Arizona Health Care Cost Containment System

Contract Year Ending 2021 External Quality Review Annual Technical Report

for

Regional Behavioral Health Authorities

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 Regional Behavioral Health Authority (RBHA) 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 *Preventive Screening* 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 2021 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 RBHA Contractors[1-3] listed below to provide services to members enrolled in the AHCCCS RBHA Medicaid managed care program. Associated abbreviations are included.

Table 1-1—AHCCCS Contracted RBHA Providers

RBHA Contracted Providers	
Contractor Name	**Contractor Abbreviation**
Arizona Complete Health – Complete Care Plan	AzCH-CCP RBHA
Mercy Care	Mercy Care RBHA
Health Choice Arizona	HCA RBHA

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 provided to AHCCCS members. 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.

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*

[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.

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 could be compared to the National Committee for Quality Assurance's (NCQA's) Quality Compass®,[1-5] national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-6] MY 2020. 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.

RBHA Aggregate Findings

Table 1-2 presents the MY 2020 aggregate performance measure results for the RBHA Integrated serious mental illness (SMI) 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.

Table 1-2—MY 2020 Aggregate Performance Measure Results for the RBHA Integrated SMI Program

Performance Measure	MY 2020 Performance
Maternal and Perinatal Health	
Prenatal and Postpartum Care	
Postpartum Care	64.2%
Behavioral Health Care	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	56.9%
Antidepressant Medication Management	
Effective Acute Phase Treatment	53.6%
Effective Continuation Phase Treatment	40.3%

[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] Quality Compass® is a registered trademark of NCQA.

[1-6] HEDIS® is a registered trademark of NCQA.

Performance Measure	MY 2020 Performance
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.1%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	
7-Day Follow-Up—Total	20.4%
30-Day Follow-Up—Total	30.1%
Follow-Up After Emergency Department Visit for Mental Illness	
7-Day Follow-Up—Total	60.3%
30-Day Follow-Up—Total	75.2%
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total	65.8%
30-Day Follow-Up—Total	82.1%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	
Total Initiation of AOD—Total	41.3%
Total Engagement of AOD—Total	11.4%
Care of Acute and Chronic Conditions	
Comprehensive Diabetes Care	
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	45.2%
Preventive Screening	
Breast Cancer Screening	
Total	37.0%
Cervical Cancer Screening	
Cervical Cancer Screening	49.9%

** 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.

RBHA Aggregate Conclusions and Recommendations

Table 1-3—AHCCCS 2021 Aggregate Performance Measurement Strengths, Opportunities for Improvement, and Recommendations for the RBHA Integrated SMI Program

Performance Measurement
Program Strengths
1. In the Behavioral Health Care domain, performance measure rates for all three RBHA Integrated SMI Contractors and the RBHA Integrated SMI Contractors Aggregate for *Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence, Follow-Up After Emergency Department Visit for Mental Illness,* and *Follow-Up After Hospitalization for Mental Illness* met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020, indicating that members were accessing follow-up care with a mental health provider within seven days 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.[1-7]
Program Opportunities for Improvement and Recommendations
1. In the Maternal and Perinatal Health domain, performance measure rates for all three RBHA Integrated SMI Contractors and the RBHA Integrated SMI Contractors Aggregate for *Prenatal and Postpartum Care—Postpartum Care* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and 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. Recommendation: HSAG recommends that AHCCCS support the RBHA Integrated SMI 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. The RBHA Integrated SMI 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 improved community outreach and education). Additionally, the RBHA Integrated SMI Contractors should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, the RBHA Integrated SMI Contractors should implement appropriate interventions to improve the performance related to postpartum care.

[1-7] 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.

Program Opportunities for Improvement and Recommendations
2. In the Behavioral Health Care domain, the RBHA Integrated SMI Contractors' and the RBHA Integrated SMI Contractors Aggregate performance measure rates for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* and both *Initiation and Engagement of AOD Abuse or Dependence Treatment* indicators did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020, indicating opportunities for improvement. Regarding *Adherence to Antipsychotic Medications for Individuals with Schizophrenia,* the RBHA Integrated SMI Contractors' performance indicates medication nonadherence among members with schizophrenia, which may lead to an increase of relapse or hospitalization.[1-8] Regarding *Initiation and Engagement of AOD Abuse or Dependence Treatment,* the RBHA Integrated SMI Contractors performance indicates that members with a new episode of AOD dependence were not always accessing AOD services or medication-assisted treatment (MAT) within 14 days of diagnosis or within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[1-9] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended Recommendation: HSAG recommends that AHCCCS support the RBHA Integrated SMI Contractors in conducting a root cause analysis to determine why members were not adhering to their antipsychotic medications or receiving timely AOD services or MAT. 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 RBHA Integrated SMI Contractors should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, the RBHA Integrated SMI Contractors should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, the RBHA Integrated SMI Contractors should implement appropriate interventions to improve the performance related to aspects of behavioral health.
3. In the Preventive Screening domain, the RBHA Integrated SMI Contractors' and the RBHA Integrated SMI Contractors Aggregate 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

[1-8] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Jan 25, 2022.

[1-9] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Jan 25, 2022.

Program Opportunities for Improvement and Recommendations
dying from these types of cancers and can lead to a greater range of treatment options and lower healthcare costs.[1-10] 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 AHCCCS support the RBHA Integrated SMI 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 RBHA Integrated SMI Contractors should implement appropriate interventions to improve the performance related to preventive screenings.

Performance Improvement Projects (PIPs)

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the RBHA SMI population. Breast cancer and cervical cancer screenings increase the chances of detecting these cancers early when they might be easier to treat. Prevention offers the most cost-effective long-term strategy for the control of cancer. Policies, programs, and projects should be implemented to raise awareness, to reduce exposure to cancer risk factors, and to ensure that individuals are provided with the information and support needed to participate in preventive screenings. The objective of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer and cervical cancer screenings. 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 1-4 provides 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.

[1-10] 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.

Table 1-4—AHCCCS 2021 PIP Strengths, Opportunities for Improvement, and Recommendations for the RBHA Integrated SMI 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 *Preventive Screening* PIP. HSAG recommends that AHCCCS continue to support the Contractors in the implementation of interventions for the *Preventive Screening* 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 its provider network. AHCCCS resumed OR activities in June 2021. For this report, AHCCCS provided findings for the AzCH-CCP RBHA OR. Since a review was not conducted for the other RBHA Contractors, aggregate results are not available; however, the results from the AzCH-CCP RBHA are presented. For the Mercy Care and HCA RBHA Contractors, AHCCCS conducted the OR review in June and July 2021, respectively; however, final documentation was not available to include within this year's report.

For the AzCH-CCP RBHA OR, AHCCCS reviewed a total of 13 standard areas. AzCH-CPP RBHA achieved full compliance (100 percent compliance score) in four standard areas. AzCH-CCP RBHA demonstrated strong performance in the four standard areas, with a compliance score of 95 percent or greater. Any standard below 95 percent requires a corrective action. Only one standard area was scored below 90 percent (at 87 percent), demonstrating high compliance overall. Of 158 total standards, AzCH-CCP was found to have a total of 29 standards with required actions.

Table 1-5—AHCCCS 2021 OR Strengths, Opportunities for Improvement, and Recommendations for the RBHA Integrated SMI Program

Operational Reviews
Program Strengths
1. For the one RBHA Contractor reviewed, the overall scores demonstrated high compliance generally.
2. AzCH-CCP RBHA score 100 percent in the general administration, quality improvement, reinsurance, and third party liability standards.

Program Opportunities for Improvement and Recommendations
1. AzCH-CCP received a total of 29 standards with required actions across these standard areas. Recommendation: HSAG recommends that AHCCCS support AzCH-CCP as it completes its CAP.
2. ORs were postponed during CYE 2021 for Mercy Care RBHA and HCA RBHA. Recommendation: HSAG recommends that AHCCCS continue performing OR reviews with the ACC Contractors to ensure continuity with compliance.

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 1-6 provides a high-level overview of the 2021 CAHPS Program strengths, opportunities for improvement, and recommendations. Caution should be exercised when evaluating the results as the comparative population is primarily an acute Medicaid population.

Table 1-6—AHCCCS 2021 CAHPS Strengths, Opportunities for Improvement, and Recommendations for the RBHA Integrated SMI Program

CAHPS
Program Strengths
1. None of the member experience ratings for the program aggregate met or exceeded the 75th percentiles for any of the measures; therefore, no strengths were identified.
Program Opportunities for Improvement and Recommendations
1. Member experience ratings for the program aggregate 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*, *Customer Service*, *Coordination of Care*, and *Advising Smokers and Tobacco Users to Quit* were below the 25th percentiles. **[Quality, Access, and/or Timeliness]** Recommendation: HSAG recommends that the RBHAs evaluate the factors that may be driving lower experience scores and develop initiatives designed to improve quality of care, timeliness

Program Opportunities for Improvement and Recommendations
of care, and access to care. In addition, the RBHAs should provide training and resources to providers to promote smoking cessation with their adult members.

Network Adequacy Validation (NAV)

Biannually, each RBHA Contractor submits its contracted network to AHCCCS along with its internal assessment of compliance with the applicable standards. HSAG's NAV considered compliance with 12 AHCCCS-established time/distance standards for specific provider types and populations applicable to the RBHA Contractors. HSAG assembled biannual analytical results for the CYE 2021 measurement period for all member coverage areas for each RBHA Contractor. Additionally, detailed time/distance results were presented to AHCCCS and each Contractor in an interactive Tableau dashboard filterable by line of business (LOB), Contractor, urbanicity, county, and provider category.

HSAG's biannual NAV evaluated the extent to which RBHA Contractors' provider networks met AHCCCS' minimum time/distance network requirements. HCA RBHA and Mercy Care RBHA met all applicable minimum network standards in both quarters. AzCH-CCP RBHA met all standards across all counties with exception of the Dentist, Pediatric standard in Cochise County in CYE 2021, Quarter 2, and the PCP, Adult standard in La Paz County for CYE 2021, Quarter 2.

Table 1-7 provides a high-level overview of AHCCCS' NAV program strengths, opportunities for improvement, and recommendations for CYE 2021. Refer to Appendix E for the complete study methodology and RBHA Contractor results by quarter and county.

Table 1-7—AHCCCS 2021 NAV Strengths, Opportunities for Improvement, and Recommendations for the RBHA Integrated SMI Program

Network Adequacy Validation
Program Strengths
1. In CYE 2021, Quarter 4, all RBHA Contractors met all time/distance network standards for all counties.
Program Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that AHCCCS support the RBHA Contractors in continuing to monitor and maintain existing provider network coverage.
Recommendation: The RBHA Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.

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 RBHA 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.

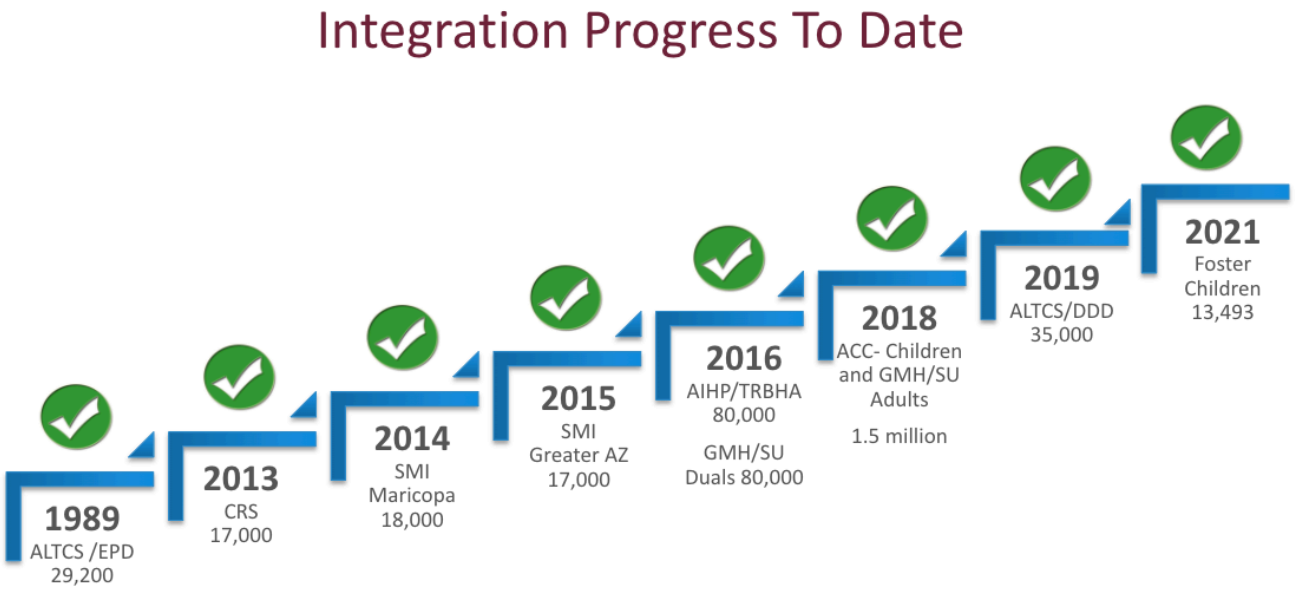
On April 1, 2014, approximately 17,000 members with SMI residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Beginning October 1, 2015, members residing in other counties were transitioned to one 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. The recommendations provided to AHCCCS in the *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Regional Behavioral Health Authorities*[3-7] are summarized below, along with each along with AHCCCS's response.

Table 3-2—AHCCCS Follow-Up on Prior Year Recommendations for the RBHA Integrated SMI Program

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended AHCCCS work with the RBHA Integrated SMI 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)* AHCCCS implemented a *Preventive Screening* PIP for the RBHA SMI population (Baseline Measurement Year: CYE 2019) with the goal of demonstrating a statistically significant increase in the number and percentage of women receiving Breast Cancer Screenings and Cervical Cancer Screenings, followed by sustained improvement for one consecutive year. As part of the PIP, Contractors are required to conduct a root cause and barrier analysis, examining and reporting potential barriers to women receiving breast cancer screenings and cervical cancer screenings and implement interventions to promote screenings. Calendar Year 2021 served as an intervention year for this PIP (to account for the impact of the COVID-19 PHE, this PIP includes two intervention years within its design). In CYE 2021, AHCCCS implemented its Health Disparity Summary & Evaluation deliverable to be submitted as part of the Contractors' Quality Management/Performance Improvement (QM/PI) Program Plan submissions. The Health Disparity Summary & Evaluation will be utilized for

[3-7] Arizona Health Care Cost Containment System. *Contract Year Ending 2020 External Quality Review Annual Report for AHCCCS Regional Behavioral Health Authorities*, July 2021. Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2020/CYE2020ExternalQualityReviewAnnualReportBehavioralHealthServices.pdf. Accessed on: Mar 6, 2022.

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

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG did not provide recommendations for AHCCCS for PIPs in CYE 2020.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* This section is not applicable, as no recommendations were provided in CYE 2020.

3. Prior Year Recommendation from the EQR Technical Report for Operational Reviews:
HSAG did not provide recommendations for AHCCCS for PIPs in CYE 2020.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* This section is not applicable, as no recommendations were provided in CYE 2020.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG did not provide recommendations for AHCCCS for network adequacy validation in CYE 2020.
AHCCCS' Response: *(Note—The narrative within the response section was provided by AHCCCS and has not been altered by HSAG except for minor formatting)* This section is not applicable, as no recommendations were provided in CYE 2020.

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 Regional Behavioral Health Authorities (RBHA), 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 RBHA

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that the RBHA Integrated SMI Contractors focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for cancer in women. The RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
AzCH-CCP RBHA's Response: AzCH-CCP ACC has implemented the following interventions to increase member engagement around breast cancer and cervical cancer screenings: • Promotoras are community service workers who conduct outreach to members in Yuma 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 a breast cancer screening gap and 20 appointments for members with a cervical cancer screening gap. • Mobile mammogram events are a collaboration with an imaging company to provide mammograms to the public at no cost. – Thirteen mobile mammogram events were held open to public starting in September 2020 through December 2020. • My Health Pays Rewards is a member incentive program that provides an annual reward for members who obtain their cervical cancer screening. – A total of 662 members received their cervical cancer screening My Health Pays reward. This reward was the second highest obtained in CY 2020.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Breast Cancer Screening Mailers reminding members to obtain their breast cancer screenings. Mailers are sent via email if available, or physical mail if no email is available. These mailers include reminders for cervical cancer screening as well. – Breast Cancer Screening mailers had a total of 42,013 emails sent and 6,515 physical mailers sent in CY 2020. Please note this includes the ACC population as well. • Quality management (QM) and case management (CM) partnership to train staff on necessity of breast cancer screenings. QM provided desktop talking points, electronic health record (EHR) resource information, and EHR-based letters to send out to members. CM is inputting touchpoints with members into the EHR HEDIS Structured Notes. – HEDIS Structured Notes are specific progress notes that assist in appropriately capturing HEDIS specific information during member and care manager interaction. • Interactive voice recording (IVR), email, and text (SMS) program to educate about and encourage members to obtain their necessary screenings. – The IVR and Email campaign for Adult Preventive (BCS and CCS) was paused for the majority of the year due to COVID in an effort to reduce member abrasion and provider burden. When the program was active, a total of 2,639 members were engaged. • Provider Outreach Campaigns – Community Meetings – Provider Panels – Top 50 Provider Outreach • Provide 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. • Provider Education Materials – *Path to 5 Stars Quick Reference Guide for Quality Measurements*, inclusive of current and baseline performance measures. • Presentations on preventive care and well visits during the provider essential communication call.
HSAG Assessment: HSAG has determined that AzCH-CCP RBHA has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that AzCH-CCP RBHA continue to leverage the collaborations developed through the *E-Prescribing* PIP and further promote partnerships to ensure that the success of the PIP is maintained.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Additionally, HSAG recommended that the RBHAs identify and prioritize barriers to develop robust strategies and interventions for the PIP. The RBHAs were encouraged to monitor the progress of the PIP interventions employed to increase the rate of women receiving a breast cancer screening, then adjust interventions as needed to ensure that the rates continue to increase.
AzCH-CCP RBHA's Response: The interventions that were put in place over the course of the PIP have been integrated into standard business practice. AzCH-CCP RBHA Pharmacy will continue to provide educational materials and technical assistance to individual prescribers via the dedicated Pharmacy Liaison. AzCH-CCP Pharmacy will continue providing education and technical assistance will be provided to the prescriber network on a routine basis. AzCH-CCP RBHA identified the following barriers to assist in focusing interventions to better engage members in care: • Member engagement was low across the board for preventive measures due to COVID-19. Additionally, due to the increase of provider burden because of COVID-19 the majority of member and provider outreach was paused for a portion of CY 2020. • Lack of member awareness of why the screenings are important to complete. Previously, AzCH-CCP RBHA identified one of the main barriers to be lack of member awareness of the need for breast and cervical cancer screenings. To combat that, AzCH-CCP RBHA implemented direct outreach and mailer campaigns for members for all preventive screenings. In an effort to increase engagement, the My Health Pays member cervical cancer screening incentive was continued through another year. The Preventive Screening PIP will be analyzed via the PDSA cycle to ensure ongoing improvement and appropriate corrections are made.
HSAG Assessment: HSAG has determined that AzCH-CCP RBHA 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 RBHA for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
AzCH-CCP RBHA'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:
HSAG recommended all RBHA Contractors continue to monitor and maintain their existing provider network.
AzCH-CCP RBHA's Response: AzCH-CCP RBHA will continue to monitor, maintain, and grow the existing network. Despite the failure to meet the network requirement for Dentist, Pediatric noted in CYE 2019 Quarter 4 and CYE

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy:
2020 Quarter 1, it was noted that the requirement was met as of CYE 2021 Quarter 2. This was achieved by diligent work through CYE 2020 and CYE 2021 by our provider network to outreach and contract dental providers. Additionally, to continue to provide accessible services AzCH-CCP works 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 COVID-19 PHE.
HSAG Assessment: HSAG has determined that AzCH-CCP RBHA has addressed the prior year recommendation.

HCA RBHA

Table 5-2—Prior Year Recommendations and Responses for HCA RBHA

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that the RBHA Integrated SMI Contractors focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for cancer in women. The RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
HCA RBHA's Response: HCA has been promoting a Health Home Model with our Integrated Clinics in the RBHA GSA. This means that the Integrated Health Home can treat the behavioral health diagnoses and symptoms of the member, develop a rapport, and build a trauma-informed relationship with the members where these barriers are dramatically reduced. The Integrated Health Home can then leverage this relationship and assist the member in navigating acute care settings and getting required screenings. Much of this care can be provided in the Integrated Clinic where support of case managers and peer support specialists is readily available. These staff also receive education on assisting members with navigating Acute Care settings when services must be provided by specialty providers. The success of this model is reflected in that HCA was the only RBHA that did not show a significant decline in the Cervical Cancer Screening measure. HCA will continue to promote integration between the Behavioral Health and Acute Care systems.
HSAG Assessment: HSAG determined that HCA RBHA has addressed the prior year recommendation.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that HCA RBHA continue to provide ongoing support to its providers in order to further increase the number of providers and sustain provider buy-in for the *E-Prescribing* PIP. Additionally, HSAG recommended that the RBHAs identify and prioritize barriers to develop robust strategies and interventions for the PIP. The RBHAs were encouraged to monitor the progress of the PIP interventions employed to increase the rate of women receiving a breast cancer screening, then adjust interventions as needed to ensure that the rates continue to increase.
HCA RBHA's Response: With regard to the Electronic Prescribing PIP, HCA puts a lot of emphasis on provider support and education. HCA holds regular meetings, forums, and workgroups, such as the Adult/Child Work Group and CEO Meeting to serve as forums for this support and education. Regarding the Preventive Screening PIP, HCA already follows these recommendations as part of our PIP process. Identifying barriers and monitoring interventions is part of the PIP process as are reported on in the annual PIP reports.
HSAG Assessment: HSAG determined that HCA RBHA 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 RBHA for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.
HCA RBHA's Response: ORs were not conducted in CYE 2019 for the RBHA Contractors. AHCCCS intended to conduct ORs in CYE 2020; however, due to COVID-19, on-site OR reviews were postponed. AHCCCS conducted the OR with HCA in CYE 2021.
HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy:
HSAG recommended that all RBHA Contractors continue to monitor and maintain their existing provider network.
HCA RBHA's Response: The HCA Network Department monitors regularly for network adequacy.
HSAG Assessment: HSAG determined that HCA RBHA has addressed the prior year recommendation.

Mercy Care RBHA

Table 5-3—Prior Year Recommendations and Responses for Mercy Care RBHA

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended that the RBHA Integrated SMI Contractors focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for cancer in women. The RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers.
Mercy Care RBHA's Response: Interventions and activities in place to increase compliance with Breast Cancer Screening and Cervical Cancer Screening include: • 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 who are due for a mammogram to sign an order form which MC then utilizes to contact the member and assist with scheduling mammogram • Member financial incentives • Electronic provider gaps in care notifications • Provider site visits The HEDIS MY 2020 rate for Breast Cancer Screening is 36.92%. This demonstrates a improvement as compared to the AHCCCS calculated CYE 2019 rate, however, it continues to fall below the AHCCCS minimum performance standards (MPS). Root cause analysis for this measure has been conducted by MC staff and additional interventions are in the process of being implemented as a result of that analysis. The HEDIS MY 2020 rate for Cervical Cancer Screening is: 53.53%. This demonstrates a improvement as compared to the AHCCCS calculated CYE19 rate and also exceeds the AHCCCS MPS.
HSAG Assessment: HSAG has determined that Mercy Care RBHA has addressed the prior year recommendation.
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended that the RBHAs identify and prioritize barriers to develop robust strategies and interventions for the PIP. The RBHAs were encouraged to monitor the progress of the PIP interventions employed to increase the rate of women receiving a breast cancer screening, then adjust interventions as needed to ensure that the rates continue to increase.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

Mercy Care RBHA's Response:

CYE 2020 represents the intervention year for the *Preventive Screening* PIP. Root Cause/Barrier Analysis for both Breast Cancer Screening and Cervical Cancer Screening has been conducted.

As a result of the conducted Root Cause/Barrier Analysis, the following additional interventions are being considered for implementation in late 2021/early 2022.

- Additional provider education for those areas identified as underutilizers
  - Work with those providers to discuss how we can help utilize a mobile mammogram program to reach their members
  - Work with those providers to promote our incentive program for breast cancer screenings
- Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers
- Develop and implement a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members ages 50–74, as well as members ages 52–59
- Send out cervical cancer screening mailer biannually
- Ensure members are aware of availability of transportation to appointments.
- Find family practice or OB providers that have later office hours/Saturday hours.
- Encourage provider to ask members if they have received pap test at OB; if not, assist member schedule for their office or the member's OB office.
- Encourage provider to offer HPV vaccination to all 11–26 year old's.

Make it priority for Maternal and Child Health (MCH) representative to meet with provider and office staff, specifically in areas that are in need (Phoenix), at a minimum of once per year to review provider outreach manual.

HSAG Assessment: HSAG has determined that Mercy Care RBHA 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 RBHA for ORs in CYE 2020, as the activity was postponed due to the COVID-19 PHE.

Mercy Care RBHA's Response:

N/A—ORs were not conducted in CYE 2019 for the RBHA Contractors. AHCCCS intended to conduct ORs in CYE 2020; however, due to COVID-19, on-site OR reviews were postponed.

HSAG Assessment: Not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy:
HSAG recommended that all RBHA Contractors continue to monitor and maintain their existing provider network.
Mercy Care RBHA's Response: Mercy Care met all standards; no updates to report.
HSAG Assessment: HSAG determined that Mercy Care RBHA has addressed the prior year recommendation.

6. Contractor Best and Emerging Practices

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

AzCH–CCP RBHA

- 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 RBHA 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 public health emergency. 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 RBHA 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 RBHA members are incentivized 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 RBHA revised the Wellth program to cover 12 months for 2021 and was relaunched in July 2021 and is currently underway.
- Pyx: AzCH-CCP RBHA 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 RBHA had over 1,300 members onboarded and anticipated 1,500 enrolled members by the end of 2021. Additionally, Pyx has the capability to refer members for additional assistance or to crisis resources. As of CY 2021 Q3, 73% of onboarded members were connected to health plan resources. Members who had accessed Pyx more than once showed a decrease in their loneliness score compared to their original screening.

HCA RBHA

- Utilizing Telehealth to Maximize Member Engagement: To solve access to care challenges and barriers associated with accessing care, HCA RBHA reviewed potential technology solutions and identified critical populations and their servicing providers with the greatest need including, Tribal and rural communities. HCA RBHA 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 RBHA 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 RBHA set up tele-crisis response with Flagstaff Medical Center. HCA 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 RBHA staff to a range of different providers.
  - HCA RBHA 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.

- Pyx Health: HCA RBHA contracted with Pyx Health application to improve rates of loneliness and social isolation due to the COVID-19 public health emergency for members with an SMI designation. The application is smart phone-based technology that provides live compassionate support and members can be connected directly to HCA RBHA, their Health Home, or community-based agencies. As of September 2021, all 6,288 members with an SMI designation were eligible for Pyx and received AHCCCS approved outreach via postcard mailings and test messages to inform them about Pyx. HCA RBHA identified members who had accessed crisis services, emergency department services, or had a billing claim for SDOH issues and were connected by phone outreach with Pyx Compassionate Support Center due to high risk of loneliness or social isolation. Since the application rollout, 30% of HCA RBHA Pyx users show an improvement in loneliness overtime with an average decrease of two points on the six-point UCLA-3 loneliness scale (a significant improvement). 40% of Pyx users also showed a decrease in depression by a patient health questionnaire-2 (PHQ-2) depression screen. During a recent survey, 53% of Pyx users reported that the application helped them avoid an emergency department or crisis service. HCA RBHA will continue to provide the Pyx application to members with an SMI designation and will expand targeted outreach to demographic groups most impacted by loneliness and social isolation.
- Wellth: In 2020, HCA RBHA partnered with Wellth. Wellth is a medication and treatment adherence reward program accessible to members through a smart phone application. The program went live in February 2021 to engage, motivate, train healthy habits, and reward successes. HCA RBHA's priority is the management of chronic health conditions for members with an SMI

designation with a focus on comorbid conditions such as, diabetes, hyperlipidemia, schizophrenia, chronic obstructive pulmonary disease (COPD), hypertension, asthma, and heart failure. HCA RBHA sent targeted mailings to members meeting these criteria and encouraged enrollment in the reward program. Preliminary data showed that enrolled members are participating at a high level, of the 562 members enrolled they have an 90% adherence rate. Wellth users showed an 80% decrease in inpatient days, 15% decrease in ED utilization, and a 31% increase in medication adherence. The Wellth reward program is being successfully implemented and HCA RBHA will expand Wellth to include Dual-Eligible Special Needs Plan (D-SNP) members with chronic conditions.

Mercy Care RBHA

- Permanent Supportive Housing: With the significant increase in unsheltered persons experiencing homelessness in Maricopa County, permanent supportive housing (PSH) services are designed to assist Mercy Care RBHA members in obtaining and/or maintaining independent housing in the community of their choice. PSH services are offered to members to maximize housing stability, prevent returns to homelessness, connect members to health care and treatment, and employment opportunities. During CYE 2021, four providers were reviewed for fidelity to the Substance Abuse and Mental Health Services Administration (SAMHSA) model of PSH and scored an average of 79%. This average represents a 20% increase of fidelity from the first-year providers that were reviewed in 2014-2015. Additionally, PSH service providers reported a housing retention rate of 93% for 2021, demonstrating that Mercy Care RBHA members engaged in PSH services are maintaining housing in their community.
- Medication Assisted Treatment: Mercy Care RBHA currently has 49 opioid treatment providers (OTP) locations and 1,624 office-based opioid treatment providers (OBOT) that offer medication assisted treatment (MAT) throughout Arizona. MAT is the use of pharmacological medications, counseling, and behavioral health therapies to treat substance use disorders. Mercy Care RBHA receives quarterly provider reporting deliverables from contracted providers on member census, average length of stay, counseling engagement, peer support engagement, intake complete, referrals submitted, tapering members, and community engagement efforts. Annually, providers submit completed member satisfaction surveys and System of Care staff meet with providers to complete the MAT provider screening tool. Screening tool results are used to develop technical assistance topics and to provide resources needed. Since 2018, Mercy Care RBHA has opened three MAT Access Points, which allow members to access services 24/7. Several OTP locations have expanded hours of operation. Mercy Care RBHA has seen a 46% increase in members receiving MAT services and member retention has improved by 10.5%.
- Assertive Community Treatment: Assertive community treatment (ACT) is the highest level of outpatient services available in the RBHA serious mental illness (SMI) network. The goal of ACT is to provide a comprehensive array of services, including addressing social determinants of health (SDOH) for each Mercy Care RBHA member receiving ACT services. Mercy Care RBHA follows the SAMHSA ACT criteria. Approximately 7% of the RBHA SMI population is receiving ACT services, exceeding the national best estimates of 4%. Mercy Care RBHA ACT network consists of 24 ACT teams comprising of 20 ACT teams with a primary care provider (PCP) partnership, 3

Forensic ACT (FACT) teams with PCP partnership, and 1 Medical ACT (MACT) team providing integrated and specialty care. Each ACT team is maximized at 100 members receiving services from a team of 12 staff including, psychiatrists, nurses, housing specialists, employment specialists, rehabilitation specialists, peer support, substance abuse specialists, independent living specialist, ACT specialist, program assistant, clinical coordinator, and other staff. By having a robust team, it provides the opportunity for a higher impact of services for Mercy Care RBHA most vulnerable members. ACT teams provide 24/7 coverage and are available to respond to crisis after hours. Currently, Mercy Care RBHA receives monthly provider reports for emergency department (ED) visits, hospital admissions (behavioral health and physical health), and other data sources. The data from these reports are reviewed monthly by Mercy Care medical directors. Future data reporting will include demographic information to help identify health disparities and promote health equity for Mercy Care RBHA members.

- Based Practice for Supported Employment: Mercy Care RBHA utilized SAMHSA Evidence Based Practice of Supported Employment (SE) model in assisting individuals with SMI designation to obtain community competitive jobs and support services to maintain employment. The SE model is an evidence-based practice with fidelity elements related to staffing, organization, and services designed to increase system capacity for RBHA members to ensure access to SE services. When employees with mental health issues receive effective treatment it can result in lower medical costs, increased productivity, lower absenteeism, and decreased disability costs.[6-1] SE reduces utilization of intensive inpatient services, dependence on Medicaid funded care and benefit programs, and stigma related to mental health. [6-2] Mercy Care RBHA has seven SE providers with employment specialists (ES) on-site. A key component of SE is collaboration of SE providers, clinical teams, and the AZ vocational rehabilitation program to increase care coordination as it relates to employment opportunities. Maricopa County supported employment utilization rate is 31% and on-going support employment utilization rate is 7.1% and exceed the national average benchmarks. SE services are perceived by members to the most helpful in their recovery. Since 2014, Mercy Care RBHA has seen an increase in the rate of employment for individuals engaged in SE services. During 2021, the monthly average increased to 555 members employed per month. 2022 Q1 had an average of 594 members employed per month for members engaged in SE services. Mercy Care RBHA implementation of the SE model has allowed the network to focus on an evidence-based practice that supports members obtain and maintain employment. Mercy Care RBHA continues to provide training and technical assistance that has proved valuable to members.

[6-1] U.S. Department of Health & Human Services. Mental Health Myths and Facts. Available at: http://www.mentalhealth.gov/basics/mental-health-myths-facts. Accessed on: Jan 26, 2022.

[6-2] Case Western Reserve University. Jack, Joseph and Morton School of Applied Social Sciences, Center for Evidence-Based Practices. Supported Employment/Individual Placement & Support. Available at: https://www.centerforebp.case.edu/practices/se. Accessed on: Jan 26, 2022.

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 an 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 RBHA Integrated SMI Contractors provide integrated physical and behavioral health services to covered members determined to have an SMI. RBHA Integrated SMI Contractors are also responsible for the provision of crisis services to all individuals, including but not limited to, crisis telephone services, community-based mobile crisis teams, and facility-based crisis stabilization services.

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 utilized 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 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

[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.

performance measure rates could not be performed. In future years, trending will be incorporated into this report.

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 performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS.

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

Performance Measurement—RBHA Integrated SMI 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 RBHA Integrated SMI Contractor's data systems 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 RBHA Integrated SMI Contractor is provided in Table 7-1, displaying if each RBHA Integrated SMI 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 RBHA Integrated SMI Contractor'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 7-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for RBHA Integrated SMI Contractors

Data Type	AzCH-CCP RBHA	HCA RBHA	Mercy Care RBHA
Medical Services Data	*Met*	*Met*	*Met*
Enrollment Data	*Met*	*Met*	*Met*
Provider Data	*Met*	*Met*	*Met*
Medical Record Review Processes	*Met*	*Met*	*Met*
Supplemental Data	*Met*	*Met*	*Met*
Data Preproduction Processing	*Met*	*Met*	*Met*
Data Integration and Reporting	*Met*	*Met*	*Met*

Performance Measure Results

Table 7-2 presents the MY 2020 performance measure rates for each RBHA Integrated SMI Contractor and the RBHA Integrated SMI 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 RBHA Integrated SMI Contractors

Performance Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	Aggregate
Maternal and Perinatal Care				
Prenatal and Postpartum Care				
Postpartum Care	69.8%	67.9%	59.9%	64.2%
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	60.2%	45.0%	57.2%	56.9%
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.6%	58.4%	53.8%	53.6%
Effective Continuation Phase Treatment	39.3%	43.2%	40.3%	40.3%

Performance Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	Aggregate
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	71.4%	74.7%	75.3%	74.1%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence				
7-Day Follow-Up—Total	22.0%	16.9%	20.7%	20.4%
30-Day Follow-Up—Total	30.8%	28.6%	30.1%	30.1%
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	52.8%	61.2%	64.6%	60.3%
30-Day Follow-Up—Total	70.7%	75.5%	77.8%	75.2%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	48.5%	57.4%	72.9%	65.8%
30-Day Follow-Up—Total	71.7%	75.2%	86.5%	82.1%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment				
Total Initiation of AOD—Total	44.3%	34.0%	41.4%	41.3%
Total Engagement of AOD—Total	14.0%	7.8%	10.9%	11.4%
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	55.7%	47.0%	33.6%	45.2%
Preventive Screening				
Breast Cancer Screening				
Total	37.3%	36.7%	36.9%	37.0%
Cervical Cancer Screening				
Cervical Cancer Screening	50.4%	40.1%	53.5%	49.9%

** 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 RBHA Integrated SMI 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:

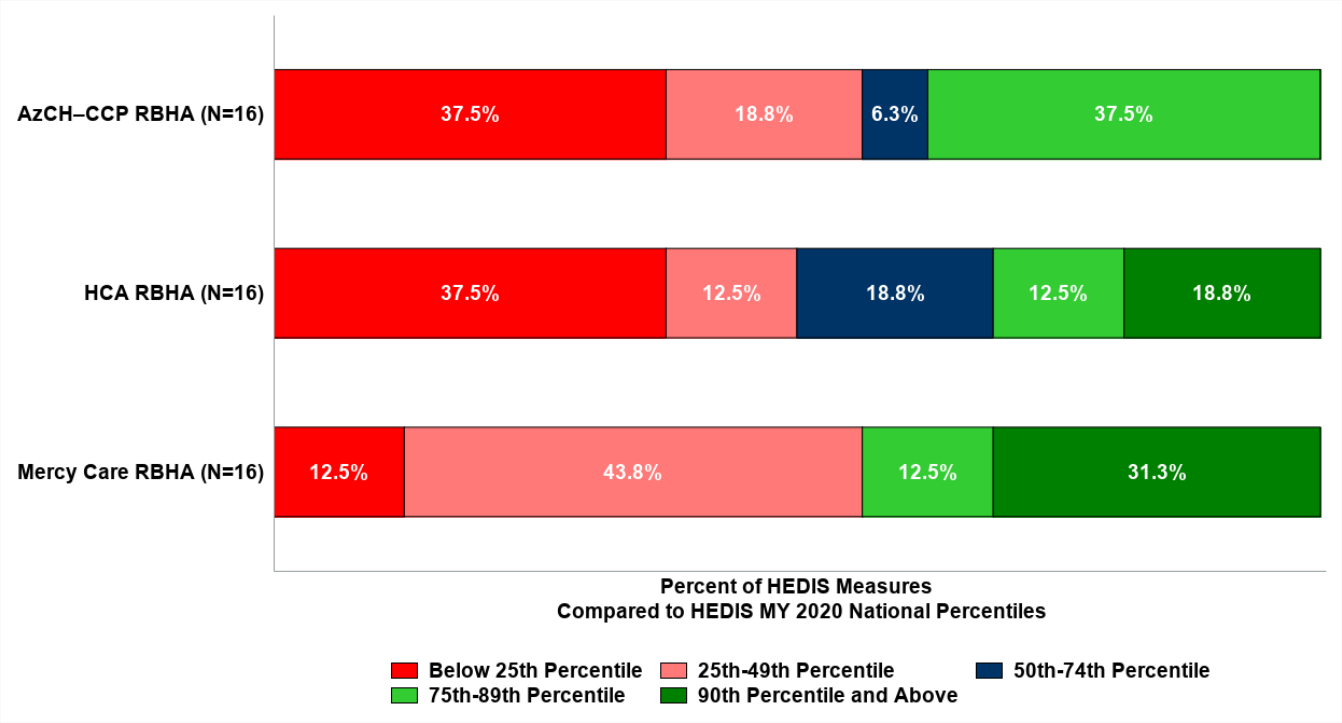
★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Table 7-3—MY 2020 National Percentiles Comparison for RBHA Integrated SMI Contractors

Performance Measure	AzCH–CCP RBHA	HCA RBHA	Mercy Care RBHA	Aggregate
Maternal and Perinatal Health				
Prenatal and Postpartum Care				
Postpartum Care	★	★	★	★
Behavioral Health Care				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	★★	★	★★	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	★	★★★	★★	★★
Effective Continuation Phase Treatment	★★	★★★	★★	★★★
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	★	★★	★★	★★
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				
Total Initiation of AOD—Total	★★	★	★★	★★
Total Engagement of AOD—Total	★★★	★	★★	★★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	★	★★	★★★★★	★★
Preventive Screening				
Breast Cancer Screening				
Total	★	★	★	★
Cervical Cancer Screening				
Cervical Cancer Screening	★	★	★★	★

Figure 7-1 displays the RBHA Integrated SMI 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 RBHA Integrated SMI Contractors



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-3 in Appendix A for the assignment of performance measures to the Quality, Timeliness, and Access areas.)

AzCH-CCP RBHA

Table 7-4—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP RBHA

Strengths
1. AzCH-CCP RBHA performed well within the Behavioral Health Care domain, with six of 12 (50.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
2. Overall, AzCH-CCP RBHA had seven of 16 (43.7 percent) measure rates meet or exceed the 50th percentile, with six of these measure rates meeting or exceeding the 75th percentile. All seven measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care domain.
Opportunities for Improvement and Recommendations
1. For Federally Qualified Health Centers (FQHCs) and facilities, manual research was completed by AzCH-CCP RBHA 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 RBHA 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 RBHA 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 RBHA 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 Care domain, AzCH-CCP RBHA'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, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that AzCH-CCP RBHA conduct a root cause analysis to determine why female members were not receiving timely postpartum care. AzCH-CCP RBHA 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 RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, AzCH-CCP

Opportunities for Improvement and Recommendations
RBHA should implement appropriate interventions to improve the performance related to postpartum care.
4. In the Behavioral Health Care domain, AzCH-CCP RBHA's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* fell below the 25th percentile. Regarding *Antidepressant Medication Management,* AzCH-CCP RBHA's performance indicates 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.[7-2] Regarding *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,* AzCH-CCP RBHA's performance indicates that people with SMI who use antipsychotics and who are at increased risk of cardiovascular diseases and diabetes were not being appropriately screened for diabetes. Lack of appropriate care for diabetes for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[7-3] Members may have had difficulties finding access to care due to the COVID-19 PHE, or this weakness may be a result of disparities in the population served. Recommendation: HSAG recommends that AzCH-CCP RBHA 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 accessing care and services in order to implement appropriate interventions. AzCH-CCP RBHA 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 RBHA should implement appropriate interventions to improve the performance related to these measures.

[7-2] 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.

[7-3] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD, SMD, SMC). Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/#:~:text=Diabetes%20Screening%20for%20People%20with,test%20during%20the%20measurement%20year. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
5. In the Care of Acute and Chronic Conditions domain, AzCH-CCP RBHA'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. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[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 RBHA 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 RBHA should implement appropriate interventions to improve the performance related to this chronic condition.
6. In the Preventive Screening domain, AzCH-CCP RBHA'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 health care costs.[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 AzCH-CCP RBHA 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 RBHA should implement appropriate interventions to improve the performance related to preventive screenings.

[7-4] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 25, 2022.
[7-5] 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.

HCA RBHA

Table 7-5—Strengths, Opportunities for Improvement, and Recommendations for HCA RBHA

Strengths
1. HCA RBHA performed well within the Behavioral Health Care domain, with eight of 12 (66.7 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
2. Overall, HCA RBHA had eight of 16 (50.0 percent) measure rates meet or exceed the 50th percentile, with three of these measure rates meeting or exceeding the 90th percentile. All eight measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care domain.
Opportunities for Improvement and Recommendations
1. HCA RBHA'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 RBHA was able to resolve the identified issues related to the four PQI measures, in order to avoid future performance measure reporting errors, HSAG recommends that HCA RBHA take additional steps to ensure 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 RBHA was required to re-run data for multiple measures based on a source that was not refreshed prior to submitting preliminary rates. Additionally, HCA RBHA 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 RBHA 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
3. In the Maternal and Perinatal Health domain, HCA RBHA'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 RBHA conduct a root cause analysis to determine why female members were not receiving timely postpartum care. HCA RBHA 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 RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HCA RBHA should implement appropriate interventions to improve the performance related to postpartum care.
4. In the Behavioral Health Care domain, HCA RBHA's performance measure rates for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* and both *Initiation and Engagement of AOD Abuse or Dependence Treatment* indicators fell below the 25th percentile, indicating opportunities for improvement. Regarding *Adherence to Antipsychotic Medications for Individuals with Schizophrenia,* HCA RBHA's performance indicates medication nonadherence among members with schizophrenia, which may lead to an increase of relapse or hospitalization.[7-6] Regarding *Initiation and Engagement of AOD Abuse or Dependence Treatment,* HCA RBHA's performance indicates that members with a new episode of AOD dependence were not always accessing AOD services or MAT within 14 days of diagnosis or within 34 days of the initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[7-7] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended.

[7-6] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Jan 25, 2022.

[7-7] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Jan 25, 2022.

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that HCA RBHA conduct a root cause analysis to determine why members were not adhering to their antipsychotic medications or receiving timely AOD services or MAT. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. HCA RBHA should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of service providers, or the need for community outreach and education). Additionally, HCA RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, HCA RBHA should implement appropriate interventions to improve the performance related to behavioral health measures.
5. In the Care of Acute and Chronic Conditions domain, HCA RBHA'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. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. 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 RBHA 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 RBHA should implement appropriate interventions to improve the performance related to this chronic condition.
6. In the Preventive Screening domain, HCA RBHA'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 RBHA conduct 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, HCA RBHA should implement appropriate interventions to improve the performance related to preventive screenings.

Mercy Care RBHA

Table 7-6—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care RBHA

Strengths
1. Mercy Care RBHA performed well within the Behavioral Health Care domain, with six of 12 (50.0 percent) measure rates meeting or exceeding the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020. Mercy Care RBHA's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* in the Care of Acute and Chronic Conditions domain also met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020.
2. Overall, Mercy Care RBHA had seven of 16 (43.7 percent) measure rates meet or exceed the 50th percentile, with five of these measure rates meeting or exceeding the 90th percentile. Seven of the measure rates that met or exceeded the 50th percentile were in the Behavioral Health Care domain, and one was in the Care of Acute and Chronic Conditions domain.
Opportunities for Improvement and Recommendations
1. Mercy Care RBHA did not collect or assign the provider specialty within its source system. Mercy Care RBHA 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 RBHA 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 RBHA 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 new measures' or revised measures' technical specifications. Recommendation: HSAG recommends that Mercy Care RBHA 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 RBHA'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 RBHA conduct a root cause analysis to determine why female members were not receiving timely postpartum care. Mercy Care RBHA

Opportunities for Improvement and Recommendations
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 RBHA should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Mercy Care RBHA should implement appropriate interventions to improve the performance related to postpartum care.
4. In the Preventive Screening domain, Mercy Care RBHA's performance measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* fell below the 25th percentile and 50th percentile, 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. 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 RBHA 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, Mercy Care RBHA should implement appropriate interventions to improve the performance related to preventive screenings.

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, performed 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. The QAPI program must focus on clinical and nonclinical areas, and include 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 the Contractor 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. AHCCCS may mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS for this PIP.

Preventive Screening PIP Background and Objective

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Preventive Screening* PIP for the RBHA SMI population. 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. AHCCCS will then conduct annual measurements to evaluate Contractor performance, with remeasurement years in alignment with calendar years: the first

remeasurement 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 *Preventive Screening* PIP.

Table 8-1—Timeline for *Preventive Screening* PIP

PIP—*Preventive Screening*				
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.

Early detection of breast cancer and cervical cancer is important when providing effective interventions. Breast cancer is the most common female cancer in the United States for every major ethnic group, the second most common cause of cancer death in women,[8-1] and accounts for 15 percent of all new cancer diagnoses in the U.S.[8-2] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Cervical cancer is a type of cancer that occurs in the cells of the cervix. The risk of developing cervical cancer can be reduced by having screening tests and receiving a vaccine that protects against human papillomavirus (HPV) infection.

Breast cancer and cervical cancer screenings increase the chances of detecting certain cancers early, when they might be easier to treat. Prevention offers the most cost-effective long-term strategy for the control of cancer. Policies, programs, and projects should be implemented to raise awareness, to reduce exposure to cancer risk factors, and to ensure that individuals are provided with the information and support needed to participate in preventive screenings.

The objective of the *Preventive Screening* PIP is to increase the number and percentage of breast cancer screenings and cervical cancer screenings. The eligible population for breast cancer screening includes women, 50 to 74 years of age, who were continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period. The eligible population for cervical cancer screenings includes women, 21 to 64 years of age, who were continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percentage of breast cancer screenings and cervical cancer screenings, followed by sustained improvement for one consecutive year.

[8-1] Jemal A, Siegel R, Ward E, Hao Y, Xu J, Thun MJ. Cancer statistics, 2009. CA Cancer J Clin. 2009 Jul-Aug;59(4):225-49. doi: 10.3322/caac.20006. Epub 2009 May 27. PMID: 19474385.
[8-2] Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD; 2016.

Table 8-2 and Table 8-3 show the indicator, numerator, and denominator that will be used to measure the baseline of this PIP.

Table 8-2—*Preventive Screening* PIP Indicator 1

PIP Measure Indicator 1: *Breast Cancer Screening* (BCS)	
Indicator 1: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**Numerator:** Number of women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
	Denominator: The eligible population.

Table 8-3—*Preventive Screening* PIP Indicator 2

PIP Measure Indicator 2: *Cervical Cancer Screening* (CCS)	
Indicator 2: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last 3 years • Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women ages 30 to 64 who had cervical cytology/hrHPV cotesting within the last 5 years.	**Numerator:** Number of women who were screened for cervical cancer as outlined in the associated technical specifications.
	Denominator: The eligible population.

Preventive Screening 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.

RBHA Contractor Results

Table 8-4 presents AzCH-CCP RBHA's baseline rate for each PIP Measure Indicator for the *Preventive Screening* PIP.

Table 8-4—*Preventive Screening* PIP Baseline Rates for AzCH-CCP RBHA

Health Plan	Baseline Year	PIP Measure Indicator 1: BCS	PIP Measure Indicator 2: CCS
AzCH-CCP RBHA	CYE 2019	38.5%	43.9%

Table 8-5 presents HCA RBHA's baseline rate for each PIP Measure Indicator for the *Preventive Screening* PIP.

Table 8-5—*Preventive Screening* PIP Baseline Rates for HCA RBHA

Health Plan	Baseline Year	PIP Measure Indicator 1: BCS	PIP Measure Indicator 2: CCS
HCA RBHA	CYE 2019	36.6%	41.0%

Table 8-6 presents Mercy Care RBHA's baseline rate for each PIP Measure Indicator for the *Preventive Screening* PIP.

Table 8-6—*Preventive Screening* PIP Baseline Rates for Mercy Care RBHA

Health Plan	Baseline Year	PIP Measure Indicator 1: BCS	PIP Measure Indicator 2: CCS
Mercy Care RBHA	CYE 2019	35.8%	43.5%

PIP Validation Contractor Comparison

Table 8-7 presents each Contractor's comparative baseline rate for each PIP Measure Indicator for the *Preventive Screening* PIP.

Table 8-7— *Preventive Screening* PIP Comparative Baseline Rates

Health Plan	Baseline Year	PIP Measure Indicator 1: BCS	PIP Measure Indicator 2: CCS
AzCH-CCP RBHA	CYE 2019	38.5%	43.9%
HCA RBHA	CYE 2019	36.6%	41.0%
Mercy Care RBHA	CYE 2019	35.8%	43.5%

Preventive Screening PIP Findings

For the *Preventive Screening* PIP, all RBHA Contractors provided lists of interventions that were in place for CY 2021, which 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 Contractor's targeted members and providers for outreach and education related to breast and cervical cancer screenings. Outreach methods included person-to-person and automated phone calls, text message campaigns, emails, and physical mailers. Additionally, several Contractors partnered or collaborated with other organizations to provide access to needed services. These interventions may impact indicator performance, which will be evaluated after the first remeasurement year (CY 2022). Improvement for subsequent remeasurement years in comparison to the baseline year will be evaluated utilizing Contractor-calculated performance measure rates that have undergone EQRO validation.

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

AzCH-CCP RBHA

AzCH-CCP RBHA provided a list of interventions for the *Preventive Screening* PIP that were in place for CY 2021. Interventions focused on the full eligible population. Table 8-8 presents strengths, opportunities for improvement, and recommendations for AzCH-CCP RBHA.

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

Strengths
1. AzCH-CCP RBHA developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions AzCH-CCP RBHA had in place for CY 2021: • Mobile mammogram events providing screenings and education for members and the public related to breast cancer screenings **[Quality, Access, and Timeliness]** • Collaboration with various external organizations to facilitate reminders, education, and/or appointment scheduling assistance for members regarding needed services **[Access and Timeliness]** • Member outreach, including blitz call campaigns, emails, text messages, and physical mailers to educate and remind members of recommended services **[Timeliness]** • Community outreach campaigns for members with identified care gaps in Yuma and Maricopa counties **[Access]** • Collaboration with the American Cancer Society on training for providers **[Quality]**

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

HCA RBHA

HCA RBHA provided a list of interventions for the *Preventive Screening* 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 8-9 presents strengths, opportunities for improvement, and recommendations for HCA RBHA.

Table 8-9—Strengths, Opportunities for Improvement, and Recommendations for HCA RBHA

Strengths
1. HCA RBHA developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions HCA RBHA had in place for CY 2021: • Member outreach and education regarding recommended services **[Timeliness]** • Provider outreach, including providing gaps-in-care reports and communication regarding closing gaps in care **[Timeliness]** • Collaboration with vendor partners to ensure access to services **[Access]** • Provider education on breast cancer awareness and preventive care through "Awareness Months" **[Quality]**
Opportunities for Improvement and Recommendations
Recommendation: While the PIP is in an intervention year and no opportunities for improvement have yet been identified, HCA RBHA should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

Mercy Care RBHA

Mercy Care RBHA provided a list of interventions for the *Preventive Screening* 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 8-10 presents strengths, opportunities for improvement, and recommendations for Mercy Care RBHA.

Table 8-10—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care RBHA

Strengths
1. Mercy Care RBHA developed and implemented interventions that may lead to improvement in indicator outcomes. Below is a summary of notable interventions Mercy Care RBHA 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]** • Collaboration with partner organizations regarding closing gaps in care by assisting members with scheduling appointments **[Access and Timeliness]** • Provider outreach, including providing gaps-in-care reports and communication regarding closing gaps in care **[Timeliness]** • Incentives for members to receive needed services **[Timeliness]** • Site visits to provide education to providers on cervical cancer screenings **[Quality]**
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 RBHA 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 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

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 its provider network. AHCCCS resumed OR activities in June 2021. AHCCCS conducted a comprehensive OR for AzCH-CCP RBHA in CYE 2020. Details regarding the standard areas reviewed for AzCH-CCP RBHA are included in the findings. For the Mercy Care and HCA RBHA Contractors, AHCCCS conducted the OR review in June and July 2021, respectively; however, final documentation was not available to include within this year's report.

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. Validation of Organizational Assessment and Structure Performance Methodology.

Standards

The OR was organized into 13 areas of focus. Each standard area consisted of several standards designed to measure the Contractor's performance and compliance. The following are the 13 focus areas and number of standards involved in each (note that not all standards are applicable for each Contractor):

- Division of Grants Administration (DGA), four standards
- Corporate Compliance (CC), five standards
- Claims and Information Systems (CIS), 10 standards

- Delivery Systems (DS), 17 standards
- General Administration (GA), three standards
- Grievance Systems (GS), 17 standards
- Adult, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and Maternal Child Health (MCH), 19 standards
- Medical Management (MM), 36 standards
- Member Information (MI), 10 standards
- Quality Improvement (QI), 10 standards
- Quality Management (QM), 15 standards
- Reinsurance (RI), four standards
- Third-Party Liability (TPL), 10 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 with the federal regulations.

Table 9-1—Crosswalk of AHCCCS Standards with Federal 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
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

OR Focus Areas	Medicaid Managed Care Requirement
Member Information (MI)	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
Quality Improvement (QI)	438.330, 438.240, 438.242
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

**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.*

Contractor-Specific Results

AzCH-CCP RBHA

AHCCCS conducted a review of AzCH-CCP RBHA from February 18, 2020, through February 21, 2020. A copy of the draft version of the report was provided to the Contractor on April 26, 2021. The report was finalized May 24, 2021. AzCH-CCP RBHA was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate based on the evidence available at the time of review.

Scoring

For the three-year review cycle, AHCCCS conducted a comprehensive OR considering 13 standard areas. Table 9-2 presents the total number of standards; the standard area scores; and the total number, if any, of standards with required corrective actions for each standard area reviewed for AzCH-CCP RBHA.

Table 9-2—Standard Areas and Compliance Scores for AzCH-CCP RBHA

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards with Required Corrective Actions
Division of Grants Administration (4)	360/400	90%	3
Corporate Compliance (5)	450/500	90%	1
Claims and Information Systems (10)	902/1,000	90%	4
Delivery Systems (16)	1,457/1,600	91%	5
General Administration (3)	300/300	100%	0
Grievance Systems (17)	1,612/1,700	95%	2

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards with Required Corrective Actions
Adult, EPSDT, and Maternal Child Health (18)	1,569/1,800	87%	5
Medical Management (36)	3,523/3,600	98%	5
Member Information (10)	950/1,000	95%	1
Quality Improvement (10)	1,000/1,000	100%	0
Quality Management (13)	1,258/1,300	97%	3
Reinsurance (4)	400/400	100%	0
Third Party Liability (7)	800/800	100%	0

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

AzCH-CCP RBHA Findings

For this OR, AHCCCS reviewed a total of 13 standard areas. AzCH-CPP RBHA achieved full compliance (100 percent compliance score) in four standard areas: GA, QI, RI and TPL. AzCH-CCP RBHA demonstrated strong performance in the GS, MM, MI, and QM standard areas, with a compliance score of 95 percent or greater. Only one standard area, MCH, was scored below 90 percent, demonstrating high compliance overall.

The results of the OR demonstrated opportunities for improvement, as AzCH-CPP RBHA scored less than compliant in nine of the 13 standard areas reviewed: DGA, CC, CIS, DS, GS, MCH, MM, MI, and QI. AzCH-CCP received a total of 29 standards with required actions across these standard areas.

For the DGA standard area, AzCH-CCP RBHA was found to be lacking a specific staff position and a policy demonstrating adherence to 45 CFR §96.124. For the CC standard area, AHCCCS found that AzCH-CCP' RBHA's Corporate Compliance Plan lacked language surrounding analysis of fraud, waste, and abuse. AHCCCS found that for the CIS standard, AzCH-CCP RBHA needed to update information on remittance advice, ensure interest policy and procedures are consistent with ACOM Policy 203, and ensure its system includes correct contracted rates. For the GS standard area, AHCCCS identified two required actions. For these required actions, AzCH-CCP RBHA must ensure that all written acknowledgement letters are issued within five business days of receipt on all claim disputes filed and ensure that all claim disputes are issued with the correct rule, regulation, policy, or procedure as required on the Notices of Decision.

AHCCCS identified five required corrective actions for each of the following standard areas: DS, MCH, and MM. For the DS standard area, AHCCCS required that AzCH-CCP RBHA update its provider manual to include requirements outlined in ACOM 416, ensure that the Provider Affiliation Transmission (PAT) file includes accurate addresses, ensure that it uses the definitions outlined in ACOM 436 to identify populations used in its time and distance calculations, adhere to requirements outlined in ACOM 439, monitor and separately report federal grant funding categories.

For the MCH standard area, AHCCCS identified several findings related to ensuring that pregnancy and postpartum care provided to women with a substance use disorder follows American College of Obstetricians and Gynecologists (ACOG) recommendations. In addition, AHCCCS required that AzCH-CCP RBHA collaborate with appropriate agencies and programs to provide education assistance with referrals for eligible EPSDT members, conduct follow-up to ensure timely and appropriate treatment for EPSDT members, and demonstrate monitoring and implementation of interventions for referrals and follow-up for AzCH-CCP RBHA EPSDT members identified as underweight and/or overweight.

For the MM standard area, AHCCCS required that AzCH-CCP RBHA develop a process to ensure that medical records submitted are reviewed for medical necessity within one day of receipt; retrospective records are reviewed within 30 days of receipt; and policies, procedures, or a work process that demonstrate how AzCH-CCP RBHA identifies compliance with mental health parity on an ongoing basis are implemented.

AHCCCS also required that AzCH-CCP RBHA notify affected members in a timely manner when a PCP or frequently utilized provider leaves the network. In the QM standard area, AHCCCS required that AzCH-CCP RBHA update policies and procedures for quality of care, abuse/complaint tracking, and trending for member/system resolution, and develop staff training and an inter-rater reliability process.

HCA RBHA and Mercy Care RBHA Findings

For the Mercy Care and HCA RBHA Contractors, AHCCCS conducted the OR review in June and July 2021, respectively; however, final documentation was not available to include within this year's report. Therefore, there are no findings to report.

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

AzCH-CCP RBHA

Table 9-3 presents the strengths, opportunities for improvement, and recommendations for AzCH-CCP RBHA.

Table 9-3—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP RBHA

Strengths
1. AzCH-CPP RBHA achieved full compliance (100 percent compliance score) in four standard areas: GA, QI, RI and TPL. **[Quality, Access, Timeliness]**
2. Although it did not meet full compliance, AzCH-CCP RBHA scored between 95 percent and 98 percent for the GS, MM, MI, and QM standard areas. **[Quality, Access, Timeliness]**

Opportunities for Improvement and Recommendations
1. AHCCCS identified a few areas where findings concerned timeliness, including conducting follow-up to ensure timely and appropriate treatment for EPSDT members, ensuring that all written acknowledgement letters were issued within five business days, ensuring that medical records were reviewed for medical necessity within one day of receipt, ensuring that retrospective records were reviewed within 30 days of receipt, and ensuring that written notice about termination of a contracted provider was disseminated to members within 15 days after receipt or issuance of the termination notice. **[Timeliness]** Recommendation: HSAG recommends that AzCH-CCP RBHA work to ensure that timeliness measures are adhered to through staff training and/or monitoring.
2. AHCCCS identified areas were policies, procedures, or plans required development or enhancement, including developing a policy that demonstrating adherence to 45 CFR §96.124; adding language surrounding analysis of fraud, waste, and abuse to the compliance plan; ensuring interest policy and procedures are consistent with ACOM Policy 203; ensuring that AzCH-CCP RBHA uses the definitions outlined in ACOM 436 to identify populations used in its time and distance calculations; implementing policies, procedures, or a work process that demonstrates how AzCH-CCP RBHA identifies compliance with mental health parity; and updating policies and procedures for quality of care, abuse/complaint tracking, and trending for member/system resolution, including developing staff training and an inter-rater reliability process. **[Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA ensure that current policies and documents include adequate details of its processes.
3. Pertaining to information systems and providers, AHCCCS found opportunities for improvement where Az-CCP RBHA needed to fill a specific staff position; update information on remittance advice; ensure that its system included correct contracted rates; ensure that all claim disputes are issued with the correct rule, regulation, policy, or procedure as required on the Notices of Decision; monitor and separately report federal grant funding categories; ensure that the PAT file includes accurate addresses; and update its provider manual to include requirements outlined in ACOM 416. **[Access, Quality]** Recommendation: HSAG recommends that AzCH-CCP RBHA strategize to ensure that its system and provider findings are reviewed to ensure compliance with State and federal requirements.
4. Pertaining to the member population and the provision of services for members, AHCCCS identified opportunities for improvement regarding requirements outlined in ACOM 439; ensuring that pregnancy and postpartum care provided to women with a substance use disorder follows ACOG recommendations; ensuring that AzCH-CCP RBHA collaborates with appropriate agencies and programs to provide education, assistance with referrals for eligible EPSDT members, and demonstration of monitoring and implementing interventions for referrals; and follow-up for EPSDT members identified as underweight and/or overweight. **[Access, Quality]**

Opportunities for Improvement and Recommendations
Recommendation: HSAG recommends that AzCH-CCP RBHA focus effort on ensuring that special populations, such as EPSDT members and pregnant women, have appropriate access, treatment, monitoring, follow-up, and tracking as required.

HCA RBHA

Table 9-4 presents the strengths, opportunities for improvement, and recommendations for HCA RBHA.

Table 9-4—Strengths, Opportunities for Improvement, and Recommendations for HCA RBHA

Strengths
No OR findings were provided for CYE 2021; therefore HSAG did not provide strengths.
Opportunities for Improvement and Recommendations
No OR findings were provided for CYE 2021. Recommendation: Although no OR findings were provided for CYE 2021, HSAG recommends that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

Mercy Care RBHA

Table 9-5 presents the strengths, opportunities for improvement, and recommendations for Mercy Care RBHA.

Table 9-5—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care RBHA

Strengths
No OR findings were provided for CYE 2021; therefore, HSAG did not provide strengths.
Opportunities for Improvement and Recommendations
No OR findings were provided for CYE 2021. Recommendation: Although no OR findings were provided for CYE 2021, HSAG recommends that the Contractor continue to remedy any findings identified in its CAP to ensure that it remains compliant with the requirements in each of the AHCCCS focus areas.

10. Consumer Assessment of Healthcare Providers and Systems Results

AHCCCS required the administration of member experience surveys to members determined to have SMI and who were receiving physical and behavioral health services from one of three RBHAs: AzCH-CCP RBHA, HCA RBHA, or Mercy Care RBHA. 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, and three Effectiveness of Care measures.

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

AzCH-CCP RBHA

Table 10-1 shows the scores and overall member experience ratings on each CAHPS measure for AzCH-CCP RBHA. Caution should be exercised when evaluating the results as the comparative population is primarily an acute Medicaid population.

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

Measure	2021 Scores
Global Ratings	
Rating of Health Plan	★ 48.5%
Rating of All Health Care	★ 43.1%
Rating of Personal Doctor	★ 59.2%
Rating of Specialist Seen Most Often	★ 59.8%
Composite Measures	
Getting Needed Care	★ 76.9%
Getting Care Quickly	★ 77.6%
How Well Doctors Communicate	★ 88.7%

Measure	2021 Scores
Customer Service	★★ 89.0%
Individual Item Measure	
Coordination of Care	★ 78.8%
Effectiveness of Care Measures	
Advising Smokers and Tobacco Users to Quit	★★ 74.5%
Discussing Cessation Medications	★★ 51.4%
Discussing Cessation Strategies	★★ 47.4%
Star Assignments Based on Percentiles: ★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th-74th ★★ 25th–49th ★ Below 25th	

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

Strengths
1. None of AzCH-CCP RBHA's member experience ratings for any of the measures met or exceeded the 75th percentiles; therefore, no strengths were identified for AzCH-CCP RBHA.
Opportunities for Improvement and Recommendations
1. AzCH-CCP RBHA'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*, and *Coordination of Care* were below the 25th percentiles. Recommendation: HSAG recommends that AzCH-CCP RBHA evaluate the factors that may be driving lower experience scores and develop initiatives designed to improve quality of care, timeliness of care, and access to care.

HCA RBHA

Table 10-3 shows the scores and overall member experience ratings on each CAHPS measure for HCA RBHA.

Table 10-3—NCQA Comparisons for HCA RBHA

Measure	2021 Scores
Global Ratings	
Rating of Health Plan	★ 54.2%
Rating of All Health Care	★ 43.6%
Rating of Personal Doctor	★ 61.4%
Rating of Specialist Seen Most Often	★ 53.3%
Composite Measures	
Getting Needed Care	★ 76.5%
Getting Care Quickly	★ 75.6%
How Well Doctors Communicate	★★ 92.0%
Customer Service	★★ 87.9%
Individual Item Measure	
Coordination of Care	★ 80.1%
Effectiveness of Care Measures	
Advising Smokers and Tobacco Users to Quit	★ 68.9%
Discussing Cessation Medications	★★ 49.5%
Discussing Cessation Strategies	★ 38.4%
Star Assignments Based on Percentiles: ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th	

Table 10-4—Strengths, Opportunities for Improvement, and Recommendations for HCA RBHA

Strengths
1. None of HCA RBHA's member experience ratings for any of the measures met or exceeded the 75th percentiles; therefore, no strengths were identified for HCA RBHA.
Opportunities for Improvement and Recommendations
1. HCA RBHA'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*, *Coordination of Care*, *Advising Smokers and Tobacco Users to Quit*, and *Discussing Cessation Strategies* were below the 25th percentiles. Recommendation: HSAG recommends that HCA RBHA evaluate the factors that may be driving lower experience scores and develop initiatives designed to improve quality of care, timeliness of care, and access to care. In addition, HCA RBHA should provide training and resources to providers to promote smoking cessation with their adult members.

Mercy Care RBHA

Table 10-5 shows the scores and overall member experience ratings on each CAHPS measure for Mercy Care RBHA.

Table 10-5—NCQA Comparisons for Mercy Care RBHA

Measure	2021 Scores
Global Ratings	
Rating of Health Plan	★★ 58.3%
Rating of All Health Care	★ 44.9%
Rating of Personal Doctor	★ 59.9%
Rating of Specialist Seen Most Often	★ 56.4%
Composite Measures	
Getting Needed Care	★ 78.2%
Getting Care Quickly	★★ 80.3%
How Well Doctors Communicate	★ 88.4%

Measure	2021 Scores
Customer Service	★ 84.5%
Individual Item Measure	
Coordination of Care	★ 70.7%
Effectiveness of Care Measures	
Advising Smokers and Tobacco Users to Quit	★ 71.7%
Discussing Cessation Medications	★★★ 54.5%
Discussing Cessation Strategies	★★★ 48.7%
Star Assignments Based on Percentiles: ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th	

Table 10-6—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care RBHA

Strengths
1. None of Mercy Care RBHA's member experience ratings for any of the measures met or exceeded the 75th percentiles; therefore, no strengths were identified for Mercy Care RBHA.
Opportunities for Improvement and Recommendations
1. Mercy Care RBHA'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*, *Customer Service*, *Coordination of Care*, and *Advising Smokers and Tobacco Users to Quit* were below the 25th percentiles. Recommendation: HSAG recommends that Mercy Care RBHA evaluate the factors that may be driving lower experience scores and develop initiatives designed to improve quality of care and access to care. In addition, Mercy Care RBHA should provide training and resources to providers to promote smoking cessation with their adult members.

CAHPS Contractor Comparison

HSAG compared the RBHAs' results to the SMI Program (i.e., combined results of the RBHAs) to determine if the RBHAs' results were statistically significantly different than the SMI Program. Table 10-7 shows a summary of the statistically significant results of this analysis.

Table 10-7—RBHA Plan Comparisons: Statistically Significant Results

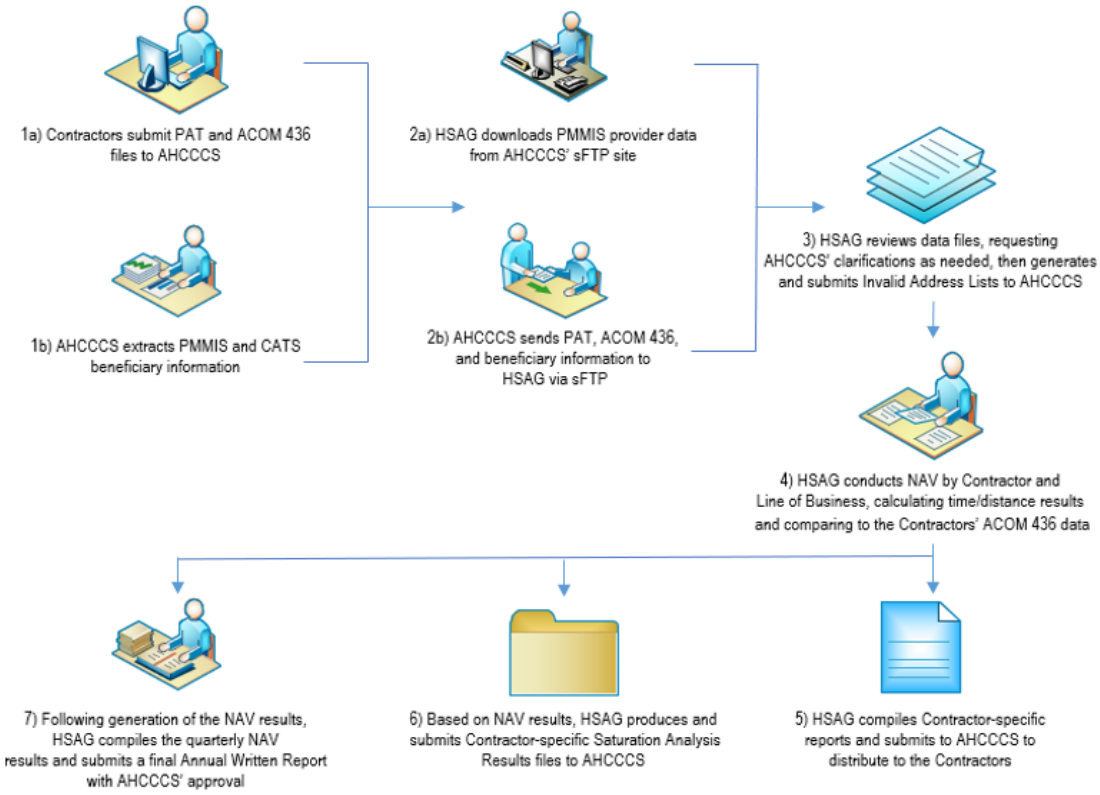
	Rating of Health Plan
AzCH-CCP RBHA	↓
HCA RBHA	
Mercy Care RBHA	↑

The cell shaded in grey indicates the score was not statistically significantly higher or lower than the SMI Program for the measure and RBHA.
↑ *Statistically significantly higher than the SMI Program.*
↓ *Statistically significantly lower than the SMI Program.*

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' RBHA Contractors.[11-1] HSAG's biannual NAV considered each RBHA Contractor's compliance with 12 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 RBHA Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors in each quarter that data could be compared.

HSAG's biannual validation of the RBHA Contractors' results reflect minor discrepancies between the Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors 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.

Note that in selected instances, a RBHA Contractor reported county-specific time/distance compliance results for a standard in which HSAG's validation did not identify any members meeting the age requirements who would be considered for these standards. These instances are indicated with "NR" in the Appendix E tables and primarily occur among standards specific to pediatric members (i.e., HSAG identified no pediatric members for its time/distance calculation of the specific standard).

Additionally, the RBHA population included children in foster care enrolled in the Comprehensive Medical and Dental Program (CMDP) from January 1, 2021, through March 30, 2021. However, these children may not have had accurate ZIP code information in the PMMIS member data, resulting in inaccurate time/distance results for the three behavioral health-related standards for which the RBHAs served these children. While RBHA compliance results for minimum network requirements may align between HSAG and each Contractor, the Contractors' time/distance results for these children may not have been based on the child's actual place of residence. Beginning April 1, 2021, responsibility for these members in all counties was transferred to DCS CHP's subcontracted health plan, Mercy Care.

Table 11-1 summarizes HSAG's assessment of each RBHA Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the RBHA Contractor met the minimum network standard for all assigned counties during the biannual assessment, and an "X" indicates that the RBHA 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 RBHA Contractors

Minimum Network Requirement	AzCH-CCP RBHA	HCA RBHA	Mercy Care RBHA
Behavioral Health Outpatient and Integrated Clinic, Adult	✔	✔	✔
Behavioral Health Outpatient and Integrated Clinic, Pediatric[1]	✔	✔	✔

Minimum Network Requirement	AzCH-CCP RBHA	HCA RBHA	Mercy Care RBHA
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	✔	NA	✔
Cardiologist, Adult	✔	✔	✔
Cardiologist, Pediatric[2]	✔	✔	✔
Crisis Stabilization Facility	✔	✔	✔
Dentist, Pediatric[2, 3]	✕	✔	✔
Hospital	✔	✔	✔
Obstetrics/Gynecology (OB/GYN)	✔	✔	✔
Pharmacy	✔	✔	✔
PCP, Adult	✕	✔	✔
PCP, Pediatric[2]	✔	✔	✔

1) HSAG's validation identified no RBHA members under 18 years of age for consideration in the Behavioral Health Outpatient and Integrated Clinic, Pediatric standard in all counties and quarters, except Coconino County in CYE 2021 Quarter 2.
2) HSAG's time/distance calculation results for AzCH-CCP – RBHA's and HCA – RBHA's compliance with pediatric standards include fewer than five members younger than 21 years in Apache, Gila, Graham, Greenlee, La Paz, and Santa Cruz counties during the measurement period.
3) HSAG identified one instance in which the RBHA Contractor's self-reported ACOM 436 results failed to meet the minimum network requirement, but HSAG's calculations indicated that the standard was met: AzCH-CCP – RBHA's CYE 2021 Quarter 4 Dentist, Pediatric result in Greenlee County.

As part of the NAV, AHCCCS maintained its feedback process for RBHA Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each RBHA 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, RBHA Contractors were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

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

Overall, for CYE 2021, Quarter 4, the most recent biannual assessment, all applicable RBHA Contractors met all minimum time/distance network requirements for all counties. Based on the biannual NAV results, Mercy Care RBHA and HCA RBHA met all standards and did not receive saturation analysis results. Although AzCH-CCP RBHA failed to meet the minimum network requirement for the Dentist, Pediatric standard in CYE 2021, Quarter 2, it met the requirement starting in CYE 2021, Quarter 4. As of CYE 2021, Quarter 4, all RBHA Contractors should continue to monitor and maintain their existing provider network coverage.

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

Table 11-2 through Table 11-4 present strengths, opportunities for improvement, and recommendations for RBHA Contractors.

AzCH-CCP RBHA

Table 11-2—Strengths, Opportunities for Improvement, and Recommendations for AzCH-CCP RBHA

Strengths
1. AzCH-CCP RBHA met all time/distance network standards for all assigned counties in CYE 2021, Quarter 4. Note: AzCH-CCP RBHA provides coverage in the following counties: Cochise, Graham, Greenlee La Paz, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
Recommendation: AzCH-CCP RBHA should continue to monitor its processes for creating the PAT files and review the PAT file for accuracy prior to submitting to AHCCCS.
Recommendation: AzCH-CCP RBHA should continue to monitor and maintain its existing provider network coverage.

HCA RBHA

Table 11-3—Strengths, Opportunities for Improvement, and Recommendations for HCA RBHA

Strengths
1. HCA RBHA met all time/distance network standards for both quarters in CYE 2021 for all assigned counties. Note: HCA RBHA provides coverage in the following counties: Apache, Coconino, Gila, Mohave, Navajo, and Yavapai.
Opportunities for Improvement and Recommendations
Recommendation: HCA RBHA should continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
Recommendation: HCA RBHA should continue to monitor and maintain its existing provider network coverage.

Mercy Care RBHA

Table 11-4—Strengths, Opportunities for Improvement, and Recommendations for Mercy Care RBHA

Strengths
1. Mercy Care RBHA met all time/distance network standards for both quarters in CYE 2021 for all assigned counties. Note: Mercy Care RBHA provides coverage in Maricopa County.
Opportunities for Improvement and Recommendations
Recommendation: Mercy Care RBHA should continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS.
Recommendation: Mercy Care RBHA should continue to monitor and maintain its existing provider network coverage.

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 Roadmap, if applicable, a completed 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.

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

[A-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.

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 Contractor 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 Contractor 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 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 RBHA Integrated SMI Contractors were grouped into the following domains of care: Maternal and Perinatal Health, Behavioral Health Care, Care of Acute and Chronic Conditions, 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 displays the technical specifications used during PMV: NCQA's HEDIS Measurement Year (MY) 2020.

Table A-2—MY 2020 Performance Measures for RBHA Integrated SMI Contractors

Performance Measure	Measure Steward
Maternal and Perinatal Care	
Prenatal and Postpartum Care—Postpartum Care	NCQA
Behavioral Health Care	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	NCQA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	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
Preventive Screening	
Breast Cancer Screening—Total	NCQA
Cervical Cancer Screening	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-3 for the assignment of performance measures to the Quality, Timeliness, and Access areas.) When applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Table A-3—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			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
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*		✓	✓
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	✓		
Preventive Screening			
Breast Cancer Screening—Total	✓		
Cervical Cancer Screening	✓		

Performance Measurement—RBHA Integrated SMI Contractors

For each RBHA Integrated SMI 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.

AzCH-CCP RBHA

HSAG determined that AzCH-CCP RBHA 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 RBHA claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with AzCH-CCP RBHA eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with AzCH-CCP RBHA provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with AzCH-CCP RBHA medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with AzCH-CCP RBHA supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with AzCH-CCP RBHA procedures for data integration and measure production.

Table A-4—MY 2020 Performance Measure Results for AzCH-CCP RBHA

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	69.8%
Behavioral Health Care		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Administrative	60.2%
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	51.6%
Effective Continuation Phase Treatment	Administrative	39.3%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative	71.4%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	22.0%
30-Day Follow-Up—Total	Administrative	30.8%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	52.8%
30-Day Follow-Up—Total	Administrative	70.7%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	48.5%
30-Day Follow-Up—Total	Administrative	71.7%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	44.3%
Total Engagement of AOD Treatment—Total	Administrative	14.0%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Administrative	55.7%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	37.3%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	50.4%

** 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.

HCA RBHA

HSAG determined that HCA RBHA 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 RBHA's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with HCA RBHA's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with HCA RBHA's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with HCA RBHA's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with HCA RBHA's supplemental data systems and processes.
- *Data Integration:* While HCA RBHA produced final validated rates for all measures, HSAG identified a concern with HCA RBHA's procedures for data integration and measure production. HSAG found that HCA RBHA 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-5—MY 2020 Performance Measure Results for HCA RBHA

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	67.9%
Behavioral Health Care		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Administrative	45.0%
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	58.4%
Effective Continuation Phase Treatment	Administrative	43.2%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative	74.7%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	16.9%
30-Day Follow-Up—Total	Administrative	28.6%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	61.2%
30-Day Follow-Up—Total	Administrative	75.5%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	57.4%
30-Day Follow-Up—Total	Administrative	75.2%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	34.0%
Total Engagement of AOD Treatment—Total	Administrative	7.8%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	47.0%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	36.7%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	40.1%

** 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.

Mercy Care RBHA

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

Table A-6—MY 2020 Performance Measure Results for Mercy Care RBHA

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	59.9%
Behavioral Health Care		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Administrative	57.2 %
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	53.8%
Effective Continuation Phase Treatment	Administrative	40.3%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative	75.3%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	20.7%

Performance Measure	Data Collection Methodology	MY 2020 Performance
30-Day Follow-Up—Total	Administrative	30.1%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	64.6%
30-Day Follow-Up—Total	Administrative	77.8%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	72.9%
30-Day Follow-Up—Total	Administrative	86.5%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	41.4%
Total Engagement of AOD Treatment—Total	Administrative	10.9%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Hybrid	33.6%
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	36.9%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	53.5%

** 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.

RBHA Integrated SMI Aggregate

Table A-7—MY 2020 Performance Measure Results for RBHA Integrated SMI Aggregate

Performance Measure	Data Collection Methodology	MY 2020 Performance
Maternal and Perinatal Care		
Prenatal and Postpartum Care		
Postpartum Care	Hybrid	64.2%
Behavioral Health Care		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Administrative	56.9%
Antidepressant Medication Management		
Effective Acute Phase Treatment	Administrative	53.6%
Effective Continuation Phase Treatment	Administrative	40.3%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative	74.1%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	Administrative	20.4%
30-Day Follow-Up—Total	Administrative	30.1%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	Administrative	60.3%
30-Day Follow-Up—Total	Administrative	75.2%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	Administrative	65.8%
30-Day Follow-Up—Total	Administrative	82.1%
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Total Initiation of AOD Treatment—Total	Administrative	41.3%
Total Engagement of AOD Treatment—Total	Administrative	11.4%
Care of Acute and Chronic Conditions		
Comprehensive Diabetes Care		
*HbA1c Poor Control (>9.0%)**	Mixed**	45.2%

Performance Measure	Data Collection Methodology	MY 2020 Performance
Preventive Screening		
Breast Cancer Screening		
Total	Administrative	37.0%
Cervical Cancer Screening		
Cervical Cancer Screening	Hybrid	49.9%

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

*** Mixed methodology indicates some Contractors used an administrative method and some used a hybrid method.*

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 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, 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.

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 RBHA 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 survey was to effectively and efficiently obtain information and gain understanding about 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 RBHAs was through the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. Adult members included as eligible for the survey were 18 years of age or older as of December 31, 2020. Members completed the survey from April to June 2021.

An English or Spanish version of the cover letter was mailed to all sampled 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 that yield 12 measures of experience) that assess respondents' perspectives on care. These measures included four global ratings, four composite scores, one individual item measure, and three Effectiveness of Care measures. The global ratings reflected members' overall experience with their 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. 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 and individual item measure, the percentage of respondents who chose a positive or top-box response was calculated. Response choices for the CAHPS composite questions and individual item in the adult Medicaid survey were "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for these measures were defined as a response of "Usually" or "Always." 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.

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

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

Also, HSAG performed plan comparisons of the results. Statistically significant differences between the RBHAs' top-box responses and the SMI Program are noted with arrows. A RBHA's top-box score that was statistically significantly higher than the SMI Program is noted with an upward green (↑) arrow. A RBHA's top-box score that was statistically significantly lower than the SMI Program is noted with a downward red (↓) arrow. A RBHA's top-box score that was not statistically significantly different than the SMI 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 RBHAs, 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	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		

Appendix E. Validation of Network Adequacy Methodology and Detailed Results

HSAG used data supplied by AHCCCS to calculate the number and percentage of RBHA members within a defined time or distance from 12 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.

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	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[3]	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[1,3]	All members	90 percent of members within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult	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
Crisis Stabilization Facility[2,3]	All members	90 percent of members within 15 minutes or 10 miles	90 percent of members within 45 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	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. Applies only to RBHA Contractors.
3. Calculations for RBHA Contractors will include CMDP members for CYE 2021, Quarter 2.

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.
- Contractor-specific Provider Affiliation Transmission (PAT) files—An aggregated data file listing each Contractor's network providers, as identified to AHCCCS by each Contractor.
- 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.

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:

- 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 RBHA 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 RBHA Contractor's self-reported methods for calculating the ACOM 436 results, as of April 2021.

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

Contractor	ACOM 436 Calculation Method
AzCH-CCP RBHA	Calculates time/distance results based on driving distances using Quest version 2019.4
HCA RBHA	Calculates time/distance results based on driving distances using Quest version 2020.4
Mercy Care RBHA	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

[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.

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 RBHA 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' RBHA 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

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

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

Minimum Network Requirement	Count of AzCH-CCP RBHA Provider Locations	Count of HCA RBHA Provider Locations	Count of Mercy Care RBHA Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Adult	499	474	443
Behavioral Health Outpatient and Integrated Clinic, Pediatric	499	474	443

[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.

Minimum Network Requirement	Count of AzCH-CCP RBHA Provider Locations	Count of HCA RBHA Provider Locations	Count of Mercy Care RBHA Provider Locations
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	215	253	318
Cardiologist, Adult	879	1,574	1,227
Cardiologist, Pediatric	975	1,956	1,366
Crisis Stabilization Facility *(only RBHA Contractors)*	616	676	570
Dentist, Pediatric	2,415	1,979	241
Hospital	95	160	96
Obstetrics/ Gynecology (OB/GYN)	1,086	1,898	1,563
Pharmacy	975	1,240	961
PCP, Adult	18,866	19,093	19,948
PCP, Pediatric	16,099	15,390	15,900

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

- Central Region: Maricopa[E-3]
- North Region: Apache, Coconino, Gila, Mohave, Navajo, Yavapai
- South Region: Cochise, Graham,[E-4] Greenlee, La Paz, Pima, Pinal, Santa Cruz,[E-5] 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 RBHA LOB.

The value, "NR," is shown for time/distance standards in which no members met the network requirement denominator for the RBHA 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.

An asterisk (*) identifies instances in which fewer than five members were included in the denominator of HSAG's time/distance results.

[E-3] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.
[E-4] 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-5] Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

Central Region: Maricopa Counties

Table E-5—RBHA Time/Distance Validation Results for Maricopa County: Percentage of Members Meeting Minimum Network Requirements

	Mercy Care RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	98.8	98.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	99.5	99.5
Cardiologist, Adult	100.0	99.9
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	99.3	99.5
Dentist, Pediatric	97.3	96.6
Hospital	100.0	99.9
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	99.5	99.5
PCP, Adult	99.7	99.7
PCP, Pediatric	99.9	99.9

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

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

Table E-6—RBHA Time/Distance Validation Results for Apache County: Percentage of Members Meeting Minimum Network Requirements

	HCA RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	97.3	96.5
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	98.6	98.7
Cardiologist, Pediatric	100.0*	100.0*
Crisis Stabilization Facility *(only RBHA Contractors)*	99.5	99.6
Dentist, Pediatric	100.0*	100.0*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	97.3	95.6
PCP, Adult	97.3	96.5
PCP, Pediatric	100.0*	100.0*

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates fewer than five members were included in the denominator of HSAG's results.
NA indicates results are not applicable to the county.

Table E-7—RBHA Time/Distance Validation Results for Coconino County: Percentage of Members Meeting Minimum Network Requirements

	HCA RBHA	
Minimum Network Requirement	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	99.2	99.4
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	99.5	99.5
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	99.7	99.5
Dentist, Pediatric	100.0	93.3
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	97.7	97.3
PCP, Adult	98.3	98.5
PCP, Pediatric	100.0	100.0

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table E-8—RBHA Time/Distance Validation Results for Gila County: Percentage of Members Meeting Minimum Network Requirements

	HCA RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Crisis Stabilization Facility *(only RBHA Contractors)*	100.0	100.0
Dentist, Pediatric	100.0*	100.0*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates fewer than five members were included in the denominator of HSAG's results.
NA indicates results are not applicable to the county.

Table E-9—RBHA Time/Distance Validation Results for Mohave County: Percentage of Members Meeting Minimum Network Requirements

	HCA RBHA	
Minimum Network Requirement	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	99.1	99.2
Dentist, Pediatric	100.0	100.0
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	98.9	99.1
PCP, Adult	99.9	100.0
PCP, Pediatric	100.0	100.0

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table E-10—RBHA Time/Distance Validation Results for Navajo County: Percentage of Members Meeting Minimum Network Requirements

	HCA RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	98.8	99.3
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	98.5	98.7
Cardiologist, Pediatric	100.0	100.0*
Crisis Stabilization Facility *(only RBHA Contractors)*	99.4	99.6
Dentist, Pediatric	100.0	100.0*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	98.8	99.3
PCP, Adult	99.9	100.0
PCP, Pediatric	100.0	100.0*

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table E-11—RBHA Time/Distance Validation Results for Yavapai County: Percentage of Members Meeting Minimum Network Requirements

	HCA RBHA	
Minimum Network Requirement	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	99.4	99.4
Dentist, Pediatric	96.2	100.0
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	98.7	98.6
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0	100.0

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

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

Table E-12—RBHA Time/Distance Validation Results for Cochise County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	99.9
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	99.6	99.8
Dentist, Pediatric	85.7	100.0
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	99.5	99.7
PCP, Adult	99.6	99.8
PCP, Pediatric	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.
NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates fewer than five members were included in the denominator of HSAG's results.
NA indicates results are not applicable to the county.

Table E-13—RBHA Time/Distance Validation Results for Graham County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	NR*
Crisis Stabilization Facility *(only RBHA Contractors)*	100.0	99.0
Dentist, Pediatric	100.0*	NR*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	95.5	98.0
PCP, Adult	95.5	96.9
PCP, Pediatric	100.0*	NR*

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table E-14—RBHA Time/Distance Validation Results for Greenlee County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Crisis Stabilization Facility *(only RBHA Contractors)*	100.0	100.0
Dentist, Pediatric	100.0*	100.0*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0*	100.0*
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table E-15—RBHA Time/Distance Validation Results for La Paz County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	NR*	100.0*
Crisis Stabilization Facility *(only RBHA Contractors)*	95.4	92.9
Dentist, Pediatric	NR*	100.0*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	96.9	94.3
PCP, Adult	87.7	94.1
PCP, Pediatric	NR*	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.

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

NA indicates results are not applicable to the county.

Table E-16—RBHA Time/Distance Validation Results for Pima County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	98.1	98.3
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	95.4	95.4
Cardiologist, Adult	99.5	99.5
Cardiologist, Pediatric	100.0	99.0
Crisis Stabilization Facility *(only RBHA Contractors)*	98.1	98.3
Dentist, Pediatric	96.2	98.1
Hospital	99.7	99.6
Obstetrics/ Gynecology (OB/GYN)	99.7	99.6
Pharmacy	98.6	98.7
PCP, Adult	99.9	99.9
PCP, Pediatric	99.0	99.0

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of HSAG's results.

Table E-17—RBHA Time/Distance Validation Results for Pinal County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	100.0	100.0
Dentist, Pediatric	100.0	100.0
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0	100.0

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates fewer than five members were included in the denominator of HSAG's results.
NA indicates results are not applicable to the county.

Table E-18—RBHA Time/Distance Validation Results for Santa Cruz County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0*	100.0*
Crisis Stabilization Facility *(only RBHA Contractors)*	100.0	100.0
Dentist, Pediatric	100.0*	100.0*
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	100.0	100.0
PCP, Adult	100.0	100.0
PCP, Pediatric	100.0*	100.0*

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.
* indicates fewer than five members were included in the denominator of HSAG's results.
NA indicates results are not applicable to the county.

Table E-19—RBHA Time/Distance Validation Results for Yuma County: Percentage of Members Meeting Minimum Network Requirements

	AzCH-CCP RBHA	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	99.7	99.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*	NR*
Behavioral Health Residential Facility *(only Maricopa and Pima counties)*	NA	NA
Cardiologist, Adult	100.0	100.0
Cardiologist, Pediatric	100.0	100.0
Crisis Stabilization Facility *(only RBHA Contractors)*	99.7	99.8
Dentist, Pediatric	100.0	100.0
Hospital	100.0	100.0
Obstetrics/ Gynecology (OB/GYN)	100.0	100.0
Pharmacy	99.7	99.8
PCP, Adult	99.7	99.8
PCP, Pediatric	100.0	100.0

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

NR represents instances in which HSAG identified no members meeting the network requirements for the county and time/distance standard.

* indicates fewer than five members were included in the denominator of 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.

AHCCCS
Arizona Health Care Cost Containment System

2021 AHCCCS NETWORK ADEQUACY REPORT

PREPARED BY:
DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS

January 25, 2022

2021 Network Adequacy Report

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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

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.