Quarter 4, the responsibility for the healthcare of children in foster care in all counties was transferred to DCS CHP's subcontracted health plan, Mercy Care. HSAG reviewed this subcontracted health plan for eight time/distance network standards for specific provider types and populations applicable to the DCS CHP subcontracted health plan.

DCS CHP's subcontracted health plan, Mercy Care, met all applicable minimum network standards in Quarter 4 except for the Behavioral Health, Outpatient and Integrated Clinic, Pediatric; Dentist, Pediatric; and Pharmacy standards in Apache County. In addition, Mercy Care did not meet the minimum time/distance standard for the Dentist, Pediatric standard in La Paz County.

Table 1-13—AHCCCS 2021 NAV Strengths, Opportunities for Improvement, and Recommendations for the DCS CHP Program

Network Adequacy Validation
Program Strengths
1. The DCS CHP subcontracted health plan met all minimum time/distance network standards during Quarter 4 in all counties except for Apache and La Paz counties.
2. The DCS CHP subcontracted health plan's performance consistently met the Behavioral Health Residential Facility; Cardiology, Pediatric; Hospital; OB/GYN; and PCP, Pediatric standards.
Program Opportunities for Improvement and Recommendations
1. Based on the quarterly NAV results, the DCS CHP subcontracted health plan did not meet all requirements for all standards across all counties. Recommendation: HSAG recommends that AHCCCS support DCS CHP its subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2021, Quarter 4, with specific attention to ensuring the availability of the following provider types: • Behavioral health outpatient and integrated clinics for children in Apache County • Pediatric dentists in Apache and La Paz counties • Pharmacies in Apache County

Refer to Appendix E for the complete study methodology as well as ACC Contractor and DCS CHP subcontracted health plan results by quarter and county.

Overall Assessment of Progress in Meeting EQRO Recommendations

During the previous year, HSAG made recommendations in the annual reports for each activity conducted. Section 3, under AHCCCS Follow-Up on Prior Year Recommendations, includes summaries of AHCCCS' follow-up actions per activity for the ACC LOB in response to HSAG's recommendations. Section 5 includes the Contactors' responses to HSAG's recommendations.

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 CMS mandatory activities for its Contractors:

- Validate Contractor PIPs—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by HSAG.
- Provide summary and findings of Contractors' performance in complying with the AHCCCS' contract requirements and the federal Medicaid managed care regulations—review performed by AHCCCS.
- Validate Contractor network adequacy—validation performed by HSAG.

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the four 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 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.

> CMS defines "quality" in the 2016 federal health care regulations at 42 CFR §438.320 as follows: Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity 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 through interventions for performance improvement.[2-1]
>
> CMS defines "access" in the 2016 regulations at 42 CFR §438.320 as follows: Access, as it pertains to external quality review, 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 defined under 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).[2-2]
>
> Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. Timeliness 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. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[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 (SFYs) 2018–2023 (Strategic Plan). The description of the Strategic Plan includes the four goals:[3-1]

- 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 sustainable healthcare system.
- AHCCCS must maintain core organizational capacity, infrastructure, 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 Medicaid Demonstration 1115 Waiver under Section 1115 of the Social Security Act, 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 appropriated budget of approximately $18.3 billion to administer its programs, which provide services for over two million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. The AHCCCS Acute Care Program began in 1982 and in 1988, AHCCCS added the Arizona Long Term Care System (ALTCS) Program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) 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 home and community based setting. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 21.7 percent of the costs. American Indian/Alaskan Native (AI/AN) members may choose to receive services through the managed care structure or may opt to receive services through the fee-for-service program. Services for children in the foster care system are offered through DCS CHP (previously CMDP).

[3-1] Arizona Health Care Cost Containment System. AHCCCS Strategic Plan: State Fiscal Years 2014–2018. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_14-18.pdf. Accessed on: Mar 10, 2021.

In October 1990, AHCCCS began coverage of comprehensive behavioral health services for children with a serious emotional disturbance (SED) 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 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 2014, a member with general mental health needs and those with a serious mental illness (SMI) designation 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 Medicare; and Medicare Part D for medications.

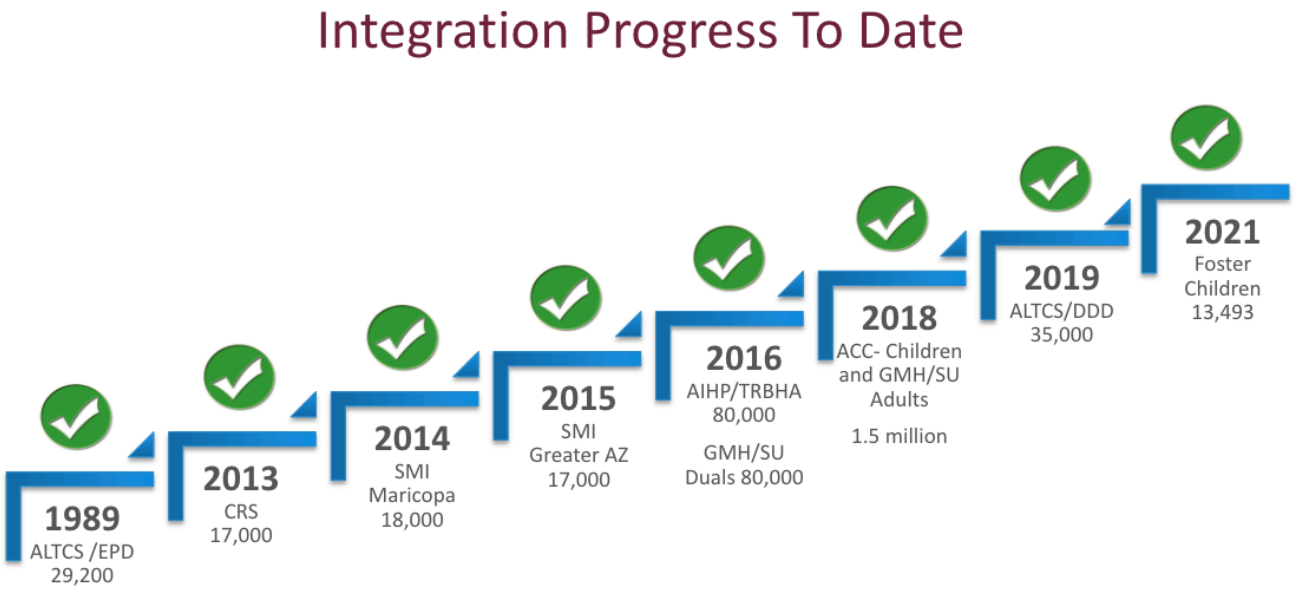
On April 1, 2014, approximately 17,000 members with SMI residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Beginning October 1, 2015, members residing in other counties were transitioned to one of two additional integrated health plans to provide both physical and behavioral healthcare services . RBHAs were also providing general behavioral health and substance use services to individuals in the DCS/CMDP foster care system and to DDD members.

Beginning July 1, 2016, DBHS merged with AHCCCS, moving contractual oversight of the RBHAs to AHCCCS.

In March of 2017, new contracts were awarded to three MCOs throughout Arizona to administer Arizona's integrated long-term care system for individuals who are elderly and/or physically disabled (ALTCS-EPD). Awards were 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 who are not enrolled in an ALTCS-EPD program to also access physical and general mental health and substance use behavioral healthcare services through a single integrated delivery system model, ACC, with 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.

Effective October 1, 2019, DDD began providing integrated behavioral health services to its members, including individuals with an SMI designation. Effective April 1, 2021, DCS/CMDP began providing integrated behavioral health services to its members and changed its program name to DCS CHP. RBHAs continue to provide specific services to individuals with an SMI designation who are not in an ALTCS program, as well as the first 24 hours of crisis services.



Effective October 1, 2022, AHCCCS expanded three ACC contracts to include RBHA services, thus furthering integration efforts.

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 regardless of whether they are receiving services through managed care or the fee-for-service program.

AHCCCS Waiver Amendment Requests and Legislative Updates

COVID-19 PHE Flexibility

CMS approved components of Arizona's requests under the 1135 Waiver, Appendix K, and the State Plan. Information regarding the status of AHCCCS Emergency Authority Requests (for the federally declared COVID-19 PHE) is available on the AHCCCS COVID-19 Federal Emergency Authorities Request web page.[3-2]

On March 17 and March 24, 2020, AHCCCS submitted requests to the CMS administrator to waive certain Medicaid and CHIP requirements in order to combat the continued spread of COVID-19. AHCCCS sought a broad range of emergency authorities, that include:

- Strengthen the provider workforce and remove barriers to care for AHCCCS members.
- Enhance Medicaid services and supports for vulnerable members for the duration of the emergency period.
- Remove cost sharing and other administrative requirements to support continued access to services.

1115 Waiver Update

CMS has extended AHCCCS' 1115 Waiver Demonstration authority for a one-year period, through September 30, 2022, while CMS continues to review the agency's full 1115 Waiver renewal application. The extension grants authority to continue specific programs for a sixth year, including the Targeted Investments (TI) Program.

The larger 1115 Waiver renewal package, submitted to CMS on December 22, 2020, and subject to negotiation, seeks to implement new initiatives such as:

- Coverage of traditional healing.
- Authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members.
- Authority to reimburse IHS and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent federal financial participation (FFP), that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan, and $1,000 dental limit for individuals ages 21 or older enrolled in the ALTCS program.
- TI 2.0.[3-3]

[3-2] Arizona Health Care Cost Containment System. COVID-19 Federal Emergency Authorities Request. Available at: https://azahcccs.gov/Resources/Federal/PendingWaivers/1135.html. Accessed on: Jan 10, 2022.
[3-3] Arizona Health Care Cost Containment System. Target Investments (TI) 2.0 Concept Paper. Available at: https://azahcccs.gov/Resources/Federal/PendingWaivers/TI2.html. Accessed on: Jan 17, 2022.

- Housing and Health Opportunities (H2O) demonstration.[3-4]

If approved, in part or in full, the next five-year waiver will run from October 1, 2022, through September 30, 2027.

More details on Arizona's 1115 Waiver renewal request (2021–2026), along with the proposal and supplemental documentation, are available on the AHCCCS Section 1115 Waiver Renewal Request (2021–2026) web page.[3-5]

The current demonstration exempts Arizona from particular provisions of the Social Security Act and also includes expenditure authority permitting FFP for State expenditures that would not otherwise qualify for federal participation. Moreover, demonstration projects must establish budget neutrality where Medicaid costs to the federal government are not expected to exceed costs to the federal government in the absence of the demonstration.

With CMS' approval of its demonstration renewal application, Arizona will continue its successful Medicaid program and implement programs including, but not limited to:

- Mandatory managed care.
- Home and community-based services for individuals in the ALTCS program.
- Administrative simplifications that reduce inefficiencies in eligibility determination.
- Integrated health plans for AHCCCS members.

1115 Waiver Evaluation

In accordance with Special Terms and Conditions (STC) 69, AHCCCS must submit a draft Waiver Evaluation Design for its 1115 Waiver demonstration. In addition, AHCCCS is also required by CMS to submit an Interim Evaluation Report and a Summative Evaluation Report of the 1115 Waiver Demonstration by December 31, 2020, and March 30, 2024, respectively.

AHCCCS has contracted with the Health Services Advisory Group (HSAG) to serve as the independent evaluator for Arizona's 1115 Waiver Demonstration. In SFY 2019, AHCCCS worked with HSAG to develop Evaluation Design Plans for the following programs:

- ACC Program
- ALTCS Program
- CMDP

[3-4] Arizona Health Care Cost Containment System. AHCCCS Housing and Health Opportunities (H2O) Demonstration. Available at: https://azahcccs.gov/Resources/Federal/HousingWaiverRequest.html. Accessed on: Jan 17, 2022.

[3-5] Arizona Health Care Cost Containment System. Arizona's Section 1115 Waiver Renewal Request (2022-2026). Available at: https://azahcccs.gov/Resources/Federal/waiverrenewalrequest.html. Accessed on: Jan 10, 2022.

- RBHAs
- TI Program
- Waiver of Prior Quarter Coverage
- AHCCCS Works Program

On November 13, 2019, AHCCCS submitted an Evaluation Design Plan to CMS for Arizona's demonstration components noted above, with the exception of AHCCCS Works. Additionally, HSAG later developed, and AHCCCS submitted, a separate evaluation design plan to CMS for the AHCCCS Works program. Arizona's waiver evaluation design plan was approved by CMS on November 19, 2020.

As required by the STCs of Arizona's approved demonstration, an Interim Evaluation Report must be submitted and discuss the evaluation progress and findings-to-date, in conjunction with Arizona's demonstration renewal application. Arizona's interim evaluation report was submitted with the waiver renewal application on December 22, 2020.

Due to data limitations and operational constraints imposed by the COVID-19 PHE , Arizona's previous interim evaluation report did not include data from all sources described in Arizona's evaluation design plan. Qualitative data based on key informant interviews and focus groups, as well as member survey data, were not collected.

For this reason, an updated interim evaluation report was developed and completed by August 30, 2021. HSAG's updated report contains results for additional years and includes findings-to-date from focus groups and qualitative interviews. In addition, the report used statistical techniques, where possible, to control for confounding factors and identify the impact of Arizona's demonstration initiatives on access to care, quality of care, and member experience with care. Once approved by CMS, AHCCCS intends to post the updated interim evaluation report to its website.

Additionally, AHCCCS worked with HSAG on developing an Evaluation Design Plan for the COVID-19 section of Arizona's 1115 Waiver, in accordance with the guidance issued by CMS on COVID-19 Section 1115 Waiver Monitoring and Evaluation. AHCCCS submitted the design plan to CMS on July 31, 2021. The COVID-19 Evaluation Design Plan was approved by CMS on February 1, 2022.

Legislative Updates

The legislature passed a number of bills in the 2021 legislative session that will impact the agency, including:

- HB 2392 (AHCCCS, graduate medical education, reimbursement) establishes a community health center graduate medical education (GME) program.
- HB 2521 (long-term care, health aides) creates a licensed health aide program to allow relatives to provide care to their family members with complex health conditions.

- SB 1505 (health information, disclosures, prohibition) allows State, county, or local health departments to disclose communicable disease and immunization-related information to the State's health information exchange (HIE).
- SB 1824/SB 1823 (budget bills) contain appropriations for State agencies and programs. Specific to the AHCCCS administration, the budget included the following items:
  - Secured authorization to spend federal funds tied to approval of the AHCCCS Housing and Health Opportunities (H2O) waiver proposal.
  - Funding for critical IT projects.
  - Additional funding for providers of services for elderly and physically disabled individuals.

The Arizona Legislature adjourned *sine die* on June 30, 2021; the general effective date for legislation is September 29, 2021.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for SFY 2022 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The Strategic Plan identifies AHCCCS' mission, vision, and core values:[3-6]

- 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.

The Strategic Plan offers four multi-year strategies:

1. **Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes**
   - Increase school safety
   - Reduce health disparities

2. **Pursue continuous quality improvement**
   - Increase use of AHCCCS' automated provider enrollment platform
   - Ensure seamless experience for individuals applying for AHCCCS benefits
   - Address the behavioral health needs of uninsured and underinsured children
   - Standardize treatment planning and placement for individuals with substance use disorders

[3-6] Arizona Health Care Cost Containment System. Fiscal Year 2022 Strategic Plan. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf. Accessed on: Jan 10, 2022.

3. **Reduce fragmentation driving toward an integrated sustainable healthcare system**
   - Improve AHCCCS member connectivity to critical social services
   - Provide a comprehensive resource for accessing treatment for opioid use disorder

4. **Maintain core organizational capacity, infrastructure and workforce planning that effectively serve AHCCCS operations**
   - Maximize use of remote work options
   - Prepare for anticipated staff retirements/departures

Key Accomplishments for AHCCCS

Following are key AHCCCS accomplishments related to the AHCCCS SFY 2020 Strategic Plan:

- Submitted proposal to CMS, outlining how AHCCCS intends to reinvest approximately $1.5 billion in funding over the next 2.5 years, available to states through the home and community-based services provision of the American Rescue Plan Act (ARPA). AHCCCS received partial approval of the proposal from CMS on September 28, 2021.
- Released a request for proposal (RFP), soliciting bids from managed care organizations interested in serving individuals determined to have a serious mental illness under a Regional Behavioral Health Agreement.
- Received a one-year extension of AHCCCS' 1115 waiver from CMS.
- Implemented Housing Administrator contract, allowing for the streamlined distribution of $30 million in rental subsidy funds to nearly 2,400 individuals each year.
- Implemented expanded Medicaid School Based Claiming Program, allowing all students to access school-based services (currently limited to students with an Individualized Education Program).

AHCCCS Quality Strategy and Quality Strategy Evaluation

AHCCCS enhanced the Quality Strategy by evaluating the report's structure, content, and data analysis. Part of the approach was to incorporate synchronized reporting processes to ensure alignment across various AHCCCS reports that relate to quality (e.g., Strategic Plan, Quality Strategy, and External Quality Review Organization Report). The AHCCCS Quality Strategy, Assessment, and Performance Improvement report is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and result-based performance improvement. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public comments. The AHCCCS Quality Strategy Evaluation is a companion document to the Quality Strategy for the purpose of evaluating the effectiveness of the AHCCCS Quality Strategy.

AHCCCS' enhanced Quality Strategy was submitted to CMS in July 2018 for review and approval. In June 2020, AHCCCS began efforts to update its Quality Strategy to reflect changes within the Arizona Medicaid delivery system as well as incorporate the feedback received from CMS, in alignment with the required elements outlined in 42 CFR §438.340. AHCCCS' Quality Strategy updates were posted to the AHCCCS website on June 30, 2021, and were submitted to CMS on July 1, 2021.

AHCCCS continues to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services.

The targeted goals for AHCCCS' quality strategy include:

- Quality Goal 1: Improve the member's experience of care, including quality and satisfaction.
- Quality Goal 2: Improve the health of the AHCCCS population.
- Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person.
- Quality Goal 4: Enhance data system and performance measure reporting capabilities.

Quality Strategy Strengths, Opportunities for Improvement, and Recommendations for Targeted Goals and Objectives to Improve Quality, Access, and Timeliness

Table 3-1 outlines Quality Strategy strengths and opportunities for improvement, as well as HSAG's recommendations to AHCCCS for improving quality, timeliness, and access pertaining to the Quality Strategy.

Table 3-1—Quality Strategy Strengths, Opportunities for Improvement, and Recommendations to Improve Quality, Access, and Timeliness

Quality Strategy
Strengths
AHCCCS maintains a multi-faceted Quality Strategy that aims to improve health outcomes for members by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. **[Quality, Access, and Timeliness]**
Opportunities for Improvement and Recommendations
HSAG recommends that AHCCCS: • Persist in its efforts to improve the member experience of care, improve the health of populations, and reduce the per-capita growth of the cost of healthcare services. • Continue its efforts to evaluate and further expand data system capabilities in order to better understand and serve the member population. • Continue to monitor Contractor performance and adjust goals to encourage a positive trend in performance

Opportunities for Improvement and Recommendations
• Encourage and support each Contractor to continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations.

Follow-up to the prior year's Quality Strategy recommendations is not included within the report as no recommendations were provided in the CYE 2020 EQR Technical Reports specific to the AHCCCS Quality Strategy. AHCCCS will provide a response to these recommendations, which will be published in the annual technical report released in April of 2023.

AHCCCS Follow-Up on Prior Year Recommendations

HSAG made recommendations to AHCCCS for improving the quality of healthcare services furnished to AHCCCS members in the *Contract Year Ending 2020 External Quality Review Annual Report*.[3-7] These recommendations for ACC Contractors are summarized in Table 3-2, along with AHCCCS' response.

Table 3-2—Follow-Up on Prior Year Recommendations from AHCCCS for ACC Program

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 Minimum Performance Standard (MPS) related to access to care. Additionally, HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* AHCCCS implemented a *Back to Basics* PIP (Baseline Measurement Year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year. Calendar Year 2021 served as an intervention year (to account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design). AHCCCS collaborated with the Contractors (via a variety of stakeholder meetings and ad-hoc information seeking requests conducted during the report year) to identify: experienced barriers, current activities, and potential performance improvement strategies for enhancing performance in pediatric access to care.

[3-7] Arizona Health Care Cost Containment System. *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Complete Care and Comprehensive Medical and Dental Program (CMDP)*, July 2021. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2020/CYE2020ExternalQualityReviewAnnualReportACCandCMDP.pdf. Accessed on: Jan 19, 2022.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
AHCCCS transitioned from utilizing EQRO calculated rates to measure and report Contractor-level data to utilizing Contractor-calculated performance measure rates that have undergone EQRO validation starting with its calendar year 2020 performance measures. Beginning with its CYE 2021 contract amendments, AHCCCS transitioned from its use of internally established MPS to the use of national benchmark data (i.e., NCQA HEDIS Medicaid Mean and CMS Medicaid Median) to evaluate Contractor performance. AHCCCS also intends to utilize line of business specific historical performance data to evaluate Contractor, line of business, and agency performance. The CYE 2019 AHCCCS Statewide *Follow-Up After Hospitalization for Mental Illness* (NCQA) performance measure rates (7- and 30-day rates) exceeded the NCQA Medicaid Mean. Beginning CYE 2019, the *Follow-Up After Hospitalization for Mental Illness* (NCQA) measure—7-day rate was included as a value based purchasing withhold measure for the ACC line of business.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women.
AHCCCS Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* Beginning CYE 2021, the *Breast Cancer Screening* measure was included as a value based purchasing withhold measure for the ACC line of business. In CYE 2021, AHCCCS implemented its Health Disparity Summary & Evaluation deliverable to be submitted as part of the MCO Quality Management/Performance Improvement (QM/PI) Program Plan submissions. The Health Disparity Summary & Evaluation will be utilized for Contractors to provide 1.) an analysis of the effectiveness of implemented strategies and interventions in meeting its health equity goals and objectives during the previous Calendar Year, 2.) a detailed overview of the Contractor's identified health equity goals/objectives for the upcoming Calendar Year, and 3.) targeted strategies/interventions planned for the upcoming Calendar Year to achieve its goals.
3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended that AHCCCS continue its oversight of the Contractors as they continue to monitor and maintain existing provider networks, with specific attention to pediatric dentists in Apache, Coconino, and La Paz counties and pharmacies in Apache and Coconino counties.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* Due to the delay experienced in finalizing and publishing the CYE 2020 EQR reports, AHCCCS included a summary of activities related to the recommendations included within these reports that occurred during the current reporting period (CYE 2021). AHCCCS anticipates continued follow-up to further address these recommendations during CYE 2022.

HSAG made recommendations to AHCCCS for improving the quality of healthcare services furnished to AHCCCS members in the *Contract Year Ending 2020 External Quality Review Annual Report*.[3-8] These recommendations for DCS CHP are summarized in Table 3-3, along with AHCCCS' response.

Table 3-3—Follow-Up on Prior Year Recommendations from AHCCCS for DCS CHP Program

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS support DCS CHP and its subcontracted health plan to increase rates for the performance measures that failed to meet the CYE 2019 Minimum Performance Standard (MPS) related to access to care.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* AHCCCS implemented a *Back to Basics* PIP (Baseline Measurement Year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year. Calendar Year 2021 served as an intervention year (to account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design). AHCCCS collaborated with the Contractors (via a variety of stakeholder meetings and ad-hoc information seeking requests conducted during the report year) to identify experienced barriers, current activities, and potential performance improvement strategies for enhancing performance in pediatric access to care. AHCCCS transitioned from utilizing EQRO calculated rates to measure and report Contractor-level data to utilizing Contractor-calculated performance measure rates that have undergone EQRO validation starting with its calendar year 2020 performance measures. Beginning with its CYE 2021 contract amendments, AHCCCS transitioned from its use of internally established MPS to the use of national benchmark data (i.e., NCQA HEDIS Medicaid Mean and CMS Medicaid Median) to evaluate Contractor performance. AHCCCS also intends to utilize line of business specific historical performance data to evaluate Contractor, line of business, and agency performance.
2. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG recommended that AHCCCS monitor the progress of DCS CHP in implementing CAPs for required actions following the most recent review.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)*

[3-8] Arizona Health Care Cost Containment System. *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Complete Care and Comprehensive Medical and Dental Program (CMDP)*, July 2021. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2020/CYE2020ExternalQualityReviewAnnualReportACCandCMDP.pdf. Accessed on: Jan 19, 2022.

2. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
Due to the delay experienced in finalizing and publishing the CYE 2020 EQR reports, AHCCCS included a summary of activities related to the recommendations included within these reports that occurred during the current reporting period (CYE 2021). AHCCCS anticipates continued follow-up to further address these recommendations during CYE 2022.

4. Quality Initiatives

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services. The July 2021 enhanced Quality Strategy and Quality Strategy Evaluation, 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 several initiatives and best practices underway aimed at building a more cohesive and effective healthcare system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology (HIT), and working with private sector partners to further innovation to the greatest extent.

Systemwide Quality Initiatives/Collaboratives

Accessing Behavioral Health Services in Schools[4-1]

AHCCCS covers medically necessary behavioral health services for Medicaid-enrolled students. Many of these services are provided directly on school campuses, making it easier for students to get services where they are, and as soon as they need help.

The Arizona Department of Education (ADE) and AHCCCS created the Behavioral Health Resource Guide for principals, other education administrators, school mental health professionals, and anyone who wishes to be a voice that promotes the need for school mental health resources in Arizona.

Jake's Law Covers Students Without Insurance

In 2020, the Arizona State Legislature allocated $8 million for behavioral health services in school settings for students who are underinsured or uninsured. Known as the Children's Behavioral Health Services Fund (or Jake's Law), schools must develop a policy to refer students for behavioral health services, and to allow families to opt-in or opt-out of the referral process each year. This funding is available through June 2022.

[4-1] Arizona Health Care Cost Containment System. Accessing Behavioral Health Services in Schools. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/. Accessed on: Jan 10, 2022.

Behavioral health services under this funding are provided to students by participating health care providers contracted with the three Regional Behavioral Health Authorities (RBHAs): Mercy Care (in Central Arizona), Arizona Complete Health Complete Care (in Southern Arizona), and Health Choice Arizona (in Northern Arizona).

Project AWARE

Project AWARE is a federal initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to build and expand the partnership between education and mental health systems at both the state and local levels. The Arizona Project AWARE team is a partnership between ADE, AHCCCS, and three local school districts. Project AWARE is focused on ensuring access to behavioral health services for students by establishing referral pathways and formal communication between schools, parents, and behavioral health providers. Project AWARE also works to support the implementation of suicide prevention trainings as required by the Mitch Warnock Act.

Building A Health Care System: Care Coordination and Integration[4-2]

AHCCCS has various initiatives designed to improve care coordination and communication while reducing fragmentation to create a healthcare system with more effective outcomes. AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources.

ALTCS EPD Members

ALTCS EPD has been integrated since its inception in 1989. Individuals covered under an ALTCS EPD plan have always received integrated physical, behavioral health, and long term-services and support through one health plan. Additionally, each individual enrolled in one of AHCCCS' ALTCS EPD plans is assigned a dedicated case manager at the health plan level who provides care coordination and advocacy for the member.

Medicare and Medicaid Dual Eligibles

Medicare presents one of the greatest challenges to states serving individuals dually eligible for Medicaid and Medicare. Medicare is its own distinct, complex system of care operated by the federal government with little to no interface with state Medicaid programs. For the over 170,000 Arizonians who are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, individuals "fall through the cracks," inefficient care is provided, and optimal health outcomes are not achieved.

[4-2] Arizona Health Care Cost Containment System. Building an Integrated Health Care System. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/. Accessed on: Feb. 23, 2022.

AHCCCS continues developing integration initiatives to increase alignment and improve service delivery for individuals covered by both Medicare and Medicaid. AHCCCS moved toward increasing the coordination of health service delivery between the two health programs by contracting with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are affiliated with its partner Medicaid health plan. Requiring each Medicaid health plan to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual-eligible members in the same health plan for both Medicare and Medicaid services to the greatest possible extent. Enrolling in specialized Medicare plans allows dual-eligible members to receive all their healthcare services, including prescription drug benefits, from a single, integrated health plan.

Persons with an SMI Designation

In Arizona, behavioral health has historically been a carved-out benefit separately managed by RBHAs. As such, a person with an SMI designation could navigate up to four different healthcare systems to get care. Navigating the healthcare system is one of the greatest barriers to accessing care. The results for Arizonians with an SMI designation were less than optimal. Concerns around poor medication management and stigma caused many people to forgo physical healthcare. Because many persons with SMI also experience comorbidities, management of chronic diseases like diabetes or hypertension was also poor.

The RBHAs play a critical role in providing integrated physical and behavioral health services for members with an SMI designation. Enrollment in each geographic service area (GSA) as of September 1, 2021, for Title XIX/XXI covered members determined to have an SMI designation:

- North GSA: 6,272.
- Central GSA: 26,822.
- South GSA: 14,305.

The RBHAs provide crisis services including telephone, community-based mobile, and facility-based stabilization (including observation not to exceed 24 hours), and SAMHSA grants and other services, including housing. Effective October 1, 2021, Arizona Behavioral Health Corporation began administering the AHCCCS Housing Program to provide a housing support program for individuals with mental health issues who are experiencing homelessness.

On October 1, 2022, AHCCCS is updating its contracts with MCOs for health insurance coverage for individuals with an SMI designation. Select ACC Contractors will have expanded responsibilities as an ACC Contractor with a Regional Behavioral Health Agreement (ACC-RBHA). The ACC-RBHAs will be responsible for the provision of integrated care addressing physical health and behavioral health for members with an SMI designation. AHCCCS will continue to work collaboratively with the ACC-RBHAs to evaluate methods to reduce program complexity, administrative burden, and unnecessary administrative and medical costs and to improve care coordination and disease/chronic care management.

Beginning October 1, 2018, ACC plans became the integrated health plans for the majority of AHCCCS members. This transition affected approximately 1.5 million members. Through this major system initiative, AHCCCS has streamlined the service delivery system for members who had previously needed to coordinate physical and behavioral health benefits through two separate health plans while also simplifying the payment streams for the services received by members. This transition also included the flexibility for individuals designated to Children's Rehabilitative Services (CRS) to choose their ACC plan.

Children with Special Health Care Needs (SHCN): CRS

CRS was started in 1929 to serve children with complex healthcare needs who require specialized services. Services for the treatment of CRS qualifying conditions were previously managed solely through the CRS program. Medicaid members would then have to access routine or other non-CRS specialty physical healthcare through their AHCCCS acute plan and behavioral health through the RBHA. For children who were Medicare eligible, the family had one additional hurdle. Arizona families attempting to care for their child with special healthcare needs were being asked to navigate up to four healthcare systems.

Beginning October 1, 2018, members that qualify for a CRS designation and are not enrolled with DES/DDD have a choice of ACC plans in their area. The ACC plan manages care for all services (including CRS, other non-CRS physical health services, and all covered behavioral health services). Effective October 1, 2019, members enrolled with DES/DDD use their assigned DES/DDD plan for all of their CRS and non-CRS physical health and behavioral health services. DES/DDD continues to provide long-term care services for these members. On April 1, 2021, CMDP changed to DCS CHP. American Indian and Alaska Native members with a CRS designation have a choice of an ACC plan or the American Indian Health Program, thus minimizing the need for members to navigate multiple systems for care.

ALTCS DD Members

DES/DDD serves as the ALTCS Contractor for members with intellectual and developmental disabilities. Beginning October 1, 2019, for its membership, DES/DDD assumed the responsibility of covering behavioral health services and services for those with qualifying CRS conditions. DES/DDD delegated this responsibility to two integrated subcontracted health plans—Mercy Care Plan and UnitedHealthcare Community Plan. ALTCS DD enrollment as of September 2021 was 37,072.

Integrating Services for Children and Youth in the Foster Care System

On April 1, 2021, CMDP changed to DCS CHP. Children in foster care are able to get physical health, including CRS services, and behavioral health services from one health plan, through a subcontracted health plan named Mercy Care DCS CHP. Covered services for children in foster care remain the same. Enrollment as of September 2021 was 13,657.

Justice System Transitions

AHCCCS has partnered with state and county governments to improve coordination within the justice system and create the most cost-effective and efficient ways to transition individuals leaving the criminal justice system. A significant number of men, women, and children transitioning out of jail and prison into communities are in need of services for behavioral and physical health conditions. Many of these individuals are eligible for Medicaid.

To facilitate the transition, AHCCCS is engaged with the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR), the Arizona Department of Juvenile Corrections (ADJC), and most Arizona counties covering the majority of the State's population, including the two largest—Maricopa and Pima—in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. This exchange allows ADCRR, ADJC, and county jails to electronically send discharge dates, which simplifies the process of transitioning directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon discharge. To support this, AHCCCS Contractors are required to have a justice systems liaison that can ensure a connection to needed behavioral health services following release. In addition, AHCCCS medical management coordinates with counties to facilitate a transition of care into ACC health plans for persons being discharged with serious physical illnesses, such as cancer or other illnesses, that present public health concerns or require immediate attention.

Electronic Visit Verification[4-3]

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS mandated Electronic Visit Verification (EVV) for nonskilled (attendant care, personal care, homemaker, habilitation, respite) and in-home skilled nursing services (home health) services on January 1, 2021. In addition to the legislative intent of EVV to prevent, detect, and recover improper payments due to fraud, waste, and abuse, AHCCCS is using EVV to ensure, track, and monitor timely service delivery and access to care for members receiving services in their homes or community.

Emergency Triage, Treat and Transport to Transform EMS Delivery[4-4]

The Emergency Triage, Treat and Transport initiative (ET3) is a voluntary, five-year CMS Innovation Center Payment Model designed to provide greater flexibility to ambulance care teams addressing emergency healthcare needs. The goal of this program is to decrease unnecessary transports to emergency departments and reduce hospital admissions, while simultaneously connecting members with the appropriate level of care, at the right time and at the right place, in order to improve quality and

[4-3] Arizona Health Care Cost Containment System. Electronic Visit Verification. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/. Accessed on: Feb 22, 2022.
[4-4] Arizona Health Care Cost Containment System. Emergency Triage, Treat and Transport (ET3). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/ET3/. Accessed on: Feb 22, 2022.

reduce costs. AHCCCS began reimbursing qualified emergency transportation providers for providing ET3 services on and after October 1, 2021.

AHCCCS Housing Programs[4-5]

The AHCCCS Housing Programs (AHP) provide Non-Title XIX/XXI State General Funded permanent supportive housing (PSH) programs to assist members with a designation of SMI or with a general mental health and/or substance use disorder (GMHSUD) who are experiencing homelessness or housing instability. AHP follows the SAMHSA community-based permanent supportive housing standards that specify that members should have a renewable lease, the right of entry and exit (not restricted by program), and can voluntarily select services. Housing subsidies are provided for permanent supportive housing in scattered unit sites (Scattered Site Program) and dedicated site-based units (Community Living Program). All units must meet minimum health and safety standards set forth by Federal Housing Quality Standards (HQS) and have a reasonable rent based on market standards. AHP also provides housing-related supports and payment such as deposits, move-in assistance, eviction prevention, and damage(s) related to member occupancy.

PSH related Medicaid reimbursable wrap-around supportive housing services not only help AHCCCS members obtain and maintain housing, but also help lower utilization of emergency and crisis services.

Health Equity Committee[4-6]

Formally established in July 2020, the Health Equity Committee is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS-eligible individuals and members. This committee is responsible for overseeing and managing recommendations as they relate to policy, data, health plan oversight, and emerging healthcare innovation strategies for over 2 million Arizonians.

Healthy People 2030 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

This committee is responsible for identifying health disparities among AHCCCS-eligible individuals and members by using AHCCCS utilization and quality improvement data to advance policy and/or contracting strategies to improve the health equity of AHCCCS' populations and programs. This committee will communicate existing health equity strategies currently being implemented by the

[4-5] Arizona Health Care Cost Containment System. AHCCCS Housing Programs. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHP/. Accessed on: Jan 10, 2022.
[4-6] Arizona Health Care Cost Containment System. Health Equity Committee. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/HEC/index.html. Accessed on: Jan 10, 2022.

agency, identify needed improvements to existing strategies (if appropriate), develop and/or evaluate key metrics, and articulate future interventions aimed at eliminating health disparities.

Committee goals:

- Understand health disparities among AHCCCS members.
- Effectuate policy changes and support the implementation of strategies for positive improvement where known disparities exist, creating opportunities for the more equitable provision of services and supports.
- Raise the visibility of AHCCCS' commitment to health equity and the strategies in place to ensure the equitable provision of services and supports.
- Improve health outcomes for AHCCCS members.
- Identify challenges and barriers that AHCCCS members have in accessing covered services.

Incentivizing Quality: Payment Modernization[4-7]

Modernizing the way healthcare services are purchased means rethinking the end product. Traditional reimbursement structures favor the provider with higher production numbers (i.e., performs more services without regard to outcome). To bend the cost curve, there must be a paradigm shift such that reimbursement favors the provider who achieves a quality health outcome. That is why payment modernization is a critical policy strategy for moving to a financially sustainable and value-based healthcare delivery system.

To that end, AHCCCS is continuing its pursuit to implement long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based healthcare systems where patients' experiences and population health are improved through aligned incentives with Contractor and provider partners, and there is a commitment to continuous quality improvement and learning.

Strategies

- Align Payer & Provider Incentives: Establish payment systems that encourage collaboration to improve affordability, access, and quality results for individuals.
- Payment and Care Delivery Transformation: Transform the healthcare delivery system and achieve the three-part aim outlined by the Institute of Medicine (IOM): better care, healthy people/healthy communities, and affordable care.
- Innovate through Competition: Enact performance expectations that reward innovation and results.
- Pay for Value: Pay for outcomes of care rather than quantity of care.

[4-7] Arizona Health Care Cost Containment System. AHCCCS Payment Modernization. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/. Accessed on: Jan 10, 2022.

- Collaborative Learning: AHCCCS is a committed partner in the Health Care Payment Learning and Action Network (LAN), The goal of the LAN is to accelerate the healthcare system's adoption of effective alternative payment models (APMs). AHCCCS will work to continue to shift an increasing percentage of payments into Categories 3 and 4 value-based structures. The LAN also has a compendium of APM resources for healthcare providers and payers.

Improving Communications: Health Information Technology[4-8]

Since 2006, AHCCCS providers and Contractors have been supporting a single statewide HIE, Health Current, a Contexture organization. AHCCCS encourages providers to adopt health information technology tools that help store and share member health records, streamline the delivery of healthcare services, and improve member healthcare outcomes.

Between 2011 and 2021, AHCCCS and CMS administered an electronic health record (EHR) incentive program that awarded $691 million to Arizona providers for installing EHR systems. To help healthcare providers move from paper-based records to electronic health records to be able to easily retrieve and transfer data, AHCCCS implemented the Arizona Medicaid Electronic Health Record Incentive Program. The incentive payment program was designed to support qualified providers with health information technology transition and instill the use of EHRs in meaningful ways to improve the quality, safety, and efficiency of patient healthcare.

Benefits of adopting EHR technology include:

- More real-time clinical information to better inform provider care planning.
- Increased administrative efficiencies.
- Potential to reduce repeated health-related testing.
- Improved communication between providers.

December 31, 2021, was the final day that states could make Medicaid Promoting Interoperability Program payments to Medicaid eligible professionals (EPs) and hospitals.

Connecting Communities: The Importance of Private Sector Partners[4-9]

The AHCCCS program was founded on a competitive, public/private partnership model. AHCCCS began in 1982 as the first statewide mandatory managed care program, placing all enrollees (except American Indians/Alaska Natives) in health plans for acute care, long-term care, and behavioral health

[4-8] Arizona Health Care Cost Containment System. Using Technology to Improve Patient Care. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/HIT/. Accessed on: Jan 10, 2022.
[4-9] Arizona Health Care Cost Containment System. Connecting Communities: The Importance of Private Sector Partners. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/PrivateSectorPartners/. Accessed on: Jan 10, 2022.

(known as RBHAs). Medicaid managed care has evolved and answered the call toward continued innovation and population health strategies.

These Contractors do far more than simply pay claims. Today's health plans use sophisticated data analytics tools to assess member risk and develop innovative intervention protocols. In addition, health plans engage their members in person-centered approaches. This often means engaging families and communities, too, so that members have the tools they need to manage their own health. This level of engagement also assists the health plan in developing strategies that respond to community needs. The connection, relationship, and transparency between AHCCCS and the health plans as well as the community, providers, and members served is integral to a successful public/private partnership.

Telehealth Services[4-10]

Delivering healthcare services through telehealth provides an alternative way for AHCCCS members to see their healthcare providers. AHCCCS covers all major forms of telehealth technologies and holds ongoing discussions with contracted managed care health plans, providers including Indian Health Services (IHS)/ Tribal (638) facilities, and members to determine how telehealth should be leveraged to serve AHCCCS members and improve health outcomes.

Telehealth is the use of digital technology, like computers, telephones, smartphones, and tablets, to access healthcare services remotely. AHCCCS members who cannot travel to an office can use these devices from their homes to attend healthcare appointments with their healthcare providers. Telehealth can make access to healthcare more convenient, saving time and transportation costs.

AHCCCS covers all major forms of telehealth services. Asynchronous (also called "store and forward") occurs when services are not delivered in real-time but are uploaded by providers and retrieved, perhaps to an online portal. Telephonic services (audio-only) use a traditional telephone to conduct healthcare appointments. Telemedicine involves interactive audio and video, in a real-time, synchronous conversation. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.

During the COVID-19 PHE, AHCCCS added flexibilities to telehealth coverage to promote physical distancing and limit the spread of COVID-19 while also promoting access to healthcare; these flexibilities are posted in the AHCCCS COVID-19 FAQs on telehealth.[4-11]

[4-10] Arizona Health Care Cost Containment System. Telehealth Services. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/. Accessed on: Jan 11, 2022.

[4-11] Arizona Health Care Cost Containment System. Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19). Telehealth Delivery and Billing. Available at: https://www.azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#telehealth. Accessed on: Jan 11, 2022.

Transforming Healthcare Delivery: Targeted Investments (TI) Program[4-12]

The TI Program provides financial incentives to eligible AHCCCS providers to develop systems that integrate and coordinate physical and behavioral healthcare. The TI Program aims to reduce fragmentation that occurs between acute care and behavioral healthcare, increase efficiencies in service delivery for members with behavioral health needs, and improve health outcomes for the affected populations.

In accordance with 42 CFR §438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral healthcare for Medicaid members.

AHCCCS 2021 Year in Review[4-13]

The COVID-19 PHE continued to be an overarching priority in 2021. AHCCCS also achieved significant innovations in technology, policy, and service delivery that streamlined business processes and improved care coordination.

Innovations in Service Delivery and Technology

- Awarded Competitive Contract Expansion contracts to three AHCCCS ACC Contractors to serve individuals with a SMI designation.
- Submitted the AHCCCS Housing and Health Opportunities (H2O) demonstration waiver request to CMS, aimed at enhancing the availability of housing-related services and support for individuals experiencing homelessness or at risk of homelessness.
- Expanded the existing Medicaid School Based Claiming program to allow all Medicaid-enrolled children to access health care services on school campuses (not just those students with an Individualized Education Program).
- Implemented the ET3 program to reduce unnecessary transports to emergency departments and allow members to be transported to alternate destinations.
- Launched the Opioid Services Locator tool and fostered increased community opioid and stimulant primary prevention efforts; developed a toolkit on psychostimulants, fentanyl, and targeted strategies on counterfeit pills.
- With the State's HIE, launched a closed loop referral system to make it easier for clinicians to connect members to needed social services.

[4-12] Arizona Health Care Cost Containment System. Targeted Investments Program Overview. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/. Accessed on: Jan 11, 2022.

[4-13] Arizona Health Care Cost Containment System. 2021 Year in Review. Available at: https://www.azahcccs.gov/shared/Downloads/News/2022/2021YearInReview.pdf. Accessed on: Jan 17, 2022.

- Implemented Arizona's EVV program to ensure access to care for members who receive in-home services and supports.
- Provided behavioral health services to 6,000 students either on school campuses or in established clinics in response to referrals for services.
- In alignment with the Home and Community Based Services (HCBS) Enhanced Federal Match provision allowing states to supplement existing funding, AHCCCS submitted a spending plan for more than $1 billion detailing how the agency will use additional federal funding to strengthen and enhance the HCBS system of care for seniors, individuals with disabilities, individuals with a SMI designation, and children with behavioral health needs.

Response to the COVID-19 Public Health Emergency

- Maintained coverage for all members enrolled during the federally declared public health emergency; enrollment increased nearly 24 percent over the last 22 months.
- Implemented strategies to increase COVID-19 vaccination rates among vulnerable AHCCCS members, including mobile-based vaccine distribution for members enrolled in ALTCS. Achieved ALTCS vaccine rates as high as 78 percent.
- Maintained the Crisis Counseling Program to help individuals and communities recover from the PHE; served more than 17,000 unique individuals statewide with crisis counseling and group counseling/public education.
- Distributed over $18 million in additional COVID-19 relief funding to nursing facilities.

Other Systemwide Quality Initiatives/Collaboratives[4-14]

Promoting Access in Medicaid and CHIP Managed Care

Published by CMS in June 2021, the Promoting Access in Medicaid Managed Care: Behavioral Health Provider Network Adequacy Toolkit highlights AHCCCS' efforts to integrate physical and behavioral health services for Medicaid members in Arizona.[4-15] By integrating physical and behavioral health services it made it easier for the AHCCCS to require managed care plans to cover primary and behavioral health care integration and to coordinate services between the two. Arizona used the TI Program to promote the integration and coordination of physical and behavioral healthcare for Medicaid

[4-14] Arizona Health Care Cost Containment System. Awards, Studies, and Highlights. Available at: https://www.azahcccs.gov/AHCCCS/AboutUs/awardsandstudies.html. Accessed on: Jan 17, 2022.

[4-15] Center for Medicare & Medicaid Services. *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit*, June 2021. Available at: https://www.azahcccs.gov/shared/Downloads/News/2021/CMSPromotingAccessinMedicaidandCHIPManagedCareJune2020.pdf. Accessed on: Jan 27, 2022.

members. Arizona also includes a differential adjusted payment to increase services in rural and remote areas, such as tribal lands. Through this payment program, managed care plans provide a rate increase to eligible providers for all claims and encounters with AHCCCS across the state.

Arizona enhanced access to services by approving asynchronous technologies, such as store-and-forward, which allows for the electronic transmission of medical information. This supports clinical decision making for providers and increases efficiency.

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

Arizona Paid Caregiver Survey Report

In Arizona, paid caregivers—including direct care workers, paid family caregivers, and direct support professionals, among others—provide critical daily support to thousands of older adults and people with disabilities. As the need for these essential workers escalates, the state faces a pressing question: what can be done to improve paid caregiving jobs and enhance the supports that these workers deliver? To help address this question, the organization, PHI, partnered with four AHCCCS managed care organizations to survey the paid caregiver workforce about their experiences and insights. The survey findings revealed the following recommendations and opportunities for improvement:

- Support paid caregivers during the COVID-19 PHE.
- Promote diversity, equity, and inclusion.
- Improve access to additional hours and full-time schedules.
- Recruit new workers online while also leveraging personal connections.
- Implement supportive supervisory practices.
- Promote existing advancement opportunities and create new career pathways.
- Expand training opportunities for paid caregivers.
- Include paid caregivers' voices when evaluating interventions.

MACPAC June 15, 2021, Report to Congress

The Medicaid and CHIP Payment and Access Commission (MACPAC) highlighted Arizona's Non-Emergency Medical Transportation (NEMT) benefit, integrated benefit for dually eligible populations, and crisis system in its June 15, 2021, report to Congress.

The NEMT benefit allows members to access secure, comfortable, and reliable transportation for nonemergent need, if they are not able to provide, secure, or pay for transportation on their own, and free transportation is not available. Additionally, the state is maximizing its Medicare Improvement for

Patients and Provider Act (MIPPA) authority by providing fully integrated care for dually eligible members. Furthermore, Arizona provides crisis services including three regional 24-hour hotlines, mobile crisis response teams, and facility-based crisis stabilization. The crisis system in Maricopa County, Arizona which provides these three core components, led to an estimated $260 million reduction in inpatient spending by providing crisis services.

Spotlight on Member Engagement and Elevating the Consumer Voice

States and MCOs use member advisory councils to shape Medicaid strategy, service design, delivery, and program structure at the state and plan level. Elevating the consumer voice through advisory councils ensures that the experiences of Medicaid members inform program design and policy decisions and improve access to care. However, while advisory councils are a mechanism for elevating member voice and input on Medicaid and health plan service delivery, consumer engagement and retention within these advisory structures is often very challenging. This study completed by the nonpartisan and objective research organization NORC at the University of Chicago details how Banner Health and AHCCCS are working together to engage Medicaid members in advisory councils. Strategies to support more effective member engagement in advisory councils include:

- Train members in leadership, policy, and governance structures.
- Offer incentives to demonstrate to members that their time and input is valued.
- Leverage data to inform issue areas.
- Develop and formalize clear processes for raising issues within the plan and to the state.
- Establish close Contractor-state collaboration.
- Establish a feedback loop that communicates changes or results back to the community.
- Work closely with community-based organizations.

Social Determinants of Health (SDOH) and Risk Adjustment: Arizona Medicaid Innovations

AHCCCS recently updated the methodology for risk adjusting the capitation rates paid to ACC Contractors. With the recent recognition of the impact that socio-economic factors have on an individual's well-being, health outcomes, and health care costs, several state Medicaid programs have begun to incorporate a limited number of social risk factors (commonly referred to as social determinants of health [SDOH]) into their risk adjustment methodologies.

Medicaid Forward: Behavioral Health

AHCCCS was highlighted for its crisis services in Medicaid Forward: Behavioral Health, a report published by the National Association of Medicaid Directors that provides examples of evidence-backed, sustainable policy and program solutions that states are implementing to improve Medicaid members' mental health and well-being. AHCCCS' programs and policies include:

- Forming a task force to address behavioral health concerns arising due to the COVID-19 PHE.
- Providing peer support to members with an addiction and supporting a training academy for peers.
- Operating regional 24-hour crisis telephone lines to respond to individuals in need and dispatch mobile response teams, if necessary.
- Directing plans to cover services provided by 24-hour crisis stabilization/observation and detox facilities, 24-hour outpatient clinics, and crisis response.
- Supporting information exchange between Medicaid and the corrections department.

5. Assessment of Contractor Follow-Up to Prior Year Recommendations

From the findings of each Contractor performance for the CYE 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to AHCCCS members. The recommendations provided to each Contractor for the EQR activities in the *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Complete Care and Comprehensive Medical and Dental Program (CMDP)*, July 2021, are summarized below, along with each Contractor's response and HSAG's assessment of the degree to which the response was addressed, partially addressed, or not addressed. HSAG may have made minor edits to enhance readability. Some of the Contractors may have included rates in their responses to the recommendations. Please note that these are self-reported rates and are not validated by AHCCCS or the EQRO.

AzCH-CCP ACC

Table 5-1—Prior Year Recommendations and Responses for AzCH-CCP ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services. HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. Additionally, HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
AzCH-CCP ACC's Response: AzCH-CCP ACC currently has multiple interventions around *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits*, *Children and Adolescents' Access to Primary Care Practitioners*, and *Annual Dental Visit*. Interventions included Behavioral Health Residential Facility

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
(BHRF) Well and Dental Visit Direct Outreach, where QM staff will be educating BHRF staff on the importance of well and dental visits for members in residence, as well as coordinating members to obtain such services. In CYE 2020, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) team hosted 17 BHRF Zoom meetings in order to educate BHRF staff about importance of closing care gaps with EPSDT age members, reviewed the recommended frequency of well visits according to the EPSDT Periodicity Schedule, CDC Immunization schedule, and impact of psychiatric medication on health, i.e., weight gain, diabetes, and dental complications. The information was well received, and the EPSDT team assisted in coordination with BHRF to provide members the needed services. AzCH-CCP ACC has implemented multiple interventions to increase member engagement around breast cancer and cervical cancer screenings. Promotoras are community service workers who conduct outreach to members in Yuma and Maricopa who have identified care gaps. They assist in scheduling appointments and address barriers to completing those appointments. The promotoras successfully outreached a total 515 members and assisted in making appointments for members with breast cancer and/or cervical cancer screening gaps. AzCH-CCP ACC has implemented various interventions in CYE 2020 to increase follow-up after hospitalization for both 7-day and 30-day. For example, Wellth, a medication adherence reward program that incentivizes members to take their daily medication. In CYE 2020, the Wellth program was a success, with a 96% average adherence among enrolled members who completed their session. The medication adherence was 88% for all members who engaged with the program, including members who did not necessarily complete their session. The total number of members who activated was 3,044 and the total number of members who completed their session was 2,003. This program was well received by the eligible populations, and Wellth reported members outreaching them to enroll without prompting. The following provider education and outreach interventions cross all performance measures: Provider outreach campaigns (community meetings, provider panels, and a top 50 provider outreach). AzCH-CCP ACC also provided frequent support to strategic partners to increase performance by providing progress via monthly quality meetings, provision of performance measure reports, references, and tools. Strategic partner support was provided on a monthly basis with offered performance scorecards, care gap lists, and educational materials. These meetings provided opportunities for strategic partners to identify internal opportunities and review health plan data for inconsistencies with their own. Additional provider education and outreach interventions included provider education materials (*Path to 5 Stars Quick Reference Guide for Quality Measurements*, inclusive of current and baseline performance measures), and presentations on preventive care and well visits during the provider essential communication call.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG Assessment: HSAG has determined that AzCH-CCP ACC has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC plans should continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
AzCH-CCP ACC's Response: AzCH-CCP ACC attributes the statistically significant increases for all indicators to the success of the implemented interventions. However, the targeted provider technical outreach driven by the EPSDT tracking form information and internal claims report gave the AzCH-CCP ACC EPSDT team the path to concentrate where their actions would provide the most influence. Additionally, AzCH-CCP ACC completed an internal project focused on the processing and follow-up of EPSDT tracking forms and subsequently developmental screening forms. This revised process has expanded the use of the internal medical health record capabilities and assisted in flushing out the reporting capabilities so targeted outreach occurs in a timelier manner. The AzCH-CCP ACC EPSDT team includes education and additional information regarding the benefits of well-child visits during all provider outreach, which includes the targeted EPSDT provider outreach, monthly provider essential calls, and the top provider-specific workgroups. These are also methods used to solicit information regarding barriers that the provider has identified and begin collaboration on how to address them. The AzCH-CCP ACC EPSDT team has incorporated all interventions into a standard process to continue the excellent progress made since the beginning of this performance improvement project.
HSAG Assessment: HSAG has determined that AzCH-CCP ACC has addressed the prior year recommendation.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for AzCH-CCP ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
AzCH-CCP ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
HSAG recommended that each ACC Contractor should continue to monitor and maintain its existing provider network as of CYE 2020 Quarter 3, with specific attention to ensuring the availability of the

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
following provider types among the applicable ACC Contractors (note that AzCH-CCP ACC does not serve Apache or Coconino counties): • Pediatric dentists in Apache, Coconino, and La Paz counties. • Pharmacies in Apache and Coconino counties.
AzCH-CCP ACC's Response: AzCH-CCP ACC has closed the dental network gap in La Paz County. This was achieved by diligent work through CYE 2020 and CYE 2021 by our provider network to outreach and contract with as many available dentists in La Paz as possible. Additionally, to continue to provide accessible services, AzCH-CCP worked to bring mobile dental clinics to rural and underserved areas. These mobile clinics were paused in 2020 and through the majority of 2021 due to the public health emergency.
HSAG Assessment: HSAG has determined that AzCH-CCP ACC has addressed the prior year recommendation.

BUFC ACC

Table 5-2—Prior Year Recommendations and Responses for BUFC ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services. HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. Additionally, HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

BUFC ACC's Response:

Given the significant decrease in all performance measures, BUFC ACC will continue to implement and slightly modify some interventions to improve on the measures to include greater emphasis on strategies that align with the public health emergency strategies to slow the spread of COVID-19.

BUFC ACC continued to emphasize the importance of comprehensive visits for children and adolescents and women's screening for breast cancer and cervical cancer.

BUFC ACC implemented the following member and provider initiatives to increase access to primary care practitioners for children and adolescents and access to annual dental services:

- Member annual EPSDT reminder cards
- Provider in-person and virtual site visits by health plan clinical quality analyst to review EPSDT requirements and list of members in need of service
- 100 percent review of provider-submitted EPSDT forms to ensure provider compliance with the EPSDT Periodicity Schedule
- Continued partnership with select value-based purchasing (VBP) providers to share information and develop collaborative outreach initiatives to ensure that members are receiving all preventative health services
- Updated member handbook indicating that a well-child visit/check is synonymous with EPSDT
- Provider education forum on EPSDT
- Dental mailers that include dental home notification, broken appointment notification, dental reminder, EPSDT Annual Checkup reminder, and Healthy Beginnings information.

BUFC ACC implemented the following initiatives related to cervical cancer screenings:

- Provider in-person and virtual site visits by clinical quality analyst EPSDT coordinators who visit provider sites to review EPSDT requirements
- Member newsletter article on cervical cancer screening
- Provider manual information on cervical screening requirements
- Facebook articles educating on the importance of preventive screenings
- VBP collaboration—data sharing on cervical cancer screening performance
- Cervical cancer screening postcard reminder notifications to eligible members

BUFC ACC will work with providers and members to establish potential performance improvement strategies and solutions to increase comprehensive visits for children and adolescents that follow the American Academy of Pediatrics' (AAP's) Recommendations for Preventive Pediatric Health Care.

Although COVID-19 continued to negatively impacted the follow-up after hospitalization for mental illness 7- and 30-day member and provider initiatives measures, as members were fearful of receiving services on site due to COVID-19, BUFC ACC implemented the following initiatives:

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Include measures in the VBP program • BUFC ACC system of care is creating the attribution model to better align members with health homes if they have utilized one to determine specific follow-up • BUFC ACC contracts with the Terros Bridging Gap program to perform this outreach and follow up with this specific population • New AHCCCS/Health Plan shared project with focus on follow-up after hospitalization for behavioral health issues began 2021 with focus on new technology advances in the HIE to support better coordination of care among hospitals and providers • The importance of this measure and all performance measures is shared with providers and members consistently through newsletters • Early Implementation strategy using Pyx health application (Pyx health app) outreach about the importance of follow-up after all hospitalizations is in place and shared with those BUFC ACC members utilizing the Pyx health app. • Continued tracking and trending of claims data. • BUFC ACC is looking to implement the BLAZE platform to monitor and track outreach and engagement after hospitalization as well as follow up appointment scheduling and adherence for members. Additionally, BUFC ACC implemented the following *Ambulatory Care, ED Visits* improvement strategies: • BUFC ACC engaged high-risk/high-use members into case management services • BUFC ACC provides transition of care support for those high ED utilizers or high risk for ED bounce back • BUFC ACC provides ongoing notification of high ED utilizers to providers • Nurse Now and urgent care education provided to members and providers • BUFC ACC uses New York University criteria to identify avoidable ED visits for follow-up
HSAG Assessment: HSAG has determined that BUFC ACC has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC plans continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
BUFC ACC's Response: PIPs continue to be extremely important and valuable projects that maintain focus on a particular topic to its resolution or improvement. As such, BUFC ACC has continued to track improvements in previously submitted and closed PIPs.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG Assessment: HSAG has determined that BUFC ACC has partially addressed the prior year recommendation.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for BUFC ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
BUFC ACC ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
HSAG recommended that each ACC Contractor continue to monitor and maintain its existing provider network as of CYE 2020 Quarter 3, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors (note that BUFC ACC does not serve Apache or Coconino counties): • Pediatric dentists in Apache, Coconino, and La Paz counties • Pharmacies in Apache and Coconino counties Additionally, BUFC ACC should continue to review quarterly PAT data files for accuracy prior to submitting the files to AHCCCS.
BUFC ACC's Response: BUFC ACC covers the following counties: Central and Southern GSAs, Maricopa, Gila, Pinal, Pima, Yuma, Cochise, La Paz, Graham, Greenlee, and Santa Cruz. BUFC ACC has completed an analysis of time/distance requirements for members with a noted opportunity for improvement in La Paz County related to pediatric dentists.
HSAG Assessment: HSAG has determined that BUFC ACC has partially addressed the prior year recommendation.

Care 1st ACC

Table 5-3—Prior Year Recommendations and Responses for Care 1st ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommends that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommends that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. Additionally, HSAG recommends that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
Care 1st ACC's Response: For the *Children and Adolescents' Access to Primary Care Practitioners* measure, Care1st demonstrated significant improvement in performance for two of the measure indicators: 7–11 Years and 12–19 Years. The *Children and Adolescents' Access to Primary Care Practitioners* measure is retired starting in MY 2020; therefore, CYE 2019 represents the last year ACC Contractors were evaluated for this measure. During 2021, COVID-19 continued to negatively impact members' willingness and/or ability to access routine dental services, as evidenced by a significant drop in the NCQA national mean. Based on quantitative and qualitative analyses, COVID-19 continues to pose a barrier, as parents/healthcare decision makers are reluctant to seek services. Despite this challenge, Care1st has actively continued outreach to parents/healthcare decision makers to remind them of the importance of good oral health for their children and that they can safely visit their dental providers. In addition, Care1st expanded its outreach for younger children in MY 2021, to encourage the receipt of dental services beginning at 1 year of age and establishing a dental home provider. It also provided oral health outreach to pregnant women to educate them about how to care for their infants' teeth; a flyer is sent to pregnant members in their third trimester, which includes information on how to clean baby's mouth and that the first dental visit should take place around the baby's first birthday. This information is also included in the Newborn Welcome call made to new moms. Outreach by text and mail to parents/healthcare decision makers also continued, as well as direct outreach to members 18–20 years old. Care1st staff continued sharing gaps in care for this measure with provider groups, along with their rates compared with Care1st overall, and worked with value-based primary care providers to encourage improved performance in referring pediatric members for dental services, which has been shown to improve completion of dental visits. Under a contract with DentaQuest, the Contractor's dental benefit manager, dentists also received information regarding gaps in care and are incentivized to complete visits, particularly preventive services.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
During 2021, Care1st provided focused educating on the *Follow-Up After Hospitalization for Mental Illness* performance measure to both behavioral health and physical health providers, sharing reference material in one-on-one meetings, provider forums, and on the Plan's website. It also worked to expand the number of providers who are able to offer Medication Assisted Treatment (MAT), since opioid use disorder is a top contributing factor to mental health-related admissions. Care1st care coordinators and care managers continued to assist members with making and attending their 7-day follow-up appointments, utilizing an inpatient discharge report to aid in identifying members immediate to discharge. During 2021, Care1st undertook a variety of member-facing activities for the *Breast Cancer Screening* performance measure, including attempting to contact members with gaps in care to make appointments for screening, utilizing Member Newsletter articles to educate members on the risks associated with breast cancer and importance of regular screening mammography, and sending text messages to members with gaps in care. Provider-facing interventions included sending provider rosters identifying members with gaps in care for breast cancer screening, sharing performance with value-based providers compared to their peers overall, and distributing Breast Cancer Screening Measure Guides with appropriate billing codes to providers. During 2021, Care1st undertook a variety of member-facing activities for the *Cervical Cancer Screening* performance measure, including attempting to contact members with gaps in care to make appointments for screening, utilizing Member Newsletter articles to educate members on the risks associated with cervical cancer and when screening should be done, and sending text messages to members with gaps in care. Provider-facing interventions included sending provider rosters identifying members with gaps in care for cervical cancer screening, and sharing performance with value-based providers compared to their peers overall.Care1st analyzed data by GSA, county, and race/ethnicity for the HEDIS measure of Child and Adolescent Well Visits (WCV) for MY 2020 to identify disparities and opportunities among children in the submeasure of ages 3 to 11 years. In CYE 2021, Care1st performed analysis of measurement year (MY) 2020 rates by Geographic Service Area (GSA), county, race/ethnicity, primary language spoken and age group to identify disparities in utilization of services and opportunities for improvement.
HSAG Assessment: HSAG has determined that Care 1st ACC has addressed the prior year recommendation.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC plans continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
Care 1st ACC's Response: Care1st continued to promote well-child visits and developmental screenings through enhanced parental education via text focused on the barrier of parents/caregivers lacking specific information about what to expect at different ages and thus, a lack of interest in or compliance with early well-

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
child visits and developmental screenings. The Plan also continued to work with providers to address many of the concerns physicians had about conducting developmental screenings that were identified at the beginning of the PIP, such as reimbursement uncertainty, insufficient training, and limited knowledge or availability of referral options for follow-up assessments and services. While the implementation of AHCCCS policy to reimburse providers for developmental screening separate from the well-child visits addressed the physician concern of cost, it was the efforts of the Plan to educate providers about this separate reimbursement and how to claim it that contributed to the success of the PIP. As of October 2021, Care1st further improved its rate of developmental screening in MY 2020, with a rate of 40.0%.
HSAG Assessment: HSAG has determined that Care 1st ACC has addressed the prior year recommendation.
3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for Care 1st ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
Care 1st ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.
4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
HSAG recommended each ACC Contractor continue to monitor and maintain its existing provider network as of 2020 Quarter 3, with specific attention to ensuring the availability of the following provider types, as applicable to the contractors' GSAs (note that Care 1st does not serve La Paz County): • Pediatric dentists in Apache, Coconino, and La Paz counties • Pharmacies in Apache and Coconino counties
Care 1st ACC's Response: During the previous contract year, Care1st continued to use Quest Analytics software to verify the adequacy of the geographic distribution of its PCP, OB/GYN, dental, behavioral health, specialist, and pharmacy providers serving both the ACC and KidsCare populations. Quest Analytics reports are run quarterly and map the existing membership against the contracted practice sites and locations of the identified providers. The results of the availability analysis are reviewed against AHCCCS standards outlined in Policy 436 of the AHCCCS Contractor Operations Manual (ACOM) and used to update the Network Needs List. The Network Needs List was and continues to be used throughout the year to correct network gaps through recruiting efforts focused on key areas without desired access to care. In addition to the specialties that are broken out in the analysis, Care1st works to contract with all other available specialties in its geographic service areas. Through this analysis, network management targets zip codes and provider types identified as at risk for failure to meet AHCCCS and Care1st standards.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
Pediatric Dentists: Care1st partners with DentaQuest to administer its dental program. Care1st and DentaQuest used the AHCCCS saturation data to identify any opportunities to recruit new providers, and found that the Plan is already contracted with the providers or that the providers are not viable due to being IHS providers, providers are out of adequacy guidelines, or the data was incorrect. Pharmacies: Care1st used Quest analytics reports and the AHCCCS Saturation data to identify gaps and any opportunities to recruit new providers. The pharmacy network is delegated and administered by CVS Caremark, Care 1st's pharmacy benefit manager (PBM). CVS Caremark is responsible for the recruitment and management of the pharmacy network. As a national PBM, CVS Caremark maintains a large pharmacy network with most national pharmacy chains, as well as independent and in-store pharmacy providers. Both CVS Caremark and Care1st continue to use geographic mapping software to assess for possible inadequacies in the pharmacy network. Behavioral Health Outpatient and Integrated Clinics, Adult: Care1st continued to perform analyses to identify gaps and will continue to closely monitor any changes in the network and potential recruitment opportunities. To ensure members in this county receive needed services, outpatient behavioral health and integrated clinics have been providing telehealth services to adult members in Apache County. Behavioral Health Outpatient and Integrated Clinics, Pediatric: Care1st continued to perform analyses to identify gaps and will continue to closely monitor any changes in the network and potential recruitment opportunities. To ensure members in this county receive needed services, outpatient behavioral health and integrated clinics have been providing telehealth services to adult members in Apache County.
HSAG Assessment: HSAG has determined that Care 1st ACC has addressed the prior year recommendation.

HCA ACC

Table 5-4—Prior Year Recommendations and Responses for HCA ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. Additionally, HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
HCA ACC's Response: HCA performed analysis and developed an action plan for the *Annual Dental Visits* measure. Action plans for this measure included: • Quarterly claims review to be used for data collection. • Collaboration to increase the number of oral health fairs. • Partnership to bring a mobile dental van to rural communities to close gaps in care. • Delivery of member roster with gaps in care to providers on a monthly basis. • Outreach to members through phone calls and written communication. • Identification of EPSDT tracking forms with dental referrals and contact the member/parents for follow-up. • Monitoring of provider submission of Missed Dental Appointment logs and follow-up on members with missed appointments to educate, address barriers, and assist in rescheduling. HCA also performed analysis and developed an action plan for the *Follow-Up After Hospitalization for Mental Illness* measure. Action plans for this measure included: • Working with hospitals on discharge planning and notifications. • Health Care Buddies program, calling members to remind them of follow-up appointments. • Stand-Alone Transition of Care (TOC) program that would assist those individuals needed follow-up care and coordination of other services, SDOH housing. • Readmission analysis, how to present to providers, lack of follow-up. • Work group meeting regularly, data analysis, discharge plans reviewed from hospitals for provider intervention. • Health Current ED alerts, if admitted, possible Provider Portal utilization.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Action plans for adolescent well-care visits included claims being used for data collection; education and outreach to the members/parents/guardians on the importance of EPSDT/well-visits through monthly member newsletters, birthday cards, reminder letters, and phone communication; and collaboration to organize health fairs and assist with calls to schedule appointments. Action plans for breast cancer screenings included providing practices with mammogram gaps-in-care rosters and working with providers on orders and follow through; medical record review to identify potential opportunities to close gaps-in-care and assist with provider education; coordinating activities with vendor partners such as Simon Medical and AZ Tech Radiology; and providing member education through website communication. Action plans related to cervical cancer screenings included coordinating scheduling through appropriate staff on member care team; working with providers on orders and follow through; reviewing best practices of provider groups scoring well on the measure; member outreach; delivering cervical cancer screening gap lists to primary care providers; and implementing a text message campaign before or after the phone call to let members know why HCA is/was calling.
HSAG Assessment: HSAG has determined that HCA ACC has addressed the prior year recommendation.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC plans continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
HCA ACC's Response: HCA has made significant improvement in the *Developmental Screening* measure since the initiation of the CAP. The baseline rate for the measure was 24.1%. The rate during remeasurement year 2 was 34.9%, demonstrating and overall relative percentage change of 44.8%. The HCA PIP Team, EPSDT Team, and provider representatives have continued their efforts to improve this measure. For CYE 2021, HCA has made the following action plan for the *Developmental Screening* measure: • EPSDT tracking forms will be reviewed for developmental screening notation. • The EPSDT management will pull a quarterly report of providers who have low completion rates and collaborate with the Quality Management team to educate the need to conduct and document screening using the appropriate tools. • Education to providers on the availability of additional reimbursement when a developmental screening is performed using AHCCCS-approved tool. • Outreach calls will be conducted to encourage parents/guardians to discuss any concerns with the child's development at their EPSDT appointment and request screening, when appropriate.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HCA has completed the following analysis of the action plan and results. The EPSDT staff continued to screen all tracking forms and identify the ones sent without developmental screening documentation. Noncompliant providers were notified immediately and educated on the requirement of screening members during the 9-, 18-, and 24-month EPSDT visit. HCA makes monthly outreach to providers to educate on the proper billing for the developmental screening tools. In Q2, HCA contacted and educated 37 providers. HCA has continued member outreach to educate on the importance of developmental screenings and for the parents to ask for it during the EPSDT visit. Education will be provided through the member newsletter and during outreach calls to parents of members between the ages of 0 and 2 years old.
HSAG Assessment: HSAG has determined that HCA ACC has addressed the prior year recommendation.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for HCA ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
HCA ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
HSAG recommended each ACC Contractor continue to monitor and maintain its existing provider network as of CYE 2020, Quarter 3, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors (note that HCA ACC serves all identified counties): • Pediatric dentists in Apache, Coconino, and La Paz counties • Pharmacies in Apache and Coconino counties
HCA ACC's Response: HCA ACC strived to proactively identify potential network gaps, engage in recruitment efforts, and develop innovative approaches to ensure continuity of care and member access to services. HCA further ensured that for each county served, geo-mapping reports via Quest Analytics reflect the time and distance from their original residence. Interventions taken to resolve network issues have included individual meetings and technical assistance with providers, fax blasts, provider forums and CEO meetings where technical assistance was provided, and internal technological improvements such as greater website and portal functionality. HCA ACC has a broad pharmacy network that is not anchored to our PBM [pharmacy benefit manager] (CVS), giving our members more 24-hour store options. Our pharmacy network includes Walgreens and all major grocery stores. In addition, HCA ACC members have the opportunity to fill prescriptions using mail order pharmacy for personalized delivery via United States Postal Service (USPS). HCA ACC monitored access in all counties due to

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
the nationwide shortage of pharmacists, but has consistently attained a 99% overall network adequacy score. Over the past year, HCA ACC has aligned members with physicians who focus on improving the quality of healthcare delivered and achieving optimal clinical outcomes. We have also filled network gaps by adding dentists, behavioral health care providers, orthopedic practices, and hospitals to the network. We have expanded crisis stabilization services in the Northern Arizona GSA, the continuum of substance use disorder treatment, and specialty services, while adhering to COVID-19 safety protocols. HCA ACC currently meets all RBHA AHCCCS time and distance standards. We identified issues with our ACC network of pediatric dentists (Coconino/Apache) and pediatric PCPs (Coconino), both of which were caused by recent changes in member residence and provider office locations. In response, we worked in coordination with a pediatric dental office in Northern Arizona to provide mobile dentistry, added teledentistry, and provided transportation to neighboring counties. We are actively working to increase capacity in all identified areas by recruiting new providers, collaborative residency and intern programs, mobile health clinics, and by identifying new technologies to support members in rural areas. In addition to conducting outreach to all of the identified dental providers to discuss network expansion opportunities, HCA has implemented the following initiatives to address network gaps: • The first initiative is the Dental Health Fairs: HCA partners with dental practices to schedule overdue or noncompliant children for examinations and preventive treatment. HCA identifies members with care gaps, outreaches to them, distributes educational materials, and schedules their appointments at a scheduled health fair. All Dental Health Fairs are attended by HCA staff to help ensure a smooth and successful process. These events are held on weekends to provide opportunities for working families to attend.
HSAG Assessment: HSAG has determined that HCA ACC has addressed the prior year recommendation.

Mercy Care ACC

Table 5-5—Prior Year Recommendations and Responses for Mercy Care ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. Additionally, HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
Mercy Care ACC's Response: Initiatives related to *Children and Adolescents' Access to Primary Care Practitioners 25 months–6 years; Children and Adolescents' Access to Primary Care Practitioners 12–19 years;* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* included digital outreach to members in need of a well-child visit (text messaging, email, interactive voice response [IVR] calls); program incentives; telephone outreach to members turning 3–6 years of age (completing a three-way call with their provider to schedule the visit will be conducted); written reminders and second reminders; member financial incentive to complete a well-child visit; written provider outreach; electronic provider gaps in care notifications; and provider site visits. Initiatives related to *Follow-Up After Hospitalization for Mental Illness* included digital outreach to members after hospitalization (text messaging, email, IVR calls); IVR calls to members post-discharge to ensure members are aware of the importance of post-discharge follow-up visits; VBS program incentives for members receiving FUH visit within three days of discharge; and Tableau inpatient census report shared with ACOs and providers to ensure they are aware of member discharges and can assist with coordinating a follow-up visit. Interventions and activities in place to increase compliance with *Breast Cancer Screenings* and *Cervical Cancer Screenings* included digital outreach to members in need of a well-woman visit (text messaging, email, IVR calls); written educational outreach; partnership with SimonMed imaging to close gaps in care; coordination with providers for members who are due for a mammogram to sign an order form that MC then utilizes to contact the member and assist with scheduling mammogram; member financial incentives; electronic provider gaps in care notifications; and provider site visits.
HSAG Assessment: HSAG has determined that Mercy Care ACC has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC plans continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
Mercy Care ACC's Response: Interventions and activities in place to increase compliance with developmental screening included monitoring of the provider data management system to determine if providers submitting developmental screenings have evidence of a developmental screening training certificate; site visits with providers to provider education on developmental screening; written provider outreach, which includes mailings to PCPs for members in need of an EPSDT visit(s) and/or immunizations, which included a reminder on the requirement to conduct developmental screenings at the 9, 18, and 24 month visits; provider mailing listing the requirements for developmental screenings, which also included resources for providers; Developmental Screening 101 Flyer; and inclusion of developmental screening in value-based service (VBS) incentive contracts.
HSAG Assessment: HSAG has determined that Mercy Care ACC has addressed the prior year recommendation.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for Mercy Care ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
Mercy Care ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
HSAG recommended each ACC Contractor continue to monitor and maintain its existing provider network as of CYE 2020 Quarter 3, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors (note that Mercy Care ACC does not serve Apache, Coconino, or La Paz counties): • Pediatric dentists in Apache, Coconino, and La Paz counties • Pharmacies in Apache and Coconino counties Additionally, Mercy Care ACC should continue to review quarterly PAT data files for accuracy prior to submitting the files to AHCCCS.
Mercy Care ACC's Response: Mercy Care is not contracted in these areas for ACC; Mercy Care has no reported fails in any contracted areas for any service. Mercy Care routinely reviews PAT data files for accuracy prior to submission.
HSAG Assessment: HSAG has determined that Mercy Care ACC has addressed the prior year recommendation.

MCC ACC

Table 5-6—Prior Year Recommendations and Responses for MCC ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services. HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. Additionally, HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
MCC ACC's Response: MCC ACC identified potential root causes related to low access to care performance for the performance measures that failed to meet the CYE 2019 MPS related to access to care, the *Follow-Up After Hospitalization for Mental Illness* performance measure, and preventive screenings for women measures and established new and enhanced interventions: evidence-based practices shown to be effective in the same/similar populations. Interventions included internal, external, member-focused, and provider-focused interventions and are described below. Performance measures that failed to meet the CYE 2019 MPS related to access to care: • A comprehensive review of nonadherent members was done to uncover specific missing provider mapping gaps • Increased data capture by increasing outreach to providers to receive additional supplemental data feeds and EHR access • MCC ACC implemented a member rewards gift card program for members who received well-care visits to increase member incentive • Increased MCC ACC administrative support for member and provider outreach • Launched welcome calls and quality measure outreach to members to educate the members and/or their guardians on the importance of well-child visits

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Follow-Up After Hospitalization for Mental Illness: • Increased telehealth utilization for members due to the COVID-19 PHE • Increased coordination of care through engaging regularly with behavioral health inpatient hospitals to educate and support timely admission/discharge notifications and importance of scheduled timely follow-ups • Increased MCC ACC administrative support for member and provider outreach • A comprehensive review of nonadherent members was done to uncover specific missing provider mapping gaps Preventive screenings for women: • Increased data capture by increasing outreach to providers to receive additional supplemental data feeds and EHR access (these include service providers as well as lab/imaging providers) • Increased MCC ACC administrative support for member and provider outreach • Launched welcome calls and quality measure outreach to members to educate members on the importance of preventive breast and cervical cancer screenings
HSAG Assessment: HSAG has determined that MCC ACC has addressed the prior year recommendation.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC Contractors continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
MCC ACC's Response: MCC ACC did not provide a response regarding PIPs.
HSAG Assessment: HSAG has determined that MCC ACC has not addressed the prior year recommendation.
3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for MCC ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
MCC ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Analysis:
HSAG recommended each ACC Contractor continue to monitor and maintain its existing provider network as of CYE 2020 Quarter 3, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors (note that MCC ACC does not serve Apache, Coconino, or La Paz counties): • Pediatric dentists in Apache, Coconino, and La Paz counties • Pharmacies in Apache and Coconino counties
MCC ACC's Response: Not applicable, as MCC ACC does not serve any of the identified counties.
HSAG Assessment: Not applicable.

UHCCP ACC

Table 5-7—Prior Year Recommendations and Responses for UHCCP ACC

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services. HSAG recommended that AHCCCS work with the ACC Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2019 MPS. The ACC Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issues (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. HSAG recommended that AHCCCS work with the ACC Contractors to increase preventive screenings for women. The ACC Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers. The ACC Contractors should ensure that members receive screenings in accordance with the United States (U.S.) Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and cervical cancer.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
UHCCP ACC Response: UHCCP, following its CYE 2020 Work Plan, implemented a series of member and provider-based interventions designed to improve the access to care for members. Member and provider interventions included: • Member financial incentive to obtain a well-child visit; • IVR calls to guardians of members to schedule a well-child visit with their assigned PCP; • Live outbound calls to guardians of members to help facilitate the scheduling of a visit with the child's PCP and address any barriers that adversely impact access to care; • Reminder letters to guardians of members to schedule a well-child visit with their PCP; • Provider gaps-in-care reports given to the majority of our providers on a monthly basis listing members in need of access to care; value-based contracts with our largest provider groups financially incentivizing providers to improve access to care; and • Financial incentive to 100 provider groups to improve their performance on well-child measures. UHCCP also implemented a series of actions designed to help the member schedule an appointment with a behavioral health professional after discharge from a hospital for mental illness, including: utilization management assistance with scheduling appointment with members for follow-up after discharge; outreach to low-performing facilities to discuss/address barriers to finding aftercare appointments; provide identified facilities with resources such as provider look up website, information about Express Access program, and telemental health options (as appropriate); provide additional resources as needed, such as verified list of outpatient providers with timely access; and value based contracts with behavioral health homes that includes the performance measure *Follow-up After Hospitalization for Mental Illness*. In addition, as a means to further improve UHCCP's performance on the *Cervical Cancer Screening* measure, in CYE 2021 UHCCP sent a biannual "Cervical Cancer Screening Flyer and Cover Letter" to members who had not received this preventative health care service.
HSAG Assessment: HSAG has determined that UHCCP ACC has addressed the prior year recommendation.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the ACC plans continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
UHCCP ACC Response: UHCCP ACC will continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers. UHCCP has improved the percentage of members obtaining developmental screening from 22.3% in 2016 to 37.4% in 2019. UHCCP has continued to demonstrate progress with improving the

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
percentage of members receiving developmental screening. UHCCP calculated the CYE 2020 *Developmental Screening* rate and is currently at 45.3%. UHCCP has submitted to AHCCCS the CYE 2022 work plan and the following are the planned member and provider initiatives designed to maintain and continuously improve upon the health plan's performance on developmental screening: • Educate providers in bulletins and/or newsletters annually on the enhanced reimbursement the requirement of completing training for each tool and training opportunities • Provider education at the quarterly provider forums and distributed to providers directly via Clinical Practice Consultants (CPCs) • CPC provider site visits include review of developmental screenings and list of members 9, 18, and 24 months of age who are due for screening • Track rates and report results quarterly in the EPSDT quarterly reports • Live outbound telephone calls to 8-month-olds that incorporates message to guardian to request developmental screening at 9, 18, and 24 month well child visits • Mailing to guardians of 9-month old's encouraging the guardian to talk to their doctor about developmental screening
HSAG Assessment: HSAG has determined that UHCCP ACC has addressed the prior year recommendation.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for UHCCP ACC for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
UHCCP ACC's Response: This section is not applicable, as no recommendations were provided in CYE 2020.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended each ACC Contractor continue to monitor and maintain its existing provider network as of CYE 2020 Quarter 3, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors (note that UHCCP ACC does not serve Apache, Coconino, or La Paz counties): • Pediatric dentists in Apache, Coconino, and La Paz counties • Pharmacies in Apache and Coconino counties Additionally, UHCCP ACC should continue to review quarterly PAT data files for accuracy prior to submitting the files to AHCCCS.
UHCCP ACC Response: UHCCP is not contracted in the counties of Apache, Coconino, and La Paz counties for the ACC LOB.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
UHCCP evaluates the contracted network on a quarterly basis. When gaps in the network are identified, UHCCP conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted to include noncontracted providers and any new providers that enter the county. UHCCP ACC's review also includes research through various public resources, such as the internet and phone book directories. These reviews are conducted monthly to ensure any new or expanding providers are approached and brought into the network.
HSAG Assessment: HSAG has determined that UHCCP ACC has addressed the prior year recommendation.

DCS CHP

Table 5-8—Prior Year Recommendations and Responses for DCS CHP[5-1]

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended AHCCCS work with the ACC Contractors to increase rates for the performance measures that failed to meet the CYE 2019 MPS related to access to care. Once the causes are identified, the ACC Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase access to primary care practitioners for children and adolescents and access to annual dental services.
DCS CHP's Response: CYE 2021 was a year of significant transition for DCS CHP. Integration required significant coordination and attention to the ability of members to seamlessly transfer from CMDP to DCS CHP. As such, DCS CHP has taken over the efforts from CMDP to address performance measure improvement. For MY 2020 performance as reported by DCS CHP, interventions and activities in place to increase compliance with the measures *Children and Adolescents' Access to Primary Care Practitioners 25 months–6 years; Children and Adolescents' Access to Primary Care Practitioners 12–19 years;* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* included digital outreach to members in need of a well-child visit (text messaging, email, IVR calls); VBS program incentives; telephone outreach to members turning 3–6 years of age (completing a three-way call with their provider to schedule the visit will be conducted); written reminders and second reminders; member financial incentive to complete a well-child visit; written provider outreach; electronic provider gaps in care notifications; and provider site visits.

[5-1] DCS CHP previously operated as CMDP; as such, recommendations are listed in the *Contract Year Ending 2020 External Quality Review Annual Report* for CMDP.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Interventions and activities in place to increase compliance with the measures *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-up—Total* included digital outreach to members after hospitalization (text messaging, email, IVR calls); IVR calls to members post-discharge to ensure members are aware of the importance of post-discharge follow-up visits; VBS program incentives for members receiving FUH visit within three days of discharge; and Tableau inpatient census report shared with ACOs and providers to ensure they are aware of member discharges and can assist with coordinating a follow-up visit.
HSAG Assessment: HSAG has determined that DCS CHP has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the Contractors continue to promote well-child visits and developmental screenings with providers and work to keep lines of communication with providers open to continue to identify and address barriers.
DCS CHP's Response: Prior to April 1, 2021, DCS CHP conducted activities to address the developmental screening of children in foster care. Any additional activities planned were severely curtailed during the COVID-19 PHE in 2020 and 2021. Activities conducted were limited to: • Monthly review all EPSDT forms and the screening tools submitted by providers. • Developmental screening tool education sent out to providers through at least two provider newsletters; • Maintaining updated developmental screening tool resources online for providers. • Developmental screening and services were also addressed in coordination with Arizona Early Intervention Program (AzEIP) and AzEIP providers, on entry of the child into the health plan. After April 1, 2021, the above activities continued with the DCS CHP subcontracted health plan. The following are additional interventions and activities that occurred in 2021: • Monitoring the Council for Affordable Quality Healthcare (CAQH) credentialing database to determine if providers submitting developmental screenings have evidence of a developmental screening training certificate. • Site visits with providers to provider education on developmental screening. • Written provider outreach, which includes mailings to PCPs for members in need of an EPSDT visit(s) and/or immunizations, which includes a reminder on the requirement to conduct developmental screenings at the 9, 18, and 24 month visits. • Provider mailing listing the requirements for developmental screening, which also includes resources for providers. • Developmental Screening 101 Flyer. Inclusion of developmental screening in VBS incentive contracts.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG Assessment: HSAG has determined that DCS CHP has addressed the prior year recommendation.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG made the following general recommendations: • DCS CHP 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, DCS CHP should ensure that current policies and documents include adequate details of its processes. This was evident more frequently in the Grievance Systems and Adult, EPSDT, and Maternal Health standard areas. • DCS CHP 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. • DCS CHP should request technical assistance meetings with AHCCCS on areas of deficient knowledge and processes.
DCS CHP's Response: DCS CHP collaborated with its subcontracted health plan to ensure a smooth transition as it pertained to HSAG OR recommendations. Moving forward, future activities will be conducted in collaboration with the DCS CHP subcontracted health plan. Aspects of this transition included but were not limited to: oversight of medical record review processes, ongoing audits, collaborating with the DCS CHP subcontracted health plan to develop oversight processes related to quality reviews, working with the DCS CHP subcontracted health plan to analyze prior authorization data to determine the best approach to prior authorizations for DCS CHP members, continuous internal trainings, continuously updating policies and procedures as necessary, and engaging in several meetings to assist in transitions in the area of OR.
HSAG Assessment: HSAG has determined that DCS CHP has addressed the prior year recommendation.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG did not provide recommendations for DCS CHP for network adequacy.
DCS CHP Response: Not applicable.
HSAG Assessment: Not applicable.

6. Contractor Best and Emerging Practices

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

AzCH-CCP ACC

- Lab2u at Home Lab Kits: The Lab2u at home lab kits are designed to deliver lab tests for HbA1c at no cost to the member for AzCH-CCP ACC members 18–75 years of age with diabetes (types 1 and 2). Members can complete the tests in the comfort of their own home, increasing access to care during the COVID-19 PHE. Lab tests are returned via mail by the member for lab processing and results are then forwarded to the member and member's primary care physician for any necessary outreach and follow up. AzCH-CCP ACC achieved an increased return rate for the HbA1c lab kits of 25% from MY 2020 to MY 2021 and consistent improvement in the Comprehensive Diabetes Care – Poor Control (HbA1c > 9%) (CDC – A1c) performance measure.
- Wellth: Wellth is a medication adherence reward program available to members through a smart phone application. AzCH-CCP ACC incentivized members for completing daily tasks aimed at educating and creating healthy medication habits and increasing medication adherence. The program was well-received and successful in 2020, with a 96% average adherence among enrolled members who completed their sessions, and the program showed a higher adherence rates for the 180-day program vs the 90-day program that members were placed in. During 2021, AzCH-CCP ACC revised the Wellth program to cover 12 months for 2021 and was relaunched in July 2021 and is currently underway.
- Pyx Health: AzCH-CCP ACC launched Pyx Health, a mobile application to address loneliness, social isolation, assist in developing a support system, and support with social determinates of health (SDOH). On average, Pyx onboards 45 members per month and as of October 2021, AzCH-CCP ACC had over 1,300 members onboarded. Members who had accessed Pyx more than once showed a decrease in their loneliness score compared to their original screening score.

BUFC ACC

- Annual Dental Visits 2-20 Years: BUFC ACC recognizes the importance of oral health during childhood and prevention of more serious dental issues. To increase the number of children ages 2-20 years old receiving preventative dental service(s), BUFC ACC ensures that all dental referrals are attended to. The BUFC ACC Quality Department conducts telephones outreach to non-compliant members/caregivers to assist them in scheduling preventative dental visits. Dental educational materials are provided to members through the member newsletter and social media. BUFC ACC partnered with a dental vendor (DentaQuest) to identify members who are due for preventative treatment and provide educational materials and appointment reminders. Additionally, the BUFC ACC Quality Outreach team, targeted members who missed two preventative dental visits to

schedule a dental visit. These efforts showed an 8.76% increase in preventative dental visits completed.

- Breast Cancer Screening: With the increasing rate of breast cancer, BUFC ACC distributes annual mailings to non-compliant members regarding mammography and the importance of screenings. Additional interventions such as, educating members on the important of cancer screenings and providing assistance with scheduling at an image facility are provided by BUFC ACC. For additional member education, BUFC ACC posts Facebook articles on preventative cancer screenings. The Quality Department has a partnership with Assured Imaging, a mobile mammogram unit vendor. Assured Imaging hosted various mammogram events in 2021 with plans to host more events in 2022. During the breast cancer awareness month of October, the Quality team observes the month by focusing on mammogram member outreach. The breast cancer screening measure is also part of BUFC ACC's Value-Based Contracts to help increase mammogram screenings with providers.
- Follow-Up After Hospitalization for Mental Illness (FUH): BUFC ACC developed multiple interventions to increase the number of follow-up appointments for members to ensure better health outcomes. AHCCCS and BUFC ACC are working on interventions to include a more comprehensive health information exchange (HIE) for all level providers in hospitals and emergency departments (ED) to ensure better coordination of care and appointment adherence. BUFC ACC interventions include:
  - Creation of the attribution model to better align members with health homes to determine specific follow up.
  - Banner Health University Plans (BUHP) behavioral health discharge coordinators have daily team meetings with behavioral health medical directors to support comprehensive discharge plans, including access to 7-day follow-up appointments and other services.
  - Readmission staffing takes place to ensure complex members have comprehensive services upon discharge, as applicable.
  - BUFC ACC has new contracts with Terros Bridging the Gap program to perform outreach and follow-up with specific populations.
  - AHCCCS, CMS, and BUFC ACC launched a shared project in 2021 with focus on *Follow-Up After Hospitalization* for behavioral health issues.
  - Strategies are discussed at meetings with behavioral health providers, clinics, medical directors, and CEO's.
  - Current planning is underway to implement an Integrated Network of Southern Arizona, which will focus on strategies to maximize outcomes and adherence to treatment for complex members.
  - Early implementation strategy using Pyx Health application for outreach and attempt telephonic contact about the importance of follow-up after hospitalization.
  - In 2022, implementation plan of BLAZE, a technical platform to support share information regarding member discharge and outpatient appointment scheduling and adherence for members and providers.

Care 1st ACC

- Maternal and Child Health Outreach: from Healthy Pregnancy to Healthy Childhood: Care1st ACC is focused on increasing timely access to prenatal and early well-child services. Care1st ACC uses a high-touch, tailored approach to outreach to pregnant women and parents/health care decision makers of EPSDT members in the first 30 months of life, with a goal of reaching all members and parents. This approach utilized tailored telephone counseling, which has been shown to improve adherence to obtaining preventive services.[6-1] Upon initial phone contact, a maternal and child health care engagement specialist assesses the member's needs based on their individual circumstances, including asking questions to detect potential depression, which trigger referral to case management for potential behavioral health (BH) and/or substance use disorder (SUD) services. Assessment is followed by advising the member of available services, getting agreements for services, and assisting with services. Members contacted receive a maternity "welcome packet" with information to assist them on their pregnancy and postpartum journey. Upon completion of prenatal and postpartum visits, members are eligible for incentives. A newborn welcome call and postpartum calls continue the support to new moms. EPSDT care engagement specialists outreach based on the AHCCCS EPSDT Periodicity Schedule during the baby's first two years, using the high-touch, tailored approach. The goals of the outreach initiative include improving the rate of timely prenatal visits, improving the rate of postpartum visits, and improving well-visits during the first 30 months of life. Goals are assessed according to current specifications for HEDIS measures.
- Pacify Mobile Application: Care1st ACC was the first Arizona health plan to utilize Pacify, an innovative application for smart phones. The application allows members in the late stages of pregnancy or up to one year after the baby's birth to instantly call a certified lactation consultant, registered dietitian, or registered nurse for help and advice at any time, seven days a week. Pacify is an evidenced-based approach to improving health outcomes for new moms and babies. Care1st ACC made Pacify available at no cost to members, to facilitate "virtual visits" with a lactation consultant or dietitian via video call. Pacify also provides one-touch connection to registered nurses through the NurseLine, assistance from the Care1st ACC maternity/postpartum staff, or connection to a Crisis Hotline for urgent BH issues. After enrollment in Pacify, members receive push notifications sent to their phone that provide important health education and reminders, that are tailored to each member's delivery date or baby's date of birth.
- Text Messaging: Using an evidence-based approach, Care 1st ACC continued to engage members through text messaging that goes beyond simply sending messages with reminders of services needed or generic health education. Research shows that interactive and tailored text messages are successful in promoting self-activation among Medicaid members.[6-2] A centerpiece of Care1st ACC's strategy to reach and activate members is sending tailored short messages to members. Text

[6-1] Miller S, Azor Hui S, Wen KY, et al. Tailored telephone counseling to improve adherence to follow-up regimens after an abnormal pap smear among minority, underserved women. *Patient Education and Counseling*. December 2013; 93(3):488-95.
[6-2] Gates A, Stephens J, Artiga S. Profiles of Medicaid Outreach and Enrollment Strategies: Using Text Messaging to Reach and Enroll Uninsured Individuals into Medicaid and CHIP. Kaiser Family Foundation. March 2014 Issue Brief. Available at: https://www.kff.org/medicaid/issue-brief/profiles-of-medicaid-outreach-and-enrollment-strategies-using-text-messaging-to-reach-and-enroll-uninsured-individuals-into-medicaid-and-chip/. Accessed on: Jan 19, 2022.

messages sent to pregnant and postpartum members contain a URL link and a brief intro message that connects the member to a visually engaging web page, with educational content aimed at the member's stage of pregnancy, based on weeks of gestation. The messages for members birth to 15 months have an educational focus on developmental milestones, as well as immunizations, well visits and parenting tips, based on the child's age in weeks.

- Community Partnerships: Care1st ACC employs several community partnership initiatives to support improved health outcomes. These initiatives are based on evidence that connecting members to needed resources – from food and housing to financial assistance and childcare – can help eliminate barriers to care and pave a path toward better health and independence.[6-3, 6-4, 6-5] Care1st ACC community partnership initiatives for CYE 2021 included:
  - Community Connections Help Line – Peer coaches provide a comprehensive needs assessment and then refer members to organizations that can address their needs. During the call, peer coaches can check for and assist in closing care gaps. Within a couple weeks, they follow up to make sure that the member's needs were fulfilled. The Care1st ACC Member Advocacy team also sends out a resource newsletter to staff twice a month, which contains useful information on programs that may help members and contacts for these community resources.
  - Care1st Avondale Resource and Housing Center – The Avondale Resource and Housing Center was the first of its kind in the Southwest Valley, made possible by an innovative public-private partnership between Care1st ACC and the City of Avondale. Care1st ACC funds operations for the center, while the city of Avondale is responsible for recruiting participating non-profit agencies, coordinating their services, and evaluating the outcomes. The non-profits are provided space in the center at no cost in exchange for providing the much-needed services in the Southwest Valley (note: this facility has been transferred to Care1st ACC's affiliated health plan, which serves the Central GSA, as of October 1, 2021).
  - Pop-up "Welcome Rooms" – The pop-up "welcome rooms" are located at selected community organizations and provide information and assistance to visitors, regardless of whether they are Care 1st ACC members, and serve as sites for special events, such as health screenings. Our Welcome Room strategy in Arizona also includes engagement efforts through promotoras and community health workers, peer and family support specialists, and care coordinator staff. The Welcome Room is staffed by Care1st ACC associates who are trained to respond to current and prospective members.
  - Home Matters – Care1st ACC formed partnerships designed to strengthen the network of housing resources. In 2020, Care1st ACC made a large donation to "Home Matters to Arizona" to support affordable housing and healthier communities. The Home Matters to Arizona Fund

[6-3] Pruitt Z, Emechebe N, Quast T, et al. Expenditure reductions associated with a social service referral program. *Population Health Management*, Vol. 21, No. 6. Available at: https://www.liebertpub.com/doi/10.1089/pop.2017.0199. Accessed on: Jan 19, 2022.

[6-4] Pruitt Z, Lyons Taylor P, Bryant KM. A managed care organization's call center–based social support role. *The American Journal of Accountable Care*. March 2018, Vol. 6, Issue 1. Available at: https://www.ajmc.com/view/a-managed-care-organizations-call-center-based-social-support-role. Accessed on: Jan 19, 2022.

[6-5] Taylor L. Housing and Health: An Overview of the Literature. Health Affairs. June 7, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/. Accessed on: Jan 19, 2022.

was created by eight AHCCCS health plans, including Care1st ACC, through the Arizona Association of Health Plans. Access to safe, stable housing has been shown to reduce injuries and illnesses, such as asthma and other lung diseases, infections, and lead poisoning. As well as helps reduce mental health issues like depression and substance abuse.[6-6]

  - Broadband Action Team – Care1st ACC has been a leader among Arizona health plans in driving access to increased broadband services in Arizona. Care1st ACC is an active member of the Broadband Action Team and participates in the brainstorm and planning sessions focused on addressing infrastructure issues and needs. Care1st ACC made a large donation to the Arizona Broadband Stakeholder Network, which is focused on strategies to accelerate deployment of affordable and reliable broadband internet access throughout Arizona and has representation on the Southwest Telehealth Resource Center and the Northern Arizona Telehealth Alliance. Additionally, Care1st ACC continues to advocate for rural and tribal communities and their telehealth needs. Care1st ACC's Member Advocacy department is working with community-based organizations (CBOs) to promote the Emergency Broadband Benefit (EBB) to members, including households participating in Medicaid.
  - Mohave County Childhood Immunization Steering Committee – The committee was a joint effort by Care1st ACC, First Things First (FTF), Health Choice, Northern Arizona Healthcare, and The Arizona Partnership for Immunization (TAPI). The focus of the committee was community outreach and engagement for completion of dental visits, immunizations, and child well-care visits. Localized health fairs were hosted with the support of community health clinics and individual providers to provide community resources for those in need. Outreach was done to members with gaps in care who lived within the geographical location of the health fair and appointments were made by the health plan and confirmed by the community clinic and providers. Additionally, transportation was arranged for members who needed it.

- Members Unable to Contact: Medicaid health plans often receive inaccurate contact information for members leading to challenges in reaching and servicing members in a timely manner. For Care1st ACC, the problem of missing or inaccurate contact information is even more prevalent with members located in the Northern GSA. As a result, Care1st ACC went to extensive lengths to find alternative contact phone numbers and mailing addresses, utilizing multiple systems accessible to outreach staff. The Care Engagement team started by reviewing internal systems that contain case management notes, prior authorization requests, inpatient hospital, or emergency department (ED) visit notifications, claims and membership data for additional phone numbers that would provide contact information for the member. The next step is for the team to look through various systems to find alternate contact information. The final step is outreach to recent providers based on assignment and claims. If no good phone number was found for a member, a letter is sent to the most recent address on record. These strategies are in line with best practices identified by the Center for Health Care Strategies. The goal of these efforts is to reach as many Care1st ACC members with gaps in care as possible, educate them on the preventative care they are eligible for and assist in scheduling

[6-6] Taylor L. Housing and Health: An Overview of the Literature. Health Affairs. June 7, 2018. Available at https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/. Accessed on: Jan 19, 2022.

appointments. Therefore, improving rates of preventive services such as well visits, dental visits, and breast cancer screenings.

HCA ACC

- Text Messaging to Improve Quality Performance: HCA ACC contracted with Arcadia Analytics to deliver data-driven, targeted text messaging campaigns for members related to quality performance measures and other HCA ACC selected initiatives. During 2021, text messaging campaigns sent thousands of secure messages to members on various topics. Campaigns included vaccination outreach, education about the Pyx Health application, well-child visits, and HCA ACC's PBM through CVS.
- Utilizing Telehealth to Maximize Member Engagement: To solve access to care challenges and barriers associated with accessing care, HCA ACC reviewed potential technology solutions and identified critical populations and their servicing providers with the greatest need including, Tribal and rural communities. HCA ACC telehealth outcomes and innovative programs include:
  - Collaborated with the NARBHA Institute and North Country Healthcare to obtain necessary equipment. The equipment was then distributed, assistance was provided, and the technology was launched.
  - Used grant funds in partnership with the NARBHA Institute, HCA ACC provided iPad tablets to Little Colorado Behavioral Health Centers (LCBHC) in Apache County for use by members who did not have access to a computer or bandwidth in their homes.
  - Provided a laptop and technical assistance to the Havasupai tribe in Supai for tele-crisis services.
  - Worked with members of the Arizona Telecommunications Broadband Action Team to get a hotspot to Hopi Behavioral Health. Additionally, provided a laptop and Zoom accounts to connect with the Hopi Health Care Center Emergency Room for crisis response.
  - Provided 131 Zoom HIPAA compliant host accounts to providers to use for telehealth.
  - During the spring of 2020, HCA ACC set up tele-crisis response with Flagstaff Medical Center. HCA ACC worked with other medical centers throughout the GSAs to expand the use of tele-crisis.
  - Nearly 100 telehealth technical assistance sessions have been offered by HCA ACC staff to a range of different providers.
  - HCA-ACC continues to provide all clinics and providers up-to-date policy changes and best practices from the state and federal government. Additionally, provides information on funding opportunities and offers assistance to qualified rural behavioral health clinics in filing for federal rebates on their telecommunication circuits.
  - Providing a tele-dentistry clinic that sends hygienists out to Apache County and uses synchronous and asynchronous telehealth to communicate to dentists in Flagstaff to assess and develop treatment plans.
  - Offering tele-behavioral health services for children in out-of-home placements to ensure continuity of timely care.

- Member Self-Management Tools: HCA ACC provides an array of materials to support member individual health, wellness, and literacy. Member self-management tools are evidence-based that cover topics such as, maintaining a healthy weight, smoking and tobacco use cessation, encouraging physical activity, health eating, managing stress, avoiding at-risk drinking, and identifying depressive symptoms. The tools are available on the Health Choice Arizona and Health Choice Pathway websites and are also mailed to care-managed members when the tools support the member's self-management or care management plan goals. Additionally, the self-management tools are interactive resources that allow members to enter specific personal information which then provides individuals results based on the member information entered. Between the months of April and August 2021, website-based self-management tools were utilized 57 times. HCA ACC will continue to promote the use of the tools through care management communications, member newsletters, and provider communications.

Mercy Care ACC

- Recovery Program: Recovery providers in the community work with the Mercy Care ACC population who need additional supports. The Recovery navigators help address social determinates of health (SDOH) and find supports in the community to help members with multiple complex needs. During CYE 2021, Mercy Care ACC created a "continuum of care" model that meets the physical, social, and behavioral health needs of members and offers step-down levels for recovery to achieve their fullest potential and independence. Mercy Care ACC built custodial and residential programs for members with special health care needs (SHCN) who require long-term stabilization, personal care support services, and custodial care. Additionally, Mercy Care ACC expanded the network to include providers dedicated to special needs populations and customized care delivery to meet members' needs at home or during transition to outpatient, residential, or custodial care.

MCC ACC

- Suicide Prevention: MCC ACC intensified monitoring and outreach with the increasing trend of suicide attempts across the population from 4.9% before the COVID-19 PHE to 10.5%. On May 1, 2021, MCC ACC formalized and launched the Driving Suicides to Zero program. The program uses evidence-based practices and enhanced care coordination to reduce suicides. Recovery Health Guides use real-time identification of inpatient admissions for suicide attempts to support proactive reach-in that ensures post-discharge support and peer support. After discharge, a care manager continues weekly outreach and follows-up with the member for at least six months. MCC ACC also partnered with Resilient Health to proactively address suicide risk. Members enrolled in the integrated care program with Resilient Health receive ongoing suicide risk screenings and routine assessments. This program builds strong relationships between the member, outpatient behavioral health providers, and MCC ACC to address triggers. Since implementation, MCC ACC has not lost a single member enrolled in this program to suicide.

- AZ Coordination Workgroup for Provider and Community Outreach: MCC ACC initiated an internal workgroup, the AZ Coordination for Provider and Community Outreach, by bringing together roles that impact provider engagement. The AZ Coordination for Provider and Community Outreach is driven by the Quality, Network, and Marketing and Community Outreach departments. The purpose of this workgroup is to streamline engagement processes, bridge the gap between providers and members, and collaborate internally to support the provider network. The internal teams meet weekly to discuss barriers, identify solutions, streamline provider outreach, and coordinate events in the community. Each department reports their current projects and barriers they are experiencing to the workgroup. The workgroup then comes together to eliminate barriers and identify opportunities for improvement. This team-based approach enables MCC ACC departments to share the work they are doing and come together to enhance engagement outcomes. From this internal workgroup collaboration, MCC ACC has experienced improved outcomes related to provider engagement and community relationships.
- Unable to Reach Program: The Unable to Reach Program uses MCC ACC Recovery Health Guides to reach vulnerable and/or temporarily disconnected members, establish an inviting and non-threatening environment to educate members about health conditions, system navigation, and engaging them in care or support using their own voice and choice in the matter. MCC ACC is investing in this program by hiring specialized staff, leveraging key partnerships through the Central GSA, including partnerships with Street Medicine Phoenix, Human Services Campus, Catalytic™ Health Partners (CHP), and Community Bridges, Inc. (CBI). The Unable to Reach program uses mobile and pop-up clinics to meet members where they are, and providers can successfully deliver care to hard-to-reach populations.
- Justice System Program: MCC ACC's Justice-involved Community of Care is a synthetic clinically integrated network that focuses on making critical community connections for incarcerated members. The program provides members with supports and services prior to release to help them successfully transition back to the community. The Justice-involved Community of Care creates a priority pathway for members reentering the community in the Central GSA to access care, connect to supports to address health and SDOH needs, and reduce reconviction.
- CHEEERS Recovery Program: In partnership with the CHEEERS Recovery Center to promote improved birth outcomes, MCC ACC expands access to community-based and peer support services to pregnant women with co-occurring substance use disorder (SUD) conditions to help keep them in their homes and abstain from illegal drug and alcohol use throughout their pregnancy.

UHCCP ACC

- Missed Opportunities Report: The Missed Opportunities Report is a quality-improvement initiative focused on supporting primary care practice improvement by identifying children and adolescent members in the 'well-care visit (WCV)' NCQA measure that had one or more sick visits with their assigned provider but have not had an annual WCV. The report includes UHCCP members across all lines of business including UHCCP ACC members. CPCs share the report with the provider and/or staff during monthly meetings and remains one of the most effective tools for communicating the benefits of turning a sick visit into a WCV. UHCCP ACC understands the importance of WCVs for

prevention, tracking growth and development, raising concerns, and building/sustaining a relationship between provider and member.[6-7] To further increase the WCV measure rate, UHCCP ACC conducts live and IVR reminder calls to members, reminder mailers and postcards to members, provider gaps in care mailers, provider education materials, and provider incentive programs. UHCCP Clinical Practice Consultants (CPCs) also share Patient Care Opportunity Reports (PCORs) with providers. The COVID-19 PHE has had a negative impact on the UHCCP ACC WCV rates. However, the MY 2020 WCV rate (47.0%) did exceed the NCQA 2020 National Average rate of 46.12%, and the current prospective rate (35.4%) is exceeding what it was at the same time last year (28.9%). UHCCP ACC expects the final WCV rate for MY 2021 to be at about six percentage points higher than the MY 2020 final rate. UHCCP ACC will continue to monitor the WCV rate monthly and utilize the Missed Opportunities Report and interventions.

- AZ Provider Scorecard: UHCCP's AZ Provider Scorecard supports primary care practice improvement by providing the practice information on their performance on quality measures (behavioral health, diabetes/hypertension, women's health, maternity care, and pediatric prevention) compared to other practices. The AZ Provider Scorecard rates are reflected of UHCCP members across all lines of business, including UHCCP ACC members. The AZ Provider Scorecard helps identify potentially unwarranted variations in care and provides an opening for discussions on how UHCCP can support their efforts to achieve the Triple Aim of better care, better outcomes, and better costs for the members.[6-8] To increase quality measure rates, interventions included live and IVR reminder calls to members, reminder mailings to members, provider gaps in care mailers, provider education materials, and provider incentive programs. CPCs also share PCORs which shows quality measure gaps in care with providers groups each month. The AZ Provider Scorecard has been available to share with provider groups since July 2021 and has had positive provider feedback since this type of information was not previously made available. Moving forward, UHCCP will continue to provide the AZ Provider Scorecard to providers.
- W15 Report: UHCCP produced the W15 report, a quality-improvement initiative focused on supporting primary care practice improvement by providing member specific information for members with gaps in care for the 'well-child visits in the first 15 months of life (W30-15Mos)' NCQA measure. The W15 Report includes UHCCP members across all lines of business, including UHCCP ACC members. CPCs use the W15 report to help provider groups prioritize member outreach activities to members under 15 months of age that have not yet received six well-child visits. UHCCP ACC understands the importance of well-child visits for prevention, tracking growth and development, raising concerns, and building/sustaining a relationship between provider and member.[6-9] The W15 report allows provider groups to easily identity which of their members still

[6-7] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Jan 20, 2022.

[6-8] Institute for Healthcare Improvement. IHI Triple Aim Initiative. Available at: http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx. Accessed on: Jan 20, 2022.

[6-9] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Jan 20, 2022.

have time to close gaps in care due to the narrow 15-month window of time and makes it easier to prioritize scheduling. To further increase the well-child visits in the first 15 months of life, UHCCP ACC conducts live and IVR reminder calls to members, reminder mailers and postcards to members, provider gaps in care mailers, provider education materials, and provider incentive programs. The impact of the COVID-19 PHE on the UHCCP ACC 'W30-15Mos' rate has been slight. UHCCP ACC exceeded the NCQA 2020 National Average rate of 52.93% by 12.08 percentage points in MY 2020 and the MY 2021 prospective rate is exceeding it as well. UHCCP ACC will continue monthly monitoring of the rate and utilize the W15 Report and interventions.

DCS CHP[6-10]

- Recovery Program: The Mercy Care Recovery Program assist DCS CHP's SMI, DCS children in Department of Developmental Disabilities (DDD) care, and special health care needs members. This program provides a continuity of services program for children exiting DCS care as they become adults and assisting families of high needs children. Recovery providers in the community work with the Mercy Care including the DCS CHP population who need additional supports. The Recovery navigators help address SDOH and find supports in the community to help members with multiple complex needs. During CYE 2021, Mercy Care created a "continuum of care" model that meets the physical, social, and behavioral health needs of members and offers step-down levels for recovery to achieve their fullest potential and independence. Mercy Care built custodial and residential programs for members with special health care needs (SHCN) who require long-term stabilization, personal care support services, and custodial care. Additionally, Mercy Care expanded the network to include providers dedicated to special needs populations and customized care delivery to meet members' needs at home or during transition to outpatient, residential, or custodial care.

[6-10] DCS CHP previously operated as CMDP.

7. Performance Measurement

Methodology

Title 42 of CFR §438.350(a) requires states that contract with MCOs, PIHPs, PAHPs, or PCCM entities to have a qualified EQRO perform an annual EQR that includes validation of contracted entity performance measures (42 CFR §438.358[b][1][ii]) for the preceding 12 months.

The purpose of the PMV is to assess the accuracy of performance measures reported by Contractors and to determine the extent to which performance measures reported by the Contractors follow state specifications and reporting requirements. According to the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019,[7-1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not an MCO, or an EQRO.

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/substance use 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. The ACC Contractors provide integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults, as well as CHIP (Title XXI) eligible children (under age 19) (i.e., KidsCare). The Arizona Department of Child Safety (DCS) Comprehensive Health Plan (CHP) is a health plan that is contracted with AHCCCS to provide health care coverage for children and youth in foster care in the state of Arizona. Prior to April 1, 2021, DCS CHP was known as the Comprehensive Medical and Dental Program (CMDP) providing medical and dental coverage for the foster care population with behavioral health services provided through the RBHAs.

To improve the timeliness of data collection, calculation, and reporting, AHCCCS transitioned from using EQRO-calculated performance measure rates to measure and report Contractor-level data. Starting with its CY 2020/MY 2020 performance measures, AHCCCS used Contractor-calculated performance measure rates that have undergone EQRO validation. HSAG, the EQRO for AHCCCS, conducted the program/LOB-specific PMV for each Contractor.

Additionally, the measurement period was transitioned from CYE (reflective of October 1 through September 30) to calendar year (CY) (reflective of January 1 through December 31). Beginning with its CYE 2021 contract amendments, AHCCCS also transitioned from its use of internally established MPSs to the use of national benchmark data (i.e., NCQA Quality Compass national Medicaid HMO mean) to evaluate statewide and Contractor performance. To promote quality improvement, performance measure

[7-1] The Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 9, 2021.

results will be compared to nationally recognized standards that account for national performance trends and changes in measure technical specifications. Therefore, MY 2020 performance measure results are not comparable to previous CYE performance measure results calculated by AHCCCS, and trending of performance measure rates could not be performed. In future years, trending will be incorporated into this report. Additionally, in previous years' reports, separate performance measure rates were reported for the KidsCare Contractors. However, beginning with MY 2020, KidsCare members meeting continuous enrollment criteria were included with the population/population samples for the performance measures selected for the ACC Contractors.

The following section presents the results for the mandatory CYE 2021 performance measure validation activities conducted for the MY 2020 (i.e., January 1, 2020–December 31, 2020) reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, HSAG validated a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), CMS Core Set of Children's Health Care Quality Measures for Medicaid (Child Core Set) and CHIP.

For a detailed explanation of the CYE 2021 PMV methodology, please see Appendix A.

Performance Measurement—ACC Contractors

CYE 2021 Performance Measure Validation

There are several aspects crucial to the calculation of performance measure data. These include data integration, data control, and documentation of performance measure calculations. Accurate data integration is essential for calculating valid performance measure data. The steps used to combine various data sources (including claims/encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. A Contractor's organizational infrastructure must support all necessary information systems, and its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by the Contractor. During the CYE 2021 PMV, HSAG reviewed all related documentation, which included the completed Record of Administration, Data Management, and Processes (Roadmap), if applicable, Information Systems Capabilities Assessment Tool (ISCAT), job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation. HSAG determined if the data integration processes, data control processes, and documentation of performance measure generation by the Contractors were acceptable or not acceptable.

Performance Measure Validation Contractor Comparison

During CYE 2021, HSAG evaluated each ACC Contractor's data system for processing of each data type used for reporting the Contractor's MY 2020 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings by ACC Contractor is provided in Table 7-1, displaying if each ACC Contractor met the assessed Information System (IS) standards, which demonstrates the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ACC Contractor's general findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements, including more information about "Not Met" findings, can be found in Appendix A.

Table 7-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for ACC Contractors

Data Type	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC
Medical Services Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Enrollment Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Provider Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Medical Record Review Processes	*Met*	*Not Applicable*	*Met*	*Met*	*Met*	*Met*	*Met*
Supplemental Data	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Data Preproduction Processing	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*
Data Integration and Reporting	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*	*Met*

Performance Measure Results

Table 7-2 presents the MY 2020 performance measure rates for each ACC Contractor and the ACC program aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the national Medicaid mean are shaded green.

Impacts of the COVID-19 PHE vary by performance measure and Contractor. NCQA has not released global guidance on how MY 2020 rates may be impacted by the PHE.

Table 7-2—MY 2020 Performance Measure Results for ACC Contractors

Performance Measure	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC	Aggregate
Maternal and Perinatal Care								
Prenatal and Postpartum Care								
Postpartum Care	71.8%	49.1%	61.8%	54.0%	69.8%	66.2%	73.0%	64.6%
Behavioral Health Care								
Antidepressant Medication Management								
Effective Acute Phase Treatment	54.5%	56.3%	51.8%	51.3%	48.8%[G]	62.8%	58.4%	54.2%
Effective Continuation Phase Treatment	39.7%	41.4%	36.0%	36.0%	33.3%	50.1%	41.3%	38.5%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence								
7-Day Follow-Up—Total	20.0%	14.3%	17.0%	16.7%	22.5%	19.3%	16.2%	17.7%
30-Day Follow-Up—Total	27.0%	19.8%	24.7%	24.3%	29.9%	22.4%	22.2%	24.3%
Follow-Up After Emergency Department Visit for Mental Illness								
7-Day Follow-Up—Total	48.9%	42.9%	42.7%	45.9%	54.1%	44.2%	49.5%	47.6%
30-Day Follow-Up—Total	59.4%	53.5%	53.1%	56.9%	65.4%	[G]52.2%	58.6%	58.0%
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	40.9%	33.3%	52.5%	44.3%	46.7%	28.9%	47.4%	43.6%
30-Day Follow-Up—Total	62.6%	48.1%	68.0%	60.2%	60.8%	47.2%	63.4%	59.8%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment								
Total Initiation of AOD—Total	46.8%	45.2%	46.0%	44.1%	48.8%	54.0%	47.5%	46.8%
Total Engagement of AOD—Total	17.6%	17.8%	17.6%	16.0%	17.6%	22.2%	17.8%	17.6%
Care of Acute and Chronic Conditions								
Comprehensive Diabetes Care								
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	59.4%	57.8%	46.2%	46.7%	38.2%	[G]46.2%	35.8%	45.8%

Performance Measure	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC	Aggregate
Pediatric Health								
Child and Adolescent Well-Care Visits								
Total	40.6%	34.0%	45.6%	36.9%	47.6%	30.8%	47.0%	42.8%
Well-Child Visits in the First 30 Months of Life								
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.5%	48.8%	61.9%	54.7%	66.8%	49.1%	65.0%	60.6%
Preventive Screening								
Breast Cancer Screening								
Total	52.4%	44.9%	39.5%	43.1%	54.8%	30.2%	56.4%	49.5%
Cervical Cancer Screening								
Cervical Cancer Screening	49.9%	33.9%	46.5%	45.0%	59.6%	34.5%	56.4%	49.3%

** For this indicator, a lower rate indicates better performance.*

Cells shaded green indicate that the rate met or exceeded the national Medicaid mean for HEDIS MY 2020.

Table 7-3 highlights the ACC Contractors' performance for the current year by domain of care. The table illustrates the contractors' MY 2020 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2020 percentiles, where applicable. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

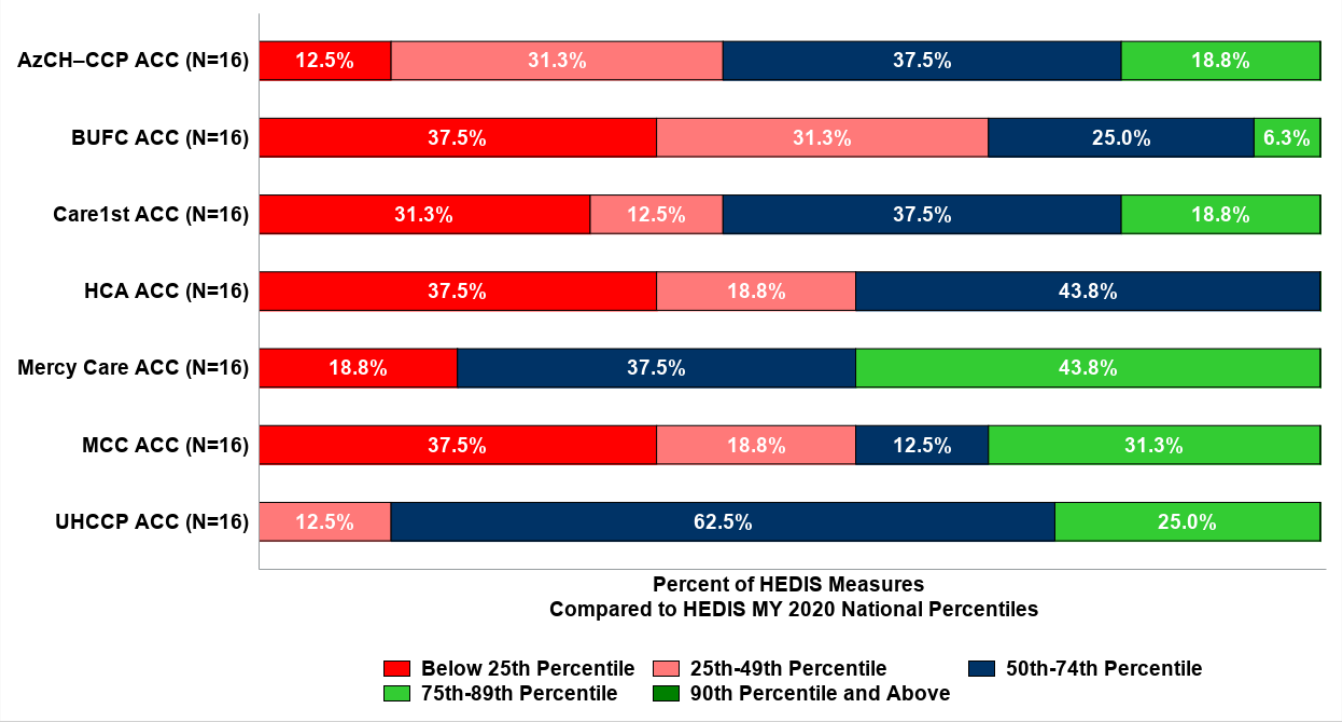
Table 7-3—MY 2020 National Percentiles Comparison for ACC Contractors

Performance Measure	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC	Aggregate
Maternal and Perinatal Care								
Prenatal and Postpartum Care								
Postpartum Care	★★	★	★	★	★	★	★★	★
Behavioral Health Care								
Antidepressant Medication Management								
Effective Acute Phase Treatment	★★	★★	★	★	★	★★★★	★★★	★★
Effective Continuation Phase Treatment	★★	★★★	★	★	★	★★★★	★★★	★★

Performance Measure	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC	Aggregate
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence								
7-Day Follow-Up—Total	★★★★	★★★	★★★	★★★	★★★★	★★★★	★★★	★★★★
30-Day Follow-Up—Total	★★★★	★★	★★★	★★★	★★★★	★★★	★★★	★★★
Follow-Up After Emergency Department Visit for Mental Illness								
7-Day Follow-Up—Total	★★★	★★★	★★★	★★★	★★★★	★★★	★★★★	★★★
30-Day Follow-Up—Total	★★★	★★	★★	★★★	★★★★	★★	★★★	★★★
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	★★★	★★	★★★★	★★★	★★★	★	★★★	★★★
30-Day Follow-Up—Total	★★★	★	★★★★	★★★	★★★	★	★★★	★★
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment								
Initiation of AOD—Total—Total	★★★	★★★	★★★	★★	★★★★	★★★★	★★★	★★★
Engagement of AOD—Total—Total	★★★	★★★★	★★★	★★★	★★★	★★★★	★★★★	★★★
Care of Acute and Chronic Conditions								
Comprehensive Diabetes Care								
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	★	★	★★	★★	★★★★	★★	★★★★	★★
Pediatric Health								
Child and Adolescent Well-Care Visits								
Total	★★	★	★★★	★	★★★	★	★★★	★★
Well-Child Visits in the First 30 Months of Life								
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	★★★★	★★	★★★★	★★	★★★★	★★	★★★★	★★★
Preventive Screening								
Breast Cancer Screening								
Total	★★	★	★	★	★★★	★	★★★	★★
Cervical Cancer Screening								
Cervical Cancer Screening	★	★	★	★	★★★	★	★★	★

Figure 7-1 displays the ACC Contractors' HEDIS MY 2020 performance compared to benchmarks. HSAG analyzed results from 11 performance measures for HEDIS MY 2020 for a total of 16 indicator rates.

Figure 7-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for ACC Contractors



Performance Measurement—DCS CHP

CYE 2021 Performance Measure Validation

There are several aspects crucial to the calculation of performance measure data. These include data integration, data control, and documentation of performance measure calculations. Accurate data integration is essential for calculating valid performance measure data. The steps used to combine various data sources (including claims/encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. A Contractor's organizational infrastructure must support all necessary information systems, and its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by the Contractor. During the CYE 2021 PMV, HSAG reviewed all related documentation, which included the completed Record of Administration, Data Management, and Processes (Roadmap), if applicable, Information Systems Capabilities Assessment

Tool (ISCAT), job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation. HSAG determined if the data integration processes, data control processes, and documentation of performance measure generation by the Contractors were acceptable or not acceptable.

During CYE 2021, HSAG evaluated DCS CHP's[7-2] data systems for processing of each data type used for reporting MY 2020 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements. A summary of these findings is provided in Table 7-4. Additional information about DCS CHP's validation results for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements, including more information about "Not Met" findings, can be found in Appendix A.

Table 7-4—Performance Measure Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for DCS CHP

Data Type	DCS CHP
Medical Services Data	*Met*
Enrollment Data	*Met*
Provider Data	*Met*
Medical Record Review Processes	*Met*
Supplemental Data	*Met*
Data Preproduction Processing	*Met*
Data Integration and Reporting	*Not Met*

Performance Measure Results

Table 7-5 presents the MY 2020 performance measure results for DCS CHP and the MY 2020 aggregate for the ACC Contractors for comparison. Performance measure rate cells shaded green indicate that DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Impacts of the COVID-19 PHE vary by performance measure and Contractor. NCQA has not released global guidance on how MY 2020 rates may be impacted by the PHE.

Table 7-5—MY 2020 Performance Measure Results for DCS CHP

Performance Measure	MY 2020 Performance	ACC Aggregate
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	66.2%	42.8%

[7-2] DCS CHP previously operated as CMDP.

Performance Measure	MY 2020 Performance	ACC Aggregate
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	53.9%	60.6%

Cells shaded green indicate that the rate met or exceeded the national Medicaid mean for HEDIS MY 2020.

Table 7-6 highlights DCS CHP's performance for the current year by domain of care. The table illustrates the MY 2020 measure rates and performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2020 percentiles, where applicable. The performance level star ratings are defined as follows:

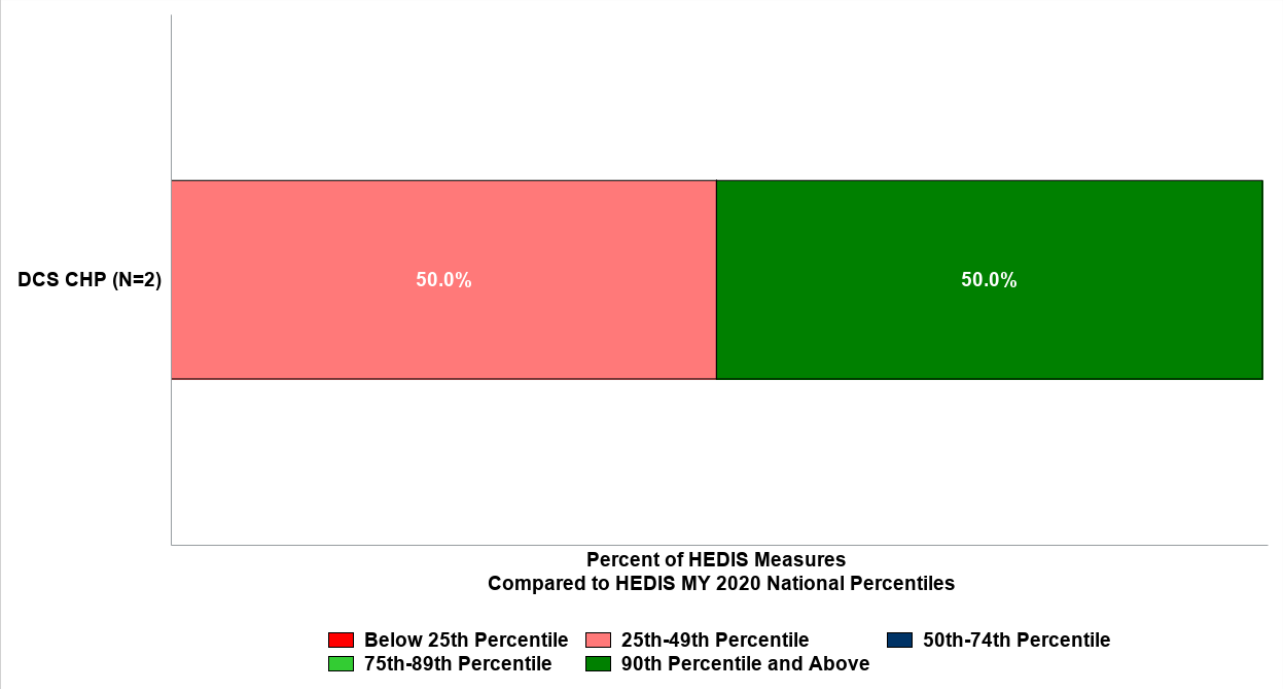
★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 7-6—MY 2020 Performance Measure Results for DCS CHP

Performance Measure	MY 2020 Performance	ACC Aggregate
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	★★★★★	★★
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	★★	★★★

Figure 7-2 displays DCS CHP's HEDIS MY 2020 performance compared to benchmarks. HSAG analyzed results from two performance measures for HEDIS MY 2020.

Figure 7-2—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DCS CHP



Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance related to providing quality, timely, and accessible care and services to AHCCCS members. (See Table A-4 in Appendix A for the assignment of performance measures to the Quality, Timeliness, and Access areas.)

AzCH-CCP ACC

Table 7-7—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP ACC

Strengths
1. AzCH-CCP ACC performed well within the Behavioral Health Care domain, with eight of 10 (80.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, all eight of these measure rates met or exceeded the 50th percentile with both measure indicator rates for *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence* meeting or exceeding the 75th percentile.

Strengths
2. One of two (50.0 percent) measure rates within the Pediatric Health domain, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits,* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and ranked at or above the 75th percentile.

Opportunities for Improvement and Recommendations
1. For FQHCs and facilities, manual research was completed by AzCH-CCP ACC to validate the practitioner specialties to meet the NCQA-required percentage to map them to the PCP provider type. Recommendation: HSAG recommends that AzCH-CCP ACC ensure the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS guidance for reporting performance measures where provider specialty type is required.
2. While AzCH-CCP ACC was not required to complete any source code updates for measures in scope of PMV, a formalized test plan was not demonstrated, which may present future risks to ensuring alignment with technical specification for new or revised measures. Recommendation: HSAG recommends that AzCH-CCP ACC conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.
3. In the Maternal and Perinatal Health domain, AzCH-CCP ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 50th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that AzCH-CCP ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. AzCH-CCP ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, AzCH-CCP ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, AzCH-CCP ACC should implement appropriate interventions to improve the performance related to postpartum care.

Opportunities for Improvement and Recommendations
4. In the Care of Acute and Chronic Conditions domain, AzCH-CCP ACC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 25th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AzCH-CCP ACC conduct a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, AzCH-CCP ACC should implement appropriate interventions to improve the performance related to this chronic condition.
5. In the Pediatric Health domain, AzCH-CCP ACC's performance measure rate for *Child and Adolescent Well-Care Visits—Total* fell below the 50th percentile, indicating that children and adolescents were not always accessing well-child visits with a PCP or OB/GYN practitioner. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[7-3] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AzCH-CCP ACC conduct a root cause analysis to determine why children and adolescents were not always accessing well-child visits. AzCH-CCP ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, AzCH-CCP ACC should implement appropriate interventions to improve the performance related to well-care visits.

[7-3] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%2015%20months%20of%20life. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
6. In the Preventive Screening domain, AzCH-CCP ACC's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 50th and 25th percentiles, respectively, indicating that women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[7-4] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AzCH-CCP ACC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, AzCH-CCP ACC should implement appropriate interventions to improve the performance related to preventive screenings.
7. In the Behavioral Health Care domain, AzCH-CCP ACC's performance measure rates for *Antidepressant Medication Management* fell below the 50th percentile, indicating that most members with a diagnosis of major depression were not receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[7-5] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that AzCH-CCP ACC conduct a root cause analysis to determine why members taking an antidepressant were not receiving continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in maintaining a medication regime in order to implement appropriate interventions. AzCH-CCP ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care or the need for improved community outreach and education), including any factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, AzCH-CCP ACC should implement appropriate interventions to improve the performance related to medication management.

[7-4] National Committee for Quality Assurance. Breast Cancer Screening (BCS). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 25, 2022.
[7-5] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 25, 2022.

BUFC ACC

Table 7-8—Strengths, Opportunities for Improvement, and Recommendations for BUFC ACC

Strengths
1. BUFC ACC performed well within the Behavioral Health Care domain, with four of 10 (40.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
2. Five measure rates, all within the Behavioral Health Care domain, met or exceeded the 50th percentile, with the measure rate for *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total* meeting or exceeding the 75th percentile.
Opportunities for Improvement and Recommendations
1. HSAG identified during the CYE 2021 PMV that BUFC ACC did not integrate data from its nonstandard supplemental data source, which it used to collect medical record abstracted data throughout the year. Recommendation: HSAG recommends that BUFC ACC clarify its understanding of any future State-specific guidance. To ensure all possible performance measure numerator compliant records are appropriately identified, HSAG further recommends that BUFC ACC document and submit its nonstandard supplemental data source for audit review and approval for future years' data integration, and continue to explore other potential data streams for future supplemental data submission. This may include electronic health record data feeds, lab result files, exclusion history files, etc.
2. BUFC ACC did not use the hybrid methodology for any performance measures eligible for hybrid reporting, which did not align with State-specific guidance. Recommendation: HSAG recommends that BUFC ACC review and clarify expectations related to hybrid/medical record review requirements for future years' reporting. This should include the planning and development of abstraction tools, data capture, and integration for non-HEDIS measures, in accordance with State-specific guidance for measures required to be reported following hybrid methodology.
3. In the Maternal and Perinatal Health domain, BUFC ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that BUFC ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. BUFC ACC should

Opportunities for Improvement and Recommendations
consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC ACC should also identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve the performance related to postpartum care.
4. In the Care of Acute and Chronic Conditions domain, BUFC ACC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 25th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that BUFC ACC conduct a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve the performance related to this chronic condition.
5. In the Pediatric Health domain, BUFC ACC's performance measure rates for *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits* fell below the 25th and 50th percentiles, respectively, indicating that children and adolescents were not always accessing well-child visits with a PCP or OB/GYN practitioner. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that BUFC ACC conduct a root cause analysis to determine why children and adolescents were not always accessing well-child visits. BUFC ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that

Opportunities for Improvement and Recommendations
their members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve the performance related to well-care visits.
6. In the Preventive Screening domain, BUFC ACC's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that BUFC ACC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve the performance related to preventive screenings.
7. In the Behavioral Health Care domain, BUFC ACC's performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up–Total* and *30-Day Follow-Up–Total* fell below the 25th and 50th percentiles, respectively, indicating that members were not always accessing follow-up care with a mental health provider within seven and 30 days following inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.[7-6] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that BUFC ACC conduct a root cause analysis to determine why members were not receiving timely follow-up care with a mental health provider. BUFC ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC ACC should identify factors related to the

[7-6] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC ACC should implement appropriate interventions to improve the performance related to follow-up visits for behavioral health-related hospitalizations.

Care 1st ACC

Table 7-9—Strengths, Opportunities for Improvement, and Recommendations for Care 1st ACC

Strengths
1. Care 1st ACC performed well within the Behavioral Health Care domain, with seven of 10 (70.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, all seven of these measure rates met or exceeded the 50th percentile, with both measure indicators rates for *Follow-Up After Hospitalization for Mental Illness* meeting or exceeding the 75th percentile.
2. One of two (50.0 percent) measure rates within the Pediatric Health domain, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits,* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and ranked at or above the 75th percentile. The other measure in this domain, *Child and Adolescent Well-Care Visits—Total,* ranked at or above the 50th percentile.
Opportunities for Improvement and Recommendations
1. Care 1st ACC elected the hybrid methodology for some measures based on the anticipated impact of medical record data (estimated approximately 80 percent completion). While there were no significant concerns with rates being underreported due to Care 1st ACC's inability to obtain medical record documentation, full medical record review could provide the Contractor with more robust and accurate data. Recommendation: HSAG recommends that Care 1st ACC review and clarify expectations related to hybrid/medical record review requirements for future years' reporting. This should include the planning and development of abstraction tools, data capture, and integration for non-HEDIS measures, in accordance with State-specific guidance for measures required to be reported following hybrid methodology.
2. In the Maternal and Perinatal Health domain, Care 1st ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served.

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that Care 1st ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. Care 1st ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, Care 1st ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Care 1st ACC should implement appropriate interventions to improve the performance related to postpartum care.
3. In the Care of Acute and Chronic Conditions domain, Care 1st ACC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 50th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that Care 1st ACC conduct a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, Care 1st ACC should implement appropriate interventions to improve the performance related to this chronic condition.
4. In the Preventive Screening domain, Care 1st ACC's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that Care 1st ACC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, Care 1st ACC should implement appropriate interventions to improve the performance related to preventive screenings.

Opportunities for Improvement and Recommendations
5. In the Behavioral Health Care domain, Care 1st ACC's performance measure rates for *Antidepressant Medication Management* fell below the 25th percentile, indicating that most members with a diagnosis of major depression were not receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[7-7] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that Care 1st ACC conduct a root cause analysis to determine why members taking an antidepressant were not receiving continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in maintaining a medication regime in order to implement appropriate interventions. Care 1st ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care or the need for improved community outreach and education), including any factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Care 1st ACC should implement appropriate interventions to improve the performance related to medication management.

HCA ACC

Table 7-10—Strengths, Opportunities for Improvement, and Recommendations for HCA ACC

Strengths
1. HCA ACC performed well within the Behavioral Health Care domain, with seven of 10 (70.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, all seven of these measure rates met or exceeded the 50th percentile.
2. One of two (50.0 percent) measure rates within the Pediatric Health domain, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits,* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.

[7-7] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
1. HCA ACC's source code did not include parameters to ensure that only inpatient hospital claims were reported in the numerator for four Prevention Quality Indicator (PQI) measures: *Diabetes Short-Term Complications Admission Rate*, *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate*, *Heart Failure Admission Rate*, and *Asthma in Younger Adults Admission Rate*. Additional skilled nursing facility claims were erroneously included in the measure numerator. Recommendation: While HCA ACC was able to resolve the issues identified related to the four PQI measures, in order to avoid future performance measure reporting errors, HSAG recommends that HCA ACC take additional steps to ensure that all future performance measure data align with the appropriate technical specifications prior to producing performance measure rates. Additional steps include: • Identifying a second programmer as a peer reviewer to formally review any HCA-created source code; • Creating and following a documented test plan to denote the expected and actual results prior to running the code; • Conducting a live system validation of data to compare raw data to the source system data to ensure alignment with the applicable measure's technical specifications, and; • Maintaining a log of any performance measure programming logic updates so any additional measures based on similar source data (e.g., inpatient claims) can be thoroughly evaluated to ensure programmatic errors are not repeated.
2. HCA ACC updated its provider mapping after submitting preliminary rates for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures, as additional FQHC providers were identified that should have been mapped to the PCP provider specialty category. Recommendation: HSAG recommends that HCA ACC routinely monitor its PCP mapping results in comparison to its known FQHCs to ensure that it does not miss identification of certain FQHCs as PCPs in final performance measure reporting, which could result in missed claims for numerator compliance.
3. HCA ACC was required to re-run data for multiple measures based on a source that was not refreshed prior to submitting preliminary rates. Additionally, HCA ACC re-ran data for measures where its initial data build for one of its measure vendors did not flag all members as eligible for mental health and chemical dependency benefits. Recommendation: HSAG recommends that HCA ACC deploy stronger mechanisms to compare its performance measure extracts provided to its software vendor(s) to its source system data to more readily identify issues associated with data refresh timing.

Opportunities for Improvement and Recommendations
4. In the Maternal and Perinatal Health domain, HCA ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that HCA ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. HCA ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, HCA ACC should also identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HCA ACC should implement appropriate interventions to improve the performance related to postpartum care.
5. In the Care of Acute and Chronic Conditions domain, HCA ACC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 50th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that HCA ACC conduct a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, HCA ACC should implement appropriate interventions to improve the performance related to this chronic condition.
6. In the Pediatric Health domain, HCA ACC's performance measure rates for *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits* fell below the 25th and 50th percentiles, respectively, indicating that children and adolescents were not always accessing well-child visits with a PCP or OB/GYN practitioner. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.

Opportunities for Improvement and Recommendations
A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that HCA ACC conduct a root cause analysis to determine why children and adolescents were not always accessing well-child visits. HCA ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, HCA ACC should implement appropriate interventions to improve the performance related to well-care visits.
7. In the Preventive Screening domain, HCA ACC's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that HCA ACC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, HCA ACC should implement appropriate interventions to improve the performance related to preventive screenings.
8. In the Behavioral Health Care domain, HCA ACC's performance measure rates for *Antidepressant Medication Management* fell below the 25th percentile, indicating that most members with a diagnosis of major depression were not receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[7-8] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

[7-8] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that HCA ACC conduct a root cause analysis to determine why members taking an antidepressant were not receiving continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in maintaining a medication regime in order to implement appropriate interventions. HCA ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care or the need for improved community outreach and education), including any factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HCA ACC should implement appropriate interventions to improve the performance related to medication management.

Mercy Care ACC

Table 7-11—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care ACC

Strengths
1. Mercy Care ACC performed well within the Behavioral Health Care domain, with eight of 10 (80.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, all eight of these measure rates met or exceeded the 50th percentile, with five measure rates (both *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence* indicators, both *Follow-Up After Emergency Department Visit for Mental Illness* indicators, and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Total—Total)* meeting or exceeding the 75th percentile.
2. Mercy Care ACC's measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and met or exceeded the 75th percentile.
3. Both of Mercy Care ACC's rates in the Pediatric Health domain, *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits,* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. The measure rate for *Child and Adolescent Well-Care Visits—Total* met or exceeded the 50th percentile, while the measure rate for *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits* met or exceeded the 75th percentile.
4. Both of Mercy Care ACC's rates in the Preventive Screening domain, *Breast Cancer Screening* and *Cervical Cancer Screening,* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, both measure rates met or exceeded the 50th percentile

Opportunities for Improvement and Recommendations
1. Mercy Care ACC did not collect or assign the provider specialty within its source systems. Mercy Care ACC reviewed the provider specialty listed in AHCCCS' Prepaid Medical Management Information System (PMMIS) for accuracy and monitored it quarterly with the Provider Acceptance Transmission report. Recommendation: HSAG recommends that Mercy Care ACC ensure that the mapping of provider specialties to HEDIS provider types is compliant with AHCCCS guidance for reporting performance measures where provider specialty type is required.
2. While Mercy Care ACC was not required to complete any source code updates for measures in the scope of PMV, a formalized test plan was not demonstrated, which may present future risks to ensuring alignment with technical specification for new or revised measures. Recommendation: HSAG recommends that Mercy Care ACC conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.
3. In the Maternal and Perinatal Health domain, Mercy Care ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that Mercy Care ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. Mercy Care ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, Mercy Care ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Mercy Care ACC should implement appropriate interventions to improve the performance related to postpartum care.
4. In the Behavioral Health Care domain, Mercy Care ACC's performance measure rates for *Antidepressant Medication Management* fell below the 25th percentile, indicating that most members with a diagnosis of major depression were not receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily

Opportunities for Improvement and Recommendations
functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[7-9] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that Mercy Care ACC conduct a root cause analysis to determine why members taking an antidepressant were not receiving continuous medication treatment. This could include conducting focus groups to identify barriers that members were experiencing in maintaining a medication regime in order to implement appropriate interventions. Mercy Care ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care or the need for improved community outreach and education), including any factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Mercy Care ACC should implement appropriate interventions to improve the performance related to medication management.

MCC ACC

Table 7-12—Strengths, Opportunities for Improvement, and Recommendations for MCC ACC

Strengths
1. MCC ACC performed well within the Behavioral Health Care domain, with seven of 10 (70.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, all seven of these measure rates met or exceeded the 50th percentile, with measure rates for both *Antidepressant Medication Management* indicators and both *Initiation and Engagement of AOD Abuse or Dependence Treatment* indicators and the *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* meeting or exceeding the 75th percentile.
Opportunities for Improvement and Recommendations
1. MCC ACC submitted two supplemental data sources that were used to support performance measure rates. Recommendation: To ensure that all possible performance measure numerator compliant records are appropriately identified, HSAG recommends that MCC ACC continue to explore other potential data streams for future supplemental data submission. This may include electronic health record data feeds, lab result files, exclusion history files, etc.

[7-9] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
2. MCC ACC began transitioning to its parent company's systems and platforms in July 2021. Therefore, MCC ACC will have data coming from both legacy and new systems for MY 2021. Recommendation: HSAG recommends that MCC ACC ensure that it maintains data system transition implementation plan documentation while transitioning its systems to its parent company and platforms in July 2021. This should include results and reconciliation for any data migrated to new systems and ensuring that data extracts from both systems have documented organization-to-vendor mapping.
3. In the Maternal and Perinatal Health domain, MCC ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 25th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that MCC ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. MCC ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, MCC ACC should also identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, MCC ACC should implement appropriate interventions to improve the performance related to postpartum care.
4. In the Care of Acute and Chronic Conditions domain, MCC ACC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 50th percentile, indicating that although members with chronic conditions may have had access to care, they were not able to manage their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that MCC ACC conduct a root cause analysis or focused study to determine why members were not maintaining their chronic health conditions at optimal levels or why some adult members were experiencing issues with access to care. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification

Opportunities for Improvement and Recommendations
of a root cause, MCC ACC should implement appropriate interventions to improve the performance related to this chronic condition.
5. In the Pediatric Health domain, MCC ACC's performance measure rates for *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits* fell below the 25th and 50th percentiles, respectively, indicating that children and adolescents were not always accessing well-child visits with a PCP or OB/GYN practitioner. Well-care visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening and counseling. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that MCC ACC conduct a root cause analysis to determine why children and adolescents were not always accessing well-child visits. MCC ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, MCC ACC should implement appropriate interventions to improve the performance related to well-care visits.
6. In the Preventive Screening domain, MCC ACC's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile, indicating that women were not receiving timely screening for breast and cervical cancers. Early detection reduces the risk of dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that MCC ACC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for breast and cervical cancers. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, MCC ACC should implement appropriate interventions to improve the performance related to preventive screenings.
7. In the Behavioral Health Care domain, MCC ACC's performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up–Total* and *30-Day Follow-Up–Total* fell below the 25th percentile, indicating that members were not always accessing follow-up care with a mental health provider within seven and 30 days following inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing

Opportunities for Improvement and Recommendations
follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.[7-10] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. Recommendation: HSAG recommends that MCC ACC conduct a root cause analysis to determine why members were not receiving timely follow-up care with a mental health provider. MCC ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, MCC ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, MCC ACC should implement appropriate interventions to improve the performance related to follow-up visits for behavioral health-related hospitalizations.

UHCCP ACC

Table 7-13—Strengths, Opportunities for Improvement, and Recommendations for UHCCP ACC

Strengths
1. UHCCP ACC performed well within the Behavioral Health Care domain, with nine of 10 (90.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Additionally, all nine measure rates in this domain met or exceeded the 50th percentile, with three measure rates (*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*, *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—7-Day Follow-Up–Total* and *30-Day Follow-Up–Total*, and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Total—Total)* meeting or exceeding the 75th percentile.
2. UHCCP ACC's measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and met or exceeded the 75th percentile.
3. Both of UHCCP ACC's rates in the Pediatric Health domain, *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits,* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. The measure rate for *Child and Adolescent Well-*

[7-10] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Jan 25, 2022.

Strengths
Care Visits—Total met or exceeded the 50th percentile, while the measure rate for *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months–Six or More Well-Child Visits* met or exceeded the 75th percentile.
4. UHCCP ACC's measure rate for *Breast Cancer Screening* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and met or exceeded the 50th percentile.

Opportunities for Improvement and Recommendations
1. While UHCCP ACC was not required to complete any source code updates for measures in the scope of PMV, a formalized test plan was not demonstrated, which may present future risks to ensuring alignment with technical specification for new or revised measures. Recommendation: HSAG recommends that UHCCP ACC conduct a formal review of its source code followed by a complete test plan, including live system validation of data, prior to reporting any performance measure data.
2. In the Maternal and Perinatal Health domain, UHCCP ACC's performance measure rate for *Prenatal and Postpartum Care—Postpartum Care* fell below the 50th percentile, indicating an opportunity to increase access to timely postpartum care. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that UHCCP ACC conduct a root cause analysis to determine why female members were not receiving timely postpartum care. UHCCP ACC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP ACC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, UHCCP ACC should implement appropriate interventions to improve the performance related to postpartum care.
3. In the Preventive Screening domain, UHCCP ACC's performance measure rate for *Cervical Cancer Screening* fell below the 50th percentile, indicating that women were not receiving timely screening for cervical cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE.

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that UHCCP ACC conduct a root cause analysis or focused study to determine why its female members were not receiving timely screenings for cervical cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, UHCCP ACC should implement appropriate interventions to improve the performance related to preventive screenings.

DCS CHP

Table 7-14—Strengths, Opportunities for Improvement, and Recommendations for DCS CHP

Strengths
1. DCS CHP performed well on measures related to pediatric health, as measure rates for both measures, Child and Adolescent Well-Care Visits—Total and Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
Opportunities for Improvement and Recommendations
1. DCS CHP developed the necessary source code for reporting the AHCCCS HEDIS and CMS Core measures rather than using an NCQA certified measures vendor. Timely source code development and rate production was problematic for MY 2020 as two measures were unable to be developed or completed: *Asthma Medication Ratio* and *Contraceptive Care—All Women*. Source code for another two measures, *Ambulatory Care* and *Inpatient Utilization*, was not completed for the required age-group stratifications, and only results for the total eligible population were reported. Additional measures for which source code was developed subsequently received a DNR designation due to variances identified during final rate review. Recommendation: HSAG recommends that DCS CHP ensure the accuracy of the source codes its subcontracted health plan will use to generate the full AHCCCS measure list. The ability to routinely produce AHCCCS measures through its subcontracted health plan's accurate source code will allow DCS CHP to monitor and trend its performance as DCS CHP oversees and verifies rates produced by its subcontracted health plan.

8. Performance Improvement Project Results

One of the four EQR-related activities mandated by the federal Medicaid managed care requirements and described at 42 CFR §438.358(b)(1)(i) is the annual validation, required by AHCCCS, of Contractors' PIPs underway during the preceding 12 months. In accordance with 42 CFR §438.330, and as required by AHCCCS, Contractors must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services furnished to members, focusing on clinical and nonclinical areas, and including PIPs designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. These PIPs must include the following:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of interventions based on performance measures.
- Planning and initiation of activities to increase and sustain improvement.

42 CFR §438.330(d)(3) also requires each Contractor to report the status and results of each PIP no less than once per year.

Conducting the Review

In the AHCCCS Medical Policy Manual, Policy 980—Performance Improvement Projects, AHCCCS mandates that Contractors participate in selected AHCCCS-mandated and Contractor self-selected PIPs. AHCCCS-mandated PIP topics are selected through analysis of internal and external data/trends and may include Contractor input. Topics take into account comprehensive aspects of member needs, care, and services for a broad spectrum of members or a focused subset of the population, including those members with special health care needs such as members receiving long-term services and supports (LTSS) [42 CFR §438.330]. AHCCCS may also mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS.

Back to Basics PIP Background and Objective

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ACC/KidsCare, DCS CHP, and DDD populations. Typically, PIPs include one intervention year; however, to account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design in which each Contractor will implement strategies and interventions to improve performance, with CYE 2019 serving as the baseline year, unless otherwise indicated. AHCCCS will then conduct annual measurements to evaluate Contractor performance, with remeasurement years aligning with calendar years: the first remeasurement year reflective of calendar year (CY) 2022 (January 1, 2022,

through December 31, 2022) and the second remeasurement year reflective of CY 2023 (January 1, 2023, through December 31, 2023). Table 8-1 presents the timeline for the *Back to Basics* PIP.

Table 8-1—Timeline for *Back to Basics* PIP

PIP—*Back to Basics*				
CYE 2019	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
Baseline	Intervention Y1	Intervention Y2	Remeasurement 1*	Remeasurement 2*

* Data for Remeasurement 1 and Remeasurement 2 will be reported and included in the CYE 2023 and CYE 2024 EQR Technical Reports, respectively, as the PIP indicator rates are based on validated performance measure rates.

Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.[8-1] Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.[8-2] Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

Maintaining good oral health is an essential component in the overall health of infants, children, and adolescents. Oral health addresses several disease prevention and health promotion topics including dental caries, tooth decay, and periodontal health. Tooth decay (or cavities) is one of the most common chronic conditions of childhood in the United States.[8-3] If untreated, tooth decay can lead to pain and infections that cause children and adolescents to experience problems with playing, learning, eating, and speaking.

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

Table 8-2 through Table 8-4 show the indicator, numerator, and denominator that will be used to measure the baseline of this PIP.

[8-1] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Mar 19, 2021.
[8-2] Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html. Accessed on: Mar 19, 2021.
[8-3] Centers for Disease Control and Prevention. Children's Oral Health, Division of Oral Health. Available at: https://www.cdc.gov/oralhealth/children_adults/child.htm. Accessed on: Mar 19, 2021.

Table 8-2—*Back to Basics* PIP Indicator 1

PIP Measure Indicator 1: *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* (W15)	
Indicator 1: Percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life. *(Not applicable for DCS CHP)*	**Numerator:** The total number of members receiving six or more well-child visits, on different dates of service, with a PCP during their first 15 months of life.
	Denominator: The eligible population.

Table 8-3—*Back to Basics* PIP Indicator 2

PIP Measure Indicator 2: *Child and Adolescent Well-Care Visits* (WCV)	
Indicator 2: Percentage of children ages 3 years to 21 years who had one or more comprehensive well-care visits with a primary care practitioner (PCP) or an OB/GYN during the measurement period.	**Numerator:** The total number of members receiving at least one well-care visit with a PCP or OB/GYN during the measurement period.
	Denominator: The eligible population.

Table 8-4—*Back to Basics* PIP Indicator 3

PIP Measure Indicator 3: *Annual Dental Visits* (ADV)	
Indicator 3: Percentage of children and adolescents ages 2 years to 21 years who received at least one dental visit during the measurement period.	**Numerator:** The total number of members receiving at least one dental visit during the measurement period.
	Denominator: The eligible population.

Back to Basics PIP Summary for CY 2021

To account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design, with CYE 2019 serving as the baseline year. CY 2020 served as an intervention year for this PIP; as the PIP is in the early stages of implementation, repeated measurements are not yet available. Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated using Contractor-calculated performance measure rates that have undergone EQRO validation. AHCCCS required the Contractors to develop and implement interventions to improve performance of the identified indicators based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. In addition, interventions implemented may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

ACC Contractor Results

Table 8-5 presents AzCH-CCP ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-5—*Back to Basics* PIP Baseline Rates for AzCH-CCP ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
AzCH-CCP ACC	CYE 2019	63.2%	46.9%	55.8%

Table 8-6 presents BUFC ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-6—*Back to Basics* PIP Baseline Rates for BUFC ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
BUFC ACC	CYE 2019	63.5%	46.6%	53.0%

Table 8-7 presents Care 1st ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-7—*Back to Basics* PIP Baseline Rates for Care 1st ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
Care 1st ACC	CYE 2019	70.5%	51.4%	63.6%

Table 8-8 presents HCA ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-8—*Back to Basics* PIP Baseline Rates for HCA ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
HCA ACC	CYE 2019	59.4%	43.6%	57.0%

Table 8-9 presents Mercy Care ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-9—*Back to Basics* PIP Baseline Rates for Mercy Care ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
Mercy Care ACC	CYE 2019	65.0%	52.9%	63.1%

Table 8-10 presents MCC ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-10—*Back to Basics* PIP Baseline Rates for MCC ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
MCC ACC	CYE 2019	49.1%*	33.9%	37.5%

*In CYE 2019, the MCC ACC performance measure rate for Indicator 1 had a small denominator, which did not allow for reporting of the measure. CY 2020 served as baseline for Indicator 1 for MCC ACC.

Table 8-11 presents UHCCP ACC's baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-11—*Back to Basics* PIP Baseline Rates for UHCCP ACC

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
UHCCP ACC	CYE 2019	65.6%	52.7%	62.2%

PIP Validation Contractor Comparison

Table 8-12 presents each ACC Contractor's comparative baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-12—*Back to Basics* PIP Comparative Baseline Rates for ACC Contractors

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
AzCH-CCP ACC	CYE 2019	63.2%	46.9%	55.8%
BUFC ACC	CYE 2019	63.5%	46.6%	53.0%
Care 1st ACC	CYE 2019	70.5%	51.4%	63.6%
HCA ACC	CYE 2019	59.4%	43.6%	57.0%
Mercy Care ACC	CYE 2019	65.0%	52.9%	63.1%
MCC ACC	CYE 2019	49.1%*	33.9%	37.5%
UHCCP ACC	CYE 2019	65.6%	52.7%	62.2%

*CY 2020 served as baseline for Indicator 1 for MCC ACC.

DCS CHP Results

Table 8-13 presents DCH CHP's[8-4] baseline rate for each PIP Measure Indicator for the *Back to Basics* PIP.

Table 8-13—*Back to Basics* PIP Baseline Rates for DCS CHP

Health Plan	Baseline Year	PIP Measure Indicator 1: W15	PIP Measure Indicator 2: WCV	PIP Measure Indicator 3: ADV
DCS CHP	CYE 2019	N/A*	72.6%	74.7%

*Indicator 1 is not applicable for DCS CHP.

Back to Basics PIP Findings

For the *Back to Basics* PIP, all Contractors provided lists of interventions that were in place for CY 2021. These lists detailed the identified population, the intervention in place, and whether or not the intervention was continued for CY 2022. Notable Contractor interventions are included in the Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations section. The most common interventions across Contractors targeted members and providers for outreach and education related to well-care and dental visits. Outreach methods included IVR, person-to-person, and automated phone calls; text message campaigns; emails; and physical mailers. Additionally, several Contractors had physician and/or member incentives in place directly tied to closing gaps in care. These interventions may impact indicator performance, which will be evaluated after the first remeasurement year (CY 2022).

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

AzCH-CCP ACC

AzCH-CCP ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-14 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC.

[8-4] DCS CHP previously operated as CMDP.

Table 8-14—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP ACC

Strengths
1. AzCH-CCP ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions AzCH-CCP ACC had in place for CY 2021: • Departmental partnership developed training for staff on well-child visits **[Quality]** • Community outreach campaigns for members with identified care gaps in Yuma and Maricopa counties **[Access]** • Member outreach campaigns, including direct phone calls, blitz call campaigns, text messages, emails, and physical mailers **[Timeliness]** • BHRF direct educational outreach and coordination for members seeking to obtain well and dental visit services **[Timeliness and Access]** • Partnership with primary care clinics to imbed "Firsts Things First" staff to provide preventive dental services during the member's well-visit appointment **[Timeliness and Access]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, AzCH-CCP ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

BUFC ACC

BUFC ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-15 presents strengths, opportunities for improvement, and recommendations for BUFC ACC.

Table 8-15—Strengths, Opportunities for Improvement, and Recommendations for BUFC ACC

Strengths
1. BUFC ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions BUFC ACC had in place for CY 2021: • In-person and web-based provider forums **[Quality]** • Targeted member mailings and follow-up mailings regarding wellness and preventive dental visits, immunizations, and EPSDT visits **[Timeliness]** • Telephonic outreach to assist members with scheduling wellness and preventive dental visits **[Timeliness]** • Educational mailings detailing benefits available **[Access]** • Educational outreach through social media, member newsletters, and the member handbook **[Timeliness and Access]**

Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, BUFC ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

Care 1st ACC

Care 1st ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-16 presents strengths, opportunities for improvement, and recommendations for Care 1st ACC.

Table 8-16—Strengths, Opportunities for Improvement, and Recommendations for Care 1st ACC

Strengths
1. Care 1st ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions Care 1st ACC had in place for CY 2021: • Targeted monthly reminders for members due for wellness or dental visits **[Timeliness]** • Proactive telephonic outreach to members in advance of recommended visits **[Timeliness]** • Educational outreach through member newsletters, text messages, and webpages **[Timeliness and Access]** • "Healthy Rewards" program member incentives **[Timeliness]** • Agreements and/or incentives with providers to close gaps-in-care **[Quality and Timeliness]** • Partnership with Head Start programs to facilitate the completion of well-child visits among members of Head Start and Care 1st ACC **[Access and Timeliness]** • Partnership with community organizations to sponsor and/or participate in community health fairs that provide well checks and dental screenings **[Access and Timeliness]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, Care 1st ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

HCA ACC

HCA ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-17 presents strengths, opportunities for improvement, and recommendations for HCA ACC.

Table 8-17—Strengths, Opportunities for Improvement, and Recommendations for HCA ACC

Strengths
1. HCA ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions HCA ACC had in place for CY 2021: • Dental and wellness "health fairs" for members to receive services **[Access and Timeliness]** • Member outreach, including letters, phone calls, physical mailers, and newsletters to educate and remind members of recommended services **[Timeliness]** • Provider outreach, including providing and discussing gaps-in-care reports and education on conducting screenings using appropriate tools **[Quality and Timeliness]** • Incentives for providers that use AHCCCS-approved tools **[Quality]** • Targeted outreach campaigns to assist members with scheduling dental and wellness appointments **[Access and Timeliness]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, HCA ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

Mercy Care ACC

Mercy Care ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-18 presents strengths, opportunities for improvement, and recommendations for Mercy Care ACC.

Table 8-18—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care ACC

Strengths
1. Mercy Care ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions Mercy Care ACC had in place for CY 2021: • Member outreach, including IVR phone calls, text messages, emails, and physical mailers to educate and remind members of recommended services **[Timeliness]**

Strengths
• Incentives for members to receive needed services **[Timeliness]** • Proactive telephonic outreach to members in advance of recommended visits with direct access to providers' offices for scheduling of needed visits **[Access and Timeliness]** • Provider outreach, including providing gaps-in-care reports and telephonic or digital communication regarding closing gaps in care **[Timeliness]** • Agreements and/or incentives for providers that show improvement in performance **[Quality and Timeliness]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, Mercy Care ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

MCC ACC

MCC ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. All interventions focused on the full eligible population. Table 8-19 presents strengths, opportunities for improvement, and recommendations for MCC ACC.

Table 8-19—Strengths, Opportunities for Improvement, and Recommendations for MCC ACC

Strengths
1. MCC ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions MCC ACC had in place for CY 2021: • Telephonic outreach to members with gaps in care to educate on the importance of wellness and dental visits and to assist with scheduling appointments for needed services **[Timeliness]** • Scheduled "clinic days" for members, including back to school and dental events **[Access and Timeliness]** • Partnership with high-volume providers to schedule "clinic days," as well as regular meetings to provide education, care gap lists, and assist providers in member outreach **[Quality, Access, and Timeliness]** • Direct member outreach through text messaging to encourage members to schedule needed services **[Timeliness]** • Agreements and/or incentives for providers to improve quality-of-care gaps **[Quality and Timeliness]**

Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, MCC ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

UHCCP ACC

UHCCP ACC provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-20 presents strengths, opportunities for improvement, and recommendations for UHCCP ACC.

Table 8-20—Strengths, Opportunities for Improvement, and Recommendations for UHCCP ACC

Strengths
1. UHCCP ACC developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions UHCCP ACC had in place for CY 2021: • Targeted medical record audit of Federally Qualified Health Center (FQHC) medical records for members who visited an FQHC but were identified as having a gap in care **[Quality]** • Member outreach, including IVR and live phone calls, physical mailers, text messages, and emails to educate and remind members of recommended services **[Timeliness]** • Provider outreach, including providing gaps-in-care and similar reports **[Timeliness]** • Provider education and training on well-child visits and oral health through a provider portal **[Quality]** • Incentives for providers that have weekend hours and/or meet other certain criteria **[Access]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, UHCCP ACC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

DCS CHP

DCS CHP provided a list of interventions for the *Back to Basics* PIP that were in place for CY 2021. Interventions either focused on the full eligible population or were targeted interventions focused on an identified associated subpopulation. Table 8-21 presents strengths, opportunities for improvement, and recommendations for DCS CHP.

Table 8-21—Strengths, Opportunities for Improvement, and Recommendations for DCS CHP

Strengths
1. DCS CHP developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions DCS CHP had in place for CY 2021: • Member outreach, including letters, phone calls, physical mailers, and newsletters to educate and remind members of recommended services **[Timeliness]** • Care management program for all members, which includes review of needed services **[Timeliness]** • Proactive telephonic outreach to members in advance of recommended visits with direct access to providers' offices for scheduling of needed visits **[Access and Timeliness]** • Provider outreach education and follow-up re-education on the use of approved developmental tools **[Quality]** • Provider outreach, including providing and gaps-in-care reports **[Timeliness]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, DCS CHP should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

9. 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 operational reviews (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 technical report.

Conducting the Review

CYE 2019 commenced a new three-year review cycle of ORs. During the three-year review cycle, AHCCCS conducted a comprehensive OR for DCS CHP, including monitoring the progress of the Contractor's implementation of CAPs required as part of the CYE 2019 OR process. Due to complications arising from COVID-19, only DCS CHP was reported on during that review period. AHCCCS did not conduct an OR for the ACC Contractors in the CYE 2020 or CYE 2021 reporting periods. AHCCCS postponed its OR activities at the onset of COVID-19 to allow the Contractors the ability to focus on ensuring members received appropriate care and services during the PHE, in part through supporting its provider network. AHCCCS resumed OR activities in June 2021.

DCS CHP was reviewed during the three-year cycle that started in CYE 2019. The findings of DCS CHP's OR were included in the CYE 2020 ACC and CMDP EQR Technical Report. Review of DCS CHP OR CAPs was put on hold due to COVID-19. Review of the CAPs resumed in CYE 2021; however, final documentation was not available to include within this year's report. The following sections will describe the process that AHCCCS uses to determine whether or not its Contractors meet compliance with federal and AHCCCS' contract requirements. For details on the review objectives, methodologies for conducting the review and for scoring, and criteria for requiring Contractors to submit CAPs, please see Appendix C.

Standards

The AHCCCS DCS CHP OR was organized into 11 areas of focus. Each standard area consisted of several standards designed to measure the Contractor's performance and compliance. The following are the 11 focus areas and number of standards involved in each:

- 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), eight applicable standards
- Quality Management (QM), 18 applicable standards
- Reinsurance (RI), four standards
- Third-Party Liability (TPL), seven applicable standards

AHCCCS conducts a review of Contractor information systems as part of its OR process. In addition to the OR process, AHCCCS evaluates the Contractors' information systems through ongoing monthly deliverables, encounter editing process, and data validation processes. Further, as of calendar year 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by the Arizona EQRO. The EQRO performance measure validation activities (detailed in Section 8) included a review of the Contractors' information systems.

Standards Crosswalk with Federal Requirements

Table 9-1 provides a crosswalk of AHCCCS' OR standards/focus areas with the federal Medicaid managed care regulations.

Table 9-1—Crosswalk of AHCCCS Operational Review Standards/Focus Areas with Federal Medicaid Managed Care Regulations

OR Focus Areas	Medicaid Managed Care Requirement
Case Management (CM)	438.208, 438.240, 438.608, 440.70, 440.169, 440.180, 440.189, 441.18, 441.400, 441.468, 441.725, 441.730
Corporate Compliance (CC)	438.242, 438.608, 438.610, 455.1, 455.17, 455.100-106, 455.436
Claims and Information Standards (CIS)	433.135, 434.6, 438.242, 438.600
Delivery Systems (DS)	438.12, 438.102, 438.206, 438.207, 438.214, 438.242

OR Focus Areas	Medicaid Managed Care Requirement
General Administration (GA)	164.530, 438.3
Grievance Systems (GS)	438.10, 438.228(a)*, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424
Adult, EPSDT and Maternal Child Health (MCH)	441.56, 441.58
Medical Management (MM)	438.62, 438.114, 438.136, 438.208, 438.210, 438.228(b)*, 438.230, 438.236, 438.240, 438.330, 438.404, 456.125-133
Member Information (MI)	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
Quality Management (QM)	438.3, 438.66, 438.206, 438.214, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 479.98, 476.160
Quality Improvement (QI)	438.330, 438.240, 438.242

**42 CFR §438.228: While not specifically cited within past operational review tools, the State conducts random reviews of each MCO, its providers, and subcontractors through its OR process to ensure that they are notifying members of adverse decisions and benefit implications when required in a timely manner. For additional clarity, this citation will be added to future review tools.*

Findings

AHCCCS postponed its OR activities at the onset of COVID-19 to allow the Contractors the ability to focus on ensuring members received appropriate care and services during the PHE, in part through supporting its provider network. AHCCCS resumed OR activities in June 2021. Therefore, there are no findings to report.

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

AzCH-CCP ACC

Table 9-2 presents the strengths, opportunities for improvement, and recommendations for AzCH-CCP ACC.

Table 9-2—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021.

Opportunities for Improvement and Recommendations
Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

BUFC ACC

Table 9-3 presents the strengths, opportunities for improvement, and recommendations for BUFC ACC.

Table 9-3—Strengths, Opportunities for Improvement, and Recommendations for BUFC ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021. Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

Care 1st ACC

Table 9-4 presents the strengths, opportunities for improvement, and recommendations for Care 1st ACC.

Table 9-4—Strengths, Opportunities for Improvement, and Recommendations for Care 1st ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021. Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

HCA ACC

Table 9-5 presents the strengths, opportunities for improvement, and recommendations for HCA ACC.

Table 9-5—Strengths, Opportunities for Improvement, and Recommendations for HCA ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021. Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

Mercy Care ACC

Table 9-6 presents the strengths, opportunities for improvement, and recommendations for Mercy Care ACC.

Table 9-6—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021. Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

MCC ACC

Table 9-7 presents the strengths, opportunities for improvement, and recommendations for MCC ACC.

Table 9-7—Strengths, Opportunities for Improvement, and Recommendations for MCC ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021. Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

UHCCP ACC

Table 9-8 presents the strengths, opportunities for improvement, and recommendations for UHCCP ACC.

Table 9-8—Strengths, Opportunities for Improvement, and Recommendations for UHCCP ACC

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR was conducted for CYE 2021. Recommendation: Although no OR was conducted during CYE 2021, HSAG recommends that the Contractor conduct an internal OR assessment to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

DCS CHP[9-1]

Table 9-9 presents the strengths, opportunities for improvement, and recommendations for DCS CHP.

Table 9-9—Strengths, Opportunities for Improvement, and Recommendations for DCS CHP

Strengths
No OR was conducted for CYE 2021; therefore, HSAG did not provide any strengths.
Opportunities for Improvement and Recommendations
No OR CAP findings were provided for CYE 2021 as a recommendation was provided. Recommendation: Although no OR CAP findings were provided for CYE 2021, HSAG recommends that DCS CHP continue working towards completing its CAP to ensure compliance with the AHCCCS focus areas.

[9-1] DCS CHP previously operated as CMDP.

10. Consumer Assessment of Healthcare Providers and Systems Results

AHCCCS required the administration of member experience surveys to members enrolled in AHCCCS ACC health plans as well as children and youth in foster care enrolled in DCS CHP. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Survey. HSAG calculated results for four global ratings, four composite measures, one individual item measure, three Effectiveness of Care measures (adult population only), three CCC composite measures (CCC population only), and two CCC individual item measures (CCC population only).

Findings and Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

AzCH-CCP ACC

Table 10-1 shows the scores and overall member experience ratings on each CAHPS measure for AZCH-CCP ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-1—NCQA Comparisons for AzCH-CCP ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★★ 60.7%	★★ 72.0%	★ 63.5%
Rating of All Health Care	★ 52.2%	★★★★ 76.6%	★ 63.0%
Rating of Personal Doctor	★★ 67.6%	★★★ 80.8%	★★★ 80.6%
Rating of Specialist Seen Most Often	★ 62.0%	★★★★★+ 82.5%+	★★+ 72.9%+
Composite Measures			
Getting Needed Care	★ 80.9%	★★★★★+ 91.3%+	★★ 86.3%
Getting Care Quickly	★★★ 84.4%	★★+ 91.4%+	★★+ 92.4%+

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
How Well Doctors Communicate	★★ 92.5%	★★★ 96.5%	★ 93.8%
Customer Service	★★ 87.5%	★+ 85.7%+	★+ 86.2%+
Individual Item Measure			
Coordination of Care	★ 80.5%	★+ 78.7%+	★+ 83.1%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★+ 60.0%+		
Discussing Cessation Medications	★+ 46.7%+		
Discussing Cessation Strategies	★+ 41.9%+		
CCC Composite Measures and Items			
Access to Specialized Services			★+ 65.3%+
Family-Centered Care (FCC): Personal Doctor Who Knows Child			★★★ 92.1%
Coordination of Care for Children with Chronic Conditions			★★★★★+ 84.5%+
Access to Prescription Medicines			★★ 90.1%
FCC: Getting Needed Information			★★ 92.2%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-2—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP ACC

Strengths
1. AzCH-CCP ACC's member experience ratings for *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care* met or exceeded the 75th percentiles for the general child population.
2. AzCH-CCP ACC's member experience rating for *Coordination of Care for Children with Chronic Conditions* met or exceeded the 90th percentile for the CCC population.
Opportunities for Improvement and Recommendations
1. AzCH-CCP ACC's member experience ratings for *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that AzCH-CCP ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care and access to care. In addition, AzCH-CCP ACC should provide training and resources to providers to promote smoking cessation with their adult members.
2. AzCH-CCP ACC's member experience ratings for *Customer Service* and *Coordination of Care* were below the 25th percentiles for the general child population. Recommendation: HSAG recommends that AzCH-CCP ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving parents'/caretakers' overall experiences with customer service and coordination of care for child members.
3. AzCH-CCP ACC's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, and *Access to Specialized Services* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that AzCH-CCP ACC focus on improving parents'/caretakers' overall experiences with the quality of care of their child's health plan and health care, including a focus on customer service, coordination of care, and access to specialized services for child members with chronic conditions. In addition, AzCH-CCP ACC should provide training and resources to improve providers' communication skills.

BUFC ACC

Table 10-3 shows the scores and overall member experience ratings on each CAHPS measure for BUFC ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-3—NCQA Comparisons for BUFC ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★★★★ 67.4%	★★★ 74.1%	★★★★ 75.0%
Rating of All Health Care	★★ 57.5%	★ 66.9%	★ 58.5%
Rating of Personal Doctor	★★★★ 73.7%	★ 73.5%	★ 69.2%
Rating of Specialist Seen Most Often	★★ 69.6%	★★★★★+ 81.0%+	★★★+ 78.7%+
Composite Measures			
Getting Needed Care	★★ 82.9%	★★+ 84.7%+	★★ 87.7%
Getting Care Quickly	★★ 82.6%	★★★+ 92.3%+	★+ 89.1%+
How Well Doctors Communicate	★★ 92.7%	★★ 94.4%	★ 92.9%
Customer Service	★★★★ 91.7%	★★+ 88.4%+	★+ 84.4%+
Individual Item Measure			
Coordination of Care	★ 79.3%	★+ 80.0%+	★+ 75.9%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★+ 72.4%+		
Discussing Cessation Medications	★+ 48.4%+		
Discussing Cessation Strategies	★+ 40.3%+		

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
CCC Composite Measures and Items			
Access to Specialized Services			★+ 68.3%+
FCC: Personal Doctor Who Knows Child			★ 86.9%
Coordination of Care for Children with Chronic Conditions			★★★★★+ 88.2%+
Access to Prescription Medicines			★★★ 91.9%
FCC: Getting Needed Information			★★ 93.1%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-4—Strengths, Opportunities for Improvement, and Recommendations for BUFC ACC

Strengths
1. BUFC ACC's member experience ratings for *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service* met or exceeded the 75th percentiles for the adult population.
2. BUFC ACC's member experience rating for *Rating of Specialist Seen Most Often* met or exceeded the 90th percentile for the general child population.
3. BUFC ACC's member experience ratings for *Rating of Health Plan* and *Coordination of Care for Children with Chronic Conditions* met or exceeded the 75th percentiles for the CCC population.
Opportunities for Improvement and Recommendations
1. BUFC ACC's member experience ratings for *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that BUFC ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving members' overall experiences with coordination of care. In addition, BUFC ACC should provide training and resources to providers to promote smoking cessation with their adult members.

Opportunities for Improvement and Recommendations
2. BUFC ACC's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, and *Coordination of Care* were below the 25th percentiles for the general child population. Recommendation: HSAG recommends that BUFC ACC focus on improving parents'/caretakers' overall experiences with their child's personal doctor and the quality of care of their child's health care, including a focus on coordination of care for child members.
3. BUFC ACC's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, *Access to Specialized Services*, and *FCC: Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that BUFC ACC focus on improving parents'/caretakers' of child members with chronic conditions overall experiences with their child's personal doctor and the quality of care of their child's healthcare, including a focus on timeliness of getting care, customer service, coordination of care, access to specialized services for child members, and personal doctors' knowledge of child members' healthcare. In addition, BUFC ACC should provide training and resources to improve providers' communication skills.

Care 1st ACC

Table 10-5 shows the scores and overall member experience ratings on each CAHPS measure for Care 1st ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-5—NCQA Comparisons for Care 1st ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★★ 59.3%	★★★ 73.9%	★★ 69.6%
Rating of All Health Care	★ 54.0%	★★★ 75.4%	★ 64.5%
Rating of Personal Doctor	★ 60.2%	★★ 76.1%	★★★ 80.9%
Rating of Specialist Seen Most Often	★ 60.7%	★+ 70.8%+	★★★+ 76.5%+

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Composite Measures			
Getting Needed Care	★ 80.5%	★★★★ 90.1%	★★★ 90.1%
Getting Care Quickly	★★ 80.7%	★★ 91.3%	★+ 91.2%+
How Well Doctors Communicate	★ 89.9%	★★★ 95.7%	★ 94.0%
Customer Service	★★ 89.0%	★+ 83.3%+	★★+ 90.7%+
Individual Item Measure			
Coordination of Care	★ 77.9%	★+ 80.0%+	★★★★+ 87.7%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★+ 61.7%+		
Discussing Cessation Medications	★+ 40.5%+		
Discussing Cessation Strategies	★+ 34.5%+		
CCC Composite Measures and Items			
Access to Specialized Services			★★+ 72.8%+
FCC: Personal Doctor Who Knows Child			★ 86.5%
Coordination of Care for Children with Chronic Conditions			★★★★★+ 81.6%+
Access to Prescription Medicines			★ 88.7%
FCC: Getting Needed Information			★★★ 94.3%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-6—Strengths, Opportunities for Improvement, and Recommendations for Care 1st ACC

Strengths
1. Care 1st ACC's member experience rating for *Getting Needed Care* met or exceeded the 75th percentile for the general child population.
2. Care 1st ACC's member experience ratings for *Coordination of Care* and *Coordination of Care for Children with Chronic Conditions* met or exceeded the 75th percentiles for the CCC population.
Opportunities for Improvement and Recommendations
1. Care 1st ACC's member experience ratings for *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that Care 1st ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care and access to care. In addition, Care 1st ACC should provide training and resources to providers to promote smoking cessation with their adult members.
2. Care 1st ACC's member experience ratings for *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care* were below the 25th percentiles for the general child population. Recommendation: HSAG recommends that Care 1st ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving parents'/caretakers' overall experiences with their child's specialist, customer service, and coordination of care for child members.
3. Care 1st ACC's member experience ratings for *Rating of All Health Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that Care 1st ACC focus on improving parents'/caretakers' of child members with chronic conditions overall experiences with the quality of care of their child's healthcare, including a focus on timeliness of getting care, personal doctors' knowledge of child members' healthcare, and access to prescription medicines for child members. In addition, Care 1st ACC should provide training and resources to improve providers' communication skills.

HCA ACC

Table 10-7 shows the scores and overall member experience ratings on each CAHPS measure for HCA ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-7—NCQA Comparisons for HCA ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★ 57.7%	★★ 70.2%	★ 65.8%
Rating of All Health Care	★ 52.4%	★★★ 74.3%	★ 59.1%
Rating of Personal Doctor	★★ 66.4%	★ 75.0%	★★ 77.3%
Rating of Specialist Seen Most Often	★★ 67.9%	★★★★★+ 87.5%+	★★★★★+ 86.2%+
Composite Measures			
Getting Needed Care	★ 79.6%	★+ 80.5%+	★+ 82.6%+
Getting Care Quickly	★★ 80.5%	★★+ 90.9%+	★★+ 93.7%+
How Well Doctors Communicate	★★ 92.3%	★★★ 95.6%	★+ 90.2%+
Customer Service	★★+ 89.5%+	★+ 83.0%+	★+ 85.7%+
Individual Item Measure			
Coordination of Care	★+ 80.4%+	★+ 76.7%+	★+ 78.0%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★+ 53.6%+		
Discussing Cessation Medications	★+ 30.6%+		
Discussing Cessation Strategies	★+ 36.1%+		

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
CCC Composite Measures and Items			
Access to Specialized Services			★★★★+ 79.5%+
FCC: Personal Doctor Who Knows Child			★+ 86.7%+
Coordination of Care for Children with Chronic Conditions			★★+ 74.7%+
Access to Prescription Medicines			★★ 89.2%
FCC: Getting Needed Information			★ 87.3%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-8—Strengths, Opportunities for Improvement, and Recommendations for HCA ACC

Strengths
1. HCA ACC's member experience rating for *Rating of Specialist Seen Most Often* met or exceeded the 90th percentile for the general child population.
2. HCA ACC's member experience ratings for *Rating of Specialist Seen Most Often* and *Access to Specialized Services* met or exceeded the 75th percentiles for the CCC population.
Opportunities for Improvement and Recommendations
1. HCA ACC's member experience ratings for *Rating of Health Plan, Rating of All Health Care*, *Getting Needed Care*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that HCA ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care and access to care. In addition, HCA ACC should provide training and resources to providers to promote smoking cessation with their adult members.
2. HCA ACC's member experience ratings for *Rating of Personal Doctor*, *Getting Needed Care*, *Customer Service*, and *Coordination of Care* were below the 25th percentiles for the general child population.

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that HCA ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care and access to care, including a focus on improving parents'/caretakers' overall experiences with their child's personal doctor, customer service, and coordination of care for child members.
3. HCA ACC's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, *FCC: Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that HCA ACC focus on improving parents'/caretakers' of child members with chronic conditions overall experiences with the quality of care of their child's health plan and healthcare, including a focus on access to care, customer service, coordination of care, personal doctors' knowledge of child members' healthcare, and answering parents'/caretakers' questions about their child's health. In addition, HCA ACC should provide training and resources to improve providers' communication skills.

Mercy Care ACC

Table 10-9 shows the scores and overall member experience ratings on each CAHPS measure for Mercy Care ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-9—NCQA Comparisons for Mercy Care ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★★★ 63.9%	★★★★★ 80.4%	★★★★ 74.5%
Rating of All Health Care	★★ 56.3%	★★★ 74.0%	★★ 69.3%
Rating of Personal Doctor	★★★★ 73.6%	★★★★★ 84.5%	★ 73.7%
Rating of Specialist Seen Most Often	★ 64.3%	★★★★★+ 77.4%+	★★★+ 77.5%+
Composite Measures			
Getting Needed Care	★★ 82.5%	★★★+ 87.8%+	★★+ 87.0%+

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Getting Care Quickly	★ 78.9%	★★+ 91.4%+	★+ 90.7%+
How Well Doctors Communicate	★★★ 93.6%	★★★★★ 97.7%	★★★ 96.6%
Customer Service	★+ 86.7%+	★+ 83.0%+	★★★+ 92.1%+
Individual Item Measure			
Coordination of Care	★★+ 83.5%+	★★+ 86.0%+	★+ 77.6%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★★+ 76.6%+		
Discussing Cessation Medications	★★+ 50.0%+		
Discussing Cessation Strategies	★+ 35.3%+		
CCC Composite Measures and Items			
Access to Specialized Services			★★+ 72.0%+
FCC: Personal Doctor Who Knows Child			★★+ 90.6%+
Coordination of Care for Children with Chronic Conditions			★+ 70.3%+
Access to Prescription Medicines			★★ 90.3%
FCC: Getting Needed Information			★★★ 93.9%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-10—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care ACC

Strengths
1. Mercy Care ACC's member experience rating for *Rating of Personal Doctor* met or exceeded the 75th percentile for the adult population.
2. Mercy Care ACC's member experience ratings for *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate* met or exceeded the 90th percentiles for the general child population.
3. Mercy Care ACC's member experience rating for *Rating of Health Plan* met or exceeded the 75th percentile for the CCC population.
Opportunities for Improvement and Recommendations
1. Mercy Care ACC's member experience ratings for *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *Customer Service*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that Mercy Care ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality and timeliness of care, including a focus on improving parents'/caretakers' overall experiences with their child's specialist and customer service. In addition, Mercy Care ACC should provide training and resources to providers to promote smoking cessation with their adult members.
2. Mercy Care ACC's member experience rating for *Customer Service* was below the 25th percentile for the general child population. Recommendation: HSAG recommends that Mercy Care ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving parents'/caretakers' overall experiences with customer service.
3. Mercy Care ACC's member experience ratings for *Rating of Personal Doctor*, *Getting Care Quickly*, *Coordination of Care*, and *Coordination of Care for Children with Chronic Conditions* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that Mercy Care ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care and timeliness of care, including a focus on improving parents'/caretakers' overall experiences with their child's personal doctor and coordination of care for child members with chronic conditions.

MCC ACC

Table 10-11 shows the scores and overall member experience ratings on each CAHPS measure for MCC ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-11—NCQA Comparisons for MCC ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★ 53.1%	★ 63.3%	★+ 58.3%+
Rating of All Health Care	★ 44.4%	★ 64.9%	★+ 55.8%+
Rating of Personal Doctor	★ 63.6%	★ 71.9%	★+ 55.8%+
Rating of Specialist Seen Most Often	★ 62.5%	★★+ 72.2%+	★+ 57.6%+
Composite Measures			
Getting Needed Care	★ 74.8%	★★+ 84.7%+	★+ 83.9%+
Getting Care Quickly	★+ 74.5%+	★★★+ 93.1%+	★★★+ 94.4%+
How Well Doctors Communicate	★ 89.8%	★★+ 94.7%+	★+ 93.1%+
Customer Service	★★+ 87.9%+	★+ 77.8%+	★★+ 90.5%+
Individual Item Measure			
Coordination of Care	★+ 79.0%+	★★★+ 89.2%+	★+ 63.6%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★+ 67.4%+		
Discussing Cessation Medications	★+ 42.9%+		
Discussing Cessation Strategies	★+ 40.8%+		

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
CCC Composite Measures and Items			
Access to Specialized Services			★★★★+ 78.0%+
FCC: Personal Doctor Who Knows Child			★+ 88.9%+
Coordination of Care for Children with Chronic Conditions			★★★+ 78.8%+
Access to Prescription Medicines			★+ 80.6%+
FCC: Getting Needed Information			★★★★★+ 96.1%+

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-12—Strengths, Opportunities for Improvement, and Recommendations for MCC ACC

Strengths
1. MCC ACC's member experience ratings for *Access to Specialized Services* and *FCC: Getting Needed Information* met or exceeded the 75th percentiles for the CCC population.
Opportunities for Improvement and Recommendations
1. MCC ACC's member experience ratings for *Rating of Health Plan, Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that MCC ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, timeliness of care, and access to care. In addition, MCC ACC should provide training and resources to providers to promote smoking cessation with their adult members.
2. MCC ACC's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service* were below the 25th percentiles for the general child population.

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that MCC ACC focus on improving parents'/caretakers' overall experiences with their child's personal doctor and the quality of care of their child's health plan and healthcare, including a focus on customer service for child members.
3. MCC ACC's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Coordination of Care*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that MCC ACC focus on improving parents'/caretakers' of child members with chronic conditions overall experiences with their child's personal doctor and specialist, and the quality of care of their child's health plan and healthcare, including a focus on access to care, coordination of care, personal doctors' knowledge of child members' healthcare, and access to prescription medicines for child members. In addition, MCC ACC should provide training and resources to improve providers' communication skills.

UHCCP ACC

Table 10-13 shows the scores and overall member experience ratings on each CAHPS measure for UHCCP ACC's adult Medicaid, general child Medicaid, and CCC Medicaid supplemental populations.

Table 10-13—NCQA Comparisons for UHCCP ACC

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
Global Ratings			
Rating of Health Plan	★★★ 66.5%	★★★ 74.2%	★★ 66.5%
Rating of All Health Care	★★★ 61.3%	★ 68.9%	★ 60.2%
Rating of Personal Doctor	★★ 67.2%	★★ 77.4%	★★★ 80.5%
Rating of Specialist Seen Most Often	★★ 65.8%	★★+ 72.2%+	★★★+ 76.8%+
Composite Measures			
Getting Needed Care	★★★ 84.0%	★+ 82.2%+	★ 81.6%
Getting Care Quickly	★★★ 85.7%	★+ 88.2%+	★+ 85.1%+

Measure	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid
How Well Doctors Communicate	★ 88.9%	★★★ 96.1%	★★ 95.6%
Customer Service	★ 86.3%	★★+ 88.5%+	★★+ 89.8%+
Individual Item Measure			
Coordination of Care	★ 78.6%	★★+ 85.7%+	★+ 83.8%+
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	★★+ 75.0%+		
Discussing Cessation Medications	★+ 46.5%+		
Discussing Cessation Strategies	★+ 32.6%+		
CCC Composite Measures and Items			
Access to Specialized Services			★+ 70.1%+
FCC: Personal Doctor Who Knows Child			★★ 90.9%
Coordination of Care for Children with Chronic Conditions			★★★★★+ 85.1%+
Access to Prescription Medicines			★ 87.6%
FCC: Getting Needed Information			★ 86.6%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 10-14—Strengths, Opportunities for Improvement, and Recommendations for UHCCP ACC

Strengths
1. UHCCP ACC's member experience rating for *Coordination of Care for Children with Chronic Conditions* met or exceeded the 90th percentile for the CCC population.
Opportunities for Improvement and Recommendations
1. UHCCP ACC's member experience ratings for *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* were below the 25th percentiles for the adult population. Recommendation: HSAG recommends that UHCCP ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving members' experiences with customer service and coordination of care. UHCCP ACC should provide training and resources to providers to improve their communication skills and promote smoking cessation with their adult members.
2. UHCCP ACC's member experience ratings for *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly* were below the 25th percentiles for the general child population. Recommendation: HSAG recommends that UHCCP ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, timelines of care, and access to care.
3. UHCCP ACC's member experience ratings for *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *Coordination of Care*, *Access to Specialized Services*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that UHCCP ACC explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, timelines of care, and access to care for child members with chronic conditions, including a focus on improving parents'/caretakers' experiences with coordination of care, access to specialized services and prescription medicines, and answering parents'/caretakers' questions about their child's health.

CAHPS Contractor Comparison

HSAG compared the Contractor results to the ACC Program to determine if Contractor results were statistically significantly different than the ACC Program. Table 10-15 shows a summary of the statistically significant results of this analysis for the adult, general child, and CCC populations.

Table 10-15—ACC Contractor Comparisons: Statistically Significant Results

Measure	AzCH-CCP	BUFC	Care1st	HCA	MCC	Mercy Care	UHCCP
Adult							
Rating of Health Plan		↑			↓		↑
Rating of Personal Doctor		↑	↓			↑	
General Child							
Rating of Health Plan					↓	↑	
CCC							
Rating of Personal Doctor	↑		↑		↓+		↑

\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

The cells shaded in grey indicate the scores were not statistically significantly higher or lower than the ACC Program for those measures and plans.

↑ *Statistically significantly higher than the ACC Program.*

↓ *Statistically significantly lower than the ACC Program.*

DCS CHP

Table 10-16 shows the scores and overall member experience ratings on each CAHPS measure for DCS CHP's[10-1] general child Medicaid and CCC Medicaid supplemental populations.

Table 10-16—NCQA Comparisons for DCS CHP

	General Child	CCC
Global Ratings		
Rating of Health Plan	★ 61.6%	★ 54.5%
Rating of All Health Care	★★ 70.2%	★ 64.7%

[10-1] DCS CHP previously operated as CMDP.

	General Child	CCC
Rating of Personal Doctor	★★ 77.2%	★★ 76.0%
Rating of Specialist Seen Most Often	★ 60.6%	★+ 65.2%+
Composite Measures		
Getting Needed Care	★★★★ 89.3%	★ 85.9%
Getting Care Quickly	★★★ 91.9%	★ 91.2%
How Well Doctors Communicate	★★★ 96.6%	★★ 95.9%
Customer Service	★+ 85.7%+	★+ 81.1%+
Individual Item Measure		
Coordination of Care	★ 77.7%	★+ 71.6%+
CCC Composite Measures and Items		
Access to Specialized Services		★+ 70.9%+
FCC: Personal Doctor Who Knows Child		★ 87.4%
Coordination of Care for Children with Chronic Conditions		★★+ 75.0%+
Access to Prescription Medicines		★ 83.9%
FCC: Getting Needed Information		★★★ 93.5%

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
A grey cell indicates that the measure does not apply to the population.
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

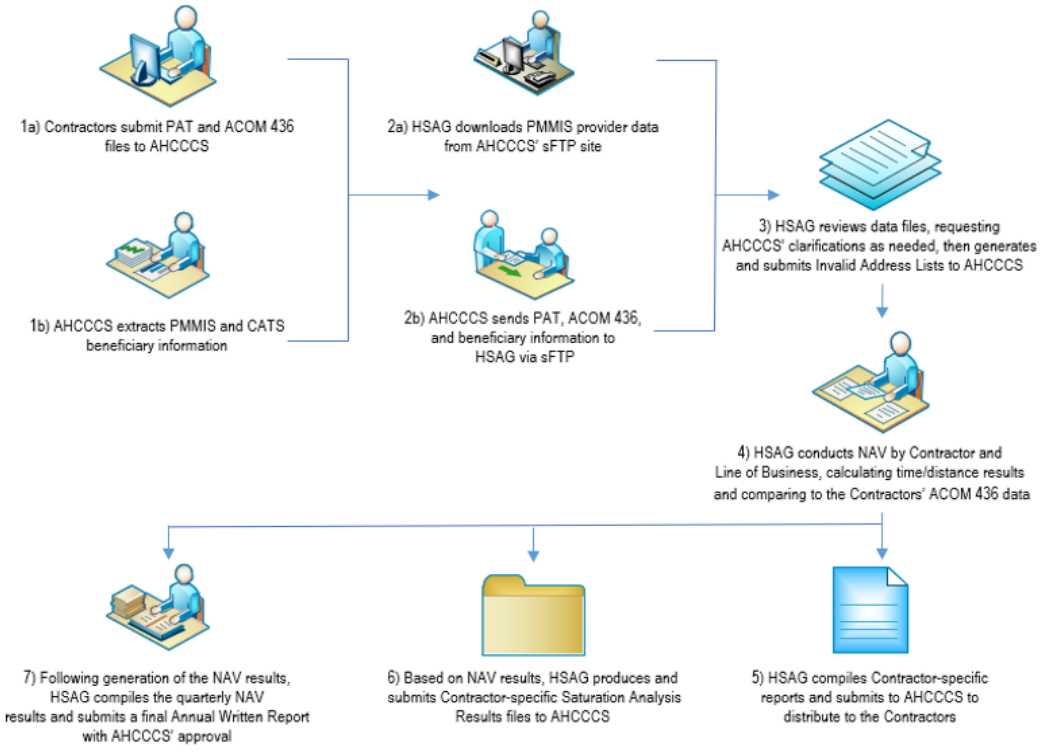
Table 10-17—Strengths, Opportunities for Improvement, and Recommendations for DCS CHP

Strengths
1. DCS CHP's member experience rating for *Getting Needed Care* met or exceeded the 75th percentile for the general child population.
Opportunities for Improvement and Recommendations
1. DCS CHP's member experience ratings for *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care* were below the 25th percentiles for the general child population. Recommendation: HSAG recommends that DCS CHP focus on improving parents'/caretakers' overall experiences with their child's specialist and the quality of care of their child's health plan, including a focus on customer service and coordination of care.
2. DCS CHP's member experience ratings for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Coordination of Care*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines* were below the 25th percentiles for the CCC population. Recommendation: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, timelines of care, and access to care for child members with chronic conditions. DCS CHP should focus on improving parents'/caretakers' overall experiences with the quality of care of their child's health plan and healthcare, including a focus on specialists, customer service, coordination of care, personal doctors' knowledge of child members' healthcare, and access to specialized services and prescription medicines.

11. Network Adequacy Validation

CYE 2021 is the third year in which AHCCCS contracted HSAG to support biannual analysis and validation of healthcare provider networks subcontracted to AHCCCS' ACC Contractors and the DCS CHP subcontracted health plan.[11-1] HSAG's biannual NAV considered each ACC Contractor's compliance with 11 AHCCCS-established time/distance standards and the DCS CHP subcontracted health plan compliance with 8 AHCCCS-established time/distance standards during the CYE 2021 measurement period.[11-2] Figure 11-1 summarizes the biannual network adequacy data process and reporting products.

Figure 11-1—CYE 2021 Biannual Network Adequacy Validation Process



Note: PAT=Provider Affiliation Transmission; PMMIS=Prepaid Medical Management Information System; CATS=Client Assessment and Tracking System; sFTP=secure file transfer protocol

[11-1] 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 the protocol was not released during this study, HSAG's analysis of the Contractor's time/distance results aligns with current federal regulations.

[11-2] The AHCCCS Contractors Operations Manual (ACOM), Section 436—Network Standards defines time/distance standards, as well as provider identification and members' county assignment criteria. The ACOM is available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.

In addition to HSAG's NAV activities, AHCCCS measures network adequacy using other mechanisms outlined in Appendix F.

HSAG conducted biannual validation between the ACC Contractors' and the DCS CHP subcontracted health plan's self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors and the subcontracted health plan in each quarter that data could be compared.

ACC

HSAG's biannual validation of the ACC Contractors' results reflects minor discrepancies between the Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors and LOBs in each quarter that data could be compared. While minor differences (i.e., less than 1 percentage point) between HSAG's time/distance calculation results and each Contractor's time/distance calculation results were common, these findings are most likely attributable to the timing of the input data, software versions used by each Contractor (refer to Table E-3), or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 11-1 summarizes HSAG's assessment of each ACC Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ACC Contractor met the minimum network standard for all assigned counties during the biannual assessment, and an "X" indicates that the ACC Contractor failed to meet one or more minimum network standards in any assigned county or quarter. Appendix E contains NAV results specific to each county and biannual validation period.

Table 11-1—Summary of CYE 2021 Compliance with Minimum Time/Distance Network Requirements for ACC Contractors

Minimum Network Requirement	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC
Behavioral Health Outpatient and Integrated Clinic, Adult	✔	✔	✘	✘	✔	✔	✔
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✔	✔	✘	✘	✔	✔	✔
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	✔	✔	✔	✔	✔	✔	✔
Cardiologist, Adult	✔	✔	✔	✔	✔	✔	✔

Minimum Network Requirement	AzCH–CCP ACC	BUFC ACC	Care1st ACC	HCA ACC	Mercy Care ACC	MCC ACC	UHCCP ACC
Cardiologist, Pediatric	✔	✔	✔	✔	✔	✔	✔
Dentist, Pediatric	✕	✕	✕	✕	✔	✕	✔
Hospital	✔	✔	✔	✔	✔	✔	✔
Obstetrics/Gynecology (OB/GYN)	✔	✔	✔	✔	✔	✔	✔
Pharmacy	✔	✔	✕	✕	✔	✕	✔
PCP, Adult	✕	✔	✕	✔	✔	✔	✔
PCP, Pediatric	✕	✔	✕	✕	✔	✔	✔

The ACC Contractors' performance consistently met the Behavioral Health Residential Facility; Cardiologist Adult and Pediatric; Hospital; and OB/GYN standards while struggling to meet standards for Dentist, Pediatric; PCP, Pediatric; and Pharmacy. However, several Contractors demonstrated PAT data issues, which impacted HSAG's time/distance results and the validation of Contractors' ACOM 436 results, including BUFC ACC and MCC ACC in CYE 2021, Quarter 4.

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

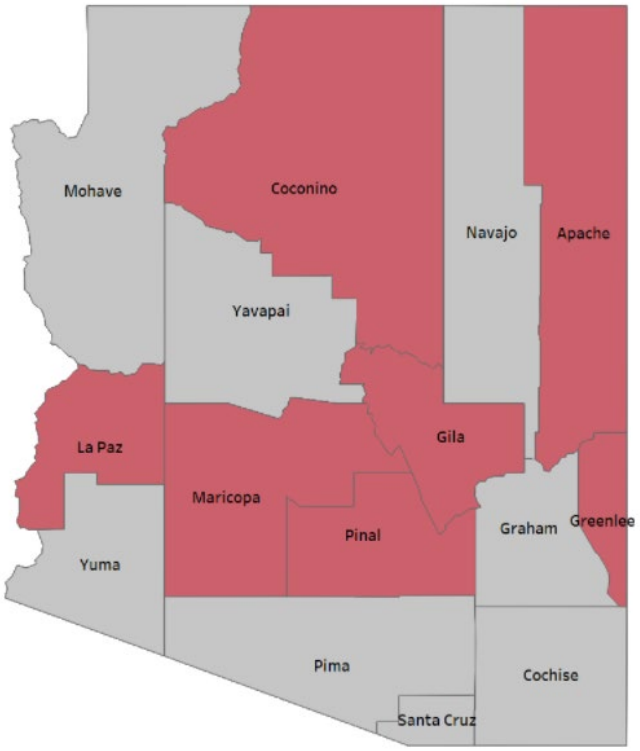
- In CYE 2021, Quarter 4, MCC ACC's data did not include the majority of its subcontracted PBM's and dental benefit manager's (DBM's) networks. This influences the validated compliance for any calculations for these provider types.
- In CYE 2021, Quarter 4, MCC ACC's data included substantially increased numbers of providers used to measure the adult and pediatric Behavioral Health Outpatient and Integrated Clinic standards compared to prior submissions. AHCCCS' review found that MCC ACC was duplicating records submitted for the same clinic address. This potentially influenced the validated compliance for these provider types.
- In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the Contractor, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

As part of the NAV, AHCCCS maintained its 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 biannual network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG's saturation analysis results. When issues were identified,

ACC Contractors were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Figure 11-2 summarizes how ACC Contractors performed on meeting the time/distance standards by county as of CYE 2021, Quarter 4. Red shading indicates that one or more ACC Contractor failed to meet one or more time/distance standards. Gray shading indicates that all ACC Contractors met all time/distance standards in the given county.

Figure 11-2—Summary of CYE 2021 Quarter 4 Compliance with Minimum Time/Distance Network Requirements by County for ACC Contractors



Overall, for CYE 2021, Quarter 4, the most recent biannual assessment, all applicable ACC Contractors met all minimum time/distance network requirements for all counties except for Apache, Coconino, Greenlee, Gila, Pinal, Maricopa, and La Paz counties.

Based on the NAV results, no ACC contractor met all requirements for all standards across all quarters and counties. However, in Cochise, Graham, Mohave, Navajo, Santa Cruz, and Yavapai counties, both applicable ACC Contractors met all standards for all quarters. After accounting for data-related findings, validation results for ACC Contractors suggested no network concerns for Gila, Maricopa, Pima, Pinal, and Yuma counties.

Each ACC Contractor should continue to monitor and maintain its existing provider network coverage as of CYE 2021, Quarter 4, with specific attention to ensuring the availability of the following provider types among the applicable ACC Contractors:

- Behavioral health outpatient and integrated clinics for adults or children in Apache County
- PCPs for adults or children in Apache County
- Pediatric dentists in Apache, Coconino, Greenlee, and La Paz counties
- Pharmacies in Apache and Coconino counties

Additionally, the ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.

DCS CHP

Table 11-2 summarizes HSAG's assessment of DCS CHP[11-3] subcontracted health plan's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the DCS CHP subcontracted health plan met the minimum network standard for all assigned counties during the Quarter 4 assessment, and an "X" indicates that the DCS CHP subcontracted health plan failed to meet one or more minimum network standards in any assigned county. Appendix E contains NAV results specific to each county during the Quarter 4 validation period.

Table 11-2—Summary of CYE 2021 Compliance with Minimum Time/Distance Network Requirements for DCS CHP Subcontracted Health Plan

Minimum Network Requirement	DCS CHP
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✕
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	✔
Cardiologist, Pediatric	✔
Dentist, Pediatric	✕
Hospital	✔
Obstetrics/Gynecology (OB/GYN)	✔
Pharmacy	✕
PCP, Pediatric	✔

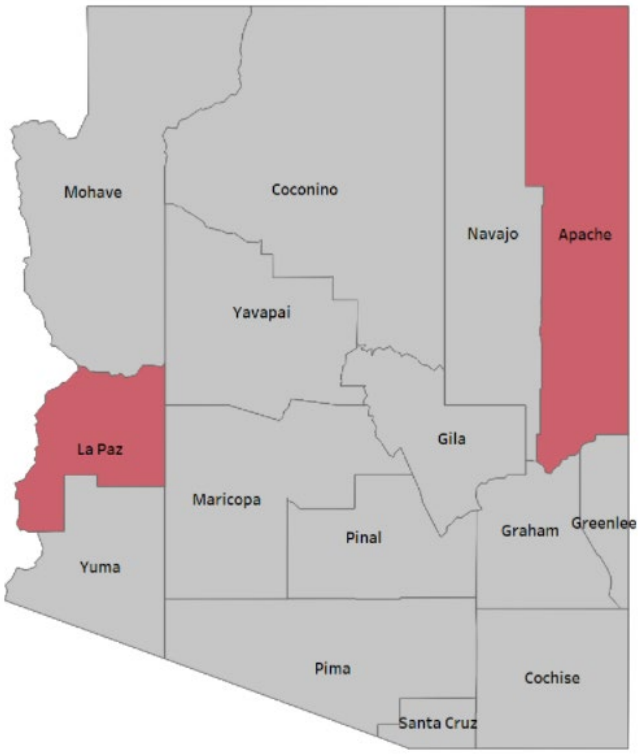
[11-3] DCS CHP previously operated as CMDP.

The DCS CHP subcontracted health plan met minimum network standards during Quarter 4 for the majority of counties; however, it did not meet the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Dentist, Pediatric; and Pharmacy standards in La Paz County, and the Dentist, Pediatric standard in Apache County.

As part of the NAV, AHCCCS maintained its feedback process for the DCS CHP subcontracted health plan to review and improve the accuracy of its data submissions. Specifically, AHCCCS supplied the DCS CHP subcontracted health plan with a copy of HSAG's biannual network adequacy analysis, a copy of the PAT file that HSAG used to conduct the analysis, and a copy of HSAG's saturation analysis results. When issues were identified, the DCS CHP subcontracted health plan was expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

Figure 11-3 summarizes how the DCS CHP subcontracted health plan performed on meeting the time/distance standards by county as of CYE 2021, Quarter 4. Red shading indicates that the DCS CHP subcontracted health plan failed to meet one or more time/distance standards. Gray shading indicates that the DCS CHP subcontracted health plan met all time/distance standards in the given county.

Figure 11-3—Summary of CYE 2021 Quarter 4 Compliance with Minimum Time/Distance Network Requirements by County for DCS CHP Subcontracted Health Plan



Overall, for CYE 2021, Quarter 4 (the most recent biannual assessment), the DCS CHP subcontracted health plan met all minimum time/distance network requirements except for Apache and La Paz counties.

The DCS CHP subcontracted health plan should continue to monitor and maintain its existing provider network coverage as of CYE 2021, Quarter 4, with specific attention to ensuring the availability of the following provider types:

- Behavioral health outpatient and integrated clinics for children in Apache County
- Pediatric dentists in Apache and La Paz counties
- Pharmacies in Apache County

Quality, Access, and Timeliness—Strengths, Opportunities for Improvement, and Recommendations

Table 11-3 through Table 11-10 outline strengths, opportunities for improvement, and recommendations for each contractor.

AzCH-CCP ACC

Table 11-3—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP ACC

Strengths
1. AzCH-CCP ACC met all time/distance network standards in assigned counties for both quarters in CYE 2021, except for Greenlee and La Paz counties. Note: AzCH-CCP ACC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. AzCH-CCP ACC failed to meet the time/distance standard for pediatric dentists in Greenlee and La Paz counties. Recommendation: AzCH-CCP ACC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of pediatric dentists in Greenlee and La Paz counties.

BUFC ACC

Table 11-4—Strengths, Opportunities for Improvement, and Recommendations for BUFC ACC

Strengths
1. BUFC ACC met all time/distance network standards in assigned counties for both quarters in CYE 2021, except for La Paz County. Note: BUFC ACC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. BUFC ACC failed to meet the time/distance standard for pediatric dentists in La Paz County. Recommendation: BUFC ACC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of pediatric dentists in La Paz County.
3. In CYE 2021, Quarter 4, BUFC ACC submitted provider data for dentists that did not include the specialty codes used to identify dentists meeting the criteria for the pediatric dentist provider category. Recommendation: BUFC ACC should continue to monitor its process for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.

Care 1st ACC

Table 11-5—Strengths, Opportunities for Improvement, and Recommendations for Care 1st ACC

Strengths
1. Care 1st ACC met all time/distance network standards in assigned counties for both quarters in CYE 2021, except for Apache and Coconino counties. Note: Care 1st ACC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. Care 1st ACC failed to meet 6 of the 10 applicable standards in Apache County for CYE 2021, Quarter 4. Recommendation: Care 1st ACC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of behavioral health outpatient and integrated clinics for adults or children, pediatric dentists, pharmacies, and PCPs for adults or children in Apache County.

HCA ACC

Table 11-6—Strengths, Opportunities for Improvement, and Recommendations for HCA ACC

Strengths
1. HCA ACC met all time/distance network standards in assigned counties for both quarters in CYE 2021, except for Apache County. Note: HCA ACC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards.

Opportunities for Improvement and Recommendations
Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. HCA ACC failed to meet 5 of the 10 applicable standards in Apache County for CYE 2021, Quarter 4. Recommendation: HCA ACC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of behavioral health outpatient and integrated clinics for adults and children, pediatric dentists, pharmacies, and PCPs for children in Apache County.
3. HCA ACC failed to meet 2 of the 10 applicable standards in Coconino County for CYE 2021, Quarter 4. Recommendation: HCA ACC should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of pediatric dentists and pharmacies in Coconino County.

Mercy Care ACC

Table 11-7—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care ACC

Strengths
1. Mercy Care ACC met all time/distance network standards in all assigned counties for both quarters in CYE 2021. Note: Mercy Care ACC provides coverage in the following counties: Gila, Maricopa, and Pinal.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
Recommendation: While HSAG did not have any recommendations specific to its existing provider network coverage, Mercy Care ACC should continue to monitor and maintain its existing provider network coverage.

MCC ACC

Table 11-8—Strengths, Opportunities for Improvement, and Recommendations for MCC ACC

Strengths
1. After accounting for data-related findings, MCC ACC met all time/distance network standards in all assigned counties for both quarters in CYE 2021. Note: MCC ACC provides coverage in the following counties: Gila, Maricopa, and Pinal.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. In CYE 2021, Quarter 4, MCC ACC's data did not include the majority of its subcontracted PBM's and DBM's networks, which affected calculated performance for these provider types. Recommendation: MCC ACC should continue to monitor its process for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.

UHCCP ACC

Table 11-9—Strengths, Opportunities for Improvement, and Recommendations for UHCCP ACC

Strengths
1. UHCCP ACC met all time/distance network standards in all assigned counties for both quarters in CYE 2021. Note: UHCCP ACC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
Recommendation: While HSAG did not have any recommendation specific to its existing provider network coverage, UHCCP ACC should continue to monitor and maintain its existing provider network coverage.

DCS CHP

Table 11-10—Strengths, Opportunities for Improvement, and Recommendations for DCS CHP

Strengths
1. DCS CHP subcontracted health plan met all time/distance network standards in assigned counties for CYE 2021, Quarter 4, except for Apache and La Paz counties. Note: DCS CHP provides coverage statewide in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma.
Opportunities for Improvement and Recommendations
1. Isolated data issues may have contributed to specific instances affecting ACC Contractors' compliance with time/distance standards. Recommendation: The ACC Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
2. DCS CHP subcontracted health plan failed to meet 3 of the 7 applicable standards in Apache County for CYE 2021, Quarter 4. Recommendation: DCS CHP subcontracted health plan should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of behavioral health outpatient and integrated clinics for children, pediatric dentists, and pharmacies in Apache County.
3. DCS CHP subcontracted health plan failed to meet the Dentists, Pediatric standard in La Paz County for CYE 2021, Quarter 4. Recommendation: DCS CHP subcontracted health plan should continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of pediatric dentists in La Paz County.

Appendix A. Validation of Performance Measure Methodology and Additional Results

In accordance with 42 CFR §438.240(b), AHCCCS requires Contractors to have a Quality Management/Performance Improvement (QM/PI) program that includes measuring and submitting data to AHCCCS related to Contractor performance. Validating MCO and PIHP performance measures is one of the three mandatory EQR activities described at 42 CFR §438.358(b)(2). The requirement at §438.358(a) allows states, their agents that are not MCOs or PIHPs, or an EQRO to conduct the mandatory activities. MCOs/PIHPs may report performance results to a state (as required by the state), or the state may calculate the MCOs'/PIHPs' performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs and validated annually.

The purpose of the PMV is to assess the accuracy of performance measures reported by Contractors and to determine the extent to which performance measures reported by the Contractors follow state specifications and reporting requirements. According to the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019,[A-1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not an MCO, or an EQRO.

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities, HSAG obtained a list of the performance measures that AHCCCS selected for validation.

HSAG then prepared a document request letter that was submitted to the Contractors outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure, as applicable; a completed HEDIS MY 2020 Record of Administration, Data Management, and Processes (Roadmap), if applicable; a completed Information Systems Capabilities Assessment Tool (ISCAT); any additional supporting documentation necessary to complete the audit; a timetable for completion; and instructions for submission. HSAG also forwarded a letter that included requested documentation needed to complete the medical record review validation (MRRV) process. HSAG responded to any audit-related questions received directly from the Contractors during the pre-on-site phase.

[A-1] The Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Dec 7, 2021.

Approximately two weeks prior to the on-site visit, HSAG provided each Contractor with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with each Contractor to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the Contractor.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed this data:

- **NCQA's HEDIS MY 2020 Roadmap:** Contractors completed and submitted the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures, if applicable. HSAG used responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** Contractors completed and submitted an ISCAT to supplement the information included in the Roadmap and address data collection and reporting specifics of non-HEDIS measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** Contractors that calculated the performance measures using source code were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by AHCCCS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). Contractors that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures. If the Contractors outsourced programming for HEDIS measure production to an outside vendor, the Contractors were required to submit the vendor's NCQA measure certification reports.
- **Medical record documentation:** Contractors completed the medical record review (MRR) section within the Roadmap. In addition, Contractors submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the Contractor. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by the Contractor and then used the MRRV results to determine if the findings impacted the audit results for each performance measure rate.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual On-Site Activities

HSAG conducted an on-site visit with each Contractor. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap documentation:** This session was designed to be interactive with key staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and Roadmap, if applicable, and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes:** This evaluation included a review of the information systems, focusing on claims processing, enrollment and disenrollment data processing, and tracking changes. The evaluation also encompassed a review of the Contractor's claims processing steps through its encounter data submissions to AHCCCS, reviewing for a general reconciliation, however acknowledging that the encounter data submissions would not include all denied claims, based on AHCCCS' guidance to the Contractors. Throughout the evaluation HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff included executive leadership, enrollment specialists, claims processors, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the enrollment, eligibility, and claims performance measure data.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each Contractor provided a listing of the data that it had reported to AHCCCS to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS and Core Set measures. HSAG selected a random sample from the submitted data and requested that the Contractor provide proof of service documents or system screenshots that allowed for validation against the source data in the system. These data were also reviewed live in the Contractor's systems during the on-site review for verification, which provided the Contractor an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting.

There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the Contractor.

Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the Contractors have system documentation which supports that the Contractor appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT, Roadmap, and on-site visit, and revisited the documentation requirements for any post-on-site activities.

Performance Measure-Specific Findings

Based on all validation activities, HSAG determined results for each performance measure. The CMS PMV protocol identifies three possible validation finding designations for performance measures, which are defined in Table A-1.

Table A-1—Designation Categories for Performance Measures

Report (R)	Measure data were compliant with the specifications required by the State and the rate reported was valid.
Do Not Report (DNR)	Measure data were materially biased.
Not Applicable (NA)	Not applicable; the Contractor was not required to report the measure (i.e., small denominator).

According to the CMS protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of "DNR" because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of "R."

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results will render a particular measure as "DNR."

Required Performance Measures

The selected MY 2020 performance measures for the ACC Contractors and DCS CHP were grouped into the following domains of care: Maternal and Perinatal Care, Behavioral Health Care, Care of Acute and Chronic Conditions, Pediatric Health, and Preventive Screening. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractors and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance. Table A-2 and Table A-3 display the technical specifications used during PMV for the ACC Contractors and DCS CHP, respectively: NCQA's HEDIS MY 2020, CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) for Federal Fiscal Year (FFY) 2021, and CMS Core Set of Children's Health Care Quality Measures for Medicaid (Child Core Set) and CHIP for FFY 2021.

Table A-2—MY 2020 Performance Measures for ACC Contractors

Performance Measure	Measure Steward
Maternal and Perinatal Care	
Prenatal and Postpartum Care—Postpartum Care	NCQA
Behavioral Health Care	
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	NCQA
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	NCQA
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	NCQA
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	NCQA
Total Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and *Total Engagement of AOD Treatment—Total*	NCQA
Care of Acute and Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	NCQA
Pediatric Health	
Child and Adolescent Well-Care Visits—Total	NCQA
Developmental Screening in the First Three Years of Life—Total	CMS
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	NCQA
Preventive Screening	
Breast Cancer Screening—Total	NCQA
Cervical Cancer Screening	NCQA

Table A-3—MY 2020 Performance Measures for DCS CHP

Performance Measure	Measure Steward
Pediatric Health	
Child and Adolescent Well-Care Visits—Total	NCQA
Developmental Screening in the First Three Years of Life—Total	CMS
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	NCQA

HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance related to providing quality, timely, and accessible care and services to AHCCCS members. (See Table A-4 for the assignment of performance measures to the Quality, Timeliness, and Access areas.) If applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Table A-4—Assignment of Performance Measures to the Quality, Timeliness, and Access Areas

Performance Measure	Quality	Timeliness	Access
Maternal and Perinatal Care			
Prenatal and Postpartum Care—Postpartum Care	✓	✓	✓
Behavioral Health Care			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*		✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*		✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*		✓	✓
Total Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and *Total Engagement of AOD Treatment—Total—Total*		✓	✓
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	✓		
Pediatric Health			
Child and Adolescent Well-Care Visits—Total	✓		✓
Developmental Screening in the First Three Years of Life	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✓		✓
Preventive Screening			
Breast Cancer Screening—Total	✓		
Cervical Cancer Screening	✓		

Performance Measurement—ACC Contractors

For each ACC Contractor, the following information is provided: findings from the CMS EQR Protocol 2 audit and a table that includes MY 2020 performance for all measures, including those measures that could not be compared to the NCQA Quality Compass national Medicaid HMO mean. Some measures could not be compared to NCQA Quality Compass national Medicaid HMO mean because they are from the Adult or Child Core Set or national means were not available.

AzCH-CCP ACC

HSAG determined that AzCH-CCP ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with AzCH-CCP ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with AzCH-CCP ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with AzCH-CCP ACC's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with AzCH-CCP ACC's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with AzCH-CCP ACC's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with AzCH-CCP ACC's procedures for data integration and measure production.

Table A-5—MY 2020 Performance Measure Results for AzCH-CCP ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	71.8%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	54.5%
Effective Continuation Phase Treatment	Administrative	39.7%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	20.0%
30-Day Follow-Up—Total	Administrative	27.0%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	48.9%
30-Day Follow-Up—Total	Administrative	59.4%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	40.9%
30-Day Follow-Up—Total	Administrative	62.6%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	46.8%
Total Engagement of AOD Treatment—Total	Administrative	17.6%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Administrative	59.4%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	40.6%
Developmental Screening in the First Three Years of Life†		
Total	Hybrid	17.0%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	61.5%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	52.4%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	49.9%

* A lower rate indicates better performance for this measure.
† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*
Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

BUFC ACC

HSAG determined that BUFC ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with BUFC ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with BUFC ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with BUFC ACC's provider data systems or processes.
- *Medical Record Review Process:* BUFC ACC did not perform hybrid review for MY 2020; therefore, the medical record review process is not applicable.
- *Supplemental Data:* HSAG identified no concerns with BUFC ACC's supplemental data systems and processes.
- *Data Integration:* While BUFC ACC produced final validated rates for all measures, HSAG identified a concern with BUFC ACC's procedures for data integration and measure production. HSAG found that BUFC ACC was only loading paid medical claims, which was identified as a missed opportunity since many of the performance measure specifications allow the use of denied claims to count toward numerator compliance.

Table A-6—MY 2020 Performance Measure Results for BUFC ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Administrative	49.1%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	56.3%
Effective Continuation Phase Treatment	Administrative	41.4%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	14.3%
30-Day Follow-Up—Total	Administrative	19.8%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	42.9%
30-Day Follow-Up—Total	Administrative	53.5%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	33.3%

Performance Measure	Data Collection Methodology	MY 2020 Performance
30-Day Follow-Up—Total	Administrative	48.1%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	45.2%
Total Engagement of AOD Treatment—Total	Administrative	17.8%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Administrative	57.8%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	34.0%
Developmental Screening in the First Three Years of Life†		
Total	Administrative	33.3%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	48.8%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	44.9%
Cervical Cancer Screening		
Cervical Cancer Screening	Administrative	33.9%

* A lower rate indicates better performance for this measure.

† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

Care 1st ACC

HSAG determined that Care 1st ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Care 1st ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Care 1st ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with Care 1st ACC's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Care 1st ACC's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Care 1st ACC's supplemental data systems and processes.
- *Data Integration:* HSAG identified a concern with Care 1st ACC's procedures for data integration and measure production. For some measures, Care 1st ACC's rates benchmarked lower than comparable benchmarks or ACC averages given that Care 1st ACC did not elect to obtain medical record data for all measures eligible for hybrid methodology. Therefore, these measures likely underreport Care 1st ACC's actual performance. While Care 1st ACC's administrative rates were valid for MY 2020 reporting, caution should be exercised when making the comparison of performance measure rates for measures in which the hybrid and administrative methodology are different.

Table A-7—MY 2020 Performance Measure Results for Care 1st ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	61.8%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	51.8%
Effective Continuation Phase Treatment	Administrative	36.0%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	17.0%
30-Day Follow-Up—Total	Administrative	24.7%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	42.7%
30-Day Follow-Up—Total	Administrative	53.1%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	52.5%
30-Day Follow-Up—Total	Administrative	68.0%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	46.0%
Total Engagement of AOD Treatment—Total	Administrative	17.6%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	46.2%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	45.6%
Developmental Screening in the First Three Years of Life†		
Total	Administrative	3.4%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	61.9%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	39.5%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	46.5%

* A lower rate indicates better performance for this measure.

† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

HCA ACC

HSAG determined that HCA ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with HCA ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with HCA ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with HCA ACC's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with HCA ACC's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with HCA ACC's supplemental data systems and processes.
- *Data Integration:* While HCA ACC produced final validated rates for all measures, HSAG identified a concern with HCA ACC's procedures for data integration and measure production. HSAG found that HCA ACC had not initially correctly reported multiple measures due to incorrectly including skilled nursing facility claims in measures required to include acute inpatient hospital claims.

Table A-8—MY 2020 Performance Measure Results for HCA ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	54.0%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	51.3%
Effective Continuation Phase Treatment	Administrative	36.0%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	16.7%
30-Day Follow-Up—Total	Administrative	24.3%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	45.9%
30-Day Follow-Up—Total	Administrative	56.9%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	44.3%
30-Day Follow-Up—Total	Administrative	60.2%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	44.1%
Total Engagement of AOD Treatment—Total	Administrative	16.0%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	46.7%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	36.9%
Developmental Screening in the First Three Years of Life†		
Total	Hybrid	38.7%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	54.7%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	43.1%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	45.0%

* A lower rate indicates better performance for this measure.
† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*
Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

Mercy Care ACC

HSAG determined that Mercy Care ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Mercy Care ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Mercy Care ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with Mercy Care ACC's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Mercy Care ACC's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Mercy Care ACC's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Mercy Care ACC's procedures for data integration and measure production.

Table A-9—MY 2020 Performance Measure Results for Mercy Care ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	69.8%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	48.8%
Effective Continuation Phase Treatment	Administrative	33.3%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	22.5%
30-Day Follow-Up—Total	Administrative	29.9%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	54.1%
30-Day Follow-Up—Total	Administrative	65.4%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	46.7%
30-Day Follow-Up—Total	Administrative	60.8%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	48.8%
Total Engagement of AOD Treatment—Total	Administrative	17.6%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	38.2%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	47.6%
Developmental Screening in the First Three Years of Life†		
Total	Hybrid	51.3%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	66.8%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	54.8%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	59.6%

* A lower rate indicates better performance for this measure.
† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*
Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

MCC ACC

HSAG determined that MCC ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with MCC ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with MCC ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with MCC ACC's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with MCC ACC's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with MCC ACC's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with MCC ACC's procedures for data integration and measure production.

Table A-10—MY 2020 Performance Measure Results for MCC ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	66.2%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	62.8%
Effective Continuation Phase Treatment	Administrative	50.1%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	19.3%
30-Day Follow-Up—Total	Administrative	22.4%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	44.2%
30-Day Follow-Up—Total	Administrative	52.2%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	28.9%
30-Day Follow-Up—Total	Administrative	47.2%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	54.0%
Total Engagement of AOD Treatment—Total	Administrative	22.2%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	46.2%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	30.8%
Developmental Screening in the First Three Years of Life†		
Total	Hybrid	10.5%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	49.1%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	30.2%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	34.5%

* A lower rate indicates better performance for this measure.

† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

UHCCP ACC

HSAG determined that UHCCP ACC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with UHCCP ACC's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with UHCCP ACC's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with UHCCP ACC's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with UHCCP ACC's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with UHCCP ACC's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with UHCCP ACC's procedures for data integration and measure production.

Table A-11—MY 2020 Performance Measure Results for UHCCP ACC

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	73.0%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	58.4%
Effective Continuation Phase Treatment	Administrative	41.3%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	16.2%
30-Day Follow-Up—Total	Administrative	22.2%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	49.5%
30-Day Follow-Up—Total	Administrative	58.6%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	47.4%
30-Day Follow-Up—Total	Administrative	63.4%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	47.5%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Total Engagement of AOD Treatment—Total	Administrative	17.8%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	35.8%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	47.0%
Developmental Screening in the First Three Years of Life†		
Total	Administrative	45.3%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	65.0%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	56.4%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	56.4%

* A lower rate indicates better performance for this measure.

† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

ACC Aggregate

Table A-12—MY 2020 Aggregate Performance Measure Results for ACC Contractors

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Mixed**	64.6%
Behavioral Health Care		
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	54.2%
Effective Continuation Phase Treatment	Administrative	38.5%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	17.7%
30-Day Follow-Up—Total	Administrative	24.3%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	47.6%
30-Day Follow-Up—Total	Administrative	58.0%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	43.6%
30-Day Follow-Up—Total	Administrative	59.8%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	46.8%
Total Engagement of AOD Treatment—Total	Administrative	17.6%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Mixed**	45.8%
Pediatric Health		
Child and Adolescent Well-Care Visits		
Total	Administrative	42.8%
Developmental Screening in the First Three Years of Life†		
Total	Mixed**	35.4%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative	60.6%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	49.5%
Cervical Cancer Screening		
Cervical Cancer Screening	Mixed**	49.3%

* A lower rate indicates better performance for this measure.
** *Mixed methodology indicates some Contractors used an administrative method and some used a hybrid method.*
† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*
Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

Performance Measurement—DCS CHP

HSAG determined that DCS CHP [A-2] followed the measure specifications and produced reportable rates for some of the measures in the scope of the validation of performance measures. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with DCS CHP's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with DCS CHP's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with DCS CHP's provider data systems or processes.
- *Medical Record Review Process:* Since DCS CHP did not identify any numerator positive cases through hybrid reporting, a medical record review validation of abstraction accuracy could not be completed; however, HSAG was able to review DCS CHP's medical record review processes. Based on a limited medical record review scope, HSAG did not identify concerns with DCS CHP's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with DCS CHP's supplemental data systems and processes.
- *Data Integration:* HSAG identified concerns with DCS CHP's procedures for data integration and measure production. Timely source code development and rate production was problematic for MY 2020 reporting. Two measures were unable to be developed or completed, *Asthma Medication Ratio* and *Contraceptive Care—All Women*. Source code for another two measures, *Ambulatory Care* and *Inpatient Utilization,* was not completed for the required age-group stratifications, and only results for the total eligible population were reported. Additional measures for which source code was developed subsequently received a DNR designation due to variance identified during the final rate review.

[A-2] DCS CHP previously operated as CMDP.

Table A-13—MY 2020 Performance Measure Results for DCS CHP

Performance Measure	MY 2020 Performance
Pediatric Health	
Child and Adolescent Well-Care Visits	
Total	66.2%
Developmental Screening in the First Three Years of Life†	
Total	46.6%
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	53.9%

† *Indicates the measure was not compared to the MY 2020 national Medicaid mean.*

Cells shaded green indicate that the rate met or exceeded the MY 2020 national Medicaid mean.

Appendix B. Validation of Performance Improvement Project Methodology

Performance Improvement Project Design

AHCCCS' PIPs are developed according to 42 CFR §438.330. AHCCCS requires Contractors to conduct PIPs that focus on both clinical and nonclinical areas. AHCCCS designs PIPs to correct significant system problems and/or achieve significant improvement in health outcomes and member satisfaction. Improvements need to be sustained over time through the measurement of performance using objective quality indicators, implementation, and evaluation of interventions to achieve improvement in access to and quality of care, and planning and initiation of activities for increasing or sustaining improvement.

AHCCCS' clinical focus topics may include primary, secondary, and/or tertiary prevention of acute, chronic, or behavioral health conditions; care of acute, chronic, or behavioral health conditions; high-risk services; and continuity and coordination of care.

AHCCCS' nonclinical focus topics may include availability, accessibility, and adequacy of the Contractors' service delivery systems; cultural competency of services; interpersonal aspects of care; and appeals, grievances, and other complaints.

Data Collection Methodology

AHCCCS' evaluation of the Contractors' performance on the selected measures is based on systematic, ongoing collection and analysis of accurate, valid, and reliable data, as collected, and analyzed by AHCCCS. The Contractors' methodology (including project indicators, procedures, and timelines) aligns with the guidance and direction provided for all AHCCCS-mandated PIPs. The Contractors are required to include internal rates and results used as the basis for analysis (both quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions. Depending on the PIP, AHCCCS may direct Contractors to collect all or some of the data used to measure performance. In such cases, AHCCCS requires that the Contractors have qualified personnel collect data and ensure interrater reliability if more than one person is collecting and entering data. Contractors must submit specific documentation to verify that indicator criteria were met.

Measurement of Significant Improvement: How Data Were Aggregated and Analyzed

AHCCCS expects the Contractor to implement interventions to achieve and sustain statistically significant improvement, followed by sustained improvement for one consecutive year, for each PIP indicator. The Contractor shall initiate interventions that result in significant improvement, sustained over time, in its performance for the PIP indicators being measured. Improvement shall be evidenced in repeated measurements of the PIP indicators specified for each active PIP. AHCCCS determines a

Contractor has demonstrated significant improvement when the improvement in the PIP indicator rate(s) from one measurement year to the next measurement year is statistically significant. .

AHCCCS determines a Contractor has demonstrated sustained improvement when the Contractor achieves both of the following conditions:

- Establishes how the significant improvement can be reasonably attributable to interventions implemented by the Contractor (i.e., improvement occurred due to the project and its interventions, not another unrelated reason).
- Maintains, or increases, the improvements in performance for at least one year after the significant improvement in performance was first achieved.

Performance Improvement Project Reporting

Beginning CY 2020, AHCCCS-mandated PIPs begin on a date that corresponds with a calendar year. Baseline data for the PIP are collected and analyzed at the beginning of the PIP. During the first year of the PIP [B-1], AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

AHCCCS requires Contractors to use the plan-do-study-act (PDSA) method to test changes (interventions) quickly and refine them, as necessary. AHCCCS expects that Contractors will implement this process in as short a time frame as is practical, based on the PIP topic. Contractors are expected to use several PDSA cycles within the PIP lifespan and include the PDSA in the annual and final PIP report submissions.

Annual measurements are utilized to evaluate Contractor performance. AHCCCS may conduct interim measurements, depending on the resources required, to collect and analyze data. Annual measurements (rates and results) are used as the basis for quantitative and qualitative analysis, and the selection/modification of interventions.

Contractors are required to submit a formal PIP report to AHCCCS in accordance with the contract. AHCCCS reviews and validates each Contractor PIP Report submission to ensure alignment with AHCCCS PIP policy and checklist requirements are met. Following this review, each AHCCCS Contractor is provided formal feedback and may be required to resubmit its PIP Report if such requirements are not met.

AHCCCS requires Contractors' participation in the PIP to continue until demonstration of significant and sustained improvement is shown, as outlined above.

[B-1] To account for the impact of the COVID-19 PHE, the *Breast Cancer Screening* and *Back to Basics* PIPs, which began in CYE 2019, each include two intervention years within its design.

Appendix C. Validation of Organizational Assessment and Structure Performance Methodology

Objectives for Conducting the Review

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 monitors 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.[C-1]

AHCCCS' methodology for conducting the OR includes the following:

- Reviewing supporting documentation and evidence of implementation that the Contractor was required to submit to AHCCCS
- Conducting interviews with key Contractor administrative and program staff

[C-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 11, 2021.

AHCCCS conducts activities following the review that include 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 focus area and standard is individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards.

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

As needed throughout the preparation of this report, AHCCCS clarifies 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 obtains from conducting the OR, HSAG organizes and aggregates the performance data for each Contractor. HSAG then analyzes the data by focus area.

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

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 disagreements related to the findings. AHCCCS reviews and responds to any Contractor disagreements based on review of the Contractor information, then revises the report if necessary. AHCCCS issues the final report to the Contractor, describing the findings, scores, and required CAPs.

Scoring Methodology: How Data Were Aggregated and Analyzed

Each focus 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. 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 focus area score. 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 Plans

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 D. CAHPS Methodology

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information and gain understanding about patients' and parents'/caretakers' of child patients experience with healthcare. These surveys cover topics important to members, such as communication skills of providers and accessibility of services.

Technical Methods of Data Collection

To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data.

The technical method of data collection for the ACC health plans was through the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the adult population and through the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (with the CCC measurement set) for the child population. The technical method of data collection for DCS CHP was through the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (with the CCC measurement set). Adult members included as eligible for the survey were 18 years of age or older as of December 31, 2020. Child members included as eligible for the surveys were 17 years of age or younger (less than 18 years of age) as of December 31, 2020. Adult ACC members and parents/caretakers of child ACC members completed the surveys from February to June 2021. Parents/caretakers of DCS CHP members completed the surveys from May to August 2021.

An English or Spanish version of the cover letter was mailed to all sampled adult members and the parents/caretakers of all sampled child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey through the survey website with a designated login. The cover letters included a toll-free number that respondents could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and a second reminder postcard. Finally, a third survey mailing was sent to all nonrespondents.

The surveys included a set of standardized items (40 items for the CAHPS 5.1 Adult Medicaid Health Plan Survey that yield 12 measures of experience and 76 items for the CAHPS 5.1 Child Medicaid Health Plan Survey that yield 14 measures of experience) that assess respondents' perspectives on care. These measures included four global ratings, four composite scores, one individual item measure, three Effectiveness of Care measures (adult population only), and five CCC composites/items (CCC population only). The global ratings reflected members' and parents'/caretakers' overall experience with

their/their child's personal doctors, specialists, health plans, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The individual item measure is an individual question that looked at coordination of care. The Effectiveness of Care measures assessed the various aspects of providing medical assistance with smoking and tobacco use cessation. The CCC composites and items are sets of questions and individual questions that looked at different aspects of care for the CCC population (e.g., *Access to Prescription Medicines* or *Access to Specialized Services*). If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

Description of Data Obtained

HSAG aggregated data from survey respondents into a database for analysis. Results of the CAHPS surveys are found in Section 11.

For each of the four global ratings, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, individual item measure, and CCC composites/items, the percentage of respondents who chose a positive or top-box response was calculated. Response choices for the CAHPS composite questions, individual item, and CCC composites/items in the adult and child Medicaid surveys were: (1) "Never," "Sometimes," "Usually," and "Always" and (2) "Yes" and "No." A positive or top-box response for these measures were defined as a response of (1) "Usually" or "Always" and (2) "Yes." For the Effectiveness of Care questions, HSAG calculated overall scores. Response choices were "Never," "Sometimes," "Usually," and "Always." Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The scores presented deviate from NCQA's methodology of calculating a rolling average using the current and prior years' results, since only the current year's results were available.

How Data Were Aggregated and Analyzed

HSAG performed comparisons of the results to NCQA's Quality Compass Benchmark and Compare Quality Data to derive the overall member experience ratings.[D-1] Ratings of one (★) to five (★★★★★) stars were determined for each measure using the percentile distributions shown in Table D-1.

[D-1] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020.* Washington, DC: NCQA, September 2020.

Table D-1—Percentile Distributions

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Also, HSAG performed Contractor comparisons of the results. Statistically significant differences between the ACC health plans' top-box responses and the ACC Program are noted with arrows. A health plan's top-box score that was statistically significantly higher than the ACC Program is noted with an upward green (↑) arrow. A health plan's top-box score that was statistically significantly lower than the ACC Program is noted with a downward red (↓) arrow. A health plan's top-box score that was not statistically significantly different than the ACC Program is not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the ACC health plans and DCS CHP, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table D-2.

Table D-2—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Specialist Seen Most Often	✓		
Rating of Personal Doctor	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Coordination of Care	✓		
Advising Smokers and Tobacco Users to Quit	✓		

CAHPS Topic	Quality	Timeliness	Access
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		
Access to Specialized Services	✓		✓
FCC: Personal Doctor Who Knows Child	✓		
Coordination of Care for Children with Chronic Conditions	✓		
Access to Prescription Medicines	✓		✓
FCC: Getting Needed Information	✓		

Appendix E. Validation of Network Adequacy Methodology and Detailed Results

HSAG used data supplied by AHCCCS to calculate the number and percentage of ACC and DCS CHP members within a defined time or distance from up to 11 types of AHCCCS-defined providers. As Table E-1 describes, these time/distance standards vary by provider type and county, and some standards may not apply to every Contractor or subcontracted health plan.

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

Provider Type	Member Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
Behavioral Health Outpatient and Integrated Clinic, Adult[2]	Members aged 18 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
Behavioral Health Outpatient and Integrated Clinic, Pediatric	Members younger than 18 years	90 percent of members within 15 minutes or 10 miles	90 percent of members within 60 miles
Behavioral Health Residential Facility[1]	All members	90 percent of members within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult[2]	Members aged 21 years and older	90 percent of members within 30 minutes or 20 miles	90 percent of members within 75 minutes or 60 miles
Cardiologist, Pediatric	Members younger than 21 years	90 percent of members within 60 minutes or 45 miles	90 percent of members within 110 minutes or 100 miles
Dentist, Pediatric	Members younger than 21 years	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
Hospital	All members	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
Obstetrics/Gynecology (OB/GYN)	Female members aged 15 to 45 years	90 percent of members within 45 minutes or 30 miles	90 percent of members within 90 minutes or 75 miles
Pharmacy	All members	90 percent of members within 12 minutes or 8 miles	90 percent of members within 40 minutes or 30 miles
PCP, Adult[2]	Members aged 21 years and older	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
PCP, Pediatric	Members younger than 21 years	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles

1. Applies only to Maricopa and Pima counties.
2. Calculations for DCS CHP will not include standards applicable only to adults (i.e., Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; or PCP, Adult).

Data Sources

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

- Prepaid Medical Management Information System (PMMIS) provider data—Data files maintained by AHCCCS that list all AHCCCS-contracted providers and their corresponding addresses.
- AHCCCS member data—A data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data. PMMIS data elements include the addresses and other necessary demographic information on AHCCCS members. Specific data elements from CATS identify all AHCCCS members who live in their own homes for calculation of the Nursing Facility time/distance standard.
- DCS CHP member data—A data file identifying the place of residence for DCS CHP members, supplied only for CYE 2021, Quarter 4.
- Contractor-specific Provider Affiliation Transmission (PAT) files—An aggregated data file listing each Contractor's network providers, as identified to AHCCCS by each Contractor. In CYE 2021, Quarter 4, a separate file identified the DCS CHP providers.
- Contractor-specific ACOM 436 submissions—One Microsoft (MS) Excel workbook for each Contractor and LOB with a tab listing the Contractor's results for compliance with county-level time/distance standards. In CYE 2021, Quarter 4, an additional workbook contained the DCS CHP ACOM 436 submission.

Table E-2 shows the effective dates for the data files supplied to HSAG in each measurement period.

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

Data Source	CYE 2021 Quarter Two	CYE 2021 Quarter Four
Measurement Period	April 2021	October 2021
PMMIS Providers	April 2021	October 2021
AHCCCS Members	April 2021	October 2021
Contractor-Specific PAT Providers	April 2021	October 2021
Contractor-Specific ACOM 436 Submissions	April 2021	October 2021

Study Indicators

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

1. **Time/Distance Calculation**: HSAG's calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, LOB, and county, using member and PAT data.
   - Study indicators show the percentage of members assigned by AHCCCS to the specified county, with access to any provider location serving the LOB 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 LOB and county.
     - A score of "*met*" indicates that HSAG's time/distance results show a percentage of members at or above the time/distance standard.
     - A score of "*not met*" indicates that HSAG's time/distance results show a percentage of members below the time/distance standard.
     - The value "*NA*" identifies standards not applicable to the LOB and/or geography.
     - The value "*NR*" identifies standards for which no members met the network requirement denominator for the LOB and geography; therefore, HSAG calculated no corresponding time/distance result.
   - 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 provider locations not reflected in each Contractor's quarterly PAT file for each applicable time/distance standard scored as *"not met."*

Analytical Process

HSAG used the Quest Analytics Suite software, version 2021.3 (Quest) to geocode the PAT and PMMIS addresses for members and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized member 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 member (PMMIS) and provider (PAT) addresses into datasets that were used with Quest to calculate the percentage of members meeting the time/distance standards described in Table E-1. Biannual county-specific time/distance calculations were conducted separately for each LOB and excluded less than 1 percent of members 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 member and the nearest provider location (i.e., the time or distance for the member 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 biannual ACOM 436 submission, HSAG compared the time/distance results calculated from the PMMIS and PAT data against the biannual ACOM 436 time/distance results submitted to AHCCCS by each Contractor.

Biannual analyses reflect the following measurement periods, which is a change from the previous quarterly measurement periods:

- CYE 2021, Quarter Two (Q2): January 1–March 31, 2021
- CYE 2021, Quarter Four (Q4): July 1–September 30, 2021

Additionally, detailed time/distance results were presented to AHCCCS and the Contractors each quarter as interactive Tableau dashboards containing the following information:

- Network Adequacy Assessment Comparison—Time and Distance: A dashboard assessing the differences between Contractors' network adequacy results and HSAG's results calculated for the time/distance standards.
- Network Adequacy Assessment Trending—Time and Distance: A dashboard comparing Contractor and HSAG Network Adequacy Assessment results across reporting periods by county, urbanicity, and provider category.
- Time and Distance Standards Assessment: A dashboard assessing Contractors' compliance with time and distance standards by county, urbanicity, and provider category.

Analytical Considerations

AHCCCS does not define the software or process by which each ACC Contractor calculates the biannual ACOM 436 time/distance results. HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result if Contractors use different versions of Quest during each of the different data network validations.[E-1] Table E-3 describes each ACC Contractor's self-reported methods for calculating the ACOM 436 results, as of April 2021.

Table E-3—AHCCCS ACC Contractors' ACOM 436 Calculation Methods, as of April 2021

Contractor	ACOM 436 Calculation Method
AZCH-CCP ACC	Calculates time/distance results based on driving distances using Quest version 2019.4
BUFC ACC	Calculates time/distance results based on driving distances using Quest version 2020.1
Care1st ACC	Calculates time/distance results based on driving distances using Quest version 2020.4

[E-1] AHCCCS' member address data may not always reflect a member's place of residence (e.g., use of post office boxes), or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the member's exact residential location for records that do not use a standard street address.

Contractor	ACOM 436 Calculation Method
HCA ACC	Calculates time/distance results based on driving distances using Quest version 2020.4
MCC ACC	Calculates time/distance results based on driving distances using Quest version 2020.4
Mercy Care ACC	Calculates time/distance results based on driving distances using Quest version 2020.4
UHCCP ACC	Calculates time/distance results based on driving distances using Quest version 2020.4

AHCCCS members may seek care from network providers practicing outside of the member's county of residence. As such, HSAG considered all applicable provider locations within a LOB when calculating time/distance results. This appendix presents, by LOB, the biannual validation results for Contractors' county-specific time/distance network standards. However, HSAG's time/distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

Additionally, HSAG's time/distance calculations did not include some facilities available to American Indian members enrolled with an ACC Contractor. American Indian members, Title XIX and Title XXI, on- or off-reservation, and eligible to receive services, may choose to receive services at any time from an American Indian Health Facility, IHS Facility, a Tribally-Operated 638 Health Program, or an Urban Indian Health Program (I/T/U) (American Reinvestment and Recovery Act of 2009 [ARRA] Section 5006(d), and State Medicaid Director Letter [SMDL] 10-001). These facilities are not included in the calculations in this report. As a result, member access may be under-reported, particularly in areas with high concentrations of these facilities.

Similarly, HSAG's validation included time/distance standards that do not reflect all potential healthcare needs or service delivery options for AHCCCS' ACC members. Selected time/distance standards may be addressed through telehealth, mobile service providers, mail delivery for prescriptions, or other emerging service delivery approaches that may be evaluated using metrics other than time/distance calculation results.

Detailed Validation of Network Adequacy Results

ACC

Table E-4 presents the counts of ACC Contractors' provider locations[E-2] identified for each time/distance network standard for CYE 2021, Quarter 4 (i.e., the July 1–September 30, 2021, measurement period).

Table E-4—Summary of CYE 2021, Quarter 4 Provider Locations by Time/Distance Network Standard and Contractor for ACC

Minimum Network Requirement	Count of AzCH-CCP Provider Locations	Count of BUFC Provider Locations	Count of Care1st Provider Locations	Count of HCA Provider Locations	Count of Mercy Care Provider Locations	Count of MCC Provider Locations	Count of UHCCP Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Adult	499	561	499	474	555	1,134	573
Behavioral Health Outpatient and Integrated Clinic, Pediatric	499	561	499	474	555	1,134	573
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	215	252	299	253	349	265	202
Cardiologist, Adult	879	980	1,275	1,574	1,847	542	3,025
Cardiologist, Pediatric	975	1,075	1,447	1,956	2,045	590	3,211
Dentist, Pediatric	2,412	2,724	2,590	1,979	3,061	66	2,483
Hospital	95	168	76	160	130	460	81
Obstetrics/ Gynecology (OB/GYN)	1,086	1,259	1,465	1,898	2,539	931	3,756
Pharmacy	975	952	845	1,240	962	5	812
PCP, Adult	18,866	24,918	13,435	19,114	24,771	28,084	57,709
PCP, Pediatric	16,099	22,320	11,285	15,409	20,121	23,679	48,113

[E-2] The number of provider locations contributing to time/distance calculation results is a function of contractor's PAT data quality and integrity; the presence of multiple physical locations for an individual provider may cause the appearance of a greater number of provider locations than physically exist. Since HSAG is unable to identify which PAT provider locations would be appropriate to exclude from analyses, all active provider locations are reflected in the network adequacy results. These data limitations may impact the validity of HSAG's time/distance results, and the magnitude of the impact may vary by provider type and county.

DCS CHP

Table E-5 presents the counts of DCS CHP Contractors' provider locations [E-3] identified for each time/distance network standard for CYE 2021, Quarter 4 (i.e., the July 1–September 30, 2021, measurement period).

Table E-5—Summary of CYE 2021, Quarter 4 DCS CHP Provider Locations by Time/Distance Network Standard and Contractor for DCS CHP

Minimum Network Requirement	Count of DCS CHP Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Pediatric	369
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	124
Cardiologist, Pediatric	1,866
Dentist, Pediatric	3,061
Hospital	108
Obstetrics/ Gynecology (OB/GYN)	2,371
Pharmacy	961
PCP, Pediatric	17,800

[E-3] The number of provider locations contributing to time/distance calculation results is a function of contractor's PAT data quality and integrity; the presence of multiple physical locations for an individual provider may cause the appearance of a greater number of provider locations than physically exist. Since HSAG is unable to identify which PAT provider locations would be appropriate to exclude from analyses, all active provider locations are reflected in the network adequacy results. These data limitations may impact the validity of HSAG's time/distance results, and the magnitude of the impact may vary by provider type and county.

This section presents biannual validation findings specific to the ACC LOB, with one results table for each of the following counties by region:

- Central Region: Gila, Maricopa,[E-4] Pinal
- North Region: Apache, Coconino, Mohave, Navajo, Yavapai
- South Region: Cochise, Graham,[E-5] Greenlee, La Paz, Pima, Santa Cruz,[E-6] Yuma

Each county-specific table summarizes biannual validation results containing the percent of members 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 LOB.

The value, "NR," is shown for time/distance standards in which no members met the network requirement denominator for the ACC LOB and county; therefore, HSAG calculated no corresponding time/distance result.

Yellow color-coding identifies instances in which HSAG's time/distance results met the minimum network requirement, but differed from the Contractor's ACOM 436 results.

Red color-coding identifies instances in which HSAG's time/distance results that did not meet the compliance standard, regardless of the Contractor's ACOM 436 results.

[E-4] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.

[E-5] 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.

[E-6] Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

Central Region: Gila, Maricopa, and Pinal Counties

Table E-6—ACC Time/Distance Validation Results for Gila County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC		Care1st ACC		HCA ACC		Mercy Care ACC		MCC ACC		UHCCP ACC	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**
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
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
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	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
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
Dentist, Pediatric	100.0	100.0	99.9	99.9^	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0†	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
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
Pharmacy	100.0	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
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
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

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

† In CYE 2021, Quarter 4, Molina's data did not include the majority of its subcontracted PBM's and DBM's networks. This influences the validated compliance for any calculations for these provider types.

‡In CYE 2021, Quarter 4, Molina's data included substantially increased numbers of providers used to measure the adult and pediatric Behavioral Outpatient and Integrated Clinic standards, as compared to prior submissions. AHCCCS' review found that Molina was duplicating records submitted for the same clinic address. This potentially influenced the validated compliance for these provider types.

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

Table E-7—ACC Time/Distance Validation Results for Maricopa County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC		Care1st ACC		HCA ACC		Mercy Care ACC		MCC ACC		UHCCP ACC	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	98.6	98.8	99.2	99.2	99.1	99.1	98.6	98.6	98.4	98.4	98.4	98.7‡	98.9	98.9
Behavioral Health Outpatient and Integrated Clinic, Pediatric	98.7	99.0	99.2	99.2	99.2	99.1	98.9	99.0	98.5	98.5	98.3	98.6‡	99.0	99.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	98.8	98.7	99.1	99.1	98.9	98.9	98.3	99.0	99.5	99.5	99.1	99.2	98.1	98.1
Cardiologist, Adult	99.5	99.5	100.0	99.7	99.8	99.8	100.0	100.0	100.0	100.0	99.9	100.0	100.0	100.0
Cardiologist, Pediatric	99.9	99.9	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^	99.4	99.4	99.5	99.5	99.6	99.6	99.6	88.1†	99.5	99.6
Hospital	99.9	99.9	99.9	99.9	99.8	99.8	99.9	99.9	99.9	99.9	99.6	100.0	99.9	99.7
Obstetrics/ Gynecology (OB/GYN)	99.9	99.9	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	99.3	99.2	99.2	99.2	99.0	99.0	99.3	99.2	99.3	99.3	99.3	23.1†	99.1	99.1
PCP, Adult	99.8	99.8	99.8	99.8	99.6	99.7	99.6	99.7	99.7	99.7	99.6	99.6	99.8	99.8
PCP, Pediatric	99.8	99.8	99.8	99.7	99.6	99.7	99.7	99.8	99.7	99.7	99.6	99.5	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 time/distance standard results that do not meet the compliance standard based on HSAG's results.

† In CYE 2021, Quarter 4, Molina's data did not include the majority of its subcontracted PBM's and DBM's networks. This influences the validated compliance for any calculations for these provider types.

‡In CYE 2021, Quarter 4, Molina's data included substantially increased numbers of providers used to measure the adult and pediatric Behavioral Outpatient and Integrated Clinic standards, as compared to prior submissions. AHCCCS' review found that Molina was duplicating records submitted for the same clinic address. This potentially influenced the validated compliance for these provider types.

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

Table E-8—ACC Time/Distance Validation Results for Pinal County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC		Care1st ACC		HCA ACC		Mercy Care ACC		MCC ACC		UHCCP ACC	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**
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
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
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	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
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
Dentist, Pediatric	100.0	100.0	98.9	100.0^	99.5	99.8	100.0	100.0	100.0	100.0	99.9	61.9†	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
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
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	83.5†	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
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

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

† In CYE 2021, Quarter 4, Molina's data did not include the majority of its subcontracted PBM's and DBM's networks. This influences the validated compliance for any calculations for these provider types.

‡In CYE 2021, Quarter 4, Molina's data included substantially increased numbers of providers used to measure the adult and pediatric Behavioral Outpatient and Integrated Clinic standards, as compared to prior submissions. AHCCCS' review found that Molina was duplicating records submitted for the same clinic address. This potentially influenced the validated compliance for these provider types.

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results are shown for informational purposes only.

NA indicates results are not applicable to the county.

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

Table E-9—ACC Time/Distance Validation Results for Apache County: Percentage of Members Meeting Minimum Network Requirements

	Care1st ACC		HCA ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	74.9	75.1	83.5	84.5
Behavioral Health Outpatient and Integrated Clinic, Pediatric	69.7	71.5	84.5	84.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	90.5	90.3	94.1	94.6
Cardiologist, Pediatric	97.1	97.7	99.0	98.9
Dentist, Pediatric	63.3	63.6	81.7	79.5
Hospital	99.5	95.7	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	95.2	95.0	100.0	100.0
Pharmacy	78.6	77.6	87.1	86.3
PCP, Adult	91.7	86.8	92.7	91.9
PCP, Pediatric	90.4	84.0	91.3	89.3

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NA indicates results are not applicable to the county.

Table E-10—ACC Time/Distance Validation Results for Coconino County: Percentage of Members Meeting Minimum Network Requirements

	Care1st ACC		HCA ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	98.1	97.9	97.7	97.6
Behavioral Health Outpatient and Integrated Clinic, Pediatric	97.3	97.2	96.1	96.3
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	99.8	99.8	98.7	98.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	96.0	95.9	84.8	86.8
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	99.7	99.8	100.0	100.0
Pharmacy	90.3	90.4	87.8	89.2
PCP, Adult	98.6	98.6	92.3	93.6
PCP, Pediatric	98.0	97.7	96.9	98.3

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
represents time/distance standard results that do not meet the compliance standard based on HSAG's results.
NA indicates results are not applicable to the county.

Table E-11—ACC Time/Distance Validation Results for Mohave County: Percentage of Members Meeting Minimum Network Requirements

	Care1st ACC		HCA ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	99.9	99.9	99.9	99.9
Behavioral Health Outpatient and Integrated Clinic, Pediatric	99.9	99.8	100.0	99.9
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	99.9	99.9	99.9	99.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	98.5	99.0	98.8	99.4
Hospital	99.9	99.9	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	98.8	98.9	98.8	99.1
PCP, Adult	98.8	98.9	99.6	100.0
PCP, Pediatric	99.1	99.1	98.9	99.7

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 E-12—ACC Time/Distance Validation Results for Navajo County: Percentage of Members Meeting Minimum Network Requirements

	Care1st ACC		HCA ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	94.0	94.0	95.5	95.1
Behavioral Health Outpatient and Integrated Clinic, Pediatric	90.3	91.1	94.4	94.2
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	98.5	98.0	95.3	94.9
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	96.4	95.9	96.5	97.5
Hospital	100.0	99.9	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	99.9	100.0	100.0
Pharmacy	96.1	95.9	97.4	97.7
PCP, Adult	96.8	95.6	99.8	99.8
PCP, Pediatric	95.8	94.9	98.2	97.9

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 E-13—ACC Time/Distance Validation Results for Yavapai County: Percentage of Members Meeting Minimum Network Requirements

	Care1st ACC		HCA ACC	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	98.9	99.0	98.5	98.7
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	98.7	98.7	98.3	98.4
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	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.
NA indicates results are not applicable to the county

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

Table E-14—ACC Time/Distance Validation Results for Cochise County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	93.9	93.4	99.6	99.6^
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	99.7	99.7	99.6	99.6
PCP, Adult	99.6	99.7	99.7	99.6
PCP, Pediatric	99.6	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.

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.

NA indicates results are not applicable to the county.

Table E-15—ACC Time/Distance Validation Results for Graham County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	97.9	98.1	93.5	96.4^
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	98.2	99.3	96.4	97.1
PCP, Adult	98.5	98.9	99.9	98.7
PCP, Pediatric	98.3	98.8	99.5	97.9

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

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.

NA indicates results are not applicable to the county.

Table E-16—ACC Time/Distance Validation Results for Greenlee County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	99.8	99.6	100.0	99.6
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	59.3	100.0	99.6^
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	99.9	99.7	99.8	99.6
PCP, Adult	99.8	99.6	99.6	99.6
PCP, Pediatric	100.0	100.0	100.0	99.6

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

represents time/distance standard results that do not meet the compliance standard based on HSAG's results.

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.

NA indicates results are not applicable to the county.

Table E-17—ACC Time/Distance Validation Results for La Paz County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	75.7	74.9	53.3	50.7^
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	91.3	90.8	92.6	90.3
PCP, Adult	80.0	95.3	99.6	100.0
PCP, Pediatric	77.1	91.4	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 time/distance standard results that do not meet the compliance standard based on HSAG's results.

^In CYE, 2021 Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.

NA indicates results are not applicable to the county.

Table E-18—ACC Time/Distance Validation Results for Pima County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC		UHCCP ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	97.0	97.2	97.4	97.5	96.9	96.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	97.3	97.2	97.4	97.5	97.2	97.1
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	94.0	93.5	94.5	93.5	92.3	92.5
Cardiologist, Adult	99.1	99.2	99.7	99.4	99.3	99.3
Cardiologist, Pediatric	99.9	99.9	99.9	99.6	99.9	99.9
Dentist, Pediatric	97.7	98.4	98.5	98.4^	98.8	98.7
Hospital	99.5	99.4	99.5	99.5	99.5	99.5
Obstetrics/ Gynecology (OB/GYN)	99.5	99.5	99.7	99.7	99.6	99.7
Pharmacy	98.3	98.2	98.4	98.3	97.4	97.4
PCP, Adult	99.7	99.7	99.8	99.8	99.9	99.9
PCP, Pediatric	99.7	99.7	99.7	99.7	99.9	99.9

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

^In CYE 2021 Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.

Table E-19—ACC Time/Distance Validation Results for Santa Cruz County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0^
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.
NA indicates results are not applicable to the county.

Table E-20—ACC Time/Distance Validation Results for Yuma County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP ACC		BUFC ACC	
Minimum Network Requirement	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	99.8	99.8	99.7	99.7
Behavioral Health Outpatient and Integrated Clinic, Pediatric	99.9	99.9	99.7	99.8
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	99.7
Cardiologist, Pediatric	100.0	100.0	100.0	100.0
Dentist, Pediatric	99.8	99.9	99.6	99.7^
Hospital	100.0	100.0	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0	100.0	100.0
Pharmacy	99.8	99.8	99.6	99.7
PCP, Adult	99.8	99.8	99.7	99.7
PCP, Pediatric	99.8	99.9	99.7	99.7

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

^In CYE 2021, Quarter 4, BUFC ACC's data for dentists did not include the specialty codes used to identify dentists meeting the criteria for the Dentist, Pediatric category. At AHCCCS' request, HSAG used PMMIS specialty provider data for BUFC ACC's reported dentists to identify pediatric dentists and calculate the time and distance results. Due to the use of data not submitted by the health plan, HSAG was unable to accurately validate and assess compliance for BUFC ACC's reported Dentist, Pediatric provider category. Results shown are for informational purposes only.

NA indicates results are not applicable to the county.

All Regions: North, Central, and South Regions

Table E-21—DCS CHP CYE 2021 Quarter 4 Time/Distance Validation Results by County: Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Apache	Cochise	Coconino	Gila	Graham	Greenlee	La Paz	Maricopa	Mohave	Navajo	Pima	Pinal	Santa Cruz	Yavapai	Yuma
Behavioral Health Outpatient and Integrated Clinic, Pediatric	85.1	100.0	99.2	100.0	100.0	100.0	100.0	96.7	100.0	98.9	95.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA	NA	NA	NA	NA	NA	99.2	NA	NA	91.0	NA	NA	NA	NA
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.8	100.0	100.0	100.0	100.0
Dentist, Pediatric	80.9	99.4	98.5	100.0	98.0	100.0	73.3	99.7	97.1	100.0	98.5	99.9	100.0	97.4	100.0
Hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	100.0	99.3	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
Pharmacy	80.9	99.4	91.0	100.0	98.0	100.0	93.3	99.3	97.1	100.0	97.9	100.0	100.0	95.6	100.0
PCP, Pediatric	91.5	99.4	92.5	100.0	98.0	100.0	100.0	99.6	98.2	100.0	99.4	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 time/distance standard results that do not meet the compliance standard based on HSAG's results.

NA indicates results are not applicable to the county.

Appendix F. Network Adequacy Report

The following pages contain the 2021 AHCCCS Network Adequacy Report.

2021 AHCCCS NETWORK ADEQUACY REPORT

PREPARED BY:
DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS

January 25, 2022

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2021 Network Adequacy Report

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 Centers 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.

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Program Description

Arizona currently operates under an 1115 Waiver, extended by CMS on September 30, 2016. The waiver was approved for a five-year period from October 1, 2016 through September 30, 2021, with an additional approved extension through September 20, 2022. A pending request to renew the waiver for an additional five years is under review by CMS.

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 members[1], 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, Molina Complete Care[2], 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 and for a period to time, comprehensive behavioral health services to individuals enrolled in DCS/CHP 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/EPD) 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/EPD Contractors: Banner University Family Care, Mercy Care and UnitedHeathcare Community Plan. Each ALTCS/EPD Contractor is assigned to serve one or more of three county-based GSAs.

[1] Arizona American Indian members meeting specific criteria may receive services through a health plan, or may choose to receive services through the state-administered fee for service program

[2] Formerly Magellan Complete Care, which was purchased by Molina Healthcare, Inc and began doing business as Molina Complete Care July 1, 2021

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- ***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 Health Program (DCS/CHP)*** is a contracted Arizona state agency responsible for providing health care services for children in the custody of DCS as outlined under Arizona state law. Prior to April 1, 2021, DCS managed acute physical health care services directly with providers, while behavioral health services were managed through RBHAs. After April 1, DCS/CHP consolidated these services to provide integrated physical and behavioral health services through a subcontracted health plan to DCS/CHP members statewide.

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

AHCCCS Contracts are available on the AHCCCS website.

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.

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 under each contract called "Chart of Deliverables". The chart defines 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 an 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 publishes issued Administrative Actions on its website

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Deliverables Demonstrating Network Adequacy

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 network's current status 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 by the health plan until all items are addressed and the Network Plan is accepted.

The Provider Affiliation Transmission (PAT) File – The PAT file is an electronic submission outlining each health plan's contracted provider network. The file is submitted twice a year. 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 – Every six months, health plans[3] 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

[3] Prior to April 1, 2021, DCS/CHP was exempted from this requirement as state law allowed members enrolled in DCS/CHP to see any AHCCCS registered provider. The lack of a defined provider network prohibited this kind of network analysis for DCS/CHP. The law was revised to allow DCS/CHP to manage a contracted provider network as of April 1, 2021, and as a result the exemption from network reporting was removed.

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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 for all health plans, as well as some standards specific to RBHA and ALTCS/EPD 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 *(Applies to Maricopa and Pima Counties Only)*	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 *(Applies to RBHAs only)*	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 *(Applies to ALTCS/EPD Plans Only)*	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
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). AHCCCS provides HSAG with each health plan's Verification Report submission, the health plan's PAT file, the health plan's enrolled

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membership, and a file of all AHCCCS registered providers. HSAG then posts its findings to a dashboard accessible by AHCCCS and its contracted health plans.

To ensure health plans have the resources to address discrepancies found in the validation process, AHCCCS provides the following information to the health plans:

- 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 generates an annual validation report which is attached with this Network Adequacy Report (*See Attachment A HSAG Validation Report).* This report covers Contract Year Ending (CYE) 2021 with data for Quarter 2 and Quarter 4.

AHCCCS identified a number of areas where health plans appear to struggle to meet the minimum network requirements. For example, the validation of ACC contractors serving Apache County shows difficulty in meeting the time and distance requirements for several provider types, primarily Pediatric Dentists and Pharmacies. Compliance with these standards is complicated by the extremely rural nature of significant parts of these counties, as well as the presence of tribal providers that have been excluded from these time and distance calculations. In addition to Apache County, health plans also struggle with dentists in several rural counties such as La Paz and Greenlee counties.

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. When an exception is requested, AHCCCS will review certain criteria to determine if the 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 facilities[4] 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 CYE 2021 there were no exceptions 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/EPD and ALTCS/DDD health plans report compliance with minimum requirements for long term care facilities in specific areas of any county served.

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

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- All health plans report compliance with network requirements related to Multi-Specialty Interdisciplinary Clinics (MSICs).
- RBHA health plans report compliance with Mobile 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 is defined as a member who has not received services from the physician within the previous three years.

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 involving 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 CYE 2021, AHCCCS approved and monitored one material change 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 for plans to report the provider name, provider 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 insufficiency 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.