Arizona Health Care Cost Containment System

Contract Year Ending 2022 External Quality Review Annual Technical Report

for

Arizona Long Term Care System (ALTCS)

April 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, required states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the Quality, Timeliness, and Access to services provided by the contracted MCOs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Arizona Health Care Cost Containment System (AHCCCS) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO. This technical report is intended to help AHCCCS:

- Identify areas for quality improvement
- Ensure alignment among the Contractors' quality assessment and performance improvement (QAPI) requirements, the State's Quality Strategy, and the annual EQR activities
- Provide high-value care
- Enhance performance of its healthcare delivery system for Medicaid and CHIP members
- Improve AHCCCS' ability to oversee and manage the contracted MCOs (also referred to as Contractors in this report)
- Help Contactors improve their performance with respect to Quality, Timeliness, and Accessibility of care

This report addresses the AHCCCS Arizona Long Term Care System (ALTCS) Elderly and Physical Disabilities (EPD) Program and the ALTCS Developmental Disabilities (DD) Program.

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: July 27, 2022.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: July 27, 2022.

Contractors Reviewed

ALTCS Elderly and Physical Disabilities (EPD) Program

The **ALTCS-EPD Program** provides long-term services and supports as well as integrated physical and behavioral health services to eligible members who are elderly and/or have a physical disability.

Table 1-1—ALTCS-EPD Program Contracted MCOs

ALTCS-EPD Program Contractors	
Contractor Name	**Contractor Abbreviation**
Banner-University Family Care	BUFC LTC
Mercy Care	Mercy Care LTC
UnitedHealthcare Community Plan	UHCCP LTC

ALTCS Developmental Disabilities (DD) Program

The **ALTCS-DD Program** provides long-term services and supports as well as integrated physical and behavioral health services to eligible members who have a developmental disability as outlined under Arizona state law.

Table 1-2—ALTCS-DD Program Contracted MCO

ALTCS-DD Program Contractor	
Contractor Name	**Contractor Abbreviation**
Arizona Department of Economic Security, Division of Developmental Disabilities	DES/DDD

*DES/DDD provides services through two subcontracted health plans, Mercy Care and UnitedHealthcare Community Plan (UHCCP). The report uses DES/DDD when referring to the DES/DDD Contractor, and Mercy Care DD or UHCCP DD when referring to activities conducted by the DES/DDD subcontracted health plans.

Program-Level Summary of Findings and Assessment

In this section, HSAG presents program-level strengths, weaknesses (referred to in this report as opportunities for improvement), and recommendations. Each strength, opportunity for improvement, and recommendation is derived from HSAG's review of the EQR activity results.

ALTCS-EPD Program

Table 1-3 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-EPD Program based on all EQR activities conducted. Contractor-specific strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 5. ALTCS-EPD Program Contractor-Specific Results.

Table 1-3—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to performance measure validation (PMV): • Two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass®, [1-3] national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] measurement year (MY) 2021 for the: – *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure rates **[Quality]** – *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure rate **[Quality, Timeliness, Access]** – *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure rate **[Quality]** – *Controlling High Blood Pressure* measure rate **[Quality]** – *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate **[Quality]** HSAG identified the following strengths related to performance improvement projects (PIPs): • The ALTCS-EPD Program Contractors developed and implemented interventions that may lead to improvement in select PIP indicator outcomes **[Quality]** • The *Breast Cancer Screening* PIP is in an intervention phase and will offer an opportunity to improve select performance measures related to preventive healthcare for AHCCCS members **[Quality]** HSAG identified the following strengths related to compliance reviews: • The ALTCS-EPD Program Contractors' average compliance score was at or above 95 percent in the following Focus Areas: – Corporate Compliance (CC) **[Quality, Access]** – Claims and Information Standards (CIS) **[Access]** – General Administration (GA) **[Timeliness, Access]**

[1-3] Quality Compass® is a registered trademark of NCQA
[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Strengths, Opportunities for Improvement, and Recommendations
– Grievance Systems (GS) **[Timeliness, Access]** – Member Information (MI) **[Quality]** – Reinsurance (RI) **[Quality]** – Third-Party Liability (TPL) **[Quality, Timeliness, Access]** HSAG identified the following strengths related to network adequacy validation (NAV): • The applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in calendar year ending (CYE) 2022 in Mohave and Yavapai counties **[Access]** • The ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; Cardiologist, Adult and Pediatric; Hospital; and Primary Care Provider (PCP), Adult and Pediatric standards **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • All three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile for: – *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total* **[Quality, Timeliness, Access]** – *Breast Cancer Screening* **[Quality]** – *Child and Adolescent Well-Care Visits* **[Quality, Access]** – *Use of Opioids at High Dosage* **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors conduct a root cause analysis or focus study and implement appropriate interventions to improve the performance. Of note, the ALTCS-EPD Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address the *Breast Cancer Screening* measure rate. • For CY 2022 performance measure reporting, race and ethnicity stratifications (RES) will be required based on NCQA HEDIS specifications Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.

Strengths, Opportunities for Improvement, and Recommendations

HSAG identified the following opportunities for improvement related to PIPs:

- Regarding the PIPs, although the indicator rates two ALTCS-EPD Program Contractors demonstrated an increase over baseline indicator rates in both intervention years, HSAG noted a decline in the indicator rates for one ALTCS-EPD Program Contractor in both intervention years. **[Quality]**

  Recommendation: To support successful progression of the PIP in the next CY, HSAG recommends that the ALTCS-EPD Program Contractors:

  - Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary
  - Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available
  - Develop and document plans for sustaining the improvement for any demonstrated improvement in indicator rates

HSAG identified the following opportunities for improvement related to compliance reviews:

- The ALTCS-EPD Program Contractors' average score for compliance was below 95 percent in the following Focus Areas:
  - Case Management (CM) **[Quality, Access]**
  - Delivery Systems (DS) **[Timeliness, Access]**
  - Adult; Early Periodic Screening, Diagnostic, and Treatment (EPSDT); and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
  - Medical Management (MM) **[Timeliness, Access]**
  - Quality Management (QM) **[Quality]**

  Recommendation: HSAG recommends that in advance of the forthcoming ALTCS-EPD compliance review, Contractors conduct a self-assessment of the CM, DS, MCH, MM, and QM Focus Area requirements.

HSAG identified the following opportunities for improvement related to NAV:

- Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Program Contractors' compliance with time/distance standards **[Access]**
- Based on the biannual NAV results, the ALTCS-EPD Program Contractors struggled to meet the Dentist, Pediatric; Nursing Facility; and Pharmacy standards **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that with the ALTCS-EPD Program Contractors: • Seek support from AHCCCS continue to ensure ongoing monitoring of their processes for creating the Provider Affiliation Transmission (PAT) file **[Access]** • Review the PAT file for accuracy prior to submitting to AHCCCS **[Access]** • Maintain current compliances, but continue to address network gaps, as applicable **[Access]**

ALTCS-DD Program

Table 1-4 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-DD Program based on all EQR activities conducted. ALTCS-DD strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 6. ALTCS-DD Program Results.

Table 1-4—ALTCS-DD Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • The ALTCS-DD Program Contractor's (DES/DDD's) performance measure rates were at or above the 90th percentile for the: – *Antidepressant Medication Management—Effective Acute Phase Treatment* measure rate **[Quality, Timeliness, Access]** – *Effective Continuation Phase Treatment*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total* measure rates **[Quality, Timeliness, Access]** – *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure rate [**Quality**] – *Controlling High Blood Pressure* measure rate [**Quality**] HSAG identified the following strengths related to PIPs: • DES/DDD and its subcontracted health plans developed and implemented interventions that may lead to improvement in indicator outcomes **[Quality, Access]** • The *Back to Basics* PIP is in an intervention phase and will offer an opportunity to improve select performance measures related to preventive healthcare for AHCCCS members **[Quality, Access]** HSAG identified the following strengths related to compliance reviews: • Within the ALTCS-DD Program, DES/DDD scored at or above 95 percent in the following Focus Areas:

Strengths, Opportunities for Improvement, and Recommendations
– Grievance Systems (GS) **[Timeliness, Access]** – Reinsurance (RI) **[Quality]** – Third-Party Liability (TPL) **[Quality, Timeliness, Access]** HSAG identified the following strengths related to NAV: • The ALTCS-DD subcontracted health plans consistently met the Behavioral Health Residential Facility, Hospital; Obstetrics/Gynecology (OB/GYN); and PCP, Adult and Pediatric standards • Mercy Care DD met all time/distance network standards in all assigned counties for both quarters in CYE 2022, except for Apache, La Paz, Mohave, and Navajo counties • UHCCP DD met all minimum time/distance network standards in all assigned counties for both quarters in CYE 2022, except for Apache County
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • DES/DDD performance measure rates fell below the 25th percentile for the: – *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD–Total—Total* measure rate **[Quality, Timeliness, Access]** – *Engagement of AOD–Total—Total* measure rate **[Quality, Timeliness, Access]** – *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate **[Quality, Access]** – *Childhood Immunization Status—Combination 7* measure rate **[Quality]** – *Cervical Cancer Screening* measure rate **[Quality]** Recommendation: HSAG recommends that DES/DDD conduct a root cause analysis or focus study and implement appropriate interventions to improve the performance. • DES/DDD has responsibility for two subcontracted health plans' data completeness, accuracy, integration, and reporting; however, DES/DDD did not have the combined rates representing DES/DDD's aggregated results available until final rate review **[Quality]** Recommendation: While both subcontracted health plans have multiple years of extensive experience in ongoing performance measure production and reporting, and DES/DDD indicated that it implemented a new tool to conduct routine monitoring of its subcontracted health plans, the opportunity remains to further enhance oversight efforts. In addition to the use of the newly developed oversight tool on an ongoing basis, HSAG recommends that DES/DDD implement steps to validate and confirm the reported rates of each subcontracted health plan to identify trends in the individual subcontracted health plan's rates. Through use of its new tool, DES/DDD should review and compare quarterly performance rates across both subcontracted health plans and over time to identify any potential differences in services/results, areas for improvement, and

Strengths, Opportunities for Improvement, and Recommendations

best practices to integrate for all DES/DDD members. Furthermore, DES/DDD should review and confirm the final combined calculations of the DES/DDD HEDIS and Centers for Medicare & Medicaid Services (CMS) measures prior to submission for auditor review.

- While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, the audit identified a recommendation for future years' reporting **[Quality]**

  Recommendation: HSAG recommends that DES/DDD explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. DES/DDD should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.

HSAG identified the following opportunities for improvement related to PIPs:

- HSAG noted that indicator rates declined for DES/DDD for indicators 2 and 3 between the baseline year and the intervention year 1; however, both indicator rates showed some recovery in intervention year 2, with indicator 2 ending nearly at the baseline rate and indicator 3 ending above the baseline rate **[Quality]**

  Recommendation: As the PIP progresses, HSAG recommends that DES/DDD:
  - Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary
  - Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available
  - Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

HSAG identified the following opportunities for improvement related to compliance reviews:

- Within the ALTCS-DD Program, DES/DDD scored below 95 percent in the following Focus Areas:
  - Case Management (CM) **[Quality, Access]**
  - Corporate Compliance (CC) **[Quality, Access]**
  - Claims and Information Standards (CIS) **[Access]**
  - Delivery Systems (DS) **[Timeliness, Access]**
  - General Administration (GA) **[Timeliness, Access]**
  - Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations

- Medical Management (MM) **[Timeliness, Access]**
- Member Information (MI) **[Quality]**
- Quality Management (QM) **[Quality]**
- Quality Improvement (QI) **[Quality, Access]**

Recommendation: HSAG recommends that DES/DDD leadership conduct a high-level assessment of the CM, CC, CIS, DS, GA, MCH, MM, MI, QM, and QI requirements to ensure ongoing oversight of compliance for these areas.

HSAG identified the following opportunities for improvement related to NAV:

- ALTCS-DD subcontracted health plans struggled to meet the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; Dentist, Pediatric; and Pharmacy standards **[Access]**
- Mercy Care DD struggled to meet the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric standards for CYE 2022 Quarter 4 (Q4) **[Access]**
- UHCCP DD failed to meet six of the 10 applicable standards in Apache County for CYE 2022 Q4 **[Access]**

Recommendation: HSAG recommends that:

- DES/DDD seek support from AHCCCS, as needed, to continue to monitor and maintain existing provider network coverage, with specific attention to ensuring the availability of adult and pediatric behavioral health outpatient and integrated clinics and adult cardiologists in Apache County
- Mercy Care DD continue to monitor and maintain its CYE 2022 Q4 provider network coverage, with specific attention to ensuring the availability of the following provider types:
  - Behavioral health outpatient and integrated clinics for adults in Apache County
  - Cardiologists for adults in Apache County
  - Pediatric dentists in La Paz County
- UHCCP DD should continue to monitor and maintain its existing provider network coverage as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types in Apache County:
  - Behavioral Health Outpatient and Integrated Clinics, Adult and Pediatric
  - Cardiologist, Adult and Pediatric
  - Dentist, Pediatric
  - Pharmacy

2. Introduction to the EQR Technical Report

This section provides the purpose and overview of this annual EQR technical report; CMS definitions for Quality, Timeliness, and Access; and an overview of how this EQR technical report is organized.

Description of EQR Activities

Table 2-1 and Table 2-2 describe the activities conducted for each Contractor in the ALTCS-EPD Program and ALTCS-DD Program.

ALTCS-EPD Program

Table 2-1 presents the EQR activities reviewed in this report for ALTCS-EPD Program Contractors.

Table 2-1—EQR Activities Presented in the CYE 2022 External Quality Review Annual Technical Report for the ALTCS-EPD Program

Contractors Reviewed	Performance Measure Validation (PMV)*	*Breast Cancer Screening* Performance Improvement Project (PIP) Validation**	Compliance Reviews (Operational Reviews)**	Network Adequacy Validation (NAV)**
BUFC LTC	✓	✓	✓	✓
Mercy Care LTC	✓	✓	✓	✓
UHCCP LTC	✓	✓	✓	✓

*See performance measure list on page 4-1.

**For additional information and Contractor-specific findings for PIP validation, compliance reviews, and network adequacy validation, see Section 5. ALTCS-EPD Program Contractor-Specific Results.

ALTCS-DD Program

Table 2-2 presents the EQR activities reviewed in this report for the ALTCS-DD Program.

Table 2-2—EQR Activities Presented in the CYE 2022 External Quality Review Annual Technical Report for the ALTCS-DD Program

Contractors Reviewed	Performance Measure Validation*	*Back To Basics* PIP Validation**	Compliance Reviews (Operational Reviews)**	Network Adequacy Validation**
DES/DDD	✓	✓	✓	✓

*See performance measure list on page 6-2.

**For additional information and Contractor-specific findings for PIP validation, compliance reviews, and network adequacy validation, see Section 6. ALTCS-DD Program Results.

Assessing Quality, Timeliness, and Access

HSAG used the following CMS) definitions to evaluate and draw conclusions about the performance of the Medicaid Contractors in each of the domains of Quality, Timeliness, and Access. For more information on how HSAG assessed the Quality, Timeliness, and Access domains for each activity, see Appendix A. Methodology—How Conclusions Were Drawn.

Quality

CMS defines "Quality" in 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 (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through:
>
> - Its structural and operational characteristics
> - The provision of services that are consistent with current professional, evidence-based knowledge
> - Interventions for performance improvement[2-1]

Timeliness

The National Committee for Quality Assurance (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."[2-2] NCQA further states that the intent of this standard is to minimize any disruption in

[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] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

the provision of healthcare. HSAG extends this definition of "Timeliness" to include other managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing appeals and providing timely care.

Access

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).[2-3]

Overview of the Report Sections

Section 1—Executive Summary describes the authority under which the report must be provided, as well as the Contractors reviewed during CYE 2022. In addition, this section includes a program-level summary of strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

Section 2—Introduction to the EQR Technical Report provides the purpose and overview of this annual EQR technical report; CMS definitions for Quality, Timeliness, and Access; and an overview of how this EQR technical report is organized.

Section 3—Overview of AHCCCS provides a description of AHCCCS':

- Medicaid Managed Care Program History
- Waivers and Legislative Updates
- Strategic Plan
- Quality Initiatives
- Medicaid and CHIP Quality Strategy as well as HSAG's recommendations for targeting goals and objectives for quality improvement

Section 4—ALTCS-EPD Program-Level Comparative Results includes comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

Section 5—ALTCS-EPD Program Contractor-Specific Results provides (by Contractor) activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

This section also includes information about the extent to which each Contractor was able to address prior year's recommendations and Contractor best practices.

Section 6—ALTCS-DD Program Results provides, by EQR activity, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DES/DDD was able to address prior's year recommendations and DES/DDD's best practices.

Appendix A—Methodology presents, for each EQR activity:

- Objectives
- Technical methods of data collection
- Description of data obtained
- How data were aggregated and analyzed
- How conclusions were drawn

In addition, this section includes information about how program-level data were aggregated and analyzed.

Appendix B—Acknowledgements and Copyrights

3. Overview of AHCCCS

This section provides a description of AHCCCS':

- Medicaid Managed Care Program History
- Waivers and Legislative Updates
- Strategic Plan
- Quality Initiatives
- Medicaid and CHIP Quality Strategy, as well as HSAG's recommendations for targeting goals and objectives for quality improvement

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/or physical disabilities (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 28 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 the DCS CHP Program (previously Comprehensive Medical and Dental Program or CMDP).

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. 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, 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.

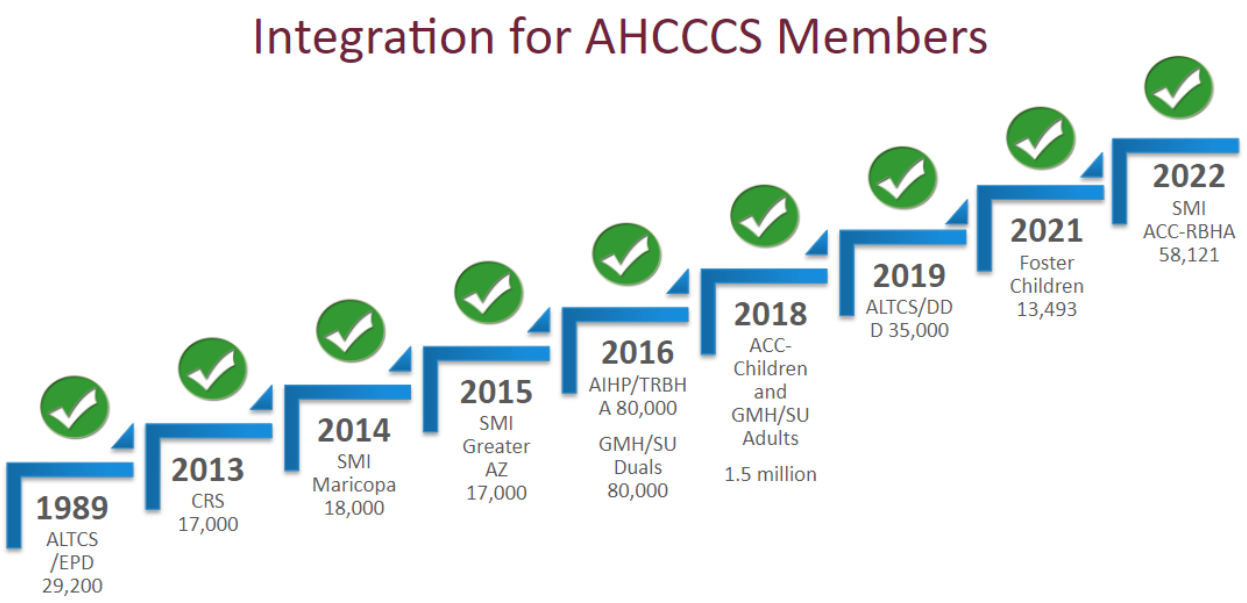
On April 1, 2014, approximately 17,000 members with SMI residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Beginning October 1, 2015, members residing in other counties were transitioned to one 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 access physical as well as general mental health and substance use behavioral healthcare services, previously provided through a RBHA, 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.

Effective October 1, 2022, AHCCCS expanded three ACC contracts to include RBHA services, thus furthering integration efforts, under the AHCCCS Complete Care – Regional Behavioral Health Agreement (ACC-RBHA) line of business (LOB). ACC-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.[3-1]



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.

[3-1] Effective October 1, 2022, the acronym 'RBHA' changed from Regional Behavioral Health Authority to Regional Behavioral Health Agreement. Services are provided by AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs).

AHCCCS Waivers and Legislative Updates

1115 Waiver Update

CMS approved Arizona's request for a five-year extension of its 1115 Waiver. This 1115 Waiver approval continues the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient, including integrated managed care for AHCCCS populations through ACC, ALTCS, the DCS CHP Program for children in foster care, and RBHAs, which provide integrated care for individuals with an SMI designation. In addition, CMS continued Arizona's waiver of retroactive eligibility, which authorizes AHCCCS to limit retroactive coverage to the first day of the month of application for all Medicaid members, except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age. In addition to renewing these historic programs, this 1115 Waiver includes approval for transformative projects intended to advance member health outcomes, including the 2.0 Targeted Investments Program (TI 2.0) and Housing and Health Opportunities (H2O) initiative.

Targeted Investments (TI) Program 2.0 Approved

AHCCCS partners with more than 120,000 registered providers across the state to provide healthcare services to Medicaid members. For the last five years, the Targeted Investments Program has helped providers integrate physical and behavioral healthcare at the point of service, increasing members' access to a full array of services and demonstrating significant improvements in health outcomes. TI 2.0 will extend the program to additional providers and continue provider incentive funding to further integration efforts, including a range of initiatives aimed at addressing social drivers of health and inequitable health outcomes.

Housing and Health Opportunities (H2O) Approved

CMS approved the new Housing and Health Opportunities project to further address health-related social needs for vulnerable populations and ensure their access to healthcare. For many years, Arizona has prioritized housing and used State General Fund dollars to support rental subsidies for nearly 3,000 individuals experiencing homelessness each year. AHCCCS and its contracted health plans have successfully leveraged this experience to expand the reach of housing opportunities, improve member health outcomes, and reduce overall healthcare costs. Recognizing that stable housing is an important component of overall health, CMS approved the H2O Program to strengthen outreach to vulnerable Medicaid members, including those experiencing homelessness, those living with an SMI, and young adults transitioning out of the foster care system. AHCCCS will be able to reimburse for up to six months of medically necessary transitional housing specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, institutions for mental diseases (IMDs), correctional facilities, and hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as

defined by 24 CFR 91.5; and enhance those services that support a member's success in housing, like tenant rights education, eviction prevention, housing transition navigation services, and medically necessary home modifications.

Tribal Dental Benefit Added

In 2020, the Arizona State Legislature approved a dental benefit expansion for American Indian/Alaska Native (AI/AN) members over the age of 21 receiving dental services at Indian Health Service (IHS) or Tribal 638 facilities. The benefit expansion removes the $1,000 limit on both the adult emergency dental benefit and the separate $1,000 limit on routine dental services rendered to adult AI/AN members enrolled in the Arizona Long Term Care System (ALTCS), when these services are rendered by Indian Health Service or Tribal 638 facilities.

This waiver approval allows AHCCCS to reimburse Indian Health Services and Tribal 638 facilities for medically necessary, AHCCCS covered dental services provided to AI/AN adult members beyond the existing $1,000 limits. The $1,000 adult emergency benefit limit and the $1,000 ALTCS adult routine benefit limit remains in place for dental services provided to American Indian/Alaska Native (AI/AN) members outside of the Indian Health Service (IHS) or Tribal 638 system.

Negotiations Continue on Traditional Healing and In-Reach Services

In its approval notice, CMS recognized the State's continued interest in reimbursing for traditional healing services offered by tribal nations. In their approval letter, CMS committed to further conversations aimed at approval for Arizona's traditional healing waiver request. Additionally, CMS noted its willingness to further explore reimbursement for pre-release services for individuals in federal, state, local, and tribal correctional facilities.

The Waiver approval is effective October 14, 2022, through September 30, 2027. All documents, including the original and amended waiver applications and the approval letter from CMS, are posted on the AHCCCS 1115 Waiver 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 to:

- 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 and
- Remove cost sharing and other administrative requirements to support continued access to services

[3-2] Arizona Section 1115 Demonstration Waiver. Available at: https://www.azahcccs.gov/Resources/Federal/waiver.html. Accessed on Nov 29, 2022.

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.[3-3]

1115 Waiver Evaluation Update

In accordance with Special Terms and Conditions (STC) 59, 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, 2023, respectively.

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

- ACC Program
- ALTCS Program
- CMDP
- RBHAs
- Targeted Investments (TI) Program
- Retroactive Coverage Waiver
- 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 pandemic, 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 beneficiary survey data, were not collected.

[3-3] COVID-19 Federal Emergency Authorities Request. Available at: https://www.azahcccs.gov/Resources/Federal/PendingWaivers/1135.html. Accessed on Nov 29, 2022.

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. CMS approved AHCCCS' Interim Evaluation Report[3-4] on October 6, 2022.

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, and CMS approved the plan on February 1, 2022.

Going forward, AHCCCS will work with HSAG on the demonstration's Summative Evaluation Report, in alignment with the approved Evaluation Design. The Summative Evaluation Report will include a longer implementation period with more robust analysis and promises to provide additional evidence to support a fuller understanding of the effects of each of the programs included on the demonstration.

Legislative Update

The Arizona State Legislature passed a number of House Bills (HBs) in the 2022 legislative session that will have impacts on the agency including:

- HB 2157 (supplemental appropriations; community-based services) provided expenditure authority to AHCCCS for implementation of its American Rescue Plan Act HCBS spending plan for SFY 2022, with certain reporting requirements and other provisions. HB 2157 was signed into law and went into effect on March 1, 2022.
- HB 2551 (CHIP; redetermination) requires AHCCCS to allow a member who is determined eligible for CHIP to maintain coverage for a period of 12 months, unless the member exceeds the age of eligibility during that 12-month period, with additional specific exceptions. Contingent upon CMS approval.
- HB 2622 (eligibility; AHCCCS) requires AHCCCS to annually renew eligibility of individuals within the foster care system until age 26, with certain specific exceptions, contingent upon CMS approval.
- HB 2691 (healthcare workforce; grant programs) creates a variety of programs to promote healthcare workforce development, including certain grant programs to be administered through AHCCCS, including the Student Nurse Clinical Rotation and Licensed or Certified Nurse Training Pilot Program and the Behavioral Health Pilot Program.
- HB 2862/HB 2863 (budget bills) contain appropriations for state agencies and programs. Specific to the AHCCCS Administration, the budget included the following items:

[3-4] AHCCCS' Interim Evaluation Report. Available at: https://www.azahcccs.gov/Resources/Reports/federal.html. Accessed on Nov 29, 2022.

- Additional funding for providers of services for elderly and physically disabled individuals
- Additional funding for increased reimbursement rates for behavioral health outpatient services and the Global Obstetric Package
- Expansion of covered services, to include chiropractic services and outpatient diabetes self-management training education, contingent upon CMS approval
- Funding to extend postpartum eligibility to 12 months, contingent upon CMS approval
- Funding for critical IT projects, such as a system integrator for AHCCCS' Medicaid Enterprise System (MES) Modernization, and funding to come into compliance with federal interoperability regulations

The Arizona Legislature adjourned Sine Die on June 24, 2022; the general effective date for legislation is September 24, 2022. The 2023 legislative session began January 9, 2023, and was underway at the time of writing this report.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for SFY 2023[3-5] presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The Strategic Plan identifies AHCCCS' mission, vision, and core values:

- 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 three multi-year strategies:

1. Provide equitable access to high quality, whole-person care
   - Increase the amount of funding to direct care workers providing home and community based services
   - Reduce health disparities
   - Increase available housing and supports
   - Improve AHCCCS member connectivity to critical social services
2. Implement solutions that ensure optimal member and provider experience
   - Finalize roadmap, detailing the modernization of AHCCCS' Medicaid Enterprise System
   - Improve transparency into delivery system performance

[3-5] AHCCCS Fiscal Year 2023 Strategic Plan 2-pager. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2023_2-Page_StrategicPlan.pdf. Accessed on: Nov 29, 2022.

3. Maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations
   - Improve employee engagement
   - Reduce the amount of time that positions remain vacant

Key Initiatives and Accomplishments for AHCCCS

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving the quality of systems, care, and services. AHCCCS provided the July 2022 enhanced Quality Strategy and Quality Strategy Evaluation, the AHCCCS Strategic Plan State Fiscal Years 2023–2027, and AHCCCS' quarterly quality assurance/monitoring activity reports. These documents 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 to improve member health outcomes.

AHCCCS has created a webpage to outline current initiatives[3-6] 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, and working with private sector partners to further innovation to the greatest extent. This web page highlights ongoing and completed initiatives with links to more detailed information, and is updated as more information becomes available.

Following are key AHCCCS accomplishments related to the AHCCCS SFY 2021 Strategic Plan.

Accessing Behavioral Health Services in School

AHCCCS partners with the Arizona Department of Education and others to ensure students, whether Medicaid-eligible or not, can receive behavioral health services either provided in a school setting or through a referral from a school.

Jake's Law and The Children's Behavioral Health Services Fund[3-7]

In 2020, the Arizona State Legislature allocated $8 million for behavioral health services in school settings for students who are underinsured or uninsured. This special allocation of one-time state funding, known as the Children's Behavioral Health Services Fund or Jake's Law, allows schools to refer students for behavioral health services for anxiety, depression, social isolation, stress, behavioral issues, or any other mental health concern. Families will not receive a bill for these services; they are

[3-6] AHCCCS Initiatives and Best Practices. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/. Accessed on: Dec 3, 2022.
[3-7] Accessing Behavioral health in Schools. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/. Accessed on: Dec 3, 2022.

covered by tax dollars. Jake's Law requires that 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. In CYE 2022, behavioral health services under this funding were provided to students by participating healthcare providers contracted with the three RBHAs: Mercy Care (in Central Arizona), Arizona Complete Health Complete Care (in Southern Arizona), and Health Choice Arizona (in Northern Arizona).

Building A Healthcare System: Care Coordination and Integration

AHCCCS has various initiatives[3-8] 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.

Improving Behavioral Health and Physical Healthcare Coordination for Individuals with an SMI Designation

On October 1, 2022, AHCCCS updated its contracts[3-9] with MCOs for health insurance coverage for individuals with an SMI designation. Three ACC Contractors now have expanded responsibilities as an ACC-RBHA Contractor[3-10] to include the provision of integrated care addressing physical health and behavioral health for members with an SMI designation and the first 24-hours of Crisis Services. 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.

Medicare and Medicaid Alignment for Dual Eligibles: Alignment Makes a Difference[3-11]

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 180,000 Arizonians who are eligible for both Medicare and Medicaid, navigating these two separate systems of care can be overwhelming. Under these circumstances, it is more likely for individuals to fall through the cracks, receive inefficient care, and not achieve optimal health outcomes.

[3-8] Building an Integrated Health Care System and Improving Care Coordination. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/. Accessed on Dec 3, 2022.
[3-9] Behavioral Health Contracts. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html. Accessed on: Dec 3, 2022.
[3-10] Effective October 1, 2022, the acronym 'RBHA' changed from Regional Behavioral Health Authority to Regional Behavioral Health Agreement. Services are provided by AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs).
[3-11] Individuals Covered By Both Medicare and Medicaid (Dual Eligible Members). Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html. Accessed on: Dec 3, 2022.

AHCCCS continues developing integration initiatives to increase alignment and improve service delivery for individuals covered by both Medicare and Medicaid. This health system fragmentation often results in poor communication, uncoordinated healthcare decisions and a lack of a patient-centered perspective. 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 ACC Medicaid health plan. Requiring each ACC 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.

Simplifying the System of Care for Children with Special Healthcare Needs: Children's Rehabilitative Services (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, 2019, members enrolled with DES/DDD use their assigned DES/DDD plan for all of their non-CRS physical health and behavioral health services. DES/DDD continues to provide long-term care services for these members. Members who qualify for a CRS designation and are not enrolled with DES/DDD have a choice of ACC plans in their service area. The ACC plan manages care for all services[3-12] (including CRS, other non-CRS physical health services, and all covered behavioral health services).

Foster care members receive CRS and non-CRS physical healthcare services from Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP) through the Department of Child Safety. American Indian and Alaska Native members with a CRS designation have a choice of an ACC Plan or the American Indian Health Program.

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[3-13] leaving the criminal justice system. A significant number of men, women, and children transitioning out of jail and

[3-12] What is Children's Rehabilitative Services (CRS) Designation? Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html. Accessed on: Dec 3, 2022.
[3-13] Support for Individuals Involved in the Justice System. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html. Accessed on: Dec 3, 2022.

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.

Awards, Studies, and Highlights

Medicaid Innovator Award[3-14]

AHCCCS received a 2022 Medicaid Innovation Award presented by the Robert Wood Johnson Foundation and the National Academy for State Health Policy. The nonpartisan award recognizes states for demonstrating creativity, leadership, and progress in their Medicaid programs despite significant public health challenges in recent years.

AHCCCS received the award for its work on initiatives to address social determinants of health and their impact on whole person care. Specifically, AHCCCS was recognized for developing the Whole Person Care Initiative, which offers a range of support services to members, including transitional housing; referrals for and transportation to community-based services such as employment and food assistance, and long-term care services to reduce social isolation.

Office of Individual and Family Affairs[3-15]

The AHCCCS Office of Individual and Family Affairs (OIFA) works to engage the community and ensure that members and their families have a voice in the agency's decisions. OIFA takes pride in helping members and family members in the behavioral public health system. The three core areas to which OIFA dedicates its efforts are:

- Bringing in the member and family member voice

[3-14] States Recognized for Medicaid Program Innovations. Available at: https://www.rwjf.org/en/library/articles-and-news/2022/08/states-recognized-for-medicaid-program-innovations.html?cid=xrs_rss-nr. Accessed on: Dec 3, 2022.
[3-15] OIFA 2021 Year in Review. Available at: https://www.azahcccs.gov/shared/Downloads/News/2022/2021_OIFA_YearInReview.pdf. Accessed on: Dec 3, 2022.

- Helping individuals navigate the behavioral health system
- Ensuring peer support services and family support services are available throughout Arizona

State Efforts to Address Medicaid Home and Community Based Services[3-16]

The Medicaid and CHIP Payment and Access Commission (MACPAC) recognized Arizona's efforts to identify and manage barriers to home- and community-based worker recruitment and retention. by inviting AHCCCS to serve as a panelist for a workforce discussion. Arizona was recognized by CMS in the Direct Service Workforce Learning Collaborative - Summary Report study published in February 2023. This report summarized various innovative programs and approaches undertaken by state Medicaid programs that were designed to build capacity in the direct service workforce.

Two of Arizona's workforce development initiatives were cited in this report.

- The Arizona Department of Education's Home Health Aide/Direct Care Worker Training Program is a partnership with the Career and Technical Education Centers of 20 high schools across the state. The program is designed to create a pipeline of Direct Care Worker (DCW) qualified high school graduates into the DCW workforces. Like all DCW training programs, each high school program must be approved by AHCCCS and operate in accordance with the standards of the AHCCCS Contractor Operations Manual 429 Direct Care Worker Training and Testing Program. Currently the program graduates approximately 800 DCW qualified students annually.
- Mercy Care (AHCCCS MCO) and Solterra (a senior living company) were recognized by CMS for creating an innovative approach to recruiting DCWs. Called Careworks, this program has several aims:
  - Develop new DCW talent pools
  - Shift social perceptions of caregiving
  - Provide career counseling to middle and high school students about the value of beginning a health career as a DCW
  - Develop an apprenticeship program for DCWs that will provide free tuition and hourly compensation for a caregiver certificate as well as a care-giving coach to every applicant

Additional Highlights

- During the COVID-19 PHE, AHCCCS used innovative approaches to expand telehealth utilization and allow providers to accept verbal consent to expedite service referrals supported ongoing delivery of services.
- AHCCCS continued collaborative efforts with Mercy Care through the RBHA in Maricopa County to ensure member access to needed services such as assertive community treatment (ACT).

[3-16] State Efforts to Address Medicaid Home and Community Based Services. Available at: https://www.azahcccs.gov/shared/Downloads/News/2022/220322_MACPAC-brief-on-HCBS-workforce.pdf. Accessed on: Dec 3, 2022.

Maricopa County has greater capacity to provide ACT than most comparison communities. It is estimated that 4.3 percent of adults with an SMI need an ACT level of care. Few communities around the country provide ACT to 4.3 percent or more of their adults who have SMI, but 6.2 percent of adults with SMI in Maricopa County received ACT in 2021.[3-17]

- In part because of partnerships with AHCCCS and stakeholders, supportive housing and supported employment services are more available in Maricopa County (especially for Medicaid recipients) than nationwide.[3-15]
- Through ongoing efforts supported by AHCCCS, the supported employment utilization rate is 32 percent and the ongoing supported employment utilization rate is 5 percent, among the highest in a benchmark analysis of comparable service delivery systems nationwide. Utilization rates among adults with SMI in Maricopa County increased from 2.5 percent in 2013 to 7.0 percent in 2021.[3-15]
- AHCCCS continues to partner with Mercy Care and direct care providers to encourage positive health outcomes for members. In 2022, 91 percent of individuals responded that they felt comfortable talking to their doctor about medications and how it made them feel, a continued increase from the 2021 response rate (89 percent). Medication services are identified as one of the most readily available services within 15 days.[3-18]
- As part of continuous quality improvement efforts supported by AHCCCS and stakeholders, 86 percent of sampled member cases reviewed included an Individual Service Plan (ISP) with services based on the member's needs, a continued improvement since the 2020 review (70 percent).[3-16]
- AHCCCS provided ongoing support to direct service providers in the utilization of technical assistance related to ongoing fidelity reviews. All direct service providers reviewed in 2021 met Substance Abuse and Mental Health Services Administration (SAMHSA) fidelity review guidelines for evidence-based practice.[3-19]

[3-17] Mercer Government Human Consulting Services, "Service Capacity Assessment Priority Mental Health Services 2022: Arizona Health Care Cost Containment System," Available at: www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2022/2022AnnualServiceCapacityAssessment.pdf. Accessed on: Nov 3, 2022.

[3-18] Mercer Government Human Consulting Services, "Quality Service Review 2022: Arizona Health Care Cost Containment System," Available at: www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2022/2022AnnualQSR_Report.pdf. Accessed on: Nov 3, 2022.

[3-19] WICHE Behavioral Health Program, "FY 2021-2022 (Year 8) Evidence Based Practices Fidelity Project: Arizona Health Care Cost Containment System," Available at: www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2022/WICHE_Year_8_EndOfYearReport-FINAL09072022.pdf. Accessed on: Nov 3, 2022.

2022 AHCCCS Year in Review

In 2022, AHCCCS enhanced healthcare service delivery, increased its use of technology to serve customers, and received national recognition for innovative work to address health-related social needs. During CY 2022[3-20], AHCCCS:

- Obtained 1115 Waiver renewal, sustaining historic innovations like managed care and the provision of home- and community-based services (HCBS) while extending the TI Program to offer incentive funding to providers who meet specific integrated care milestones and implementing the H2O demonstration.
- Received the 2022 Medicaid Innovations Award from the Robert Wood Johnson Foundation and the National Academy for State Health Policy, recognizing AHCCCS' work to advance whole-person care and address social drivers of health and inequitable health outcomes.
- Received CMS approval of the American Rescue Plan Act spending plan to allocate $1.5 billion to improving HCBS programs.
- Implemented the ACC-RBHA LOB serving individuals with an SMI designation and serving all Arizonans during the first 24 hours of crisis services. Efforts also included integrating the national 988 suicide and crisis hotline, and implementing a single, statewide crisis line (1-844-534-4673) and crisis text line (4HOPE).
- Integrated 424 American Indian and Alaska Native individuals with an SMI designation into the American Indian Health Program on October 1, 2022.
- Helped to create the Arizona Perinatal Access Line to provide real-time perinatal psychiatric consultation to primary care practitioners serving pregnant and postpartum members.
- Created a COVID-19 PHE vaccination dashboard and a performance measure data dashboard consistent with AHCCCS' commitment to enhance program performance transparency.
- Launched the AHCCCS Virtual Assistant (AVA) to handle the 25 most-asked eligibility-related questions, resulting in 12 percent fewer calls to the Division of Member and Provider Services member contact unit.
- Allocated over $25 million in Substance Abuse Block Grant COVID-19 Supplemental Funds for substance use harm reduction efforts, treatment and recovery services, and primary prevention services and $30 million in Mental Health Block Grant funding to support and expand the spectrum of mental health services available to children and adults, including First Episode Psychosis programs and school-based youth engagement specialists.
- Expanded recovery housing options and funded the first mobile medication-assisted treatment (MAT) unit with State Opioid Relief grant dollars.
- Successfully negotiated revisions to a 20-year-old agreement between the Arizona and Hawaii Medicaid programs, allowing the longstanding partnership that shares a MES to continue. The MES handles functions such as claims payment, provider enrollment, and electronic visit verification.

[3-20] 2022 AHCCCS Year in Review. Available at: https://www.azahcccs.gov/shared/Downloads/News/2023/2022YearInReview_220111.pdf. Accessed on Jan 13, 2023.

- Engaged more than 50,000 members, families, and providers in stakeholder events, launched the AHCCCS Explains video series featuring employees, and enhanced social media platforms to increase reach by 71 percent.

AHCCCS' Quality Strategy

In accordance with 42 CFR §438.340 and 42 CFR §457.1240(e), AHCCCS created the AHCCCS Quality Strategy and Quality Strategy Evaluation. During CYE 2021, AHCCCS enhanced its Quality Strategy by reevaluating its 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 EQR Reports).

The AHCCCS Quality Strategy 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 public comments and additional feedback obtained following stakeholder presentations.

- The AHCCCS Quality Strategy Evaluation is a companion document to the AHCCCS Quality Strategy for the purpose of evaluating the effectiveness of the AHCCCS Quality Strategy
- AHCCCS' enhanced Quality Strategy and Quality Strategy Evaluation were submitted to CMS in July 2021 and posted to AHCCCS' website

AHCCCS will initiate its efforts to update its Quality Strategy and Quality Strategy Evaluation in July 2023 in preparation for submitting the documents to CMS in July 2024.

Goals and Objectives

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

- Enrich the member experience through an integrated approach to service delivery
- Improve information retrieval and reporting capability by establishing new, and upgrading existing, information technologies, thereby increasing responsiveness and productivity
- Enhance current performance measures, PIPs, and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs
- Drive the improvement of member-centered outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes

Quality Goal 2: Improve the health of AHCCCS populations

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

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

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

Quality Goal 4: Enhance data system and performance measure reporting capabilities

- Evaluate current data system infrastructure
- Identify system and process limitations impacting performance measure reporting and analysis
- Leverage various data sources to produce comprehensive reliable data:
  - Collaborate with external stakeholders to facilitate access to supplemental data sources
  - Explore means for collecting and reporting performance measure data utilizing electronic health record (EHR) methodologies
- Drive continuous delivery system performance through advanced data analytics and disparity analyses

Recommendations

- HSAG noted that, with few exceptions, the indicator rates related to the *Back to Basics* PIP for DES/DDD declined during the intervention years when compared to the baseline year (CYE 2019). This decline may be due to the COVID 19 PHE. HSAG recommends that AHCCCS encourage DES/DDD to leverage existing member and provider messaging to include education about the COVID-19 PHE and safely receiving these services moving forward. Messaging should consider any specific barriers in local communities to accessing these services and how to effectively manage those barriers in a way that will address members' individual needs, as needed, within their local community.
- HSAG also recommends that AHCCCS continue to seek Contractor input and proposals when developing value-based payment models.

4. ALTCS-EPD Program-Level Comparative Results

This section includes comparative results organized by EQR-related activity, strengths, opportunities for improvement, and HSAG's recommendations for program-level performance improvement.

Performance Measure Validation

During CYE 2022, HSAG evaluated each ALTCS-EPD Program Contractor's data system for processing of each data type used for reporting the Contractor's CY 2021 performance measure data in alignment with the CMS EQR Protocol 2 audit requirements.[4-1] A summary of these findings by ALTCS-EPD Program Contractor is provided in Table 4-1. Table 4-1 also displays whether each ALTCS-EPD Program Contractor met the assessed Information Systems (IS) standards, which demonstrates whether the Contractor has effective IS practices and control procedures for data reporting. Additional information about each ALTCS-EPD Program Contractor's general findings for each data type reviewed can be found in Section 5, ALTCS-EPD Program Contractor-Specific Results. Additional information regarding the CMS EQR Protocol 2 audit requirements, including more information about the levels of scoring, can be found in Appendix A—Validation of Performance Measures.

Table 4-1—Performance Measures Validation Contractor Comparison: CMS EQR Protocol 2 Validation Results for ALTCS-EPD Program Contractors

Data Type	BUFC LTC	Mercy Care LTC	UHCCP LTC
Medical Services Data	*Met*	*Met*	*Met*
Enrollment Data	*Met*	*Met*	*Met*
Provider Data	*Met*	*Met*	*Met*
Medical Record Review Processes	*NA*	*Met*	*Met*
Supplemental Data	*Met*	*Met*	*Met*
Data Preproduction Processing	*Met*	*Met*	*Met*
Data Integration and Reporting	*Met*	*Met*	*Met*

NA indicates that the ALTCS-EPD Program Contractor did not calculate measures using the hybrid methodology.

[4-1] 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: May 4, 2022.

ALTCS-EPD Program-Level Results

Table 4-2 presents the CY 2021 aggregate performance measure results for the ALTCS-EPD Program Contractors. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. 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. Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology. ALTCS-EPD Program Aggregate rates denoted with a plus sign (+) indicate the measures were reported using a statewide weighted average that blended administrative and hybrid rates, since some ALTCS-EPD Program Contractors did not report the measure using hybrid methodology.

Table 4-2—CY 2021 Performance Measure Results for ALTCS-EPD Program Contractors

Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	ALTCS-EPD Program Aggregate
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	45.2%	72.1%	80.2%	72.0%
Effective Continuation Phase Treatment	26.2%	64.5%	71.7%	62.6%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	NA	48.0%	38.0%	44.4%
30-Day Follow-Up—Total	NA	52.0%	48.0%	51.6%
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	43.5%	47.1%	53.4%	48.9%
Engagement of AOD Treatment—Total	5.7%	5.7%	5.9%	5.8%
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	62.1%	21.9%+	29.7%+	33.0%+
Controlling High Blood Pressure				
Controlling High Blood Pressure	46.9%	71.3%+	75.9%+	68.2%+
Pediatric Health				
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	38.0%	41.9%	43.0%	41.5%
Annual Dental Visit				
Annual Dental Visit[1]	46.0%	54.6%	47.7%	51.2%
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	38.6%	32.1%	38.3%	35.4%

Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	ALTCS-EPD Program Aggregate
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	49.6	56.0	62.4	56.6
Plan All-Cause Readmissions				
*O/E Ratio—Total**	0.8150	0.6766	0.6586	0.7015
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	9.3%	12.8%	11.4%	11.9%

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).
[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2021 national Medicaid mean.
Cells shaded green indicate that the rate met or exceeded the MY 2021 national Medicaid mean.

Table 4-3 presents the CY 2020 and CY 2021 ALTCS-EPD Program Aggregate for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). ALTCS-EPD Program Aggregate rates denoted with a plus sign (+) indicate the measures were reported using a statewide weighted average that blended administrative and hybrid rates, since some ALTCS-EPD Program Contractors did not report the measure using hybrid methodology.

Table 4-3—CY 2020 and CY 2021 Performance Measure Aggregate Results for ALTCS-EPD Program Contractors

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	72.6%	72.0%	→
Effective Continuation Phase Treatment	63.0%	62.6%	→
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total	36.6%	44.4%	→
30-Day Follow-Up—Total	49.7%	51.6%	→
Initiation and Engagement of AOD Abuse or Dependence Treatment			
Initiation of AOD Treatment—Total	50.8%	48.9%	→
Engagement of AOD Treatment—Total	4.3%	5.8%	→

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care—HbA1c Poor Control (>9%)			
*HbA1c Poor Control (>9.0%)**	39.4%+	33.0%+	↑
Controlling High Blood Pressure			
Controlling High Blood Pressure	—	68.2%+	—
Heart Failure Admission Rate			
Heart Failure Admission Rate	—	166.2	—
Pediatric Health			
Child and Adolescent Well-Care Visits			
Child and Adolescent Well-Care Visits	—	41.5%	—
Annual Dental Visit			
Annual Dental Visit[1]	—	51.2%	—
Preventive Screening			
Breast Cancer Screening			
Breast Cancer Screening	36.3%	35.4%	→
Appropriate Utilization of Services			
Ambulatory Care—ED Utilization			
*Ambulatory Care—ED Utilization**	—	56.6	—
Plan All-Cause Readmissions			
*O/E Ratio—Total**	—	0.7015	—
Use of Opioids at High Dosage			
*Use of Opioids at High Dosage**	—	11.9%	—

* A lower rate indicates better performance for this measure.
+ Indicates the measure was calculated via mixed methodology in scenarios where one or more Contractors calculated the measure using administrative methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.
— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.
NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).
[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.
[2] Aggregated rates were calculated and compared from MY 2020 to MY 2021, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.

Table 4-4 highlights the ALTCS-EPD Program Contractors' performance for the current year by measure group. The table illustrates the Contractors' CY 2021 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2021 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

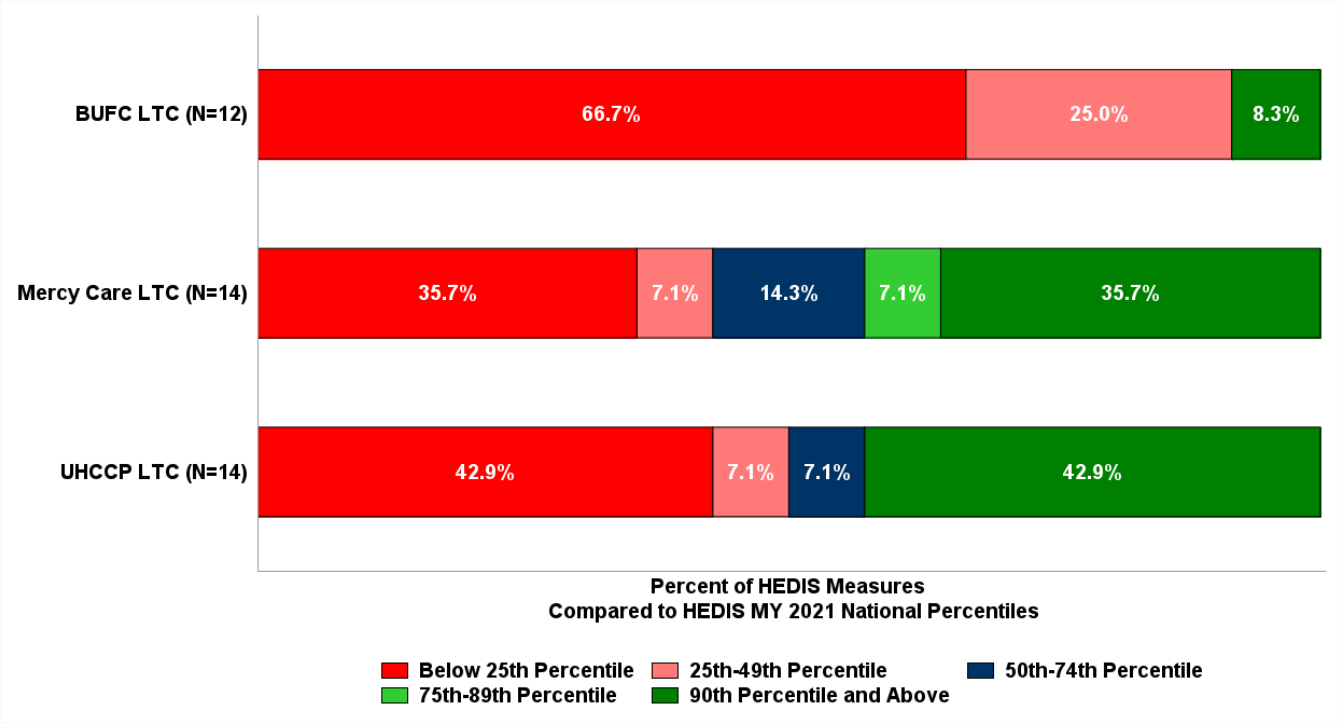
Table 4-4—CY 2021 National Percentiles Comparison for ALTCS-EPD Program Contractors

Measure	BUFC LTC	Mercy Care LTC	UHCCP LTC	ALTCS-EPD Program Aggregate
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	★	★★★★★	★★★★★	★★★★★
Effective Continuation Phase Treatment	★	★★★★★	★★★★★	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	NA	★★★★	★★★	★★★
30-Day Follow-Up—Total	NA	★★	★	★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	★★	★★★	★★★★★	★★★★
Engagement of AOD Treatment—Total	★	★	★	★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
HbA1c Poor Control (>9.0%)	★	★★★★★	★★★★★	★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	★	★★★★★	★★★★★	★★★★
Pediatric Health				
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	★	★	★	★
Annual Dental Visit				
Annual Dental Visit[1]	★★	★★★	★★	★★★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	★	★	★	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
Ambulatory Care—ED Utilization	★★	★	★	★
Plan All-Cause Readmissions				
O/E Ratio—Total	★★★★★	★★★★★	★★★★★	★★★★★
Use of Opioids at High Dosage				
Use of Opioids at High Dosage	★	★	★	★

NA indicates that the ALTCS-EPD Program Contractor was not required to report the measure (i.e., small denominator).
[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to national percentiles.

Figure 4-1 displays the ALTCS-EPD Program Contractors' HEDIS CY 2021 performance compared to NCQA CY 2021 National Percentiles. HSAG analyzed results from 11 performance measures for HEDIS CY 2021 for a total of 14 measure rates.

Figure 4-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for ALTCS-EPD Contractors



ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measure Validation

Table 4-5 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-EPD Program related to performance measures.

Table 4-5—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group: • The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure rates for two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rates met or exceeded the NCQA

Strengths, Opportunities for Improvement, and Recommendations
Quality Compass national Medicaid HMO mean for HEDIS MY 2021. These results may indicate that members with a diagnosis of major depression who were enrolled with the two ALTCS-EPD Program Contractors may be 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.[4-2] **[Quality]** • The *Initiation and Engagement of AOD or Dependence Treatment—Initiation of AOD Treatment—Total* measure rates for two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. These results may indicate that members enrolled with the two ALTCS-EPD Program Contractors may be initiating in AOD treatment, which, 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.[4-3] **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • The *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure rate for two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021, indicating that members with diabetes enrolled with the two ALTCS-EPD Program Contractors may be able to manage their condition 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.[4-4] **[Quality]** • The *Controlling High Blood Pressure* measure rate for two of the three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021, indicating that members enrolled with the two ALTCS-EPD Program Contractors who had a hypertension diagnosis may have had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[4-5] **[Quality]**
In the Appropriate Utilization of Services measure group, the *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate for all ALTCS-EPD Program Contractors as well as the ALTCS-EPD

[4-2] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 10, 2023.
[4-3] National Committee for Quality Assurance. Initiation and Engagement of AOD Abuse or Dependence Treatment. Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 21, 2023.
[4-4] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
[4-5] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**]
Opportunities for Improvement and Recommendations
In the Behavioral Health Care measure group, the rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile, indicating that members who initiated in AOD treatment may not have had two or more additional AOD treatment services or medication-assisted treatment (MAT) in the 34 days following their 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.[4-6] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors conduct a root cause analysis or focus study to determine why some members were not accessing AOD services or MAT following their initiation visit. The ALTCS-EPD Program 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 ALTCS-EPD Program Contractors should identify factors related to the COVID-19 PHE and how access to care was impacted. 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 ALTCS-EPD Program Contractors should implement appropriate interventions to improve performance related to engaging in timely treatment following the initiation visit.
In the Preventive Screening measure group, the rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Breast Cancer Screening* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile, indicating that some women may not be receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[4-7] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]**

[4-6] National Committee for Quality Assurance. Initiation and Engagement of AOD 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 30, 2023.

[4-7] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors conduct a root cause analysis or focus study to determine why some female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, the ALTCS-EPD Program Contractors should implement appropriate interventions to improve the performance related to these preventive screenings. (Of note, the ALTCS-EPD Program Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address this measure.)
In the Pediatric Health measure group, the rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Child and Adolescent Well-Care Visits* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile, indicating that some children and adolescents may not be receiving well-care visits. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[4-8] **[Quality, Access]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors conduct a root cause analysis or focus study to determine why some children and adolescents did not receive well-care visits. Upon identification of a root cause, the ALTCS-EPD Program Contractors should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.
In the Appropriate Utilization of Services measure group, the rates for all three ALTCS-EPD Program Contractors and the ALTCS-EPD Program Aggregate rate for *Use of Opioids at High Dosage* did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 and fell below the 25th percentile. These results indicate that there is an opportunity for the ALTCS-EPD Program Contractors to better monitor prescribing and utilization data and implement interventions to improve care and services around opioid prescribing. The Centers for Disease Control and Prevention (CDC) guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MED) and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[4-9] **[Quality]** Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify

[4-8] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%2015%20months%20of%20life. Accessed on: Mar 6, 2023.

[4-9] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Mar 7, 2023.

Strengths, Opportunities for Improvement, and Recommendations
members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.[4-10] Each ALTCS-EPD Program Contractor should report any completed prescription opioid monitoring effort enhancements to AHCCCS.
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.

Performance Improvement Projects

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,[4-11] and accounts for 15 percent of all new cancer diagnoses in the U.S.[4-12] Ensuring that all women receive regular breast cancer screening is critically important in disease prevention, early detection, and treatment. Breast cancer screening for women is aimed at identifying breast abnormalities as early as possible, and ideally before warning signs or symptoms are present, when the chances of survival are the highest. Even if breast cancer incidences cannot be substantially reduced for some women who are at high risk for developing the disease, the risk of death from breast cancer can be reduced by regular screenings.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Breast Cancer Screening* PIP for the ALTCS-EPD Program. The objective of the *Breast Cancer Screening* PIP is to increase the number and percentage of breast cancer screenings.

ALTCS-EPD Program-Level Results

Based on HSAG's PMV for ALTCS-EPD Program Contractors, HSAG determined that the CY 2021 indicator rates used for the *Breast Cancer Screening* PIP were valid and reliable.

[4-10] National Committee for Quality Assurance. Use of Opioids at High Dosage (HDO). Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Feb 17, 2023.
[4-11] 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.
[4-12] 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 4-6 presents the indicator rate for each Contractor during the baseline year and intervention years. For a description of the indicator used for the *Breast Cancer Screening* PIP, see Appendix A. Methodology—Validation of Performance Improvement Projects—Description of Data Obtained.

Table 4-6—ALTCS-EPD Program Contractor *Breast Cancer Screening* PIP Comparative Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020*	CY 2021
BUFC LTC	Not Reported	38.5%^	38.6%
Mercy Care LTC	37.8%	34.2%	32.1%
UHCCP LTC	34.1%	37.2%	38.3%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.
^In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure. As such, CY 2020 served as the baseline for BUFC LTC.

ALTCS-EPD Program-Level Interventions

For the *Breast Cancer Screening* PIP, all Contractors provided lists of interventions that were in place for CY 2022. These lists detailed the identified population, the intervention(s) in place, and whether the intervention(s) will be continued for CY 2023. The most common interventions across the ALTCS-EPD Program Contractors included targeting members and providers for outreach and education related to breast cancer screenings. Outreach methods included interactive voice response (IVR), person-to-person, and automated phone calls; text message campaigns; emails; and letters and other physical mailers. These interventions may impact indicator performance, which will be evaluated after validated indicator rates for the first remeasurement year (CY 2022) become available. For further description of each Contractors' interventions, see Section 5. ALTCS-EPD Program Contractor-Specific Results.

ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Validation of Performance Improvement Projects

Table 4-7 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-EPD Program related to PIPs.

Table 4-7—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
ALTCS-EPD Program Contractors developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
HSAG noted that at the program level, intervention year 2 indicator rates generally demonstrated increases in rates over intervention year 1 and baseline year rates. **[Quality]**
Opportunities for Improvement and Recommendations
While the ALTCS-EPD Contractors developed and implemented interventions that may lead to improvement in indicator outcomes, HSAG identified opportunities for improvement for one ALTCS-EPD Program Contractor. **[Quality]** Recommendation: To support successful progression of the PIPs in the next CY, HSAG recommends that the ALTCS-EPD Program Contractors: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document plans for sustaining the improvement for any demonstrated improvement in indicator rates

Compliance Reviews

AHCCCS includes the following Focus Areas in its compliance review activity. For information about compliance activities for the ALTCS-EPD Program, see Section 6. ALTCS-DD Program Results. Table 4-8 presents the Focus Areas, including each associated acronym, used by AHCCCS during its compliance review.

Table 4-8—Focus Areas and Associated Acronyms

Focus Area	Acronyms
Case Management	CM
Corporate Compliance	CC
Claims and Information Standards	CIS
Delivery Systems	DS
General Administration	GA
Grievance Systems Focus Area	GS
Adult, EPSDT, and Maternal Child Health	MCH
Medical Management	MM

Focus Area	Acronyms
Member Information	MI
Quality Management	QM
Quality Improvement	QI
Reinsurance	RI
Third-Party Liability	TPL
Integrated Systems of Care	ISOC

ALTCS-EPD Program-Level Results

AHCCCS conducts a full compliance review for each Contractor every three years. However, complications arising from the COVID-19 PHE delayed compliance activities for the ALTCS-EPD Program. AHCCCS is now on track with conducting compliance reviews every three years following the interruption, as activities are planned to resume in CYE 2023.

Following the CYE 2019 compliance reviews, AHCCCS provided each of the ALTCS-EPD Contractors with a corrective action plan (CAP) template. AHCCCS reviewed each Contractor's CAP submission and worked with the Contractors to develop an appropriate and complete response to each CAP item. AHCCCS accepted final CAPs from each Contractor during CYE 2022 and closed the ALTCS-EPD CAPs from the CYE 2019 compliance reviews. Table 4-9 presents the ALTCS-EPD Program-level results from the prior compliance review as well as the program-level average for each Focus Area.

Table 4-9—ALTCS-EPD Program-Level Compliance Review Results

Focus Areas	BUFC LTC		Mercy Care LTC		UHCCP LTC		Program-Level Average
Year Reviewed	CYE 2019	Projected 2023*	CYE 2019	Projected 2023*	CYE 2019	Projected 2023*	CYE 2019
CM	93%	TBD	82%	TBD	89%	TBD	88%
CC	100%	TBD	100%	TBD	100%	TBD	100%
CIS	99%	TBD	98%	TBD	98%	TBD	98%
DS	87%	TBD	89%	TBD	90%	TBD	89%
GA	100%	TBD	100%	TBD	100%	TBD	100%
GS	99%	TBD	100%	TBD	100%	TBD	100%
MCH	72%	TBD	93%	TBD	75%	TBD	80%
MM	94%	TBD	94%	TBD	90%	TBD	93%
MI	97%	TBD	100%	TBD	93%	TBD	97%

Focus Areas	BUFC LTC		Mercy Care LTC		UHCCP LTC		Program-Level Average
QM	83%	TBD	91%	TBD	86%	TBD	87%
QI	NR+	TBD	NR+	TBD	NR+	TBD	NR+
RI	100%	TBD	100%	TBD	100%	TBD	100%
TPL	100%	TBD	87%	TBD	100%	TBD	96%
ISOC	NR+	TBD	NR+	TBD	NR+	TBD	NR+

*TBD = "to be determined." AHCCCS will be conducting compliance reviews for the ALTCS-EPD Program Contractors during CYE 2023.
+ NR = "not reviewed." These Focus Areas were not reviewed separately during the compliance review cycle; however, elements of the Focus Areas were included in other Focus Areas (e.g., QI standards included in QM and ISOC standards included in MM).

ALTCS-EPD Program-Level Strengths, Opportunities for Improvement, and Recommendations Related to Compliance Review

Table 4-10 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-EPD Program related to compliance.

Table 4-10—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
The ALTCS-EPD Program-level average score was at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
The ALTCS-EPD Program-level average score was below 95 percent in the following Focus Areas: • Case Management (CM) **[Quality, Access]** • Delivery Systems (DS) **[Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations
• Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that in advance of the forthcoming ALTCS-EPD compliance review, Contractors conduct a self-assessment of the CM, DS, MCH, MM, and QM Focus Area requirements.

Network Adequacy Validation

ALTCS-EPD Program-Level Results

HSAG's biannual validation of the ALTCS-EPD Program Contractors' results showed minor discrepancies between the Contractors' self-reported AHCCCS Contractors Operations Manual (ACOM) 436 results and HSAG's time/distance calculations for all Contractors in each quarter for which 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 A-15), or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 4-11 summarizes HSAG's assessment of each ALTCS-EPD Program Contractor's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the ALTCS-EPD Program Contractor met the minimum network standard for each Arizona county during each of the biannual assessments, and an "X" indicates that the ALTCS-EPD Program Contractor failed to meet one or more minimum network standards in any county or quarter. Section 5. ALTCS-EPD Program Contractor-Specific Results contains NAV results specific to each Contractor and biannual validation period.

Table 4-11—Summary of CYE 2022 Compliance with Minimum Time/Distance Network Requirements for ALTCS-EPD Program Contractors

Minimum Network Requirement	BUFC LTC	Mercy Care LTC	UHCCP LTC
Behavioral Health Outpatient and Integrated Clinic, Adult	✓	✓	✓
Behavioral Health Residential Facility (only Maricopa and Pima counties)	✓	✓	✓

Minimum Network Requirement	BUFC LTC	Mercy Care LTC	UHCCP LTC
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	✓	✓
Cardiologist, Adult	✓	✓	✓
Cardiologist, Pediatric	✓	✓	✓
Dentist, Pediatric	X	✓	✓
Hospital	✓	✓	✓
Nursing Facility (Only ALTCS-EPD plans)	✓	✓	X
OB/GYN	✓	✓	✓
PCP, Adult	✓	✓	✓
PCP, Pediatric	✓	✓	✓
Pharmacy	X	✓	✓

The ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards while struggling to meet standards for Dentist, Pediatric; Nursing Facility; and Pharmacy standards. However, Contractors demonstrated PAT data issues, which impacted HSAG's time/distance results and the validation of Contractors' ACOM 436 results, including BUFC LTC and UHCCP LTC in CYE 2022 Q2.

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

In CYE 2022 Q2, BUFC LTC's submitted data did not include the majority of its subcontracted pharmacy benefit manager's and dental benefit manager's networks. This influenced the validated compliance for any calculations for these provider types. The error occurred when BUFC LTC merged its subcontracted benefits managers' network data with its network data files. BUFC LTC identified the cause and successfully tested the solution.

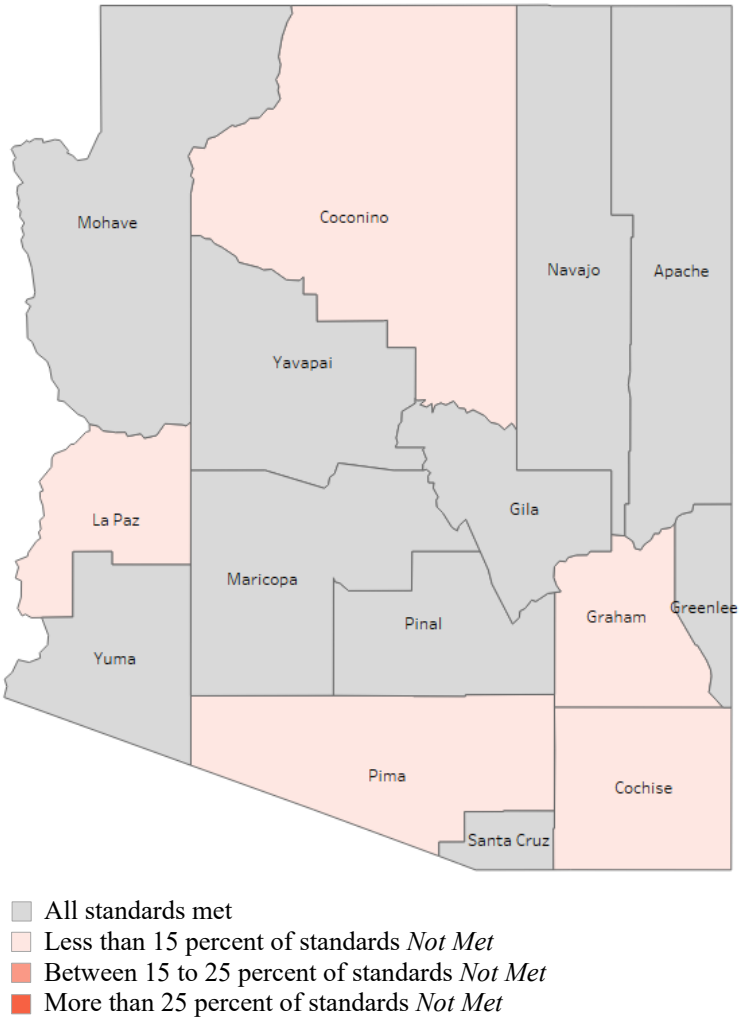
In CYE 2022 Q2, UHCCP LTC's data included substantially decreased numbers of providers used to measure the Nursing Facility standard, as compared to prior submissions. This potentially influenced the validated compliance for this provider type. A review found that most nursing facilities reported in the PAT file submission were rejected, possibly related to the use of a field not typically associated with the facility. AHCCCS has requested that the Contractor submit test files for these facilities to ensure that it uses a format that passes the process.

As part of the NAV, AHCCCS maintained its feedback process for ALTCS-EPD Program Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each

ALTCS-EPD Program Contractor with a copy of HSAG's quarterly 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, ALTCS-EPD Program Contractors were expected to research the instances and make corrections for future PAT data and/or ACOM 436 submissions.

As of CYE 2022 Q4, Figure 4-2 summarizes how ALTCS-EPD Program Contractors performed on meeting the time/distance standards by county. Red shading indicates the degree of noncompliance. Specifically, dark red shading indicates more than 25 percent of the standards were *Not Met*, medium red shading indicates between 15 and 25 percent of the standards were *Not Met*, and light red shading indicates less than 15 percent of the standards were *Not Met* in the given county. Gray shading indicates all ALTCS-EPD Program Contractors met all time/distance standards in the given county.

Figure 4-2—Summary of CYE 2022 Q4 Compliance with Minimum Time/Distance Network Standards by County for ALTCS-EPD Program Contractors



Overall, for CYE 2022 Q4, the most recent biannual assessment, all applicable ALTCS-EPD Program Contractors met all minimum time/distance network requirements except for Cochise, Coconino, Graham, La Paz, and Pima counties.

Based on the biannual NAV results, Mercy Care LTC met all minimum time/distance network standards in both quarters. Additionally, the applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in Mohave and Yavapai counties.

Each ALTCS-EPD Program Contractor should continue to monitor and maintain its existing provider network as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types among the applicable ALTCS-EPD Program Contractors:

- Dentist, Pediatric for BUFC LTC in Cochise, Graham, and Pima counties
- Pharmacy for BUFC LTC in La Paz County
- Nursing Facility for UHCCP LTC in Coconino County

ALTCS-EPD Program Conclusions, Opportunities for Improvement, and Recommendations Related to Network Adequacy Validation

Table 4-12 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-EPD Program related to NAV.

Table 4-12—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • The applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards during both quarters in CYE 2022 in Mohave and Yavapai counties **[Access]** • The ALTCS-EPD Program Contractors consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; Behavioral Health Residential Facility; Cardiologist, Adult and Pediatric; Hospital; and PCP, Adult and Pediatric standards **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting the ALTCS-EPD Program Contractors' compliance with time/distance standards **[Access]** • Based on the biannual NAV results, the ALTCS-EPD Program Contractors struggled to meet the Dentist, Pediatric; Nursing Facility; and Pharmacy standards **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors: • Seek support from AHCCCS when needed to continue to monitor their processes for creating the PAT file • Review the PAT file for accuracy prior to submitting to AHCCCS • Maintain ALTCS-EPD Program Contractor current compliances, but continue to address network gaps, as applicable

5. ALTCS-EPD Program Contractor-Specific Results

This section provides (by Contractor) activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which each Contractor was able to address prior year's recommendations and Contractor best practices.

BUFC LTC

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that BUFC LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-1 displays HSAG's PMV findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-1—CY 2021 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*Hybrid review not performed for CY 2021; therefore, the medical record review process is not applicable*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-2 presents the CY 2020 and CY 2021 BUFC LTC performance measure results that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*).

Table 5-2—CY 2020 and CY 2021 BUFC LTC Performance Measure Results

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	45.0%	45.2%	→	★
Effective Continuation Phase Treatment	42.5%	26.2%	→	★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	24.3%	NA	—	—
30-Day Follow-Up—Total	27.0%	NA	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	44.0%	43.5%	→	★★
Engagement of AOD Treatment—Total	5.6%	5.7%	→	★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	75.2%	62.1%	↑	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	46.9%	—	★
Heart Failure Admission Rate				
Heart Failure Admission Rate	—	82.4	—	—
Pediatric Health				
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	—	38.0%	—	★
Annual Dental Visit				
Annual Dental Visit[1]	—	46.0%	—	★★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	38.5%	38.6%	→	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	—	49.6	—	★★
Plan All-Cause Readmissions				
*O/E Ratio—Total**	—	0.8150	—	★★★★★
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	—	9.3%	—	★

* A lower rate indicates better performance for this measure.

Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.

[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.

— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.

↑ Indicates improvement of measure rates.

↓ Indicates decline of measure rates.

→ Indicates stable measure rates.

[2]Performance Levels for CY 2021 were based on comparisons of the HEDIS MY 2021 measure rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.

Performance Levels for 2021 represent the following percentile comparisons:

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

Strengths, Opportunities for Improvement, and Recommendations

Table 5-3 presents strengths, opportunities for improvement, and recommendations for BUFC LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-3—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Appropriate Utilization of Services measure group, BUFC LTC's *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate met or exceeded the 90th percentile, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. **[Quality]**
Opportunities for Improvement and Recommendations
BUFC LTC did not use the hybrid methodology for any performance measures eligible for hybrid reporting. The audit process revealed a misunderstanding by BUFC LTC related to the timing of when hybrid methodology could be used. The audit process clarified that as of CY 2020, Contractors are instructed to use hybrid methodology since Contractors are producing their own measure rates and that there is an audit process in place to review medical record abstraction and data integration practices. Additionally, there was some confusion between the hybrid methodology and BUFC LTC's nonstandard supplemental data process, which also used medical record data. BUFC LTC confirmed its understanding that it must use hybrid methodology, when applicable, for HEDIS MY 2022 reporting. **[Quality]** Recommendation: As BUFC LTC did not report any measures following the hybrid methodology, HSAG recommends that BUFC LTC review and clarify expectations related to hybrid/medical record review (MRR) requirements for future years' reporting to ensure it is able to align with the AHCCCS-required methodology for the specified hybrid measures. This should include the

Strengths, Opportunities for Improvement, and Recommendations
planning and development of abstraction tools, data capture, and integration for non-HEDIS measures, if required.
While BUFC LTC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit review identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: While there were no concerns with the processing of practitioner data, the audit found that BUFC LTC could benefit from a practitioner credentialing software solution from the perspective of data processing and resource efficiency. HSAG recommends that BUFC LTC continue with its planned efforts related to increased supplemental data capture via a planned project and integration of AHCCCS blind-spot data.
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. **[Quality]** Recommendation: HSAG recommends that BUFC LTC should continue to explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require race and ethnicity stratifications. BUFC LTC should continue to work with AHCCCS related to collaborative efforts to improve completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
In the Behavioral Health Care measure group: • BUFC LTC's performance measure rate for *Initiation and Engagement AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* fell below the 25th percentile, indicating that members who initiated in AOD treatment may not have had two or more additional AOD treatment services or MAT in the 34 days following their initiation visit. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[5-1] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]** Recommendation: While BUFC LTC implemented interventions specific to its CY 2020 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* rate, its rate remained low in CY 2021. HSAG therefore continues to recommend that BUFC LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT following their initiation visit. BUFC LTC 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). This could include

[5-1] National Committee for Quality Assurance. Initiation and Engagement of AOD 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 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to initiating and engaging in timely treatment following a new episode of AOD dependence. • BUFC LTC's performance measure rate for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* fell below the 25th percentile, suggesting that barriers exist for some members with a diagnosis of major depression to remain on antidepressant medication. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide.[5-2] **[Quality]** Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis or focus study to determine why some members are not managing their antidepressant medication. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to improve performance, and consider the nature and scope of the issues (e.g., whether the issues are related to barriers such as a lack of patient and provider communication or patient education) when implementing interventions.
In the Care of Acute and Chronic Conditions measure group: • BUFC LTC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* fell below the 25th percentile, indicating that some members with diabetes did not have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[5-3] [**Quality**] Recommendation: While BUFC LTC implemented interventions specific to its CY 2020 *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* rate, HSAG continues to recommend that BUFC LTC conduct a root cause analysis or focus study to determine why some members with diabetes did not have controlled HbA1c levels. 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, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to diabetes management.

[5-2] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Mar 7, 2023.
[5-3] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
• BUFC LTC's performance measure rate for *Controlling High Blood Pressure* fell below the 25th percentile, indicating that not all members were receiving appropriate screenings and treatment for managing blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-4] **[Quality]** Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis or focus study to determine why some members were not managing their high blood pressure optimally. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to improve performance related to this chronic condition.
In the Preventive Screening measure group, BUFC LTC's performance measure rate for *Breast Cancer Screening* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs.[5-5] A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person screenings due to the COVID-19 PHE. **[Quality]** Recommendation: While BUFC LTC implemented interventions specific to its CY 2020 *Breast Cancer Screening* rate, its rate remained low in CY 2021. HSAG therefore continues to recommend that BUFC LTC conduct a root cause analysis or focus study to determine why some of its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that BUFC LTC improves performance related to these preventive screenings.
In the Pediatric Health measure group, BUFC LTC's performance measure rate for *Child and Adolescent Well-Care Visits* fell below the 25th percentile, indicating that not all children and adolescents were receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-6] **[Quality, Access]**

[5-4] National Committee for Quality Assurance. Controlling High Blood Pressure. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2023.
[5-5] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 31, 2023.
[5-6] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that BUFC LTC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommends that BUFC LTC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health domain.
In the Appropriate Utilization of Services measure group, BUFC LTC's performance measure rate for *Use of Opioids at High Dosage* fell below the 25th percentile. This result provides an opportunity for BUFC LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[5-7] **[Quality]** Recommendation: HSAG recommends that BUFC LTC conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that BUFC LTC implement appropriate interventions to identify members who may be considered at high risk for opioid overuse and misuse.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-4 presents performance measure recommendations made to BUFC LTC in the CYE 2021 Annual Technical Report[5-8] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-4—BUFC LTC Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that BUFC LTC clarify its understanding of any future State-specific guidance. To ensure all possible performance measure numerator compliant records are appropriately identified, HSAG further recommended that BUFC LTC document and submit its nonstandard supplemental data source for audit review and approval for future years' data integration and continue to explore other

[5-7] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Mar 7, 2023.

[5-8] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
potential data streams for future supplemental data submission. This may include electronic health record data feeds, lab result files, exclusion history files, etc.
BUFC LTC's Response: BUFC LTC did not provide a response to this recommendation.
HSAG's Assessment: During CY 2021 PMV, BUFC LTC submitted five supplemental data sources (four standard and one non-standard) that were used to support its performance measure rates. HSAG has therefore determined that BUFC LTC has satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that BUFC LTC review and clarify expectations related to hybrid/medical record review requirements for future years' reporting. This should include the planning and development of abstraction tools and data capture and integration for non-HEDIS measures, in accordance with State-specific guidance for measures required to be reported following hybrid methodology.
BUFC LTC's Response: BUFC LTC did not provide a response to this recommendation.
HSAG's Assessment: BUFC LTC did not report any CY 2021 measures following the hybrid data collection methodology. HSAG has therefore determined that BUFC LTC did not address the prior year's recommendation.
Recommendation 3:
HSAG recommended that BUFC LTC conduct a root cause analysis to determine why members were not receiving timely follow-up care with a mental health provider. BUFC LTC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, BUFC LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to follow-up care following a hospitalization.
BUFC LTC's Response: BUFC LTC will continue to emphasize the importance of follow-up after hospitalization for mental illness through the following: • ALTCS case managers will conduct a post discharge call and assessment within 72 hours of discharge • ALTCS case managers will confirm if a follow-up visit is scheduled, and if not scheduled, offer assistance with scheduling one

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• ALTCS behavioral health case managers will conduct a member follow-up call to ensure an appointment has been made and offer any behavioral health specific assistance • Provide member education through newsletters and social media on the importance of treating mental health needs • Utilize the Pyx Application to address and assist members with their mental health needs • Continue meeting frequently to discuss additional interventions and reduce barriers
HSAG's Assessment: BUFC LTC identified interventions that were implemented for CY 2021, however, BUFC LTC did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that BUFC LTC partially addressed the prior year's recommendation.
Recommendation 4:
HSAG recommended that BUFC LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. BUFC LTC 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). 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, BUFC LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.
BUFC LTC's Response: BUFC LTC addressed this recommendation through the following initiatives: • ALTCS case managers will provide outreach and follow-up with members after a substance use disorder hospitalization • Utilize the Pyx Application to assist with mental health needs and treatment, as often substance use and dependence are linked to mental health needs • Continue referring members to behavioral health case managers as determined appropriate
HSAG's Assessment: BUFC LTC identified interventions that were implemented for CY 2021, however, BUFC LTC did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that BUFC LTC partially addressed the prior year's recommendation.
Recommendation 5:
HSAG recommended that BUFC LTC conduct a root cause analysis or focus 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 difficulties in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to chronic health conditions.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
BUFC LTC's Response: BUFC LTC addressed this recommendation through the following initiatives: • Collaborate with Sonora Quest to track and monitor A1c tests and values • Conduct outreach to those members with A1c levels >9% • ALTCS case managers will assist members with high levels by following up with providers and caregivers to determine a plan of action • An IT report identifying members who have not completed a A1c screening or have an A1c >9% is given to case managers quarterly • Provide member education through newsletters and social media postings on diabetes management
HSAG's Assessment: BUFC LTC identified interventions that were implemented for CY 2021, which was appropriate, as the recommendation was related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure. However, BUFC LTC did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that BUFC LTC partially addressed the prior year's recommendation.
Recommendation 6:
HSAG recommended that BUFC LTC conduct a root cause analysis or focus study to determine why its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, BUFC LTC should implement appropriate interventions to improve the performance related to preventive screenings.
BUFC LTC's Response: BUFC LTC addressed this recommendation through the following initiatives: • ALTCS case managers target female members in the appropriate age group for outreach and assistance with scheduling routine mammograms • Partnership with Banner Imaging to have slots open for members in order to provide better availability and quicker scheduling • Mobile mammogram units are also being contracted • Provide member education through newsletters, social media postings, and publicity around Breast Cancer Awareness month
HSAG's Assessment: BUFC LTC identified interventions that were implemented for CY 2021, however, BUFC LTC did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that BUFC LTC partially addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2022, BUFC LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP is in an intervention year, PIP validation activities focused on intervention analysis. BUFC LTC submitted interventions implemented during CY 2022 along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate BUFC LTC's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or sustained improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 5-5 provides the *Breast Cancer Screening* PIP baseline and intervention year rates for BUFC LTC.

Table 5-5—BUFC LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: *Breast Cancer Screening*	
	Baseline Year	Intervention Year
	CY 2020*	CY 2021
BUFC LTC	38.5%	38.6%

*In CYE 2019, the BUFC LTC indicator rate had a small denominator, which did not allow for reporting of the measure. As such, CY 2020 served as baseline for BUFC LTC.

Interventions

Table 5-6 presents PIP interventions for BUFC LTC during CY 2022. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-6—BUFC LTC *Breast Cancer Screening* PIP Interventions

Contractor	Interventions
BUFC LTC	• Quarterly gaps in care lists will be generated and sent to the ALTCS case managers for outreach to members still needing a breast cancer screening • Contracting with mobile mammogram units • Annual breast cancer screening mailer • Facebook articles

Strengths, Opportunities for Improvement, and Recommendations

Table 5-7 presents strengths, opportunities for improvement, and recommendations for BUFC LTC related to PIPs, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-7—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC LTC developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]** HSAG noted that the intervention year indicator rate showed a very slight increase over the baseline year indicator rate. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG noted that BUFC LTC implemented a limited number of interventions for the *Breast Cancer Screening* PIP that focused only on outreach to BUFC LTC members. Recommendation: As the PIP progresses, HSAG recommends that BUFC LTC: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Consider implementing additional meaningful interventions that may result in greater overall success in meeting the PIP goals and objectives • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-8 presents PIP recommendations made to BUFC LTC in the CYE 2021 Annual Technical Report[5-9] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided

[5-9] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-8—BUFC LTC Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP was in an intervention year and no opportunities for improvement had yet been identified, HSAG recommended that BUFC LTC continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.
BUFC LTC's Response: PIPs continue to be extremely important and valuable projects that maintain focus on a particular topic to its resolution or improvement. The PIPs are based upon internal and external trends, many include the health plans input and considers the members healthcare needs. PIPs are developed both internally at the Health Plan and externally from mandated AHCCCS PIPs. Each PIP is designed to achieve demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services. Oftentimes the interventions are aimed at addressing systemic healthcare problems. The health plan is expected to demonstrate statistically significant improvement and failure to do so could result in a CAP and extend the duration of the PIP. BUFC LTC participated in one AHCCCS mandated PIP during CYE 2021: Breast Cancer Screening. BUFC LTC participated in the following initiatives related to breast cancer: • ALTCS case managers target female members in the appropriate age group for outreach and assistance with scheduling routine mammograms • Partnership with Banner Imaging to have slots open for members in order to provide better availability and quicker scheduling • Mobile mammogram units are also being contracted • Provide member education through newsletters, social media postings, and publicity around Breast Cancer Awareness month
HSAG's Assessment: HSAG reviewed BUFC LTC's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that BUFC LTC has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

Compliance Reviews

AHCCCS conducts a full compliance review for each Contractor every three years. However, complications arising from the COVID-19 PHE delayed compliance activities for the ALTCS-EPD

Program. AHCCCS is now on track with conducting full compliance reviews every three years following the interruption, as compliance activities are projected for CYE 2023.

Results

In CY 2019, BUFC LTC scored 95 percent or above in the CC, CIS, GA, GS, MI, RI, and TPL Focus Areas. While not at or above 95 percent, BUFC LTC was found to be above the ALTCS-EPD Program average in the CM Focus Area. On April 17, 2019, AHCCCS finalized the report findings and provided BUFC LTC with a CAP submission matrix and required a CAP for any standard with a total score of less than 95 percent. In a letter dated April 4, 2022, AHCCCS informed BUFC LTC that its proposed CAP was accepted and closed. Table 5-9 presents BUFC LTC's results from the recent compliance review as well as the program-level average for each Focus Area.

Table 5-9—BUFC LTC Compliance Results Compared with ALTCS-EPD Program-Level Average Results

Focus Areas	BUFC LTC		ALTCS-EPD Program-Level Average
Year Reviewed	CYE 2019	Projected 2023*	2019
CM	93%	TBD	88%
CC	100%	TBD	100%
CIS	99%	TBD	98%
DS	87%	TBD	89%
GA	100%	TBD	100%
GS	99%	TBD	100%
MCH	72%	TBD	80%
MM	94%	TBD	93%
MI	97%	TBD	97%
QM	83%	TBD	87%
QI	NR+	TBD	NR+
RI	100%	TBD	100%
TPL	100%	TBD	96%
ISOC	NR+	TBD	NR+

*TBD = "to be determined." AHCCCS will be conducting compliance reviews for the ALTCS-EPD Program Contractors during CYE 2023.
+ NR = "not reviewed." These Focus Areas were not reviewed separately during the compliance review; however, elements of the Focus Areas were included in other Focus Areas (e.g., QI standards included in QM, and ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 5-10 presents strengths, opportunities for improvement, and recommendations for BUFC LTC related to compliance activities based on the CYE 2019 review, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-10—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
BUFC LTC scored at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
BUFC LTC scored below 95 percent in the following Focus Areas: • Case Management (CM) **[Quality, Access]** • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that in advance of the forthcoming compliance review, BUFC LTC conduct a self-assessment of the CM, DS, MCH, MM, and QM requirements.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-11 presents compliance recommendations made to BUFC LTC in the CYE 2021 Annual Technical Report[5-10] and BUFC LTC's follow-up to the recommendations, as well as an assessment of

[5-10] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

the degree to which BUFC LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-11—BUFC LTC's Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
Although no CAP findings were provided for CYE 2021, HSAG recommended 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.
BUFC LTC's Response: No CAP findings were provided for CYE 2021. Although no CAP findings were provided for CYE 2021, BUFC LTC will continue to remedy any findings identified in 2018 to ensure compliancy with the requirements in each of the AHCCCS Focus Areas. All CAPs opened as a result have been completed and closed. BUFC LTC proactively and diligently worked to meet the CAP requirements for sustainability. Multiple policies and desktops have been updated and implemented. Staff have been trained to understand these requirements as well. The quality department updated the referral documentation processes with regulatory agencies, including descriptions of any new allegations. Additionally, BUFC LTC implemented Inter-Rater Reliability (IRR) questions related to severity leveling and substantiation determination, as well as case elevation. BUFC LTC has also continued to ensure that quality of care concerns (QOC) submitted by members/families are followed through with a closure/resolution letter. Multiple trainings have been created and implemented with staff, including new trainings currently in development. BUFC LTC has additionally addressed areas of confidentiality and is ensuring protection against any and all confidentiality matters. BUFC LTC is currently preparing for an additional review in the spring of 2023 and is currently under and NCQA accreditation audit scheduled. There are no current CAPs open.
HSAG's Assessment: Based on the response provided by BUFC LTC, HSAG determined that BUFC LTC has satisfactorily addressed the prior year's recommendation.

Network Adequacy Validation

Results

HSAG evaluated BUFC LTC's compliance results with AHCCCS' time/distance standards by geographic service area (GSA) and county. This section presents biannual validation findings specific to the ALTCS-EPD line of business (LOB), with one results table for each of the following GSAs:

- Central GSA: Maricopa,[5-11] and Pinal counties
- South GSA: Cochise, Graham,[5-12] Greenlee, La Paz, Pima, Santa Cruz,[5-13] and Yuma counties

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, 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 ALTCS-EPD LOB. The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the ALTCS-EPD 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 (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Table 5-12—BUFC LTC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements

	Gila		Maricopa		Pinal	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	99.2	99.4^	100	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100*	100*^	97.1	96.8^	NR*	NR*^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	99.0	98.5	NA	NA
Cardiologist, Adult	100	100^	99.6	99.6^	100	100^
Cardiologist, Pediatric	100*	100*^	100	100^	100*	100*^
Dentist, Pediatric	50.0*[1]	100*[2]	72.7[1]	97.3[2]	0.0*[1]	100*[2]
Hospital	100	100	99.8	99.8	100	100
Nursing Facility (Only ALTCS-EPD plans)	100	100	99.6	99.3	100	100
OB/GYN	100*	100*	100	100	100	100*

[5-11] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.
[5-12] 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.
[5-13] Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

Minimum Network Requirement	Gila		Maricopa		Pinal	
	Q2	Q4	Q2	Q4	Q2	Q4
Pharmacy	99.3[1]	100	97.1[1]	99.4	100[3]	100
PCP, Adult	100^	100	99.8	99.7^	100	100^
PCP, Pediatric	100*	100*	100	97.3^	100*	100*

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 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2022 Q2, BUFC LTC's data submitted did not include the majority of its subcontracted pharmacy benefit manager's and dental benefit manager's networks. This influenced the validated compliance for any calculations for these provider types. The error occurred when BUFC LTC merged its subcontracted benefits managers' network data with its network data files. BUFC LTC identified the cause and successfully tested the solution.

[2] In CYE 2022 Q4, BUFC LTC's data submitted did not include the majority of its subcontracted dental benefit manager's network. This influenced the validated compliance for this provider type.

Table 5-13—BUFC LTC Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Cochise		Graham		Greenlee		La Paz		Pima		Santa Cruz		Yuma	
	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	100	100^	100*	100*	100^	100	99.1^	99.0^	100^	100^	99.9^	99.9^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100*	100*^	100*	100*^	NR*	NR*	NR*	NR*	93.8^	85.7^	100*	100*^	100*	100*^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	92.4	92.2	NA	NA	NA	NA
Cardiologist, Adult	100	100^	100	100^	100*	100*^	100	100^	99.0^	98.6^	100	100^	99.9^	100^
Cardiologist, Pediatric	100*	100*^	100*	100*^	NR*	NR*	100*	100*	100	100^	100*	100*	100*	100^
Dentist, Pediatric	16.7*[1]	20.0*[2]	0.0*[1]	0.0*[2]	NR*[1]	NR*[6]	0.0*[1]	100*[2]	56.3[1]	85.7[2]	100*[1]	100*[2]	0.0*[1]	100[2]
Hospital	100	100	100	100	100*	100*	100	100	99.8	99.7	100	100	100	100
Nursing Facility (Only ALTCS-EPD plans)	100	100	100	100	100*	100*	100	100	99.6	99.6	100	100	100	100
OB/GYN	100	100	100*	100*	NR*	100*	100*	100*	100	100	100*	100*	100	100
Pharmacy	96.4[1]	100	22.0[1]	100	60.0*[1]	100*	8.3[1]	85.0	91.7[1]	98.7	17.3[1]	100	99.3[1]	99.9

Minimum Network Requirement	Cochise		Graham		Greenlee		La Paz		Pima		Santa Cruz		Yuma	
	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
PCP, Adult	100^	100^	100	100	100*	100*^	100	100^	99.8^	99.9^	100^	100^	99.9^	99.9^
PCP, Pediatric	100*^	100*^	100*	100*	NR*	NR*^	100*	100*^	100^	100^	100*	100*	100*^	100

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 10 members were included in the denominator of HSAG's results.

^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

[1] In CYE 2022 Q2, BUFC LTC's data submitted did not include the majority of its subcontracted pharmacy benefit manager's and dental benefit manager's networks. This influenced the validated compliance for any calculations for these provider types. The error occurred when BUFC LTC merged its subcontracted benefits managers' network data with its network data files. BUFC LTC identified the cause and successfully tested the solution.

[2] In CYE 2022 Q4, BUFC LTC's data submitted did not include the majority of its subcontracted dental benefit manager's network. This influenced the validated compliance for this provider type.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-14 presents strengths, opportunities for improvement, and recommendations for BUFC LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-14—BUFC LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
After accounting for data-related findings, BUFC LTC met all time/distance network standards in all assigned counties for both quarters in CYE 2022, except for La Paz County. **[Access]** Note: BUFC LTC provides coverage in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: BUFC LTC failed to meet the time/distance standard for pharmacies in La Paz County **[Access]** Isolated data issues may have contributed to specific instances affecting BUFC LTC's compliance with time/distance standards **[Access]** Recommendation: HSAG recommends that BUFC LTC:

Strengths, Opportunities for Improvement, and Recommendations
• Maintain current compliances, but continue to address network gaps, as applicable • Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-15 presents NAV recommendations made to BUFC LTC in the CYE 2021 Annual Technical Report[5-14] and BUFC LTC's follow-up to the recommendations, as well as an assessment of the degree to which BUFC LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-15—BUFC LTC Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG recommended the following to BUFC LTC: • The ALTCS-EPD Program Contractors should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Continue to monitor and maintain its existing provider network coverage with specific attention to ensuring the availability of pharmacies in La Paz County • Continue to monitor its process for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS
BUFC LTC's Response: BUFC LTC conducts a quarterly network analysis which includes time and distance, minimum network requirements, and appointment availability. BUFC LTC will continue to implement improvements in this area as necessary to meet the needs of the population served. BUFC LTC provided a table that outlined BUFC LTC's time/distance requirement rates and the percent of members meeting requirement for HSAG's review.
HSAG's Assessment: Based on the CYE 2022 NAV results and the response provided by BUFC LTC, HSAG determined that BUFC LTC has satisfactorily addressed the prior year's recommendation.

[5-14] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

BUFC LTC's Best and Emerging Practices

Table 5-16 presents the best and emerging practices provided by BUFC LTC for CYE 2022. HSAG made only minor edits to BUFC LTC's submission to enhance readability. Best practice responses may be based on Contractor internal data and not EQR validated rates.

Table 5-16—BUFC LTC Best and Emerging Practices

BUFC LTC Best and Emerging Practices	
Measure	**Description**
Annual Dental Visits 2 – 20 years Goal: 42%	The importance of oral health during childhood is well documented in many studies and reports including the 2000 Surgeon General's Report on Oral Health (SRROH). The following observation was made regarding this report: "The 2000 Surgeon General's Report on Oral Health (SGROH) included a limited discussion of the condition known as Early Childhood Caries (ECC). Because of its high prevalence, its impact on young children's quality of life and potential for increasing their risk of caries in the permanent dentition, ECC is arguably one of the most serious and costly health conditions among young children." As recently as 2015, a CDC Brief Report found the following: • "Approximately 23% of children aged 2–5 years had dental caries in primary teeth • Untreated tooth decay in primary teeth among children aged 2–8 was twice as high for Hispanic and non-Hispanic black children compared with non-Hispanic white children • Among those aged 6–11, 27% of Hispanic children had any dental caries in permanent teeth compared with nearly 18% of non-Hispanic white and Asian children • About three in five adolescents aged 12–19 had experienced dental caries in permanent teeth, and 15% had untreated tooth decay • Dental sealants were more prevalent for non-Hispanic white children (44%) compared with non-Hispanic black and Asian children (31% each) aged 6–11" In addition, this same report states "Among adolescents aged 12–19, nearly three in five adolescents had experienced dental caries in permanent teeth, 15% had untreated tooth decay, and 43% had at least one dental sealant present." Given these facts, it is extremely important to continue to reach out and provide these preventive children, as early as possible in order to try to prevent these detrimental outcomes in children and positively impact some of this dental caries in permanent teeth prevalence rates seen in adolescents. Goal: The goal of this intervention is to increase the number of children ages 2-20 receiving a Preventive Dental Service at least once a year to potentially detect and treat some of

BUFC LTC Best and Emerging Practices	
Measure	**Description**
	these dental issues before they become worse and to potentially prevent more serious dental issues (e.g., periodontal disease). Intervention: BUFC LTC MCH department ensures that all dental referrals are attended to. We also provide dental educational material through our member newsletter and social media. BUFC LTC partnered with our Dental vendor (DentaQuest) to identify members who are due for a preventative treatment and/or sealants and remind them that children who receive routine preventative care are less likely to experience a major oral health issue in the future. DentaQuest also provides member educational material and appointment reminders. • Healthy Beginnings Congratulations at birth • Healthy Beginnings 1st Birthday • Healthy Beginnings 2nd Birthday • Annual Dental Home Reminder • Dental Reminder to Schedule Preventative Appointment • Dental Reminder to Schedule Preventative Appointment if non-compliant • Broken Appointment Reminder to Reschedule Preventative Appointment BUFC LTC Quality Department conducts telephonic outreach to non-compliant members/ caregivers to assist them to schedule preventative dental visits. BUFC LTC has increased claims ingestion to include all claims status. BUFC LTC will continue with utilization of case managers to encourage dental visits and follow up for members who have missed scheduled appointments. Improvement: Despite ongoing concerns through 2021 regarding COVID – 19 the rates for this measure did slightly improve and met the MPS of 42% (based on the NCQA 2020 Mean). BUFC LTC will continue to work with DentaQuest and ALTCS case managers on the implemented interventions and we anticipate an ongoing improvement in the rates. 2020 rate: 44% 2021 rate: 46%
Breast Cancer Screening Goal: 53%	Breast cancer remains the leading cause of death amongst women in the United States, with estimations of 276,480 new cases and 42,170 deaths in the year 2020. Mammogram screening has been recognized as a particularly useful tool in early disease detection, resulting in a better prognosis and diminished death rate from breast cancers. Despite the associated benefits, the overall coverage of mammogram screenings in the United States is still very low. A plethora of factors contribute to

BUFC LTC Best and Emerging Practices	
Measure	**Description**
	this low coverage among indigent women who lack health insurance coverage for screening mammography, with higher odds of these women diagnosed with advanced stages of the disease. Ethnicity, health, and socioeconomic disparities (e.g., poverty, cultural beliefs, and marital status) contribute to the low compliance with mammography screening and decreased access to prevention programs, thus increasing the disparity in breast cancer rates and outcomes amongst underserved women. Additional factors that have been noted to decrease compliance with screening mammography are the fear of pain or of a poor screening outcome, educational attainment, geographical location, lack of awareness, and co-morbidities. Studies have also shown that compliance with mammography screening varies greatly by age, educational level, access to a primary care physician, and insurance coverage status. Among the underserved population age and biopsy outcome were related to a previous lack of compliance with screening. Additionally, despite addressing the income and transportation barriers, a significant "no-show" rate persisted. This is most likely due to cultural and other nonstructural barriers. An understanding of these sociodemographic determinants can enable healthcare providers and public health workers to develop innovative strategies to increase breast cancer screening. The sociodemographic determinants most starkly impacted 40–49-year-old women who would not have been screened. This population was found to be at increased cancer risk and should be encouraged screening for breast cancer via mammography. Goal: Increase the number of members receiving a mammogram every 2 years. Intervention: BUFC LTC may have benefitted from a national and wide-spread positive message regarding Breast Cancer Awareness and recognition of Cancer survivors. Given the potential devastation to the population, this has become a national cause with easily recognized "triggers" throughout the nation (Pink Ribbons, dressing in pink, Breast Cancer Awareness Month, etc.). This is a cause that BUFC LTC has benefitted from in getting our members to these screenings. In addition, BUFC LTC reinforces these national messages with annual mailings to all members regarding mammography and the importance of attending to these. BUFC LTC has implemented additional interventions to educate members on the importance of cancer screenings and assistance with provider scheduling. Further statewide recognition and awareness campaigns regarding other types of cancer screenings may assist in further moving the screenings for those measures. BUFC LTC has a partnership with the American Cancer Society where they provide us with cancer screening member and provider material we implement into our workflows and key phrases. Moreover, BUFC LTC has also partnered with Banner Imaging to share lists of members who are due for breast cancer screenings. Banner Imaging conducts monthly outreach and schedules

BUFC LTC Best and Emerging Practices	
Measure	**Description**
	mammograms for our dual members. Added in 2020, Banner has also contracted with mobile mammogram providers to serve our rural members and members in facilities. Improvement: This measure is a focus for ALTCS for 2021 and 2022, and we are implementing several new initiatives to encourage screenings. BUFC LTC will be working with ALTCS case managers to outreach to members missing services and provide assistance with scheduling appointments. Mobile mammogram units are also being utilized. 2020 rate: 42.4% 2021 rate: 38.1%

BUFC LTC Best and Emerging Practices—References

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Mercy Care LTC

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that Mercy Care LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-17 displays HSAG's PMV findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-17—CY 2021 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-18 presents the CY 2020 and CY 2021 Mercy Care LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-18—CY 2020 and CY 2021 Mercy Care LTC Performance Measure Results

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	65.1%	72.1%	↑	★★★★★

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Effective Continuation Phase Treatment	55.4%	64.5%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	43.3%	48.0%	→	★★★★
30-Day Follow-Up—Total	55.2%	52.0%	→	★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	47.4%	47.1%	→	★★★
Engagement of AOD Treatment—Total	5.1%	5.7%	→	★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	25.8%+	21.9%+	→	★★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	71.3%+	—	★★★★★
Heart Failure Admission Rate				
Heart Failure Admission Rate	—	228.8	—	—
Pediatric Health				
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	—	41.9%	—	★
Annual Dental Visit				
Annual Dental Visit[l]	—	54.6%	—	★★★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	34.2%	32.1%	→	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	—	56.0	—	★
Plan All-Cause Readmissions				
*O/E Ratio—Total**	—	0.6766	—	★★★★★
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	—	12.8%	—	★

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.

[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.
— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.
[2]Performance Levels for CY 2021 were based on comparisons of the HEDIS CY 2021 measure rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
Performance Levels for 2021 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-19 presents strengths, opportunities for improvement, and recommendations for Mercy Care LTC related to performance measure, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-19—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group: • Four of six (66.7 percent) of Mercy Care LTC's measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021 **[Quality, Timeliness, Access]** • Mercy Care LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* were above the 75th percentile, indicating strength in providing follow-up care for behavioral health to members **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • Mercy Care LTC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[5-15] [**Quality**] • Mercy Care LTC's performance measure rate for *Controlling High Blood Pressure* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart

[5-15] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-16] [**Quality**]
In the Appropriate Utilization of Services measure group, Mercy Care LTC's *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate met or exceeded the 90th percentile, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. **[Quality]**
Opportunities for Improvement and Recommendations
While Mercy Care LTC was successful in reporting valid rates for all AHCCCS-required performance measures, the audit review identified some considerations and recommendations for future years' reporting. **[Quality]** Recommendation: HSAG recommends that Mercy Care LTC continue to ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommends that Mercy Care LTC continue to 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.
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. **[Quality]** Recommendation: HSAG recommends that Mercy Care LTC explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES. Mercy Care LTC should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
In the Behavioral Health Care measure group, Mercy Care LTC's performance measure rate for *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* fell below the 25th percentile, indicating that members who initiated in AOD treatment may not have had two or more additional AOD treatment services or MAT in the 34 days following their 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.[5-17] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]**

[5-16] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.

[5-17] National Committee for Quality Assurance. Initiation and Engagement of AOD 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 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to its *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* measure, its rate remained low in CY 2021. HSAG therefore recommends that Mercy Care LTC continue to implement appropriate interventions to improve performance related to engaging in timely treatment following initiation of treatment. HSAG also recommends that Mercy Care LTC monitor and expand upon interventions currently in place to improve performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* measure.
In the Preventive Screening measure group, Mercy Care LTC's performance measure rate for *Breast Cancer Screening* fell below the 25th percentile, indicating that not all women were receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]** Recommendation: While Mercy Care LTC conducted a root cause analysis and implemented interventions specific to its *Breast Cancer Screening* measure, its rate remained low in CY 2021. HSAG therefore recommends that Mercy Care LTC continue to implement appropriate interventions to improve the performance related to these preventive screenings. HSAG also recommends that Mercy Care LTC monitor and expand upon interventions currently in place to improve performance related to the *Breast Cancer Screening* measure.
In the Pediatric Health measure group, Mercy Care LTC's performance measure rate for *Child and Adolescent Well-Care Visits* fell below the 25th percentile, indicating that not all children and adolescents were receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-18] **[Quality, Access]** Recommendation: HSAG recommends that Mercy Care LTC identify best practices to support children in receiving well-care visits according to recommended schedules. HSAG also recommends that Mercy Care LTC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve performance related to the Pediatric Health measure group.
In the Appropriate Utilization of Services measure group, Mercy Care LTC's performance measure rate for *Use of Opioids at High Dosage* fell below the 25th percentile. This result provides an opportunity for Mercy Care LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages

[5-18] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2023.

Strengths, Opportunities for Improvement, and Recommendations
≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[5-19] **[Quality]** Recommendation: HSAG recommends that Mercy Care LTC conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that Mercy Care LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-20 presents performance measure recommendations made to Mercy Care LTC in the CYE 2021 Annual Technical Report[5-20] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-20—Mercy Care LTC Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that Mercy Care LTC 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.
Mercy Care LTC's Response:
Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), integrated clinics, and multi-specialty interdisciplinary clinics are being aligned to continue to map to PCP and mental health provide types, and Mercy Care LTC will follow the most current AHCCCS guidance to ensure all provider mapping aligns with AHCCCS standards.
HSAG's Assessment:
The Mercy Care LTC CY 2021 provider mapping did not fully align with AHCCCS guidance for reporting performance measures where provider specialty type is required. HSAG has therefore determined that Mercy Care LTC did not address the prior year's recommendation.

[5-19] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Mar 7, 2023.

[5-20] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 2:
HSAG recommended that Mercy Care LTC 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.
Mercy Care LTC's Response: Formal source code review is not allowed with the software vendor, as it is a proprietary product, but the vendor's source code is reviewed and approved by HSAG auditors on a yearly basis. The National Medicaid Quality Data team does ensure that necessary source code changes are made by the software vendor with the release of any changes to event data, and rates are reviewed monthly. Any anomalies/discrepancies/outliers that are found are reviewed, researched, and tested thoroughly before any data are reported to regulatory bodies. The National Medicaid Quality Team will continue to follow the current plan. Continued progress will include monthly event checks using vendor resources as compared to any technical specifications to ensure that the vendor is accurately capturing the right reporting elements for all core and non-core activities, as well as higher monitoring of internal back-end system integrations to ensure that all data elements are within scope to be captured for reporting.
HSAG's Assessment: Considering this recommendation's intention to ensure ongoing oversight of the vendor generating its performance measure rates, which Mercy Care LTC has explained is conducted through its monthly event checks and monitoring efforts, HSAG has determined Mercy Care LTC has satisfactorily addressed the prior year's recommendation.
Recommendation 3:
HSAG recommended that Mercy Care LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. Mercy Care LTC 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). 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 LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, Mercy Care LTC should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.
Mercy Care LTC's Response: Mercy Care LTC convened a cross functional work group to conduct root cause analysis related to the Initiation and Engagement of AOD Abuse or Dependence Treatment and identify/implement interventions to address those barriers: • Limitations caused by Part 42 restrictions which may cause make it difficult to communicate with providers about members with SUD • Lack or limited knowledge by the ALTCS Case Managers when a member has substance use/abuse issues that are identified and/or need to be addressed

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• Members who are receiving Hospice services are not always be removed from the measure denominator, which may be, at least in part, due to Hospice claims being paid by the member's primary insurance (which is not always Mercy Care) Interventions implemented/planned: • Mercy Care LTC is offering Intensive Treatment Systems, a 24-7 access point for MAT services, as a Health Home (HH) for members with serious mental illness (SMI) and we are adding MAT to each of our existing HH provider locations • Mercy Care LTC conducted a survey of the contracted Health Homes and is planning to host work groups with them to identify additional barriers to members accessing timely AOD services or MAT, as well as successes that may be implemented more broadly • Mercy Care LTC Medical Director & Psychiatrist provided training regarding Opioids to the LTC staff • Mercy Care LTC is working to establish a process by which the ALTCS Case Managers can notify the Quality Management team of ALTCS members who are receiving Hospice services, for measure exclusion Goal achievement status: During CY 2021, Mercy Care LTC successfully achieved the goal of exceeding the NCQA HEDIS® Medicaid Mean for the IET sub-measure Initiation. However, Mercy Care LTC has not yet achieved the goal of meeting the NCQA HEDIS Medicaid Mean, however for the sub-measure Engagement. Mercy Care LTC's CY 2021 rate of compliance with that sub-measure does reveal year over year improvement.
HSAG's Assessment: Mercy Care LTC identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis, however the rate remained low in CY 2021. While opportunity remains to improve its rate, HSAG has determined that Mercy Care LTC satisfactorily addressed the prior year's recommendation.
Recommendation 4:
HSAG recommended that Mercy Care LTC conduct a root cause analysis or focus study to determine why its female members were not receiving timely screening for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, Mercy Care LTC should implement appropriate interventions to improve the performance related to preventive screenings.
Mercy Care LTC's Response: As recommended, Mercy Care LTC conducted a root cause analysis for the breast cancer screening measure. This included review and analysis of factors such as demographic data including age and geographic area, as well as enrollment with the health plan and the impact of the PHE, amongst others. Additionally, Mercy Care LTC conducted disparity analysis for the ALTCS population within

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
the breast cancer screening measure, and identified a disparity related to screening within four specific zip codes. Through these analyses, Mercy Care LTC identified the following potential barriers: • Member access to mammogram facilities, particularly for those with mobility challenges • Limited awareness by the member's case manager when a member has a gap in care (is in need of a mammogram) • Incomplete data due to inclusion of members with other primary insurance – those claims may not be sent to Mercy Care LTC as they are paid by the member's primary insurer • Member postponement of many non "essential" health services Interventions implemented/planned: • Additional outreach and education to providers in underutilized areas • Partner with mobile mammography provider to complete mammograms for members with a gap in care • Improve upon the communication to ALTCS case management team and members about the availability of the incentives for mammograms • Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers • Addition of breast cancer screening measure to Value-Based programs • Partner with Pop Health Care, as the largest Mercy Care LTC PCP, to close member gaps in care • Review this topic at the ALTCS Member Council to obtain member feedback to address disparities • Develop content that is specific to this measure and identified disparities to be included in the Mercy Care Provider Conference • Implementation of year-round medical record review processes to gather compliant data for members with other primary coverage Goal achievement status: Mercy Care LTC has not yet achieved the goal of meeting the NCQA HEDIS Medicaid Mean; however, Mercy Care LTC's 2022 year to date rate of compliance with the breast cancer screening measure reveals year over year improvement, with the current rate demonstrating an improvement of nearly four percentage points, as compared to the rate at the same time last year.
HSAG's Assessment: Mercy Care LTC identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis, however the rate remained low in CY 2021. While opportunity remains to improve its rate, HSAG has determined that Mercy Care LTC satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2022, Mercy Care LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP is in an intervention year, PIP validation activities focused on intervention analysis. Mercy Care LTC submitted interventions implemented during CY 2022 along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate Mercy Care LTC's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or sustained improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 5-21 provides the *Breast Cancer Screening* PIP baseline and intervention year rates for Mercy Care LTC.

Table 5-21—Mercy Care LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
Mercy Care LTC	37.8%	34.2%	32.1%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Interventions

Table 5-22 presents PIP interventions for Mercy Care LTC during CY 2022. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-22—Mercy Care LTC *Breast Cancer Screening* PIP Interventions

Contractor	Intervention
Mercy Care LTC	• Educational outreach to female members aged 40-74 to encourage well-woman exams and mammograms (breast cancer screening). • Female members aged 40-74 receive the Breast Cancer Screening or breast cancer screening/ Cervical Cancer Screening self-mailer.

Contractor	Intervention
	• Members aged 50-74 receive breast cancer trifold education piece. • Members aged 50-74 receive partner organization notification-partner organization will be contacting those members who have not had a mammogram in the past year and assist with scheduling an appointment for a mammogram. Partner organization contacts members on the list which the health plans has provided of members in need of mammogram. • Providers are notified via mail of members who are due for a mammogram. Members are given an order form to sign and return to the health plan. We then contact the member and assist with scheduling mammogram and submitting order form. • Outreach staff contact members who still have not had a mammogram to assist with scheduling appointments. • Incentive letters are mailed annually to members who still need a mammogram, once the member completes a mammogram, and Mercy Care LTC receives/verifies the claim from the provider, the incentive is sent to the member. • Mercy Care LTC Coordinators conduct provider site visits including education on breast cancer screening guidelines and providing a list of members in need of mammogram. • Multi-channel member outreach campaign provides information on covered services and the importance of breast cancer screenings. • Twice annually, partner with Arizona Diagnostic Radiology to conduct outreach calls to members in need of a mammogram, to offer scheduling assistance. • Additional provider education for those areas mentioned that are underutilized. • Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to providers in underutilized areas. • Develop and implement a written or multi-channel outreach (text/IVR/email) intervention for newly enrolled female members aged 50-74, as well as members aged 52-59. • Addition of Breast Cancer Screening measure to Value-Based programs. • Consideration of partnership with mobile mammography provider in targeted zip codes. • Review barriers to transportation accessibility and develop interventions to address those barriers. • Improve upon the communication to ALTCS case management team and members about the availability of the incentives for mammograms.

Contractor	Intervention
	• Review this topic at the ALTCS Member Council to obtain member feedback to address disparities. • Develop content that is specific to this disparity to be included in provider newsletters and the Mercy Care Provider Conference. • Collaborate with Pop Health Care by providing a list of ALTCS members assigned to them who need a mammogram for coordination.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-23 presents strengths, opportunities for improvement, and recommendations for Mercy Care LTC related to PIPs, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-23—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care LTC developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]**
Opportunities for Improvement and Recommendations
Mercy Care LTC showed a 3.6 percentage point decline in the indicator rate between the baseline year and intervention year 1. Between intervention year 1 and intervention year 2, the indicator rate showed a decline of 2.1 percentage points. When compared to the baseline year indicator rate, the intervention year 2 rate was 5.7 percentage points below the baseline year rate. The decline noted in the indicator rate may indicate that the COVID-19 PHE had an impact on the rate of compliance with breast cancer screenings. **[Quality]** Recommendation: As the PIP progresses, HSAG recommends that Mercy Care LTC: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-24 presents PIP recommendations made to Mercy Care LTC in the CYE 2021 Annual Technical Report[5-21] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-24—Mercy Care LTC Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP was in an intervention year and no opportunities for improvement had yet been identified, HSAG recommended that Mercy Care LTC continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.
Mercy Care LTC's Response: Intervention progress: Interventions continue. Goal achievement status: The PIP goal is to demonstrate a statistically significant increase in the number and percentage of breast cancer screenings, followed by sustained improvement for one consecutive year. Mercy Care LTC's analysis of the MY 2020 and MY 2021 rates demonstrates that the PHE had a significant impact on the rates of compliance with preventive health services, such as mammograms to screen for breast cancer. The MY 2020 and MY 2021 rates demonstrated a decline as compared to the baseline (CYE 2019) rate. However, as noted above, Mercy Care LTC's 2022 year to date rate of compliance with the breast cancer screening measure reveals year over year improvement, with the current rate demonstrating an improvement when compared to the rate at the same time last year.
HSAG's Assessment: HSAG reviewed Mercy Care LTC's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that Mercy Care LTC has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

Compliance Reviews

AHCCCS conducts a full compliance review for each Contractor every three years. However, complications arising from the COVID-19 PHE delayed compliance activities for the ALTCS-EPD

[5-21] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Program. AHCCCS is now on track with conducting full compliance reviews every three years following the interruption, as compliance activities are projected for CYE 2023.

Results

In CYE 2019, Mercy Care LTC scored 95 percent or above in the CC, CIS, GA, GS, MI, and RI Focus Areas. While not at or above 95 percent, Mercy Care LTC was found to be above the ALTCS-EPD Program average in the MCH, MM, and QM Focus Areas. On July 3, 2019, AHCCCS finalized the report findings and provided Mercy Care LTC with a CAP submission matrix and required a CAP for any standard with a total score of less than 95 percent. In a letter dated September 13, 2022, AHCCCS informed Mercy Care LTC that its proposed CAP was accepted and closed. Table 5-25 presents Mercy Care LTC's results from the recent compliance review as well as the program-level average for each Focus Area.

Table 5-25—Mercy Care LTC Compliance Results Compared with ALTCS-EPD Program-Level Average Results

Focus Areas	Mercy Care LTC		Program-Level Average
Year Reviewed	CYE 2019	Projected 2023*	2019
CM	82%	TBD	88%
CC	100%	TBD	100%
CIS	98%	TBD	98%
DS	89%	TBD	89%
GA	100%	TBD	100%
GS	100%	TBD	100%
MCH	93%	TBD	80%
MM	94%	TBD	93%
MI	100%	TBD	97%
QM	91%	TBD	87%
QI	NR+	TBD	NR+
RI	100%	TBD	100%
TPL	87%	TBD	96%
ISOC	NR+	TBD	NR+

*TBD = "to be determined." AHCCCS will be conducting compliance reviews for the ALTCS-EPD Program Contractors during CYE 2023.
+ NR = "not reviewed." These Focus Areas were not reviewed separately during the compliance review; however, elements of the Focus Areas were included in other Focus Areas (e.g., QI standards included in QM and ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 5-26 presents strengths, opportunities for improvement, and recommendations for Mercy Care LTC related to compliance based on the CYE 2019 review, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-26—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care LTC scored at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]** • Grievance Systems (GS) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Reinsurance (RI) **[Quality]**
Opportunities for Improvement and Recommendations
Mercy Care LTC scored below 95 percent in the following Focus Areas: • Case Management (CM) **[Quality, Access]** • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Quality Management (QM) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that in advance of the forthcoming compliance review, Mercy Care LTC conduct a self-assessment of the CM, DS, MCH, MM, QM, and TPL requirements.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-27 presents compliance recommendations made to Mercy Care LTC in the CYE 2021 Annual Technical Report[5-22] and Mercy Care LTC's follow-up to the recommendations, as well as an

[5-22] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at:

assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-27—Mercy Care LTC's Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
Although no Operational Review (OR) CAP findings were provided for CYE 2021, HSAG recommended 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 LTC's Response: Mercy Care LTC reported that in response to the HSAG compliance recommendation, annual and ad hoc reviews have been ongoing.
HSAG's Assessment: Based on the response provided by Mercy Care LTC, HSAG determined that Mercy Care LTC has satisfactorily addressed the prior year's recommendation.

Network Adequacy Validation

Results

HSAG evaluated Mercy Care LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents biannual validation findings specific to the ALTCS-EPD LOB, with one results table for the following GSA:

- Central GSA: Gila, Maricopa,[5-23] and Pinal counties
- South GSA: Pima County

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, 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 ALTCS-EPD LOB. The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the ALTCS-EPD 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

https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

[5-23] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.

instances in which HSAG's time/distance results did not meet the compliance standard, regardless of the Contractor's ACOM 436 results.

An asterisk (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Table 5-28—Mercy Care LTC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements

	Gila		Maricopa		Pinal	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	99.5^	99.5^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100*^	100*^	99.4^	98.5^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	99.8	99.7	NA	NA
Cardiologist, Adult	100^	100^	100^	100^	100^	100^
Cardiologist, Pediatric	100*^	100*^	100^	100^	100^	100^
Dentist, Pediatric	100*	100*	99.6	99.5	100	100
Hospital	100	100	100	100	100	100
Nursing Facility (Only ALTCS-EPD plans)	100	100	99.9	100	100	100
OB/GYN	100*	100*	100	100	100	100
Pharmacy	100	100	99.7	99.7	100	100
PCP, Adult	100^	100^	99.9^	99.9^	100^	100^
PCP, Pediatric	100*^	100*^	100^	99.5^	100^	100^

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

* indicates fewer than 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 5-29—Mercy Care LTC Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements

	Pima	
Minimum Network Requirement	**Q2**	**Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	98.6^	98.5^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	96.0^	95.2^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	98.5	98.2

Minimum Network Requirement	Pima	
	Q2	Q4
Cardiologist, Adult	99.9^	99.9^
Cardiologist, Pediatric	100^	100^
Dentist, Pediatric	100	100
Hospital	100	99.8
Nursing Facility (Only ALTCS-EPD plans)	99.7	99.7
OB/GYN	98.4	100
Pharmacy	99.6	99.6
PCP, Adult	99.9^	100^
PCP, Pediatric	100^	100^

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

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-30 presents strengths, opportunities for improvement, and recommendations for Mercy Care LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-30—Mercy Care LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
Mercy Care LTC met all time/distance network standards for both quarters in CYE 2022 for all assigned counties. **[Access]** Note: Mercy Care LTC provides coverage in the following counties: Gila, Maricopa, Pima, and Pinal.
Opportunities for Improvement and Recommendations
HSAG identified no opportunities for improvement. Recommendation: While HSAG did not have any recommendations specific to its existing provider network coverage, Mercy Care LTC should continue to maintain current compliances.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-31 presents NAV recommendations made to Mercy Care LTC in the CYE 2021 Annual Technical Report[5-24] and Mercy Care LTC's follow-up to the recommendations, as well as an assessment of the degree to which Mercy Care LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-31—Mercy Care LTC Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG recommended the following to Mercy Care LTC: • Continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Continue to monitor and maintain its existing provider network coverage
Mercy Care LTC's Response: Mercy Care LTC continues to review the data provided in these reports to AHCCCS and find trends that can be corrected keeping the error ratios as low as possible. Efforts are ongoing. Current quarter error rate for this LOB: 0.30%. Mercy Care LTC routinely monitors their network for both reportable and perceived gaps. Utilizing reports from HSAG, in addition to other internal reporting methods, Mercy Care LTC reviews AHCCCS registered, non-participating providers to their existing network to identify expansion opportunities. Mercy Care LTC will continue this process, as outlined in detail in its annual network plans. During FY22, Mercy Care added over 200 new providers, with various specialties, to its network.
HSAG's Assessment: Based on the CYE 2022 NAV results and the response provided by Mercy Care LTC, HSAG determined that Mercy Care LTC has satisfactorily addressed the prior year's recommendation.

Mercy Care LTC's Best and Emerging Practices

Table 5-32 presents the best and emerging practices provided by Mercy Care LTC for CYE 2022. HSAG made only minor edits to Mercy Care LTC's submission to enhance readability. Best practice responses may be based on Contractor internal data and not EQR validated rates.

[5-24] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Table 5-32—Mercy Care LTC Best and Emerging Practices

Mercy Care LTC Best and Emerging Practices—R.O.S.E. Program with Assisted Living Centers
Mercy Care LTC has partnered with the R.O.S.E. (Resources/Outreach to Safeguard the Elderly) Program to promote awareness to the elderly community, with the focus of those age 60 and over. R.O.S.E. provides education and resources to prevent this population from falling prey to scams. The R.O.S.E. mission is to prevent the financial exploitation and defrauding of the elderly through advocacy and education. Their vision is "retirement should be the best years of your life, it should be protected at all costs." The goal is to reduce the number of victims of financial fraud. The founder of R.O.S.E. is currently presenting information about various scams to Mercy Care LTC members and residents that reside in assisted living centers in Maricopa County. Mercy Care LTC is sponsoring education of R.O.S.E. to communities working with the ALTCS Program through Mercy Community Action Resources Education Service (C.A.R.E.S.) – a community reinvestment grant. There will be a total of 10 Assisted Living Centers across Maricopa County, each community will receive two presentations six months apart for a total of 20 presentations. The first presentation occurred at Immanuel Manor Assisted Living Center on September 29, 2022. The program is offered to all residents, family members and staff at the assisted living – not just Mercy Care LTC. Our projected outcome is to increase knowledge and awareness of scams and fraud to prevent financial exploitation to the members we serve and others. All tracking will be provided by the founder as part of the outcomes in the grant agreement. The founder has a survey that will be given to every person that attended the presentation. As this program has just started, outcomes will be available once all presentations have been completed.
Mercy Care LTC Best and Emerging Practices—"Mercy Pets" Pilot Program
History: A member in a nursing home was struggling with her current placement. She had increased anxiety, stress, and behaviors. Her daughter introduced her to a ROBOCAT. The results were almost immediate with decreased episodes of anxiety, stress, and behaviors. This member's quality of life has improved significantly because of the ROBOCAT. This was the initiation of Mercy Pets. It Takes a Team: Mercy Pets is a C.A.R.E.S. collaboration between Mercy Care, TapRoot Interventions and Solutions, Inc. (TapRoot) and Immanuel Campus of Care, a CCRC (Continuing Care Retirement Community) in Peoria. Mercy C.A.R.E.S. provided a community reinvestment grant for 168 motion detection animals (Mercy Pets). The motion detection animals were distributed to Mercy Care LTC members experiencing Alzheimer's and dementia-related symptoms residing at Immanuel Campus of Care and other Mercy Care LTC network providers beginning September 2022. The purpose is to collect information on how the members respond to their Mercy Pet. TapRoot created a digital assistant called Ella® that helps caregivers personalize approaches and interventions for residents experiencing Alzheimer's and dementia-related symptoms. Ella delivers

Mercy Care LTC Best and Emerging Practices—"Mercy Pets" Pilot Program

fast and convenient information regarding each resident, their specific behavioral episodes and two to four suggested non-drug related interventions to help de-escalate certain dementia related behaviors.

Program Description:
Mercy Pets to help Mercy Care LTC members with loneliness, social isolation, stress, anxiety and possible reductions in psychotropic medications and pain medications. Behavioral problems may affect individuals with Global Cognitive Impairment (GCI) Diagnosis, increasing the cost and burden of care. Pet therapy has been known to be emotionally beneficial for many years. Robotic pets have been shown to have similar positive effects without the negative aspects of traditional pets. Robotic pet therapy offers an alternative to traditional pet therapy.

Process:

Pilot Project Sites:

1. Immanuel skilled nursing facility (SNF) started September 2022

Upcoming Project Sites:

2. Scottsdale Village Square SNF/ ALF (assisted living facility)
3. Desert Haven SNF/ALF
4. Parks Senior Villas sites Goodyear and Tucson La Canada

Facilities Responsibilities:

1. Ensure Mercy Pet is safe and owned by one member
2. Ensure Batteries are maintained
3. Stolen Mercy Pet will need to be replaced
4. Issues of Mercy Pet to be reported to case manager
5. Place members name in permanent marker or sticker on battery lid (its covered by fur so member will not see it)
6. Review both pamphlets by Joy for All (manufactures Mercy Pets) with staff
   Care Guide of Mercy Pet
   Impact and Benefits of Mercy Pet
7. Keep a spreadsheet of Mercy Care LTC members

Case Manager Responsibilities:

1. Open a Community Resources/Referral Event (CRRE) Titled: "MERCY PET" and write a description of why member received a robopet (example: behavioral health provider reviewed a recommended), include diagnoses, behaviors, any behavioral health medications, and what did they choose – a dog or cat
2. Document on reviews in Event/CRRE and as needed
3. Note any decreases in level of consciousness (LOC) or medications and increased or decreased behaviors in Mercy Pet Event/CRRE

Mercy Care LTC Best and Emerging Practices—"Mercy Pets" Pilot Program

4. Issues from facilities on Mercy Pets send to Leads

Outcomes:

- Projected outcomes for the project:
- Reduced feelings of depression, isolation, and loneliness
- Reduced use of medication
- Increased cognitive activity
- Increased feelings of purpose
- Reduced burden of care for care partners.
- Improved quality of care

More information on Joy for All Robopets:

- Cat-like movements & sounds: the revolutionary VibraPurr technology gives the cat an authentic purr that sounds and feels just like real purring. Like a real cat would, the companion pet cat is able to open and close its eyes, lift its Paw, open its mouth and move its head and body. The companion pet cat also has synthetic, soft, brushable fur inspired by real feline breeds.
- Built in sensors: using the built-in sensors, the companion pet cat responds to motion and touch such as petting and hugging, much like the real cat's people know and love, but doesn't require any special care or feeding.
- A rich experience: Designed to bring comfort, companionship, and fun to elder loved ones. The ease of care and convenience paired with the state-of-the-art technology makes for the best possible interactive experience for older adults living in senior communities or aging at home, and their caregivers or simply just a person that could use some extra company.
- Award winning: Joy for All companion pets won the caregiver friendly award from today's caregiver two years in 2016 and 2017. This product has appeared in the New York times, people magazine and the Baltimore sun. It has also been seen on CBS and the doctors and heard on BBC radio.
- Ageless innovation: ageless innovation is a global company devoted to developing fun and engaging products for older adults. Beginning with the award-winning line of Joy for All companion pets, originally designed, and launched by Hasbro, ageless innovation is focused on creating products that promote fun, joy, and play while creating meaningful connections for aging loved ones, their families, and caregivers.
- Joy for All results from the treatment with the robopet had decreased stress and anxiety in the treatment group and resulted in reductions in the use of psychotropic/anti-psychotic medications and pain medications in elderly clients with a GCI diagnosis.

Conclusions:
Treatment with the Paro robot decreased stress and anxiety in the treatment group and resulted in reductions in the use of psychoactive medications and pain medications in elderly clients with dementia.

Mercy Care LTC Best and Emerging Practices—"Mercy Pets" Pilot Program
Post survey data indicated that loneliness decreased, while mental well-being, resilience, and purpose in life improved. Frequent interactions with the pets were associated with greater improvement in mental well-being and optimism.

Mercy Care LTC Best and Emerging Practices—Pyx Health

Mercy Care LTC has partnered with Pyx Health to address our members' loneliness and social isolation. Pyx Health was founded in 2017 and blends psychology with technology in one application. Based in Tucson, Arizona, Pyx Health contracts with insurers to identify and alleviate loneliness among at-risk members through an app and call center. Pyx Health was developed for social isolation by opening lines of communication. The Pyx Health Program uniquely addresses loneliness and social isolation to positively impact avoidable hospital and emergency department (ED) utilization among members with a wide range of clinical conditions, including multiple chronic conditions, and to improve service utilization patterns efficiently and cost-effectively.

Pyx is an innovative smartphone solution that can be used on I-phones, androids, tablets, and computers by members that have access to the devices. The application is free to members as Mercy Care provides the program. Once downloaded, Pyx interacts with users through jokes, questions, and other commentary in a guided conversation. In addition, it prompts users to take a shortened version of the University of California Los Angeles (UCLA) Loneliness Scale, a widely used test for loneliness. When members test lonely, it's time for human intervention. Pyx combines artificial intelligence and a professionally trained team to intervene at precise moments in our members' journey. When they identify in the application a member as lonely or in need of a social determinant of health (SDOH) resource, Pyx's Compassionate Call Center is alerted and phones the member to check in. If this occurs during normal business hours, Pyx may contact the assigned Mercy Care LTC Case Manager to assist the member. If the call is after business hours, Pyx will assist as needed and contact the case manager for follow-up. Companion Calls can also be requested for members that do not have devices to access the application.

Interventions This Contract Year:

- 1/27/22 A list of members on ALTCS Member Council was provided to Pyx team for outreach. Feedback on experience will be requested from AMC members at the next council meetings.
- 2/24/22 All staff trained on Pyx. Referral process initiated. Request made for flyers to be approved by AHCCCS to provide to members and review during face-to-face meetings.
- 3/17/22 Pyx presented at AMC meeting; feedback provided on outreach/use.
- 5/5/22 Pyx is coordinating with Mercy Care LTC Marketing Dept to complete, and Marketing will request ALTCS approval to distribute.
- 5/12/22 New process for CM to make warm transfer to Pyx and/or provide the member with a number and website information when member reports interested and wanting more information about Pyx.
- 5/18/ 22 behavioral health clinicians will identify members who could benefit from Pyx Program while completing consults. Those that were identified will be on spreadsheet for follow-up from the supervisor.

Mercy Care LTC Best and Emerging Practices—Pyx Health
• 9/26/22 Flyers approved by ALTCS sent to case managers to begin to hand deliver and review with members at upcoming review visits. • 10/10/22 Pyx set up a meeting with Emcara to review Pyx and Emcara to promote and encourage members to sign up. Emcara is an in-home care solutions and treatment provider with a clinical team and the goal of reducing the total cost of care for vulnerable populations by 10 to 20 percent, while delivering exceptional patient experience and quality.

Mercy Care LTC Best and Emerging Practices—References
Animatronic Pets to Reduce Loneliness Among Older Adults. https://www.tandfonline.com/doi/full/10.1080/13607863.2020.1758906. Journal of Alzheimer's Disease. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5181659/. Rose Advocacy. www.roseadvocacy.org.

UHCCP LTC

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that UHCCP LTC followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 5-33 displays HSAG's PMV findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements.

Table 5-33—CY 2021 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 5-34 presents the CY 2020 and CY 2021 UHCCP LTC performance measure results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 5-34—CY 2020 and CY 2021 UHCCP LTC Performance Measure Results

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	83.0%	80.2%	→	★★★★★
Effective Continuation Phase Treatment	72.8%	71.7%	→	★★★★★

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison	2021 Performance Level[2]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	36.6%	38.0%	→	★★★
30-Day Follow-Up—Total	61.0%	48.0%	→	★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	57.8%	53.4%	→	★★★★★
Engagement of AOD Treatment—Total	2.9%	5.9%	↑	★
Care of Acute and Chronic Conditions				
Comprehensive Diabetes Care				
*HbA1c Poor Control (>9.0%)**	30.4%+	29.7%+	→	★★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	75.9%+	—	★★★★★
Heart Failure Admission Rate				
Heart Failure Admission Rate	—	148.7	—	—
Pediatric Health				
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	—	43.0%	—	★
Annual Dental Visit				
Annual Dental Visit[1]	—	47.7%	—	★★
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	37.2%	38.3%	→	★
Appropriate Utilization of Services				
Ambulatory Care—Total				
*Ambulatory Care—ED Utilization**	—	62.4	—	★
Plan All-Cause Readmissions				
*O/E Ratio—Total**	—	0.6586	—	★★★★★
Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	—	11.4%	—	★

* A lower rate indicates better performance for this measure.
\+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.
[1] The rates included for the *Annual Dental Visit* measure are limited to members 18–20 years of age. Caution should be considered when comparing the rates to the MY 2020 and/or MY 2021 national Medicaid mean.
— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.
↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
→ Indicates stable measure rates.

[2]Performance Levels for CY 2021 were based on comparisons of the HEDIS MY 2021 measure rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
Performance Levels for 2021 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Opportunities for Improvement, and Recommendations

Table 5-35 presents strengths, opportunities for improvement, and recommendations for UHCCP LTC related to performance measures, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-35—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group, UHCCP LTC's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* were at or above the 90th percentile, indicating strength in providing follow-up care for behavioral health to members **[Quality, Timeliness, Access]**
In the Care of Acute and Chronic Conditions measure group: • UHCCP LTC's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[5-25] [**Quality**] • UHCCP LTC's performance measure rate for *Controlling High Blood Pressure* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[5-26] [**Quality**]
In the Appropriate Utilization of Services measure group, UHCCP LTC's *Plan All-Cause Readmissions—O/E Ratio—Total* measure rate met or exceeded the 90th percentile, indicating that members were generally not experiencing unplanned acute readmissions within 30 days following an acute inpatient admission or observation stay. [**Quality**]

[5-25] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
[5-26] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
While UHCCP LTC was successful in reporting valid CY 2022 rates for all AHCCCS-required performance measures, the PMV audit identified some considerations and recommendations for future years' reporting: **[Quality]** Recommendation: HSAG recommends that UHCCP LTC ensure compliance with AHCCCS' requirements for continuous enrollment criteria for AHCCCS PMV reporting. Additionally, HSAG recommends that UHCCP LTC continue to 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**.**
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. **[Quality]** Recommendation: HSAG recommends that UHCCP LTC explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. UHCCP LTC should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
In the Behavioral Health Care measure group: • UHCCP LTC's performance measure rate for *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* fell below the 25th percentile, indicating that members who initiated in AOD treatment may not have had two or more additional AOD treatment services or MAT in the 34 days following their 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.[5-27] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]** Recommendation: While UHCCP LTC implemented interventions specific to its CY 2020 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* measure, its rate remained low in CY 2021. HSAG therefore continues to recommend that UHCCP LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. UHCCP LTC 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). This could include conducting focus groups to

[5-27] National Committee for Quality Assurance. Initiation and Engagement of AOD 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 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, BUFC LTC should implement interventions that address the identified root cause of the low rate, targeting the interventions so that UHCCP LTC improves performance related to engaging in timely treatment following an initiation visit. • UHCCP LTC's performance measure rate for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* fell below the 25th percentile, indicating that members were not always accessing follow-up care with a mental health provider within 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.[5-28] Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that UHCCP LTC conduct a root cause analysis to determine why some members were not receiving timely follow-up care with a mental health provider. UHCCP LTC should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of mental health service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, UHCCP LTC should implement appropriate interventions to improve performance related to follow-up care following a hospitalization.
In the Preventive Screening measure group, UHCCP LTC's performance measure rate for *Breast Cancer Screening* fell below the 25th percentile, indicating that women were not always receiving timely screening for breast cancer. Early detection reduces the risk of dying from this type of cancer and can lead to a greater range of treatment options and lower healthcare costs. A factor that may have contributed to low performance is the temporary suspension of nonurgent services and in-person PCP appointments due to the COVID-19 PHE. **[Quality]** Recommendation: While UHCCP LTC conducted a root cause analysis and implemented interventions specific to its *Breast Cancer Screening* measure, its rate remained low in CY 2021. HSAG therefore recommends that UHCCP LTC continue to implement appropriate interventions to improve performance related to members' access to timely screenings for breast cancer. HSAG

[5-28] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Jan 25, 2022.

Strengths, Opportunities for Improvement, and Recommendations
also recommends that UHCCP LTC monitor and expand upon interventions currently in place to improve performance related to the *Breast Cancer Screening* measure.
In the Pediatric Health measure group, UHCCP LTC's performance measure rate for *Child and Adolescent Well-Care Visits* fell below the 25th percentile, indicating that not all children and adolescents were receiving their well-care visits. Assessing physical, emotional, and social development is important at every stage of life, particularly for children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[5-29] **[Quality, Access]** Recommendation: HSAG recommends that UHCCP LTC identify best practices to support children in receiving well-care visits. according to recommended schedules. HSAG recommends that UHCCP LTC consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health measure group.
In the Appropriate Utilization of Services measure group, UHCCP LTC's performance measure rate for *Use of Opioids at High Dosage* fell below the 25th percentile. This result provides an opportunity for UHCCP LTC to monitor prescribing and utilization data and to implement interventions to improve care and services around opioid prescribing. The CDC guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 MED and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[5-30] **[Quality]** Recommendation: HSAG recommends that UHCCP LTC conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids. Upon identification of a root cause, HSAG recommends that UHCCP LTC implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-36 presents performance measure recommendations made to UHCCP LTC in the CYE 2021 Annual Technical Report[5-31] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations.

[5-29] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2023.
[5-30] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/. Accessed on: Mar 7, 2023.
[5-31] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-36—UHCCP LTC Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that UHCCP LTC 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.
UHCCP LTC's Response:
The measures and source code are generated by our certified software vendor, who reviewed the source code directly with the auditor. UHCCP LTC does perform QA testing on the measures, comparing the results to previous years and other markets to confirm accuracy.
HSAG's Assessment:
Considering this recommendation's intention to ensure ongoing oversight of the certified software vendor, which UHCCP LTC has explained is conducted through quality assurance testing on the measures, HSAG has determined UHCCP LTC has satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that UHCCP LTC conduct a root cause analysis to determine why members were not receiving timely AOD services or MAT. UHCCP LTC 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). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Additionally, UHCCP LTC should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, UHCCP LTC should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.
UHCCP LTC's Response:
UHCCP LTC is collaborating with Optum Behavioral Health (OBH) and other UHC state health plans in the Substance Use Disorder (SUD) Quality Metrics Workgroup. The goals of the workgroup include: • Collaboration with other substance use initiatives and workgroups (Optum and UHC) • Identification and creation of member and family materials for substance use • Identification of materials geared toward helping providers screen properly and identify care pathways for members they newly diagnose with SUD • Catalogue product list for available substance use materials

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
The areas of focus for the SUD workgroup for 2022 are to improve messaging to PCPs about screening (tools) and referral for alcohol and drug screening, Brief Intervention, and Referral to Treatment (SBIRT); cannabis use disorders; the psychological and developmental risks for youth and college-aged young adults for cannabis use; and better options to manage pain, depression, sleep, and anxiety. The workgroup is in the process of conducting a barrier analysis to identify factors impacting the diagnosis and treatment of members with SUD. They will also be implementing a PCP survey to identify how providers are currently helping members titrate off opioids.
HSAG's Assessment: UHCCP LTC identified interventions that were implemented for CY 2021 and indicated a barrier analysis is underway, however did not provide evidence of a root cause analysis upon which the interventions were based; therefore, HSAG determined that UHCCP LTC partially addressed the prior year's recommendation.
Recommendation 3:
HSAG recommended that UHCCP LTC conduct a root cause analysis or focus study to determine why its female members were not receiving timely screening for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, UHCCP LTC should implement appropriate interventions to improve the performance related to preventive screenings.
UHCCP LTC's Response: UHCCP LTC conducted a root cause analysis in November 2020 to identify why members do not receive timely breast cancer screenings. Identified barriers included that members may not know that it is a covered benefit, members may not feel it is necessary as they age, and providers may not submit claims to Medicaid if covered under another plan. UHCCP LTC continued researching root causes in 2021: from January through June 2021, UHCCP LTC Case Managers outreached members in need of a mammogram to encourage them to schedule one, and during the calls, they surveyed members on why they hadn't gotten their mammograms. As a result of the survey, the root cause analysis was updated in June to include COVID-19 and physical limitations as additional barriers. To encourage members to get mammograms, UHCCP LTC offers a gift card for getting a mammogram. The plan also mails annual reminders and performs live outreach calls to members due for a mammogram. UHCCP LTC offers accountable care organizations (ACOs) and providers incentives for meeting breast cancer screening target rates.
HSAG's Assessment: While opportunity remains for UHCCP LTC to improve its *Breast Cancer Screening* measure rate, UHCCP LTC conducted a root cause analysis and identified CY 2021 interventions. HSAG has therefore determined that UHCCP LTC has satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

In CY 2022, UHCCP LTC continued the *Breast Cancer Screening* PIP, which was initiated in CYE 2019. As this PIP is in an intervention year, PIP validation activities focused on intervention analysis. UHCCP LTC submitted interventions implemented during CY 2022 along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate UHCCP LTC's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or sustained improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 5-37 provides the *Breast Cancer Screening* PIP baseline and intervention year rates for UHCCP LTC.

Table 5-37—UHCCP LTC *Breast Cancer Screening* PIP Rates

Contractor	PIP Indicator: *Breast Cancer Screening*		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
UHCCP LTC	34.1%	37.2%	38.3%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Interventions

Table 5-38 presents PIP interventions for UHCCP LTC during CY 2022. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 5-38—UHCCP LTC *Breast Cancer Screening* PIP Interventions

Contractor	Intervention
UHCCP LTC	• SNF & ALF mailer: letter to SNFs and ALFs with list of members in need of *breast cancer screening* • Long-term care (LTC) High Risk Nurse Manager outreach of members with gaps in care in Home & Community Based Services (HCBS)

Contractor	Intervention
	• Clinical Practice Consultants (CPCs) Monthly Talking Points and Provider Care Opportunities Report (PCOR) • Case Managers (CMs) provide *breast cancer screening* education to members during assessments • CMS can authorize additional time for direct care workers to assist in coordinating trips to preventative screenings and physician offices. • Welltok IVR calls to members with *breast cancer screening* gaps in care • Program Member Outreach Program via Text, Email, or IVR • Incentive provided to members who close gaps in care • Outbound live calls by QM Staff • Provider gaps in care quarterly mailing to providers not assigned a CPC • Member Mailer: *Breast cancer screening* member reminder mailer (QM Member Mailing) • Case Manager Education: *Breast cancer screening* education series during CM weekly team meetings • Member Live Call to *Breast cancer screening* members • Mercy Care LTC Member Newsletter: *Breast cancer screening* Education • AZ Medicaid Savings Aggregation Letter "Earn bonuses through the UnitedHealthcare Community Plan Shared Savings Program" (2021/2022) • UHCCP QM & LTC collaboration with American Cancer Society (ACS) (Discuss *Breast cancer screening* and explore opportunities to work together on improving *breast cancer screening* rates) • ACS educational presentation (to LTC CM) titled "Return to Screening Initiative & Breast Cancer" • Quality measure for 2021 Community Plan-Primary Care Professional Incentive (CP-PCPi) • QM Mailings: Health Disparities: *Breast cancer screening* letter to Black members with gaps in care (Reminder letters July and follow-up letters October) • QM Live Calls: Health Disparities: *Breast cancer screening* Black members with gaps in care: a) *breast cancer screening* only and b) those with both *cervical cancer screening* and *breast cancer* and *breast cancer screening* gaps in care

Strengths, Opportunities for Improvement, and Recommendations

Table 5-39 presents strengths, opportunities for improvement, and recommendations for UHCCP LTC related to PIPs, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-39—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP LTC developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality]** HSAG noted that the intervention year 2 indicator rate increased over the intervention year 1 and baseline year indicator rates. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG did not note any opportunities for improvement for UHCCP LTC. Recommendation: As the PIP progresses, HSAG recommends that UHCCP LTC: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-40 presents PIP recommendations made to UHCCP LTC in the CYE 2021 Annual Technical Report[5-32] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[5-32] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Table 5-40—UHCCP LTC Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP is in an intervention year and no opportunities for improvement have yet been identified, HSAG recommended that UHCCP LTC should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.
UHCCP LTC's Response: UHCCP LTC initiated multiple interventions to impact LTC *breast cancer screening* rates and continues to assess the impact and effectiveness of the interventions. In MY 2021, UHCCP's LTC *breast cancer screening* rate had improved by more than four percentage points from the PIP baseline rate.
HSAG's Assessment: HSAG reviewed UHCCP LTC's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that UHCCP LTC has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

Compliance Reviews

AHCCCS conducts a full compliance review for each Contractor every three years. However, complications arising from the COVID-19 PHE delayed compliance activities for the ALTCS-EPD Program. AHCCCS is now on track with conducting full compliance reviews every three years following the interruption, as compliance activities are projected for CYE 2023.

Results

In CY 2019, UHCCP LTC scored 95 percent or above in the CC, CIS, GA, GS, MI, RI, and TPL Focus Areas. While not at or above 95 percent, UHCCP LTC was found to be above the ALTCS-EPD Program average in the CM and DS Focus Areas. On May 15, 2019, AHCCCS finalized the report findings and provided UHCCP LTC with a CAP submission matrix and required a CAP for any standard with a total score of less than 95 percent. In a letter dated May 25, 2022, AHCCCS informed UHCCP LTC that its proposed CAP was accepted and closed. Table 5-41 presents UHCCP LTC's results from the recent compliance review as well as the program-level average for each Focus Area.

Table 5-41—UHCCP LTC Compliance Results Compared with ALTCS-EPD Program-Level Average Results

Focus Areas	UHCCP LTC		Program-Level Average
Year Reviewed	CYE 2019	Projected 2023*	2019
CM	89%	TBD	88%
CC	100%	TBD	100%
CIS	98%	TBD	98%
DS	90%	TBD	89%
GA	100%	TBD	100%
GS	100%	TBD	100%
MCH	75%	TBD	80%
MM	90%	TBD	93%
MI	93%	TBD	97%
QM	86%	TBD	87%
QI	NR+	TBD	NR+
RI	100%	TBD	100%
TPL	100%	TBD	96%
ISOC	NR+	TBD	NR+

*TBD = "to be determined." AHCCCS will be conducting compliance reviews for the ALTCS-EPD Contractors during CYE 2023.
+ NR = "not reviewed." These Focus Areas were not reviewed separately during the compliance review; however, elements of the Focus Areas were included in other Focus Areas (e.g., QI standards included in QM and ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 5-42 presents strengths, opportunities for improvement, and recommendations for UHCCP LTC related to compliance, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-42—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP LTC scored at or above 95 percent in the following Focus Areas: • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • General Administration (GA) **[Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations
• Grievance Systems (GS) **[Timeliness, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
UHCCP LTC scored below 95 percent in the following Focus Areas: • Case Management (CM) **[Quality, Access]** • Delivery Systems (DS) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]** • Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** Recommendation: HSAG recommends that in advance of the forthcoming compliance review, UHCCP LTC conduct a self-assessment of the CM, DS, MCH, MM, MI, and QM requirements.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-43 presents compliance recommendations made to UHCCP LTC in the CYE 2021 Annual Technical Report[5-33] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-43—UHCCP LTC's Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
Although no CAP findings were provided for CYE 2021, HSAG recommended 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.
UHCCP LTC's Response: UHCCP had two compliance reviews in 2022 and is remedying any identified CAPs to ensure the plan remains compliant with the requirements in each of the AHCCCS Focus Areas.

[5-33] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Prior Year's Recommendation from the EQR Technical Report for Compliance
HSAG's Assessment: Based on the response provided by UHCCP LTC, HSAG determined that UHCCP LTC has satisfactorily addressed the prior year's recommendation.

Network Adequacy Validation

Results

HSAG evaluated UHCCP LTC's compliance results with AHCCCS' time/distance standards by GSA and county. This section presents biannual validation findings specific to the ALTCS-EPD LOB, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[5-34] and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, 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 ALTCS-EPD LOB. The value "NR" is shown for time/distance standards in which no members met the network requirement denominator for the ALTCS-EPD 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 (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

[5-34] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.

Table 5-44—UHCCP LTC Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements

	Gila		Maricopa		Pinal	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	99.2^	97.6^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR*^	NR*^	100^	98.6^	100*^	100*^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	98.9	98.6	NA	NA
Cardiologist, Adult	100^	100^	99.9^	99.9^	100^	100^
Cardiologist, Pediatric	NR*^	NR*^	100^	100^	100*^	100*^
Dentist, Pediatric	NR*	NR*	100	100	100*	100*
Hospital	100	100	99.9	99.9	100	100
Nursing Facility (Only ALTCS-EPD plans)	1001	100	98.7[1]	99.7	100[4]	100
OB/GYN	100*	100*	100	100	100	100
Pharmacy	100	100	99.3	99.3	100	100
PCP, Adult	100^	100^	99.8^	99.8^	100^	100^
PCP, Pediatric	NR*^	NR*^	100^	100^	100*^	100*^

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 10 members were included in the denominator of HSAG's results.

^ Indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

1 In CYE 2022 Q2, UHCCP LTC's data included substantially decreased numbers of providers used to measure the Nursing Facility standard, as compared to prior submissions. This potentially influenced the validated compliance for this provider type. A review found that most nursing facilities reported in the PAT file submission were rejected, possibly related to the use of a field not typically associated with facility. AHCCCS has requested that the Contractor submit test files for these facilities to ensure it uses a format that passes the process.

Table 5-45—UHCCP LTC Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements

	Apache		Coconino		Mohave		Navajo		Yavapai	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	97.7^	97.3^	100^	99.1^	100^	98.7^	100^	99.5^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100*^	NR*^	100*^	100*^	100*^	100*^	100*^	100*^	100^	100*^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

	Apache		Coconino		Mohave		Navajo		Yavapai	
Minimum Network Requirement	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**	**Q2**	**Q4**
Cardiologist, Adult	97.7^	95.9^	100^	100^	100^	100^	100^	99.5^	100^	100^
Cardiologist, Pediatric	100*^	NR*^	100*^	100*^	100*^	100*^	100*^	100*^	100^	100^
Dentist, Pediatric	100*	NR*	100*	100*	100*	100*	100*	100*	100	100
Hospital	100	100	100	100	99.9	99.9	100	100	100	100
Nursing Facility (Only ALTCS-EPD plans)	6.8[1]	98.0	88.8[1]	89.2	97.2[1]	97.0	27.4[1]	100	99.5[1]	100
OB/GYN	100*	100*	100*	100*	100	100	100	100	100	100
Pharmacy	100	97.3	99.2	99.1	99.4	99.7	100	100	99.8	99.9
PCP, Adult	100^	100^	100^	100^	99.6^	99.7^	100^	100^	100^	100^
PCP, Pediatric	100*^	NR*^	100*^	100*^	100*^	100*^	100*^	100*^	100^	100^

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 10 members were included in the denominator of HSAG's results.

^ indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

1 In CYE 2022 Q2, UHCCP's data included substantially decreased numbers of providers used to measure the Nursing Facility standard, as compared to prior submissions. This potentially influenced the validated compliance for this provider type. A review found that most nursing facilities reported in the PAT file submission were rejected, possibly related to the use of a field not typically associated with facility. AHCCCS has requested that the Contractor submit test files for these facilities to ensure it uses a format that passes the process.

Strengths, Opportunities for Improvement, and Recommendations

Table 5-46 presents strengths, opportunities for improvement, and recommendations for UHCCP LTC related to NAV, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 5-46—UHCCP LTC Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
UHCCP LTC met all time/distance network standards in all assigned counties for CYE 2022 Q4, except for Coconino County. **[Access]** Note: UHCCP LTC provides coverage in the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • Isolated data issues may have contributed to specific instances affecting UHCCP LTC's compliance with time/distance standards **[Access]** • UHCCP LTC failed to meet the Nursing Facility Standard in Coconino County **[Access]** Recommendation: HSAG recommends that UHCCP LTC: • Continue to monitor its processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Maintain current compliances, but continue to address network gaps, as applicable

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 5-47 presents NAV recommendations made to UHCCP LTC in the CYE 2021 Annual Technical Report[5-35] and UHCCP LTC's follow-up to the recommendations, as well as an assessment of the degree to which UHCCP LTC has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 5-47—UHCCP LTC Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG recommended the following to UHCCP LTC: • Continue to monitor processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • Continue to monitor and maintain existing provider network coverage with specific attention to ensuring the availability of nursing facilities in Coconino County
UHCCP LTC's Response: UHCCP LTC will continue to monitor and review the PAT file process on a quarterly basis. Although UHCCP LTC only submits biannually to the state of AZ, they run the PAT process quarterly to address any data discrepancies, internal/external errors, and root cause analysis. The PAT file consists of running reporting, comparing data to the state of AZ and performing data remediation as needed. Once UHCCP LTC has remediated all errors, they submit the PAT file to the state of AZ. In addition,

[5-35] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Prior Year's Recommendation from the EQR Technical Report for NAV
UHCCP LTC performs monthly reviews and audits of provider data to ensure the highest level of accuracy is maintained. UHCCP LTC will continue to evaluate the contracted network on a quarterly basis. When gaps in the network are identified, UHCCP LTC conducts a review of the area and category that has underperformed. A thorough audit of the provider community is conducted to include noncontracted providers and any new providers that enter the county. UHCCP LTC is contracted with all available nursing facilities in Coconino County and will continue to assist members in accessing care at the closest facility. UHCCP LTC is not contracted within La Paz County for the LTC LOB.
HSAG's Assessment: Based on the CYE 2022 NAV results and the response provided by UHCCP LTC, HSAG determined that UHCCP LTC has satisfactorily addressed the prior year's recommendation.

UHCCP LTC's Best and Emerging Practices

Table 5-48 presents the best and emerging practices provided by UHCCP LTC for CYE 2022. HSAG made only minor edits to UHCCP LTC's submission to enhance readability. Best practice responses may be based on Contractor internal data and not EQR validated rates.

Table 5-48—UHCCP LTC Best and Emerging Practices

UHCCP LTC Best and Emerging Practices—Behavioral Health Diabetic Education
UHCCP LTC's *Behavioral Health Diabetic Education* is a clinical and behavioral health best practice initiative aimed at educating LTC Case Managers (CM) and members about the increased risk of diabetes associated with taking antipsychotic medications and the importance of annual HbA1c tests. This initiative is targeted at UHCCP LTC members prescribed antipsychotic medications and their assigned LTC CMs. The UHCCP LTC behavioral health quarterly review/consultation process is managed by two full time lead licensed Behavioral Health Professionals (BHP) responsible for coordinating and conducting behavioral health reviews. UHCCP LTC also utilizes its CMs that are licensed BHPs to complete the quarterly review/consultation process for those CMs who are not licensed. Each CM is assigned a BHP to meet with quarterly to complete the behavioral health review. All members who are determined to SMI are also included in these reviews. During the reviews, the BHPs provide education about the increased risk of developing a diabetic condition to members taking antipsychotic medications. They are also encouraged to speak with their physician about their risk of diabetes. The CMs are educated about the importance of annual HbA1c tests to screen for diabetes for members taking antipsychotic medications. Rationale: People with a bipolar disorder or schizophrenia diagnosis are twice as likely to develop diabetes than the general population, and their risk for poorer outcomes with Type 2 diabetes is higher than it is for

UHCCP LTC Best and Emerging Practices—Behavioral Health Diabetic Education
those with diabetes alone (Mulligan, McBain, & Lamontagne-Godwin, 2018). The use of antipsychotics is a contributing factor (Cohn, 2012, p. 29). LTC CMs and members living with schizophrenia or bipolar disorder may not be aware of the increased risk of diabetes when taking antipsychotic medications and the importance of annual preventive screenings for diabetes with HbA1c tests. Including this topic as a point of discussion in the behavioral health quarterly reviews serve as a continuous reminder to LTC CMs and members of the importance of annual HbA1c tests when taking antipsychotic medications. Goal: The goal of incorporating this topic into the UHCCP LTC behavioral health quarterly reviews is to support members who are taking antipsychotic medications to avoid developing diabetes. Related Interventions: UHCCP LTC has several other interventions in place related to this best practice. In 2020, UHCCP LTC implemented a PIP to address health disparities related to diabetes for members living with a serious mental illness. One of the PIP goals is to increase the following quality measure rate: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). PIP interventions include biannual member mailers, biannual provider mailers, and a provider survey on diabetic testing practices. UHCCP LTC CPCs also share PCOR with provider groups when they meet with them each month. The PCOR shows provider groups which of their assigned members have gaps in care in the SSD measure. Outcome: The *Behavioral Health Diabetic Education* Best Practice was a new UHCCP LTC initiative in 2021. At the same time in CY2021, BHPs had provided education to 55 LTC members and their CMs during behavioral health quarterly reviews. The initiative was greatly expanded in CY2022. So far this year, 676 UHCCP LTC members and their CMs have been educated during behavioral health quarterly reviews.

UHCCP LTC Best and Emerging Practices—Pacific Dental Services Foundation
UHCCP LTC partnered with Pacific Dental Services Foundation to provide dental services to members with special needs enrolled in the LTC LOB. This dental focused best practice initiative makes oral health more accessible to UHCCP LTC members with special needs. Rationale: People with disabilities and special needs are at higher risk of oral problems such as tooth decay, malocclusion, and gum disease. Contributing factors include physical limitations, difficulty brushing and flossing, reduced saliva flow, medications, oral conditions, and restricted diets (California Childcare Health Program, ND). People with special needs also frequently have difficulties finding dentists willing to treat them, leading to even more oral problems. Pacific Dental Care Services Foundation is a special care dental provider. Special care dentistry is the branch of oral healthcare that treats people with special needs, including those with physical, medical, developmental, or cognitive conditions, that limits their ability to receive routine dental care

UHCCP LTC Best and Emerging Practices—Pacific Dental Services Foundation
(Singh, N., 2019). Special care dental providers understand the unique needs of this population, and their practices are set up to accommodate them. Accommodations might include scheduling flexibility, wheelchair accommodations, knowledge of behavioral management techniques, additional staff, protective stabilization, sedation, and specialized treatment planning. Goal: The goal of this initiative is to improve oral health for members with special needs by providing access to special care dental providers. Related Interventions: UHCCP LTC has several related interventions in place to improve oral healthcare for all members, including those with special needs, including EPSDT referral calls to members' guardians, reminder mailers and postcards to members' guardians, and provider education materials. UHCCP LTC also has CPCs who meet monthly with primary care and dental providers to share gaps in care reports for dental quality measures. Outcome: UHCCP's LTC LOB exceeded the NCQA 2022 National Average rate of 47.3% by in MY 2021, and the current MY 2022 prospective rate is also on track to exceed it.

UHCCP LTC Best and Emerging Practices—AZ Provider Scorecards
UHCCP LTC's *AZ Provider Scorecard* is a quality-improvement focused best practice initiative that supports primary care practice improvement by providing them access to information on how their performance on quality measures compares to that of their peers. The *AZ Provider Scorecard* rates are reflective of UHCCP LTC members across all lines of business and includes quality measures in the following healthcare categories: • Behavioral Health • Diabetes/Hypertension • Women's Health • Maternity Care • Pediatric Preventive The *AZ Provider Scorecard* helps identify potentially unwarranted variations in care and provides an opening for discussions on how UHCCP LTC can support their efforts to achieve the Triple Aim of better care, better outcomes, and better costs for their patients. UHCCP LTC CPCs use the *AZ Provider Scorecard* as an opportunity for further discussions with the provider groups on how to improve performance for measures where they may have scored lower than peers. CPCs meet with provider groups monthly. Prior to the meeting, the CPC applies the appropriate group-specific filters to the scorecard. It can be filtered by measure, membership tier (number of assigned members), FQHC/RHC, ACO, and CP PCPi incentive type. The scorecard uses a 1 to 5 scale to rank the groups by measure. Groups with a score of '1' would be performing below

UHCCP LTC Best and Emerging Practices—AZ Provider Scorecards
80% of peers in their membership tier for the measure, and groups with a score of '5' would be performing above 80% of peers in their membership tier for the measure. Rationale: According to a Wharton healthcare management professor, the desire to do well in their field and feel professional pride are strong intrinsic motivators for high-skilled professionals such as physicians and surgeons (Kolstad, J.T., 2013). Peer comparison reports like the *AZ Provider Scorecard* help providers better understand where they are performing relative to their peers and can be an effective motivator for improving performance. Goal: The goal in sharing the *AZ Provider Scorecard* is to support provider groups in identifying areas of variation in quality measures, both where they perform better than their peers or have an opportunity for improvement. Related Interventions: UHCCP LTC also has several related interventions in place to increase quality measure rates, including live and IVR reminder calls to members, reminder mailers and postcards to members, provider gaps in care mailers, provider education materials, and provider incentive programs. CPCs also share PCOR with provider groups when they meet with them each month. The PCOR shows provider groups which of their assigned members have quality measure gaps in care. Outcome: The *AZ Provider Scorecard* has been available to share with the provider groups since July 2021. Qualitative feedback from provider groups has generally been positive. CPCs have reported the provider groups found the information interesting, and they like the comparison to groups of similar membership size because this type of information is not available to them otherwise.

UHCCP LTC Best and Emerging Practices—References
California Childcare Health Program. (ND). Oral Health for Children with Disabilities and Special Needs. https://cchp.ucsf.edu/sites/g/files/tkssra181/f/OralHlthSpNeedsEN103006_adr.pdf. Cohn, T. (2012). The link between schizophrenia and diabetes: Vigilant metabolic monitoring informs treatment decisions. Current Psychiatry, 11(10), 29-34. Retrieved from http://www.currentpsychiatry.com/pdf/1110/1110CP_Cohn_Cov.pdf. Kolstad, Jonathan T. (2013). "Information and Quality When Motivation Is Intrinsic: Evidence from Surgeon Report Cards." *American Economic Review*, 103 (7): 2875-2910.DOI: 10.1257/aer.103.7.2875. Mulligan, K., McBain, H., Lamontagne-Godwin, F. et al. Barriers to effective diabetes management – a survey of people with severe mental illness. BMC Psychiatry 18, 165 (2018). https://doi.org/10.1186/s12888-018-1744-5. Singh, N. (2019). Providing Care to Patients with Special Needs. https://dimensionsofdentalhygiene.com/article/caring-%E2%80%A8for-patients-with-special-needs/.

6. ALTCS-DD Program Results

This section provides, by EQR activity, activity-specific strengths, opportunities for improvement, and HSAG's recommendations for performance improvement. This section also includes information about the extent to which DES/DDD was able to address prior year's recommendations and DES/DDD's best practices.

ALTCS-DD Program

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG determined that DES/DDD followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Table 6-1 displays HSAG's PMV findings for each data type reviewed in alignment with the CMS EQR Protocol 2 audit requirements.

Table 6-1—CY 2021 PMV Findings

Data Type	HSAG Findings
Medical Services Data	*No identified concerns*
Enrollment Data	*No identified concerns*
Provider Data	*No identified concerns*
Medical Record Review Process	*No identified concerns*
Supplemental Data	*No identified concerns*
Data Integration	*No identified concerns*

Results for Performance Measures

Table 6-2 presents the CY 2021 ALTCS-DD Program performance measure rates for the DES/DDD measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2021. 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. Measures reported

using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 6-2—CY 2021 National Percentiles Comparison for DES/DDD

Measure	CY 2021 Performance
Behavioral Health	
Antidepressant Medication Management	
Effective Acute Phase Treatment	73.8%
Effective Continuation Phase Treatment	62.1%
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total	68.0%
30-Day Follow-Up—Total	85.6%
Initiation and Engagement of AOD Abuse or Dependence Treatment	
Initiation of AOD Treatment—Total	33.0%
Engagement of AOD Treatment—Total	8.6%
Care of Acute and Chronic Conditions	
Comprehensive Diabetes Care	
*HbA1c Poor Control (>9.0%)**	21.8%+
Controlling High Blood Pressure	
Controlling High Blood Pressure	75.5%+
Pediatric Health	
Child and Adolescent Well-Care Visits	
Child and Adolescent Well-Care Visits	50.4%
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[1]	40.0%
Annual Dental Visit	
Annual Dental Visit	53.9%
Childhood Immunization Status	
Combination 3	77.5%+
Combination 7	38.7%+
Combination 10	31.0%+
Immunizations for Adolescents	
Combination 1	83.5%+
Combination 2	31.8%+
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose Testing—Total	57.0%
Cholesterol Testing—Total	47.3%
Blood Glucose and Cholesterol Testing—Total	45.2%

Measure	CY 2021 Performance
Preventive Screening	
Breast Cancer Screening	
Breast Cancer Screening	48.9%
Cervical Cancer Screening	
Cervical Cancer Screening	19.5%+
Appropriate Utilization of Services	
Ambulatory Care—Total	
*Ambulatory Care—ED Utilization**	29.9
Plan All-Cause Readmissions	
*O/E Ratio—Total**	1.0615

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.

Cells shaded green indicate that the rate met or exceeded the MY 2021 national Medicaid mean.

[1] Due to the small population size for the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, trending should be considered with caution.

Table 6-3 presents the CY 2020 and CY 2021 DES/DDD results for measures that could be compared to the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and MY 2021. Performance measure rate cells shaded green indicate that the rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2020 and/or MY 2021. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures reported using hybrid methodology are identified by a plus sign (+); measures without a plus sign (+) were reported using administrative methodology.

Table 6-3—CY 2020 and CY 2021 Performance Measure Results for DES/DDD

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	72.9%	73.8%	→
Effective Continuation Phase Treatment	69.7%	62.1%	→
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total	68.9%	68.0%	→
30-Day Follow-Up—Total	87.3%	85.6%	→
Initiation and Engagement of AOD Abuse or Dependence Treatment			
Initiation of AOD Treatment—Total	38.8%	33.0%	→
Engagement of AOD Treatment—Total	S	8.6%	—

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care			
*HbA1c Poor Control (>9.0%)**	24.2%+	21.8%+	→
Controlling High Blood Pressure			
Controlling High Blood Pressure	—	75.5%+	—
Heart Failure Admission Rate			
Heart Failure Admission Rate	—	6.1	—
Pediatric Health			
Child and Adolescent Well-Care Visits			
Child and Adolescent Well-Care Visits	47.9%	50.4%	↑
Developmental Screening in the First Three Years of Life			
Developmental Screening in the First Three Years of Life	—	47.8%	—
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[1]	26.2%	40.0%	→
Annual Dental Visit			
Annual Dental Visit	—	53.9%	—
Childhood Immunization Status			
Combination 3	—	77.5%+	—
Combination 7	—	38.7%+	—
Combination 10	—	31.0%+	—
Immunizations for Adolescents			
Combination 1	—	83.5%+	—
Combination 2	—	31.8%+	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total	—	57.0%	—
Cholesterol Testing—Total	—	47.3%	—
Blood Glucose and Cholesterol Testing—Total	—	45.2%	—
Preventive Screening			
Breast Cancer Screening			
Breast Cancer Screening	47.4%	48.9%	→
Cervical Cancer Screening			
Cervical Cancer Screening	—	19.5%+	—
Appropriate Utilization of Services			
Ambulatory Care—Total			
*Ambulatory Care—ED Utilization**	—	29.9	—

Measure	CY 2020 Performance	CY 2021 Performance	2020-2021 Comparison[2]
Plan All-Cause Readmissions			
*O/E Ratio—Total**	—	1.0615	—

* A lower rate indicates better performance for this measure.
+ Indicates the measure was reported using hybrid methodology.
Cells shaded green indicate that the rate met or exceeded the MY 2020 and/or MY 2021 national Medicaid mean.
[1] Due to the small population size for the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, trending should be considered with caution.
— Indicates the CY 2020 rate was not presented in the CYE 2021 Annual Technical Report; therefore, a 2020-2021 comparison is not presented in the CYE 2022 Annual Technical Report.
S indicates that fewer than 11 cases exist in the numerator of this measure; therefore, the rate was suppressed to satisfy the HIPAA Privacy Rule's de-identification standard.
[1] ↑ Indicates improvement of measure rates.
↓ Indicates decline of measure rates.
⟶ Indicates stable measure rates.

Table 6-4 highlights DES/DDD's performance for the current year by measure group. The table illustrates the Contractors' CY 2021 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2021 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

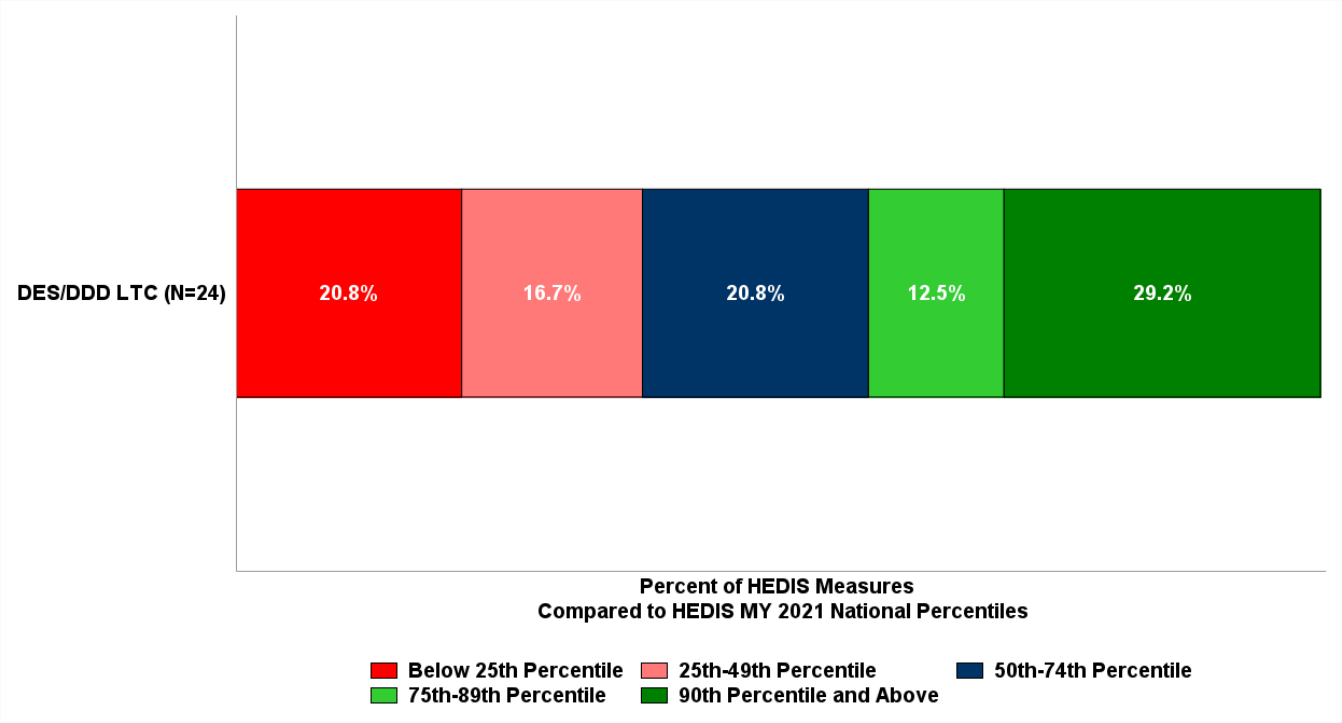
Table 6-4—CY 2021 National Percentiles Comparison for DES/DDD

Measure	CY 2021 Performance
Behavioral Health	
Antidepressant Medication Management	
Effective Acute Phase Treatment	★★★★★
Effective Continuation Phase Treatment	★★★★★
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Total	★★★★★
30-Day Follow-Up—Total	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment	
Initiation of AOD Treatment—Total	★
Engagement of AOD Treatment—Total	★
Care of Acute and Chronic Conditions	
Comprehensive Diabetes Care	
HbA1c Poor Control (>9.0%)	★★★★★

Measure	CY 2021 Performance
Controlling High Blood Pressure	
Controlling High Blood Pressure	★★★★★
Pediatric Health	
Child and Adolescent Well-Care Visits	
Child and Adolescent Well-Care Visits	★★★
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	★
Annual Dental Visit	
Annual Dental Visit	★★★
Childhood Immunization Status	
Combination 3	★★★★★
Combination 7	★
Combination 10	★★
Immunizations for Adolescents	
Combination 1	★★★
Combination 2	★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Blood Glucose Testing—Total	★★★
Cholesterol Testing—Total	★★★★
Blood Glucose and Cholesterol Testing—Total	★★★★
Preventive Screening	
Breast Cancer Screening	
Breast Cancer Screening	★★
Cervical Cancer Screening	
Cervical Cancer Screening	★
Appropriate Utilization of Services	
Ambulatory Care—Total	
Ambulatory Care—ED Utilization	★★★★
Plan All-Cause Readmissions	
O/E Ratio—Total	★★

Figure 6-1 displays DES/DDD's HEDIS MY 2021 performance compared to benchmarks. HSAG analyzed results from 15 performance measures for HEDIS MY 2021 for a total of 24 measure rates.

Figure 6-1—Comparison of Measure Indicators to HEDIS Medicaid National Percentiles for DES/DDD



Strengths, Opportunities for Improvement, and Recommendations

Table 6-5 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 6-5—DES/DDD Strengths, Opportunities for Improvement, and Recommendations for Performance Measures

Strengths, Opportunities for Improvement, and Recommendations
Strengths
In the Behavioral Health Care measure group, DES/DDD's performance measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* were at or above the 90th percentile, indicating strength in providing follow-up care for behavioral health to members. **[Quality, Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations
In the Care of Acute and Chronic Conditions measure group: • DES/DDD's performance measure rate for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* was at or above the 90th percentile, indicating that most members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[6-1] [**Quality**] • DES/DDD's performance measure rate for *Controlling High Blood Pressure* was at or above the 90th percentile, indicating that most members with a diagnosis of hypertension had controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[6-2] [**Quality**]
In the Pediatric Health measure group: • DES/DDD's performance measure rate for *Childhood Immunization Status—Combination 3* was at or above the 90th percentile, indicating that most children were getting their immunizations by their second birthday. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[6-3] [**Quality**] • DES/DDD's performance measure rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* were above the 90th percentile, indicating that most children and adolescents with ongoing antipsychotic mediation use had metabolic testing performed. Metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.[6-4]
Opportunities for Improvement and Recommendations
DES/DDD has responsibility for two subcontracted health plans' data completeness, accuracy, integration, and reporting, and DES/DDD did not have the combined rates representing DES/DDD's aggregated results available until final rate review. **[Quality]** Recommendation: While both subcontracted health plans have multiple years of extensive experience in ongoing performance measure production and reporting, and DES/DDD indicated that it implemented a new tool to conduct routine monitoring of its subcontracted health plans, the opportunity remains to further enhance oversight efforts. In addition to use of the newly developed oversight tool, on an ongoing basis, HSAG recommends that DES/DDD implement

[6-1] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
[6-2] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.
[6-3] National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 3, 2022.
[6-4] National Committee for Quality Assurance. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Available at: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/. Accessed on: Jan 30, 2023.

Strengths, Opportunities for Improvement, and Recommendations
steps to validate and confirm the reported rates of each subcontractor to identify trends in the individual subcontractor's rates. Through use of its new tool, DES/DDD should review and compare quarterly performance rates across both subcontracted health plans and over time to identify any potential differences in services/results, areas for improvement, and best practices to integrate for all DES/DDD members. Furthermore, DES/DDD should review and confirm the final combined calculations of the DES/DDD HEDIS and CMS measures prior to submission for auditor review.
While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, the audit identified a recommendation for future years' reporting. **[Quality]** Recommendation: HSAG recommends that DES/DDD explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. DES/DDD should continue working with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.
In the Behavioral Health Care measure group, DES/DDD's performance measure rates for *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD–Total—Total* and *Engagement of AOD–Total—Total* fell below the 25th percentile, indicating that some members with a new episode of AOD dependence were not always initiating treatment within 14 days of diagnosis or accessing AOD services or MAT 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. Members may have had difficulties finding access to care due to the COVID-19 PHE, as some in-person services were temporarily suspended. **[Quality, Timeliness, Access]** Recommendation: While DES/DDD's subcontracted health plans implemented interventions specific to the CY 2020 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD–Total—Total* rate, the DES/DDD rate remained low in CY 2021. HSAG therefore continues to recommend that DES/DDD conduct a root cause analysis to determine why some members were not receiving timely AOD services or MAT. DES/DDD 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). 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, DES/DDD should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, DES/DDD should implement interventions that address the identified root cause of the low rate, targeting the interventions so that DES/DDD improves performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.

Strengths, Opportunities for Improvement, and Recommendations
In the Pediatric Health measure group: • DES/DDD's performance measure rate for *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* fell below the 25th percentile, indicating that children were not always accessing well-care visits. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[6-5] 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. **[Quality, Access]** Recommendation: While DES/DDD conducted a root cause analysis and implemented interventions specific to its *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, its rate remained low in CY 2021. HSAG therefore recommends that DES/DDD continue to implement appropriate interventions to improve performance related to children accessing well-care visits. HSAG also recommends that DES/DDD monitor and expand upon interventions currently in place to improve performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. • DES/DDD's performance measure rate for *Childhood Immunization Status—Combination 7* fell below the 25th percentile, suggesting that some children were not receiving these immunizations, which are a critical aspect of preventive care for children. Childhood vaccines protect children from a number of serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease.[6-6] The COVID-19 PHE is a reminder of the importance of vaccination. The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Continued coordinated efforts between healthcare providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[6-7] **[Quality]** Recommendation: HSAG recommends that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG also recommends that DES/DDD consider conducting a root cause analysis to identify barriers that members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Pediatric Health measure group.
In the Preventive Screening measure group, DES/DDD's performance measure rate for *Cervical Cancer Screening* fell below the 25th percentile, suggesting that female members were not always receiving timely access to screening for cervical cancer. Prolonged delays in screening related to the COVID-19 PHE may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[6-8] **[Quality]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendation: HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider if there are disparities within DES/DDD's populations that contributed to lower screening rates. Upon identification of a root cause, HSAG recommends that DES/DDD request that its subcontracted health plans implement appropriate interventions to improve access to and timeliness of cancer screenings.
For CY 2022 performance measure reporting, RES will be required based on NCQA HEDIS specifications. Recommendation: HSAG recommends that DES/DDD explore data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratifications related to RES. DES/DDD should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to augment enrollment data information.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 6-6 presents performance measure recommendations made to DES/DDD in the CYE 2021 Annual Technical Report[6-9] and DES/DDD and the DES/DDD subcontracted health plans' follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD and the DES/DDD subcontracted health plans have effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

[6-5] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/#:~:text=Well%2DChild%20Visits%20in%20the,first%2015%20months%20of%20life. Accessed on: Jan 30, 2023.
[6-6] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Mar 7, 2023.
[6-7] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Mar 7, 2023.
[6-8] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Mar 7, 2023.
[6-9] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Table 6-6—DES/DDD Follow-Up to CY 2021 Performance Measure Recommendations

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
Recommendation 1:
HSAG recommended that DES/DDD increase its routine oversight of the volume and trends in each subcontracted health plan's data streams, creating tracking and monitoring reports that are reviewed and analyzed periodically to ensure that services and data are stable with no anomalies throughout the reporting year. DES/DDD should consider reviewing and comparing quarterly performance rates across its subcontracted health plans over time to identify any potential differences in services/results, areas for improvement, and best practices to integrate for all DES/DDD members.
DES/DDD's Response:
As of the 3rd quarter DDD has developed a tool to compare each subcontractor's performance measures and has begun meeting with the analytics team to build an automated process that will include trending. DDD recognizes that enhancements to analysis is key in its monitoring of its subcontracted health plans. Additionally, as of the 4th quarter, the DDD QM department has onboarded its permanent QI/Performance Improvement (PI) Manager possessing years of experience as a subject matter expert in healthcare analytics, performance, and continuous improvement.
HSAG's Assessment:
Although the DES/DDD mechanism for oversight of its subcontracted health plans' performance measure data and results was not in place during CY 2021, DES/DDD has described 3rd quarter implementation of an appropriate tool to conduct monitoring. The addition of the QI/Performance Improvement (PI) Manager to the Quality Management team provided further assurance of ongoing monitoring of subcontracted health plans' results. HSAG has therefore determined that DES/DDD has satisfactorily addressed the prior year's recommendation.
Recommendation 2:
HSAG recommended that DES/DDD conduct a root cause analysis to determine why members were not initiating treatment or receiving timely AOD services or MAT. DES/DDD 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). 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, DES/DDD should identify factors related to the COVID-19 PHE and how access to care was impacted. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to initiating and engaging in timely treatment following a new episode of AOD dependence.
DES/DDD's Response:
DES/DDD's subcontractor, UHCCP, implemented the following: The areas of focus for the SUD workgroup for 2022 are to improve messaging to PCPs about screening (tools) and referral for alcohol and SBIRT; cannabis use disorders; the psychologic aged young adults for cannabis use; and better options to manage pain, depression, sleep, and anxiety. This workgroup is in the process of conducting a barrier analysis to identify factors impacting the diagnosis and treatment of members with SUD. They will also be implementing a PCP survey to identify how providers are currently helping members titrate off opioids.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
DES/DDD subcontractor, Mercy Care, implemented the following interventions in 2022: • Offering Intensive Treatment Systems, a 24-7 access point for MAT services, as a Health Home (HH) for members with SMI and will be adding MAT to each of Mercy Care's existing HH provider locations. • Conducted a survey of the contracted Health Homes and is planning to host work groups with them to identify additional barriers to members accessing timely AOD services or MAT, as well as successes that may be implemented more broadly. • Report created to assist with identifying providers for DES/DDD members who are non-verbal and experiencing substance use issues, so that we can funnel members to them as appropriate. The report may also be used to identify network deficiencies/needs. • Mercy Care's CY 2021 rate of compliance with both IET sub-measures reveal year-over-year improvement, with the current rate for each sub-measure demonstrating an improvement of nearly five percentage points or more, as compared to the CY 2020 rate.
HSAG's Assessment: DES/DDD identified interventions that were implemented for CY 2021 as a result of conducting a root cause analysis; therefore, HSAG determined that DES/DDD satisfactorily addressed the prior year's recommendations.
Recommendation 3:
HSAG recommended that DES/DDD conduct a root cause analysis to determine why children were not always accessing well-care visits. DES/DDD should consider the nature and scope of the issues (e.g., are the issues related to barriers to accessing care, a lack of PCP or OB/GYN service providers, or the need for community outreach and education). This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to well-care visits.
DES/DDD's Response: UHCCP DD's *Back to Basics* PIP workgroup conducted its annual root cause analysis re-review in August 2022 to help determine why members may not get well-child visits. Identified barriers included members' lack of engagement with providers and providers' lack of resources, especially staffing issues caused by the pandemic. Mercy Care DD conducted a root cause analysis, inclusive of completion of a provider survey, was conducted to identify barriers to accessing well-child visits. Identified barriers include: • Members seen outside of the measurement period and not in accordance with the periodicity schedule, i.e. not having a full six visits prior to 15 months of age • Providers only see members for sick visits or shots only visits and not well-visits (adding modifier 25 and completing well-visit at time of service)

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• Accurate member phone number and address impact on the ability for member outreach to close gaps in care • Claims lag may cause providers to feel that Mercy Care DD's data is "inaccurate", and they may be less likely to use the gaps in care lists to outreach members • Incomplete data due to inclusion of members with other primary insurance – those claims may not be sent to Mercy Care DD as they are paid by the member's primary insurer • Member postponement of many non "essential" health services • Low Mercy Care denominator counts Mercy Care DD reports the following progress from 2022 interventions: • EPSDT Coordinator enhanced provider education on: – The AHCCCS periodicity schedule which requires 6 well-visits by age 15 months and annual well-visits after 24 months of age – Well-child visit codes – Sick and well-visit combination and coding (modifier 25) • Mercy Care's "unlimited" well-child visit policy. Status: implemented and ongoing. • Implementation of year-round medical record review processes to gather compliant data for members with other primary coverage. Status: implemented in May 2022 • Mercy Care DD notes that in 2022 their denominator counts were below the NCQA and AHCCCS threshold of 30 required for reporting.
HSAG's Assessment: While opportunity remains for DES/DDD to improve its *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate, DES/DDD conducted a root cause analysis and identified CY 2021 interventions. HSAG has therefore determined that DES/DDD has satisfactorily addressed the prior year's recommendation.
Recommendation 4:
HSAG recommended that DES/DDD conduct a root cause analysis or focus study to determine why its female members were not receiving timely screenings for breast cancer. This could include conducting focus groups to identify barriers that members were experiencing in accessing care and services in order to implement appropriate interventions. Upon identification of a root cause, DES/DDD should implement appropriate interventions to improve the performance related to preventive screenings.
DES/DDD's Response: UHCCP DD conducted a root cause analysis in November 2020 to identify why members do not receive timely breast cancer screenings. Identified barriers included members' lack of knowledge it is a covered benefit, members who don't feel it is necessary as they age, and providers may not submit claims to Medicaid if covered under another plan.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
UHCCP DD continued researching root causes in 2021: from January through June 2021, UHCCP LTC Case Managers outreached members in need of a mammogram to encourage them to schedule one, and during the calls, they surveyed members on why they hadn't gotten their mammograms. As a result of the survey, the root cause analysis was updated in June to include COVID-19 and physical limitations as additional barriers. To encourage members to get mammograms, UHCCP DD offers a gift card for getting a mammogram. The plan also mails annual reminders and performs live outreach calls to members due for a mammogram. UHCCP DD also offers ACOs and providers incentives for meeting breast cancer screening target rates. As recommended, Mercy Care DD conducted a root cause analysis for the breast cancer screening measure. This included review and analysis of factors such as demographic data including age and geographic area, as well as enrollment with the health plan and the impact of the PHE, amongst others. Additionally, Mercy Care DD conducted a disparity analysis for the DDD population within the breast cancer screening measure, and identified a disparity related to screening for Alaskan/American Indian/Native American members. Through these analyses, Mercy Care DD identified the following potential barriers: • Member access to mammogram facilities, particularly for those with mobility challenges • Incomplete data due to inclusion of members with other primary insurance – those claims may not be sent to Mercy Care DD as they are paid by the member's primary insurer • Member postponement of many non "essential" health services • More virtual appointments/fewer or no in-person visits (breast cancer screening cannot be performed through virtual appointments) Mercy Care DD reported the following interventions implemented in 2022 and planned for continuous improvement: • Additional outreach and education to providers in underutilized areas. • Partner with a mobile mammography provider to complete mammograms for members with a gap in care. • Partner with Arizona Diagnostics Radiology to outreach members specifically assigned to these providers. • Addition of breast cancer screening measure to Value-Based programs. Status: completed – added to 2022 VBS programs. • Develop content that is specific to this measure and identify disparities to be included in the Mercy Care Provider Conference. Status: completed in October 2022. • Implementation year-round medical record review processes to gather compliant data for members with other primary coverage. Status: implemented in May 2022.

Prior Year's Recommendation from the EQR Technical Report for Performance Measures
• Mercy Care DD's 2022 year to date rate of compliance with the breast cancer screening measure reveals year over year improvement, with the current rate demonstrating an improvement of nearly five percentage points, as compared to the rate at the same time last year.
HSAG's Assessment: In addition to demonstrating CY 2020 to CY 2021 improvement in the *Breast Cancer Screening* measure rate, DES/DDD conducted a root cause analysis and identified CY 2021 interventions; therefore, HSAG determined that DES/DDD has satisfactorily addressed the prior year's recommendation.

Validation of Performance Improvement Projects

Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. There are many benefits of well-child/well-care visits, including disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child.[6-10] Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur.[6-11] Adolescent well-care visits assist with promoting healthy choices and behaviors, preventing risky behaviors, and detecting early the conditions that can inhibit an adolescent's development.

Maintaining good oral health is an essential component in the overall health of infants, children, and adolescents. Oral health addresses several disease prevention and health promotion topics including dental caries, tooth decay, and periodontal health. Tooth decay (or cavities) is one of the most common chronic conditions of childhood in the United States.[6-12] If untreated, tooth decay can lead to pain and infections that cause children and adolescents to experience problems with playing, learning, eating, and speaking.

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ALTCS-DD population. The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits.

CY 2022 served as an intervention year for this PIP. As such, PIP validation activities focused on intervention analysis. DES/DDD submitted interventions implemented during CY 2022 along with the

[6-10] American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Mar 19, 2021.
[6-11] Centers for Disease Control and Prevention. Adolescence: Preparing for Lifelong Health and Wellness. Available at: https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html. Accessed on: Mar 19, 2021.
[6-12] Centers for Disease Control and Prevention. Children's Oral Health, Division of Oral Health. Available at: https://www.cdc.gov/oralhealth/children_adults/child.htm. Accessed on: Mar 19, 2021.

intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year.

AHCCCS will conduct an annual validation of the first remeasurement year reflective of CY 2022 (January 1, 2022, through December 31, 2022) using HSAG-calculated and validated indicator rates. AHCCCS will evaluate DES/DDD's performance based on an analysis of improvement strategies implemented and an assessment of statistically significant improvement as described in Appendix A. Methodology—Validation of Performance Improvement Projects—How Conclusions Were Drawn.

Results

HSAG determined that the PIP has a preliminary validation status of *Met*, based on valid and reliable rate calculation. Validation status based on whether significant or sustained improvement was achieved will be assessed following completion of interventions and final calculation of measures.

Table 6-7 and Table 6-8 provide the *Back to Basics* ALTCS-DD Program PIP baseline and intervention year rates for each indicator for DES/DDD. Note that Indicator 1 is not reported in this section, as it is not applicable to DES/DDD. For a description of the calculation specifications for the indicators used for the *Back to Basics* PIP, see Appendix A. Methodology—Validation of Performance Improvement Projects—Description of Data Obtained.

Table 6-7—DES/DDD *Back to Basics* PIP Rates for Indicator 2

Contractor	PIP Indicator 2: *Child and Adolescent Well-Care Visits* (*WCV*)		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020	CY 2021
DES/DDD	50.7%	47.9%	50.4%

*The CYE 2019 indicator rate was calculated by HSAG utilizing AHCCCS data.

Table 6-8—DES/DDD *Back to Basics* PIP Rates for Indicator 3

Contractor	PIP Indicator 3: *Annual Dental Visits* (*ADV*)		
	Baseline Year	Intervention Year 1	Intervention Year 2
	CYE 2019*	CY 2020*	CY 2021
DES/DDD	52.7%	43.3%	53.9%

*CYE 2019 and CY 2020 indicator rates were calculated by HSAG utilizing AHCCCS data.

Interventions

Table 6-9 presents ALTCS-DD PIP interventions for DES/DDD and the DES/DDD subcontracted health plans during CY 2022. Language in the PIP interventions section is minimally edited and generally reflective of the language provided by the Contractor.

Table 6-9—DES/DDD Program *Back to Basics* PIP Interventions

Contractor	Intervention
DES/DDD	• Provider Document Tip Sheet Well-Care Visits w/ Sick Visits • Arizona Family Health Partnership and Adolescent Champion Model Pilot Program • Incentive added to Missed Opportunities Reports • Myth vs Facts Member Letter • Patient-Centered Outcomes Research • Live calls, emails, and SMS outreach • Member Incentive (Offer, Reminder, and Redeemed Letter) • Medical Record Audit of FQHCs' billing records • Well Child and Dental Notification (postcard) • Virgin Pulse IVR Call: Dental IVR Call • Dental Special Needs Flyer • Dental Healthy Hound Flyer • On-Air—Provider education and training videos for staff and new hires which included training on oral healthcare for members. • VBCARE Best Practices Webinar: Clinical Practice Consultant (CPC) led webinar presentation with VBCARE's FQHCs to discuss best practices for converting sick visits into well-care visits • Email Campaigns: Virtual Visit All Members/Guardians • Provider Gaps in Care Mailing to Groups without an assigned CPC • CPCs meet with providers monthly to discuss: Gaps in care, child and adolescent well-care visits, missed opportunities report, incentive opportunities • Reports to targeted dental providers • FQHC/ACO medical and dental home roster alignment • Special Needs Pilot Program • EPSDT Annual Notifications • Provider EPSDT Toolkit • Value based contracts incentives • CP-PCPi Program • Shared Saving Aggregation Model Program (AZ Medicaid Aggregation Letter) • HPV educational mailing to members turning 11 years of age

Contractor	Intervention
	• Multi-modal member outreach to members who have gaps in care with well child visits and/or immunizations. Outreach includes motivational messaging distributed through email, text & IVR • Incentive offer to members 7-11 years of age to encourage receipt of a well child visit • During postpartum calls the outreach staff reviews the baby's PCP information on file and assistance is offered if parent has not made the baby's first appointment • Proactive reminder calls to parents/guardians of 6, 9, and 11-month-olds to remind them that their child is due for a well-child visit and immunizations (if appropriate) during the month; If the parent has not already made an appointment, a 3-way call is placed to the provider's office to schedule an appointment • Mailing to parents/guardians of 1-month-olds that includes a well-child magnet listing the ages that children need well visits and a booklet on immunizations and debunking immunization myths • Incentive offer to parents of 3-month-olds - if the member has 6 well child visits before they turn 15 months of age and all required immunizations prior to their 2nd birthday • Immunization magnet mailing to parents of 6-month-olds listing the immunization schedule • EPSDT Reminder cards, including information consistent with the AHCCCS periodicity schedule • EPSDT 2nd reminder cards • Written reminders: member handbook, member newsletters, and newborn booklets to promote well-child visits; EPSDT reminder cards; and well-child reminder letters • Written provider outreach process which includes mailings to PCPs for members in need of an EPSDT visit; members 0-24 months of age in need of immunizations; adolescents in need of immunizations; a reminder on the requirement to conduct a developmental screening at the 9, 18 and 24 month visits; information pertaining to the members' historical dental care and whether or not the member is due for dental care • Provider pay for performance to patient-centered medical home (PCMH)/ACO groups for improving performance in the measure • Telephone outreach to members turning 3-6 years of age during the measurement year. For members in need of an appointment, a 3-way call with their provider to schedule the visit will be conducted

Contractor	Intervention
	• Member financial incentive offered to parents/guardians of members who have not yet had a well-child exam in during the contract year • Outreach telephone calls to the member or the parent or guardian of members in need of a well exam to assist them in scheduling a visit with their PCP • Missed dental appointment outreach calls to EPSDT members who appear on weekly DentaQuest missed appointment report • Adolescent immunization reminder card is mailed to the parents/guardians of members during the month of the member's 12th birthday, reminding them of the importance of obtaining immunizations • 18-21-year-old members diagnosed with diabetes: written reminders to obtain diabetes related services • Adolescents diagnosed with asthma will receive written reminders to obtain asthma related services and to obtain a corresponding well child visit • Mailing to the Native American members in need of a well visit a cover letter and CDC brochure specific to the health of Native Americans • Follow-up calls to members who were referred for dental screening or services via an EPSDT visit • Dental mailing to members who were referred for dental screening or services via an EPSDT visit • Self-mailer is sent to members 6-9 years of age and includes information on the importance of dental sealants • Educate PCPs on the application of fluoride varnish, including the required training and the process for submission of the certificate of completion • Incentivize DentaQuest to increase preventive dental care and dental sealant application rates • DentaQuest to send dental "gaps in care" letter to contracted dental providers who have members assigned to them through the dental home program who need preventive dental care and/or dental sealant application • Missed dental appointment outreach calls to EPSDT members who appear on weekly DentaQuest missed appointment report • MCH/EPSDT, Network Management and Care Management staff will develop a collaborative outreach and engagement strategy to improve surveillance adolescent well visits • Care Management monitors gaps in care for all youth enrolled in Peds Care Management

Contractor	Intervention
	• Leverage Tribal liaisons to engage members who might be difficult to engage or find, provide health information, offer referral, assist with navigation, etc. to assist in addressing health disparities • Meet with Native Health and the Phoenix Indian Medical Center to determine if partnership opportunities exist • Face-to-face contacts between the Mercy Care DD Coordinators and providers encouraging outreach efforts on members lacking childhood immunizations and/or well-child visits • Member Mailings: 1st Well Child & Dental Notification Self Mailer 0-17 Yrs • Member Mailings: 1st Well Child & Dental Notification Self Mailer 18-20 Yrs • Member Mailings: 2nd Well Child Reminder Self Mailer 18-20 Yrs • Member Mailings: 2nd Well Child Reminder Self Mailer 0-17 Yrs • Member Mailings 2nd & 3rd Dental Notification Reminder Self Mailer 0-17 Yrs • Member Mailings: 2nd & 3rd Dental Notification Reminder Self Mailer 18-20 Yrs • Member Mailings: Dental Sealants 6-9 Yrs • Member Mailings: Developmental Screen 9/18/29 Mos • Provider Mailings: Dental Home Gaps in Care • Live Calls • UHCCP DD Annual Dental Home New Member Letter • UHCCP DD Annual Dental Home Reminder Letter • UHCCP DD Dental Dept Fluoride Varnish Letter

Strengths, Opportunities for Improvement, and Recommendations

Table 6-10 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 6-10—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to PIPs

Strengths, Opportunities for Improvement, and Recommendations
Strengths
DES/DDD developed and implemented interventions that may lead to improvement in indicator outcomes. **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
HSAG noted that for indicator 3, although DES/DDD's intervention year 1 indicator rate showed a decline from the baseline year, the intervention year 2 indicator rate increased by 10.6 percentage points over the intervention year 1 indicator rate, which showed a 1.2 percentage point increase over the baseline year indicator rate. **[Quality, Access]**
Opportunities for Improvement and Recommendations
For indicator 2, DES/DDD showed a 2.8 percentage point decline in the indicator rate between the baseline year and intervention year 1. Between intervention year 1 and intervention year 2, the indicator rate increased by 2.5 percentage points; however, when compared to the baseline year, the intervention year 2 indicator rate was slightly below the baseline year rate. The decline noted in the indicator 2 rate may indicate that the COVID-19 PHE had an impact on the rate of compliance with child and adolescent well-care visits. **[Quality, Access]** Recommendation: As the PIP progresses, HSAG recommends that DES/DDD: • Review intervention year indicator rates and adjust interventions to facilitate improvement, as necessary • Continue to implement identified interventions and assess the impact and effectiveness of the interventions after the validated indicator rates for the first remeasurement year become available • Develop and document a plan for sustaining the improvement for any demonstrated improvement in indicator rates

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 6-11 presents PIP recommendations made to DES/DDD in the CYE 2021 Annual Technical Report[6-13] and DES/DDD's and the DES/DDD subcontracted health plans' follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 6-11—DES/DDD Follow-Up to CY 2021 PIP Recommendations

Prior Year's Recommendation from the EQR Technical Report for PIPs
While the PIP is in an intervention year and no opportunities for improvement have yet been identified, HSAG recommended that DD should continue to implement identified interventions and assess the impact and effectiveness of the interventions after the first remeasurement year.

[6-13] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Prior Year's Recommendation from the EQR Technical Report for PIPs
DES/DDD's Response: Mercy Care DD interventions to improve rates of compliance with well child and dental visits amongst children continue. Mercy Care DD's analysis of the MY 2020 and MY 2021 rates demonstrates that the PHE had a significant impact on the rates of compliance with preventive health services, such as well-child and dental visits. The MY 2020 rates across all indicators demonstrated a decline as compared to the baseline (CYE 2019) rates. MY 2021 rates improved for all indicators, as compared to MY 2020; however, have not yet exceeded the baseline rates.
HSAG's Assessment: HSAG reviewed DES/DDD's PIP intervention submission, which detailed interventions implemented in CY 2022, whether the intervention will be continued, and the rationale for intervention changes or discontinuation. HSAG has determined that DES/DDD has satisfactorily continued to implement interventions, based on activities completed in CY 2022.

Compliance Reviews

AHCCCS follows a three-year compliance review cycle for each of its Contractors. AHCCCS conducted a compliance review of the ALTCS-DD Program in August 2021. The final report results were not available for publication in the prior annual technical report. Results of the CYE 2021 compliance review as well as CAP follow-up details are provided below.

Results

AHCCCS conducted a compliance review of DES/DDD from August 23–27, 2021. AHCCCS provided DES/DDD with a draft report for review on October 7, 2021. AHCCCS finalized the DES/DDD compliance report on November 8, 2021, and requested that DES/DDD provide a CAP for items that required attention. DES/DDD and AHCCCS worked together to develop a suitable plan for achieving compliance. On March 9, 2022, AHCCCS received the third CAP submission from DES/DDD. In a letter dated April 13, 2022, AHCCCS stated that it agreed with all of the proposed steps in DES/DDD's CAP. AHCCCS also provided DES/DDD with a final CAP matrix document that served as the final version of DES/DDD's CAP. Table 6-12 presents the CYE 2021 compliance review results for DES/DDD.

Table 6-12—DES/DDD Compliance Review Results

Focus Areas	DES/DDD
CM	82%
CC	87%
CIS	88%
DS	75%
GA	76%

Focus Areas	DES/DDD
GS	100%
MCH	28%
MM	64%
MI	83%
QM	85%
QI	65%
RI	100%
TPL	100%
ISOC	NR+

+ NR = "not reviewed." This Focus Area was not reviewed separately during the compliance review; however, elements of this Focus Area were included in other Focus Areas (e.g., QI standards included in QM and ISOC standards included in MM).

Strengths, Opportunities for Improvement, and Recommendations

Table 6-13 presents strengths, opportunities for improvement, and recommendations for DES/DDD related to compliance.

Table 6-13—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to Compliance

Strengths, Opportunities for Improvement, and Recommendations
Strengths
DES/DDD scored at or above 95 percent in the following Focus Areas: • Grievance Systems (GS) **[Timeliness, Access]** • Reinsurance (RI) **[Quality]** • Third-Party Liability (TPL) **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
DES/DDD scored below 95 percent in the following Focus Areas: • Case Management (CM) **[Quality, Access]** • Corporate Compliance (CC) **[Quality, Access]** • Claims and Information Standards (CIS) **[Access]** • Delivery Systems (DS) **[Timeliness, Access]** • General Administration (GA) **[Timeliness, Access]** • Adult, EPSDT, and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations
• Medical Management (MM) **[Timeliness, Access]** • Member Information (MI) **[Quality]** • Quality Management (QM) **[Quality]** • Quality Improvement (QI) **[Quality, Access]** Recommendation: HSAG recommends that DES/DDD leadership conduct a high-level assessment of the CM, CC, CIS, DS, GA, MCH, MM, MI, QM, and QI requirements to ensure ongoing oversight of compliance for these areas.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 6-14 presents compliance recommendations made to DES/DDD in the CYE 2021 Annual Technical Report[6-14] and DES/DDD's and the DES/DDD subcontracted health plans' follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 6-14—DES/DDD Follow-Up to CY 2021 Compliance Recommendations

Prior Year's Recommendation from the EQR Technical Report for Compliance
Although DES/DDD underwent a compliance review, the results were not available; however, HSAG recommended that the Contractor work to remedy the report findings to ensure that it remains compliant with the requirements in each of the AHCCCS Focus Areas.
DES/DDD's Response: UHCCP DD is remedying any identified CAPs to ensure the plan remains compliant with the requirements in each of the AHCCCS Focus Areas. UHCCP DD has finalized submission of its CAPs and tracks continued progress since the development of any new policy and procedural changes.
HSAG's Assessment: HSAG has determined that DES/DDD has partially addressed the prior year's recommendation; while the response addressed some of HSAG's recommendations, DES/DDD reported that one of its subcontractors did not provide evidence of a response to its recommendations.

[6-14] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Network Adequacy Validation

HSAG's biannual validation of the ALTCS-DD DES/DDD subcontracted health plans' results showed minor discrepancies between the Contractors' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors and lines of business in each quarter for which 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 A-15), or due to a small number of members eligible for inclusion in time/distance calculations for the standard and county.

Table 6-15 summarizes HSAG's assessment of each DES/DDD subcontracted health plan's compliance with AHCCCS' minimum time/distance network standards. A check mark indicates that the DES/DDD subcontracted health plan met the minimum network standard for each Arizona county during each of the three quarterly assessments, and an "X" indicates that the DES/DDD subcontracted health plan failed to meet one or more minimum network standards in any county or quarter.

Table 6-15—Summary of CYE 2022 Compliance with Minimum Time/Distance Network Requirements for DES/DDD Subcontracted Health Plans

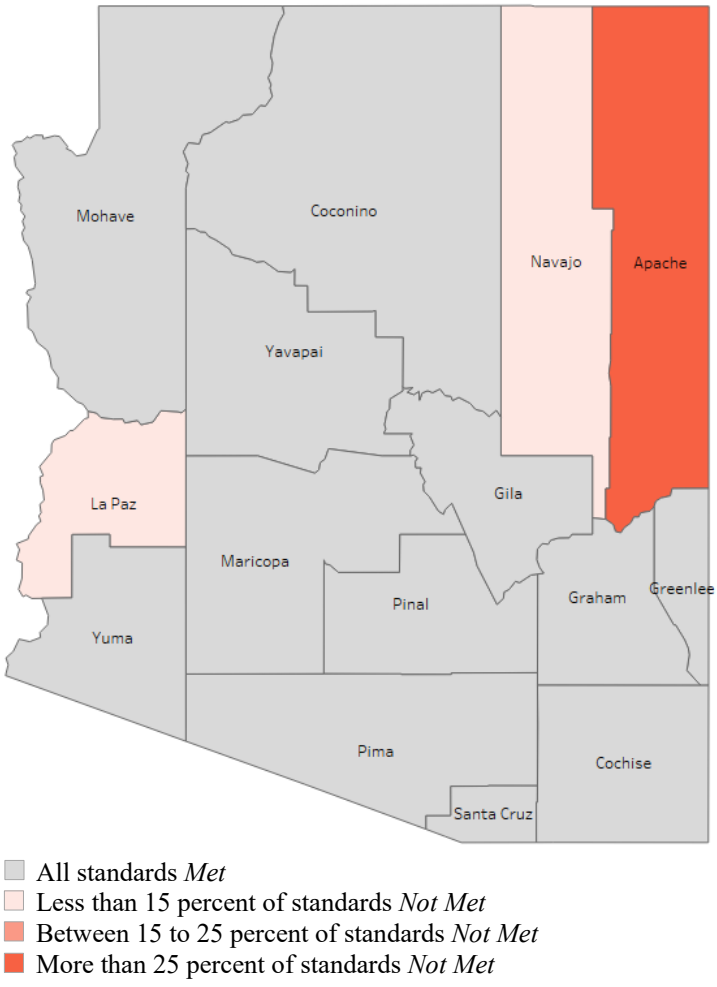
Minimum Network Requirement	Mercy Care DD	UHCCP DD
Behavioral Health Outpatient and Integrated Clinic, Adult	X	X
Behavioral Health Residential Facility (only Maricopa and Pima counties)	✓	✓
Behavioral Health Outpatient and Integrated Clinic, Pediatric	✓	X
Cardiologist, Adult	X	X
Cardiologist, Pediatric	✓	X
Dentist, Pediatric	X	X
Hospital	✓	✓
OB/GYN	✓	✓
PCP, Adult	✓	✓
PCP, Pediatric	✓	✓
Pharmacy	X	X

The DES/DDD subcontracted health plans consistently met the Behavioral Health Residential Facility, Hospital; OB/GYN; and PCP, Adult and Pediatric standards while struggling to meet the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; Dentist, Pediatric; and Pharmacy standards. However, several subcontracted health plans demonstrated PAT data issues, which impacted HSAG's time/distance results and the validation of Contractors' ACOM 436 results.

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

As of CYE 2022 Q4, Figure 6-2 summarizes how the DES/DDD subcontracted health plans performed on meeting the time/distance standards by county. Red shading indicates one or more DES/DDD subcontracted health plan failed one or more time/distance standard. Specifically, dark red shading indicates more than 25 percent of the standards were *Not Met*, medium red shading indicates between 15 and 25 percent of the standards were *Not Met*, and light red shading indicates less than 15 percent of the standards were *Not Met* in the given county. Gray shading indicates all DES/DDD subcontracted health plans met all time/distance standards in the given county.

Figure 6-2—Summary of CYE 2022 Q4 Compliance with Minimum Time/Distance Network Requirements by County for DES/DDD Subcontracted Health Plans



Overall, for CYE 2022 Q4, the most recent biannual assessment, all applicable DES/DDD subcontracted health plans met all minimum time/distance network requirements except for Apache, La Paz, and Navajo counties.

Based on the biannual NAV results, no DES/DDD subcontracted health plan met all requirements for all standards across all quarters and counties. In Cochise, Coconino, Gila, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties, both applicable DES/DDD subcontracted health plans met all standards in all quarters.

Each DES/DDD subcontracted health plan should continue to monitor and maintain its existing provider network as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types among the applicable DES/DDD subcontracted health plans:

- Behavioral Health Outpatient and Integrated Clinic, Adult for Mercy Care DD and UHCCP DD in Apache County
- Behavioral Health Outpatient and Integrated Clinic, Pediatric for UHCCP DD in Apache County
- Cardiologist, Adult for Mercy Care DD and UHCCP DD in Apache County
- Cardiologist, Pediatric for UHCCP DD in Apache County
- Dentist, Pediatric for UHCCP DD in Apache County and Mercy Care DD in Laz Paz and Navajo counties
- Pharmacy for UHCCP DD in Apache County

Results

HSAG evaluated DES/DDD's subcontracted health plans' compliance results with AHCCCS' time/distance standards by GSA and county. This section presents biannual validation findings specific to the ALTCS-DD LOB, with one results table for each of the following GSAs:

- Central GSA: Gila, Maricopa,[6-15] and Pinal counties
- North GSA: Apache, Coconino, Mohave, Navajo, and Yavapai counties
- South GSA: Cochise, Graham,[6-16] Greenlee, La Paz, Pima, Santa Cruz,[6-17] and Yuma counties

Each region-specific table summarizes biannual validation results containing the percentage of members meeting each time/distance standard by quarter and county, 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 ALTCS-DD LOB. The value "NR" is shown for time/distance standards in

[6-15] Maricopa County includes the 85342, 85358, and 85390 ZIP codes; these ZIP codes are physically located in both Maricopa and Yavapai counties.
[6-16] 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.
[6-17] Santa Cruz County includes the 85645 ZIP code; this ZIP code is physically located in both Pima and Santa Cruz counties.

which no members met the network requirement denominator for the ALTCS-DD 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 (*) indicates that fewer than 10 members were included in the denominator of HSAG's results. A carat (^) indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

Table 6-16—Mercy Care DD Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements

	Gila		Maricopa		Pinal	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	98.0^	98.1^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100^	100^	98.4^	98.2^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	99.3	99.2	NA	NA
Cardiologist, Adult	100^	100^	100^	100^	100^	100^
Cardiologist, Pediatric	100^	100^	100^	100^	100^	100^
Dentist, Pediatric	100	100	99.6	99.5	100	99.8
Hospital	100	100	100	99.9	100	100
OB/GYN	100	100	100	100	100	100
Pharmacy	100	100	99.3	99.2	100	100
PCP, Adult	100^	100^	99.7^	99.7^	100^	100^
PCP, Pediatric	100^	100^	99.6^	99.7^	100^	100^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated
using a modified Telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Table 6-17—Mercy Care DD Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements

	Apache		Coconino		Mohave		Navajo		Yavapai	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	57.1*^	66.7*^	91.7^	93.3^	100*^	100^	100*^	100*^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100*^	NR*^	100^	97.4^	100^	95.8^	100*^	100*^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	42.9*^	60.0*^	90.9^	100^	100*^	100*^	100*^	100*^	100^	100*^
Cardiologist, Pediatric	100*^	100*^	100^	100^	100^	100^	100^	100*^	100^	100^
Dentist, Pediatric	100*	100*	96.7	97.6	88.2	92.0	90.0	85.7*	100	100
Hospital	100*	100*	100	100	100	100	100	100	100	100
OB/GYN	100*	100*	100*	100*	100*	100*	100*	100*	100*	100*
Pharmacy	100*	100*	95.1	98.1	91.7	94.1	93.8	92.3	100	100
PCP, Adult	100*^	100*^	90.9^	100^	100*^	100*^	100*^	100*^	100^	100*^
PCP, Pediatric	100*^	100*^	100^	100^	94.1^	96.0^	100^	100*^	100^	100^

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 10 members were included in the denominator of HSAG's results.

^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 6-18—Mercy Care DD Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements

	Cochise		Graham		Greenlee		La Paz		Pima		Santa Cruz		Yuma	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	100^	100^	100^	100^	100*^	100*^	95.3^	95.8^	100^	100^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100^	100^	100^	100^	100*^	100*^	100*^	100*^	93.6^	93.9^	100^	100^	100^	100^

Minimum Network Requirement	Cochise		Graham		Greenlee		La Paz		Pima		Santa Cruz		Yuma	
	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	95.4	94.7	NA	NA	NA	NA
Cardiologist, Adult	100^	100^	100^	100^	100^	100^	100*^	NR*^	99.7^	99.7^	100^	100^	100^	100^
Cardiologist, Pediatric	100^	100^	100^	100^	100*^	100*^	100*^	100*^	99.8^	99.8^	100^	100^	100^	100^
Dentist, Pediatric	100	100	94.2	95.3	100*	100*	40.0*	66.7*	98.6	98.5	100	100	100	100
Hospital	100	100	100	100	100	100	100*	100*	99.5	99.6	100	100	100	100
OB/GYN	100	100	100	100	100*	100*	100*	NR*	100	100	100*	100*	100	100
Pharmacy	99.3	99.3	100	100	100	100	83.3*	100*	98.2	98.1	100	100	100	100
PCP, Adult	98.3^	98.2^	100^	100^	100^	100^	100*^	NR*^	99.7^	99.7^	100^	100^	100^	100^
PCP, Pediatric	100^	100^	98.1^	97.7^	100*^	100*^	100*^	100*^	99.4^	99.5^	100^	100^	100^	100^

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 10 members were included in the denominator of HSAG's results.

^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 6-19—UHCCP DD Time/Distance Validation Results for Central GSA—Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Gila		Maricopa		Pinal	
	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	98.5^	98.4^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100^	100^	98.7^	98.6^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	98.7	98.3	NA	NA
Cardiologist, Adult	100^	100^	99.9^	99.9^	100^	100^
Cardiologist, Pediatric	100^	100^	100^	100^	100^	100^
Dentist, Pediatric	100	100	99.6	99.5	100	100
Hospital	100	100	99.9	100	100	100
OB/GYN	100	100	99.9	100	100	100
Pharmacy	100	100	99.3	99.2	100	100

Minimum Network Requirement	Gila		Maricopa		Pinal	
	Q2	Q4	Q2	Q4	Q2	Q4
PCP, Adult	100^	100^	99.7^	99.7^	100^	100^
PCP, Pediatric	100^	100^	99.9^	99.9^	100^	100^

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

^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 6-20—UHCCP DD Time/Distance Validation Results for North GSA—Percentage of Members Meeting Minimum Network Requirements

Minimum Network Requirement	Apache		Coconino		Mohave		Navajo		Yavapai	
	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	66.7^	65.2^	98.8^	97.8^	99.8^	97.1^	96.4^	96.5^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	65.1^	70.6^	93.8^	92.2^	100^	95.4^	96.3^	93.9^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	63.8^	64.9^	99.7^	100^	100^	100^	98.8^	98.6^	100^	100^
Cardiologist, Pediatric	80.8^	79.1^	100^	100^	100^	100^	100^	99.2^	100^	100^
Dentist, Pediatric	61.5	60.5	96.8	93.4	99.7	99.7	95.5	94.5	98.8	98.4
Hospital	100	100	100	100	100	100	100	100	100	100
OB/GYN	100	100	100	100	100	100	100	100	100	100
Pharmacy	86.0	88.0	93.3	93.1	99.1	99.6	97.0	97.4	99.2	99.3
PCP, Adult	94.2^	89.5^	95.9^	98.8^	99.2^	99.1^	100^	100^	99.8^	99.8^
PCP, Pediatric	92.3^	90.7^	91.0^	93.4^	99.7^	100^	99.2^	100^	100^	100^

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.

^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.

NA indicates results are not applicable to the county.

Table 6-21—UHCCP DD Time/Distance Validation Results for South GSA—Percentage of Members Meeting Minimum Network Requirements

	Cochise		Graham		Greenlee		La Paz		Pima		Santa Cruz		Yuma	
Minimum Network Requirement	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4	Q2	Q4
Behavioral Health Outpatient and Integrated Clinic, Adult	100^	100^	100^	100^	100*^	100*^	100^	100^	98.1^	96.6^	99.0^	98.8^	100^	100^
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100^	100^	100^	100^	100^	100^	100^	100^	96.3^	94.5^	100^	100^	100^	100^
Behavioral Health Residential Facility (only Maricopa and Pima counties)	NA	NA	NA	NA	NA	NA	NA	NA	92.6	90.9	NA	NA	NA	NA
Cardiologist, Adult	100^	100^	100^	100^	100*^	100*^	100^	100^	99.9^	99.9^	100^	100^	100^	100^
Cardiologist, Pediatric	100^	100^	100^	100^	100^	100^	100^	100^	99.9^	99.9^	100^	100^	100^	100^
Dentist, Pediatric	98.0	97.7	95.9	95.6	100	100	100	100	99.0	98.8	100	100	99.8	99.7
Hospital	100	100	100	100	100	100	100	100	99.8	99.9	100	100	100	100
OB/GYN	100	100	100	100	100*	100*	100*	100*	100	100	100	100	100	100
Pharmacy	99.7	99.7	100	98.6	100	100	100	100	98.4	99.1	99.5	99.4	99.9	99.8
PCP, Adult	100^	100^	100^	100^	100*^	100*^	100^	100^	99.9^	99.9^	100^	100^	100^	100^
PCP, Pediatric	100^	100^	98.0^	97.8^	100^	100^	100^	100^	99.5^	99.6^	100^	100^	99.8^	99.7^

represents Contractor-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
* indicates fewer than 10 members were included in the denominator of HSAG's results.
^indicates that meeting the network requirement for the specified Contractor, LOB, county, and provider category was evaluated using a modified Telehealth time/distance standard established by AHCCCS.
NA indicates results are not applicable to the county.

Strengths, Opportunities for Improvement, and Recommendations

Table 6-22 presents strengths, opportunities for improvement, and recommendations for DES/DDD, as well as the related domains (Quality, Timeliness, and/or Access) for each strength and opportunity for improvement.

Table 6-22—DES/DDD Strengths, Opportunities for Improvement, and Recommendations Related to NAV

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths: • The DES/DDD subcontracted health plans consistently met the Behavioral Health Residential Facility, Hospital; OB/GYN; and PCP, Adult and Pediatric standards • Mercy Care DD met all time/distance network standards in all assigned counties for both quarters in CYE 2022, except for Apache, La Paz, Mohave, and Navajo counties

Strengths, Opportunities for Improvement, and Recommendations
• UHCCP DD met all minimum time/distance network standards in all assigned counties for both quarters in CYE 2022, except for Apache County Note: Mercy Care DD provides coverage in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma Note: UHCCP DD provides coverage in the following counties: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement: • DES/DDD subcontracted health plans struggled to meet standards for the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; Dentist, Pediatric; and Pharmacy standards • Mercy Care DD struggled to meet standards for the Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric standards for CYE 2022 Q4 • UHCCP DD failed to meet six of the 10 applicable standards in Apache County for CYE 2022 Q4 Recommendations: HSAG recommends that: • DES/DDD continue to seek support from AHCCCS in monitoring and maintaining existing provider network coverage for its subcontracted health plans, with specific attention to ensuring the availability of adult and pediatric behavioral health outpatient and integrated clinics and adult cardiologists in Apache County • Mercy Care DD should continue to monitor and maintain its existing provider network coverage as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types: – Behavioral health outpatient and integrated clinics for adults in Apache County – Cardiologists for adults in Apache County – Pediatric dentists in La Paz County • UHCCP DD should continue to monitor and maintain its existing provider network coverage as of CYE 2022 Q4, with specific attention to ensuring the availability of the following provider types in Apache County: – Behavioral Health Outpatient and Integrated Clinics, Adult and Pediatric – Cardiologist, Adult and Pediatric – Dentist, Pediatric – Pharmacy

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table 6-23 presents NAV recommendations made to the DES/DDD subcontracted health plans in the CYE 2021 Annual Technical Report[6-18] and DES/DDD's and the DES/DDD subcontracted health plans' follow-up to the recommendations, as well as an assessment of the degree to which DES/DDD has effectively addressed the recommendations. Language in the follow-up on prior year's recommendations section is minimally edited and generally reflective of the language provided by the Contractor. Follow-up responses may be based on Contractor internal data and not EQR validated rates.

Table 6-23—DES/DDD Program Follow-Up to CY 2021 NAV Recommendations

Prior Year's Recommendation from the EQR Technical Report for NAV
HSAG recommended the following to DES/DDD: • The DES/DDD subcontracted health plans should continue to monitor their processes for creating the PAT file and review the PAT file for accuracy prior to submitting to AHCCCS • The DES/DDD subcontracted health plans should continue to monitor and maintain their existing provider network coverage as of CYE 2021 Q4, with specific attention to ensuring the availability of the following provider types among the applicable DES/DDD subcontracted health plans: – Behavioral health outpatient and integrated clinics for adults or children in Apache and Coconino counties – Cardiologists for adults or children in Apache County – Pediatric dentists in Apache, La Paz, and Mohave counties – Pharmacies in Apache and La Paz counties
DES/DDD's Response: UHCCP DD continues to monitor and review the PAT file process on a quarterly basis. Although UHCCP DD only submits biannually to the state of Arizona, UHCCP DD runs the PAT process quarterly to ensure it has addressed any data discrepancies, internal/external errors, and root cause analysis. UHCCP DD has shown an increase to minimum network standards for all the recommended provider types in Apache county, with the exception of Pharmacies (additional information regarding Pharmacies is pending from Optum). Mercy Care DD 's efforts to monitor their processes for creating and reviewing the PAT file are ongoing. The current quarter's error rate for this LOB is 0.30%. Mercy Care DD routinely monitors their network for both reportable and perceived gaps. Utilizing reports from HSAG, in addition to other internal reporting methods, Mercy Care DD reviews

[6-18] Contract Year Ending 2021 External Quality Review Annual Technical Report for Arizona Long Term Care System Available at: https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-EPDandDES-DDD.pdf Accessed: December 28, 2022.

Prior Year's Recommendation from the EQR Technical Report for NAV
AHCCCS registered, non-participating providers to Mercy Care DD's existing network as a means to identify expansion opportunities. Mercy Care DD will continue this process, as outlined in detail in Mercy Care DES/DDD's annual Network Plans. During FY22, we added over 200 new providers, with various specialties, to Mercy Care DD's network. While there are some remaining gaps in the areas noted, much of those gaps are addressed through the expansion of telehealth services (up over 200% since 2020), tele/mobile dentistry, and Mercy Care DD's delegated agreement with DentaQuest to recruit based on the availability of newly registered providers.
HSAG's Assessment: Based on the CYE 2022 NAV results and the response provided by DES/DDD subcontracted health plans, HSAG has determined that DES/DDD subcontracted health plans have sufficiently addressed the prior year's recommendation.

DES/DDD Best and Emerging Practices

Table 6-24 presents the best and emerging practices provided by DES/DDD for CYE 2022. HSAG made only minor edits to DES/DDD's submission to enhance readability. Best practice responses may be based on Contractor internal data and not EQR validated rates.

Table 6-24—DES/DDD Best and Emerging Practices

DES/DDD Best and Emerging Practices—Hourly Nursing Assessment Tool (H-NAT)
Rationale: As part of DES/DDD's Current 2 Future Initiative, the Division has been working on a CAP related to deficiencies in our Nursing Assessment process since June 2019. The CAP specifically addresses deficiencies in the skilled nursing matrix being under or improperly utilized, resulting in members being placed in less acute settings (Adult Developmental Homes) instead of higher acuity settings like Medical Group Homes or Skilled Nursing Facilities. The Division contracted with the Northern Arizona University, Institute for Human Development, University Centers for Excellence in Developmental Disabilities (NAU UCEDD) to create a new tool for assessing the hours required for skilled nursing services. Research of surrounding states, for a skilled nursing assessment tool yielded no comparable tool available to assess nursing skills for members. The H-NAT assessment tool has eight components and five modifiers: Components: • General • Neurological • Respiratory

DES/DDD Best and Emerging Practices—Hourly Nursing Assessment Tool (H-NAT)

- Cardiovascular
- Nutrition
- Elimination
- Skin Integrity
- Medications

Modifiers:

- Behavior
- Communication
- Acute Care
- Training
- PRN (As applicable)

Goals:
The goal is to develop and support initial implementation of a skilled nursing tool, procedures, training, and inter-rater reliability system to determine the scope and quantity of cost-efficient and medically necessary, skilled nursing support authorized for DES/DDD members living in their homes.

Interventions:

- Nurse managers trained their nurses on H-NAT
- H-NAT available in OnBase environment
- December 2021-Present: Implementation of the H-NAT
- Nurses use the H-NAT on their members, with the supervision of their nurse managers
- NAU assessed for inter-rater reliability on H-NATS among nurses (Dec 2021)

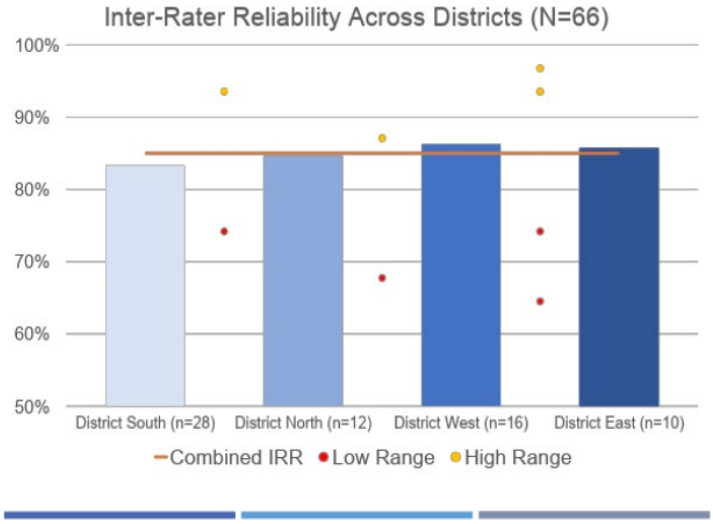
Results/Implementation:
To date, 50% of members (488 H-NATs completed out of 975 members) have had an H-NAT assessment. This percentage will continue to increase as recently the Division has implemented a new procedure that requires the nurse to complete an H-NAT when the member is due for their 90-day nursing re-assessment.

IRR Testing Results:
In total, thirty-one nurses participated in the IRR in December 2021, which is 78% of the district nurses. There were a total of sixty-six individual H-NATs completed. If the nurses answered consistently, on all 3 questions, which would result in the same time estimate, then this answer is correct. This approach in determining an inter-rater reliability estimate is cautious and nurses are not allowed any latitude in the inter-rater agreement.

DES/DDD Best and Emerging Practices—Hourly Nursing Assessment Tool (H-NAT)

The blue columns indicate the overall average rate of agreement across all H-NATs within each district. District South has the most nurses who participated and therefore their estimates should be interpreted as the most stable given their larger sample size.

The orange line indicates the overall combined IRR estimate across all districts. The outcome of .85 is interpreted by measurement experts as a high level of inter-rater reliability. The red dots below the orange bar and yellow dots above the blue bars indicate the lowest and highest range of agreement among nurses.



OVERALL IMPACT OF THE H-NAT ON MEMBER HOURS

Members	Impact H-NAT Had on Members
152	Increased Time (+2.47 hours per day)
125	Members stayed the same
73	Decreased Time (-1.82 hours per day)

Data is from October/November

Data indicates that when the H-NAT is used, it generally has resulted in increased time or member's service hours have stayed the same. Additionally, it is noted that the change in hours, whether they increase or decrease, is not significant.

DES/DDD Best and Emerging Practices—Disease/Chronic Care Management Program

Rationale:
In response to the AHCCCS 2022 compliance review's findings, the DES/DDD's Medical Management Unit has developed a Disease/Chronic Care Management Program. A Disease/Chronic

DES/DDD Best and Emerging Practices—Disease/Chronic Care Management Program

Care Management Program provides a focused assessment of opportunities and development of an intervention plan to better manage disease or conditions for targeted members, improve health outcomes and quality of life. DES/DDD has determined that the eligibility for its complex case management (CCM) Program would include members who:

1. Have been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team or
2. Is identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing or
3. Has one or more of the Fatal Five (aspiration; bowel obstruction, gastroesophageal reflux disease [GERD], dehydration, or seizures) conditions considered preventable causes of death in people with intellectual/developmental disabilities or
4. Has been diagnosed with post-COVID-19 condition(s) or
5. Has exhibited high or low utilization of services for high need conditions.

Components of the program:

- The program focuses on members with high need/high risk and/or chronic conditions
- The program includes early identification of potential members, developing individualized intervention plans that focus on the coordination of treatment and chronic disease management strategies to improve health outcomes
- The program works collaboratively with the member and/or responsible person, Support Coordination, the Planning Team and the Administrative Services Subcontractors (AdSS) to develop and implement an individualized intervention plan to promote:
  - Sustainable healthy outcomes,
  - Living well with chronic conditions,
  - Healthy lifestyles
  - Active engagement in managing their health

Embracing Person-Centered Values and Whole Person Care:

- The program provides person-centered, whole-person care that addresses the multiple drivers of health
- It uses a multidisciplinary team approach to coordinate care across settings, services, and sectors to align with the needs of the member

Goal:
The primary goal of the program at this time, until outcomes metrics are finalized, includes developing an individualized intervention plan tailored to the member's needs as a collaborative effort involving the member/caregiver, the CCM team, and the support coordination team.

Interventions:

- Staff training conference 2nd Quarter 2022
- New policy approval and implementation 2nd Quarter 2022

DES/DDD Best and Emerging Practices—Disease/Chronic Care Management Program
• Finalize procedures 3rd Quarter 2022 Results: As of the 4th Quarter, a member roster has been created and member counts shared within the DES/DDD's Medical Management Committee, including members across the districts. DES/DDD has additionally identified that 82.4% of these members reside at their personal homes, and 17% reside in a DD Group Home setting. DES/DDD has additionally begun to track referral reasons. At this time outcome data is not available but DES/DDD continues to enhance monitoring efforts and will continue to encourage referrals.

DES/DDD Best and Emerging Practices—Reducing QOCs Aged Over 60-Days (Non-Clinical)
Rationale: In March of 2020, DES/DDD identified a backlog of uninvestigated QOCs that had aged beyond 60-Days. The intent of this PIP was to continually reduce the aged backlog and sustain a level below 10% of the total QOCs, while creating a sustainable QOC process that will allow DES/DDD staff to investigate new QOCs effectively and efficiently without the support of consultation services or any other external entity. The processes developed out of the corrective action have since become identified as DES/DDD Best Practices. By concentrating on timely investigations, members' quality of care and safety can be addressed effectively and efficiently. In addition, the integrity of the oversight of DES/DDD qualified vendor/providers (QVP) is held to the highest standard. The alterations made to the investigative process with heightened monitoring help protect DES/DDD members and staff from avoidable outcomes, such as medication errors, falls, self-harm or harm to others. The changes to the processes also prevent negative quality and safety trends, provide staff information about why incidents occur within their own service and organization, and what they can do to keep their patients and themselves safe. Lastly, resolution of the aged QOCs in a timely manner have helped with tracking and trending of incidents, which DES/DDD believes will result in identifying new educational and training opportunities for QVPs and internal DES/DDD staff. Goals: • Ensure < 10% of identified QOC cases requiring investigation do not age over 60-days on a monthly basis • Decrease the number of 2nd Level Reviews classified as "Return to Investigator" to <10% of the total number of completed QOC Investigation Interventions: • Daily QOC touchpoints meetings to review inventory and direct and prioritize work related focus • Standard work development • Rapid Reassignment of cases following exit of terminated nurses • Hired two new nurse investigator supervisors • Weekly challenging-case resolution meetings

DES/DDD Best and Emerging Practices—Reducing QOCs Aged Over 60-Days (Non-Clinical)
Results: Regular monitoring and interventions have been effective in managing the timeliness of the QOC investigation process. DES/DDD has not had any aged QOCs consistently for over one-year. At this time DES/DDD is considering establishing a stretch goal that will stabilize QOCs to an average of 45 days. The rate of return has not yet met the goal. When reviewing this data trend, certain considerations should be taken into account, specifically that this data is fluid; including both backlog Return to Investigator (RTI) and new RTIs. DES/DDD will develop more refined reporting that will illustrate exclusively new RTIs moving forward. There was a statistically significant improvement from January through July and DES/DDD continues to improve and reduce RTIs through daily monitoring and reprioritizing team assignments.

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State models reviewed: Iowa, Missouri, Nevada, North Carolina, Oregon, Colorado, Utah, West Virginia, Hawaii, Maine.

Appendix A. Methodology

Appendix A—Methodology presents, for each EQR activity:

- Objectives
- Technical methods of data collection
- Description of data obtained
- How data were aggregated and analyzed
- How conclusions were drawn

In addition, this section includes information about how program-level data were aggregated and analyzed.

Validation of Performance Measures

Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the Contractors
- Determine the extent to which the specific performance measures calculated by the Contractors (or on behalf of the Contractors) followed the specifications established for each performance measure
- Identify overall strengths and areas for improvement in the performance measure calculation process

Technical Methods of Data Collection

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

- **Information Systems Capabilities Assessment Tool (ISCAT):** Contractors completed and submitted an ISCAT to address data collection and reporting specifics of their performance 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 calculated, or contracted with vendors to calculate, the non-HEDIS performance measures using source code and were required to submit the source code used to generate non-HEDIS performance measures being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance

with the measure specifications required by AHCCCS. If NCQA Certified Measures[SM, A-1] vendors were used, HSAG reviewed a copy of the certified measures reports to confirm each measure's certification status. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any).

- **Medical record documentation:** 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.
- **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.

Pre-Review Activities:

In alignment with CMS Protocol 2, several steps and actions were involved in preparing both the EQRO and each Contractor to implement and conduct the PMV activity, including:

- **Define the scope of the validation:** HSAG worked with AHCCCS to identify the performance measures to be validated for each Contractor and to confirm all standardized measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification). HSAG submitted final validated performance measure results in an agreed-upon AHCCCS-approved Microsoft (MS) Excel workbook format. HSAG provided AHCCCS with each Contractor's LOB-specific rate reporting template and provided AHCCCS with a consolidated view of the final validated rates as well. HSAG used Contractor-to-Contractor comparisons; comparisons to CY 2020 rates, where applicable; as well as comparisons to national Medicaid benchmarks, as reasonability checks.
  - A rate was considered materially biased and received a Do Not Report (DNR) designation if any identified error or errors impacted the performance measure rate by more than 5 percentage points.
  - For hybrid measure reporting, each Contractor's sampling and oversampling methodology was required to align with the measure steward's hybrid reporting specifications. If the Contractor used an oversampling rate larger than 20 percent, HSAG required the Contractor to provide evidence of NCQA approval. HSAG did not accept an oversampling rate larger than the established NCQA standard without the Contractor providing its evidence of NCQA approval.
  - HSAG followed CMS Protocol 2 in reviewing hybrid measures by conducting MRR validation of 30 records for at least two performance measures, across lines of business as applicable per Contractor, as selected by each Contractor's lead auditor.
- **Audit preparation:** HSAG confirmed the final scope of the audit with AHCCCS to ensure all written communication to the Contractors contained accurate information on the measures being

[A-1] NCQA Measure Certification[SM] is a service mark of the National Committee for Quality Assurance (NCQA).

reported. Upon obtaining AHCCCS' approval of the document request packet templates, HSAG prepared customized document request packets for each Contractor. The memo accompanying the packet provided details of the audit process and requirements, including:

- The audit timeline.
- Information about virtual review scheduling.
- A list of all measures under the scope of the audit.
- The ISCAT to complete and reference to appropriate use of the HEDIS MY 2021 Record of Administration, Data Management, and Processes (Roadmap).
- Information on source code review, as well as medical record review validation and supplemental database review, as applicable.
- Information on where and how to submit performance measure rates and required documentation.
- Next steps and whom to contact for additional information.

- **Assess the integrity of the Contractor's information systems (IS):** As part of the ISCAT, HSAG received detailed information regarding all data systems that feed into the collecting and reporting of performance measures, including patient data, provider data, claims/encounter data, survey data, and data integration processes.

HSAG used the completed ISCATs to evaluate Contractors' IS and environments, identify any existing potential barriers to data collection and reporting, verify the use and oversight of contracted vendors, and review the medical record abstraction process. Upon completing its review of the ISCAT, HSAG prepared preliminary follow-up actions and items that needed clarification in an IS Tracking Grid. HSAG used the grid throughout the audit process to communicate with the Contractors about items that needed follow-up and to document resolution of each item.

If a Contractor had a recent (i.e., July 2021 or sooner) comprehensive, independent assessment of its information systems as conducted during an NCQA HEDIS Compliance Audit™, HSAG reviewed and assessed the Contractor's responses to NCQA's Roadmap and its associated attachments. Additionally, if the Contractor had not yet received its NCQA Medicaid Health Plan Accreditation but was working through a certified HEDIS Compliance Auditor specific to its Arizona Medicaid rates, HSAG accepted and reviewed the HEDIS Roadmap responses as applicable to the Contractor's Medicaid product.

- **Conduct detailed review of measures:** HSAG obtained from each Contractor the detailed source code and programming logic used to calculate each measure when NCQA Certified Measures vendors were not used. HSAG programmers, assigned according to familiarity and expertise with the programming language each Contractor used, conducted a detailed review of each line of code to ensure strict compliance with measure specifications, identifying and estimating any potential bias, and identifying any necessary corrections. As part of this step, HSAG provided each Contractor with feedback on each measure selected for source code review. HSAG's source code reviewers conducted a line-by-line review to meet the following three objectives:

  1. Ensure strict compliance with current technical specifications, regardless of source (e.g., HEDIS or CMS) and the accuracy of programming logic. The reviewer documented any noted deviation from the specifications and provided detailed feedback to the Contractor's programmer.

2. Identify and estimate the potential for bias that each deviation can introduce to the measure calculation.
3. Flag issues requiring corrections to code, further investigation, or fixes to the sample. The reviewer documented each issue clearly and initiated discussion with the Contractor to determine action steps for resolving the identified issues.

HSAG made every attempt to identify all issues requiring action before the virtual audit so it could discuss specific strategies with the Contractor during the virtual review. After HSAG verified all corrections to code, it provided the Contractor with a final, written summary of the programming review findings and implications for measure designations. If NCQA Certified Measure vendors were used, HSAG requested the Contractors to provide a copy of the certified measures reports to confirm each measure's certification status.

- **Medical record review and validation (MRRV):** HSAG provided the Contractors with guidance through each step of the medical record review to ensure all obstacles that potentially impact hybrid reported rates were identified and corrected early in the audit process. HSAG's medical record review team participated in each Contractor's kick-off call to discuss the medical record review process and answer any questions the Contractor had. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from two hybrid measures to ensure the accuracy of the medical record data abstracted by each Contractor. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by each Contractor and used the MRRV results to determine if the findings impacted the audit results for each performance measure rate. As part of the medical record review and validation, the medical record review team:
  - Reviewed and clarified all ISCAT responses (inclusive of the Roadmap, when applicable) pertaining to the Contractor's medical record review process, including reviewer training and quality assurance, the medical record procurement approach, data integration with administrative data, and medical record vendor oversight.
  - Conducted a thorough review of the Contractor's selected data abstraction tools, functionality, and reviewer instructions.
  - Conducted a final over-read review of a sample of 30 records from two hybrid measures and all medical record exclusions, inclusive of cases across the Contractors' applicable lines of business (when applicable), to ensure the accuracy of the medical record data abstracted.
  - Identified errors and determined if they were critical or noncritical based on the following definitions:
    - **Critical error**: Any finding that changed the compliance of a measure from numerator positive to numerator negative impacting the overall rate.
    - **Non-critical error**: Any finding that did not change the overall compliance of the member and resulted in zero change to the overall rate. (i.e., data entry errors, lab result date collected versus read by MD).
  - If errors were identified, a Contractor could be required to provide additional records for review, based upon the auditor's request. Samples with errors exceeding 10 percent were determined to be materially biased, and HSAG reported the results to AHCCCS to consider adjusting the Contractor's reporting from hybrid to administrative in such instances (although none occurred

during the CY 2021 PMV). Error rates less than 10 percent were evaluated for overall rate impact and hybrid data collection would be allowed if the rate was not materially biased, based upon an impact analysis.

- **Prepare for the Contractor virtual audit**: HSAG worked with each Contractor to identify a date for the virtual audit that allowed for all appropriate Contractor staff members to be present. Once the audit schedule was finalized, HSAG sent it to AHCCCS and coordinated for AHCCCS staff members to observe audits based upon AHCCCS' request. HSAG produced a detailed agenda for the virtual audit and worked with each Contractor to ensure the agenda timeline included appropriate staff members in the sessions for which they are responsible. Before the date of the virtual audit, HSAG sent the agenda to the Contractor and to AHCCCS, if applicable.
  - Before the virtual audit, HSAG scheduled and facilitated a kick-off call with each Contractor to:
    - Discuss the audit logistics, including virtual review hosting preferences (i.e., Contractor or HSAG), key Contractor attendees, and potential vendor and/or subcontractor attendance if applicable.
    - Review the draft agenda.
    - Discuss any changes in the Contractor's processes or systems since the previous year's PMV audit.
    - Discuss the medical record review process and timeline.
    - Discuss the timelines for ISCAT submission, use of the HEDIS Roadmap, identification of supplemental data, administrative rate review, preliminary rate review, and performance measure rate submission.
    - Remind the Contractor of the scope of the audit, including measures and primary source verification (PSV) processes.
    - Discuss supplemental databases.
    - Confirm the Contractor's vendor for certified measures, if applicable.
    - Address any Contractor questions or concerns.

Virtual Site Review Activities:

HSAG conducted a virtual on-site visit with each Contractor. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual 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 (if applicable) documentation:** This session was designed to be interactive with key Contractor staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. Additionally, to reduce the administrative burden on the Contractors, HSAG allowed for submission of the same Roadmap used for the NCQA HEDIS Compliance Audit conducted by the Contractors' NCQA-licensed organizations, where appropriate and applicable as

part of their ISCAT submissions. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that 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 the processing of claims, processing of enrollment and disenrollment data, and tracking of 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. Throughout the evaluation HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key Contractor 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 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 virtual on-site review for verification, which provided the Contractor with 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 virtual 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 Contractor had system documentation which supported that it appropriately included records for measure reporting. This technique did not rely on a specific number of cases for review to determine compliance; rather, it was 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 could 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 and virtual on-site visit, and revisited the documentation requirements for any post-virtual on-site activities.

Description of Data Obtained

As identified in the CMS EQR Protocol, HSAG obtained and reviewed the following key types of data for CY 2021 as part of the PMV:

1. **ISCAT:** This was received from each Contractor. The completed ISCAT provided HSAG with background information on the Contractor's IS, policies, processes, and data in preparation for the virtual validation activities.
2. **Source code (programming language) for performance measures:** This was obtained from each Contractor and was used to determine compliance with the performance measure definitions. If NCQA Certified Measures vendors were used, HSAG requested the Contractors to provide a copy of the certified measure reports to confirm each measure's certification status.
3. **Supporting documentation:** This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
4. **Current performance measure results:** HSAG obtained the results from the measures each Contractor reported and calculated.
5. **Virtual interviews and demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key Contractor staff members as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG also performed a performance validation audit of each Contractor for AHCCCS' selected measures. HSAG evaluated each Contractor's eligibility and enrollment data systems, medical services data systems, and data integration process through an ISCAT, source code review, virtual review of the Contractor, and PSV of a selected sample of measure data.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the PMV activity conducted.

How Conclusions Were Drawn

Information Systems Standards Review

Contractors were required to demonstrate compliance with IS standards. Contractors' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine Contractor compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[A-2] The IS standards are as follows:

- Medical Services Data (Claims/Encounters): Sound Coding Methods and Data Capture, Transfer, and Entry
- Enrollment Data: Data Capture, Transfer, and Entry
- Practitioner Data: Data Capture, Transfer, and Entry
- Medical Record Review Processes: Training, Sampling, Abstraction, and Oversight
- Supplemental Data: Capture, Transfer, and Entry
- Data Preproduction Processing: Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- Data Integration: Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

HSAG used the following standardized rating methodology for PMV, as outlined in the current CMS Protocol 2:

- Reportable (R): The measure was compliant with the applicable technical specifications
- DNR: The Contractor rate was materially biased and should not be reported
- Not Applicable (NA): The Contractor was not required to report the measure due to a small denominator

Based on all validation activities, HSAG determined results for each performance measure. According to the CMS EQR PMV 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 was closely related to accurate rate reporting that could not be implemented in time to produce validated results, rendered a particular measure as "DNR."

[A-2] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

Performance Measure Results

Each Contractor's performance measure results for CY 2021 were compared to program-level aggregate rates, prior year Contractor-specific performance, and NCQA's Quality Compass national Medicaid Health Maintenance Organization (HMO) mean for CY 2021, where applicable.

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the performance measures to one or more of the three domains of care (i.e., Quality, Timeliness, and Access). This assignment to domains of care is depicted in Table A-1. The measure marked NA indicates the measure is related to utilization of services and, therefore, is not assigned to a domain.

Table A-1—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total and *Total Engagement of AOD Treatment—Total—Total*	✓	✓	✓
Care of Acute and Chronic Conditions			
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	✓		
Controlling High Blood Pressure	✓		
Heart Failure Admission Rate	✓		
Pediatric Health			
Child and Adolescent Well-Care Visits—Total	✓		✓
Developmental Screening in the First Three Years of Life	✓	✓	✓
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits*	✓		✓
Annual Dental Visit			✓
Childhood Immunization Status—Combination 3, *7*, and *10*	✓		

Performance Measure	Quality	Timeliness	Access
Immunizations for Adolescents	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Preventive Screening			
Breast Cancer Screening—Total	✓		
Cervical Cancer Screening	✓		
Appropriate Utilization of Services			
*Ambulatory Care—ED Visits****	NA	NA	NA
Plan All-Cause Readmissions—Observed Readmissions and *O/E Ratio*	✓		
Use of Opioids at High Dosage	✓		

*Not assigned to a domain as a lower or higher rate does not indicate better or worse performance.

Validation of Performance Improvement Projects

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a health plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators
- Implementation of systematic interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

Breast Cancer Screening PIP

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Breast Cancer Screening* PIP for the ALTCS-EPD Program. The objective of the *Breast Cancer Screening* PIP is to increase the number and percentage of breast cancer screenings. The goal is to demonstrate a statistically significant increase in the number and percentage of breast cancer screenings followed by sustained improvement for one consecutive year.

Back to Basics PIP

In CYE 2019 (October 1, 2018, through September 30, 2019), AHCCCS implemented the *Back to Basics* PIP for the ALTCS-DD Program. The objective of the *Back to Basics* PIP is to increase the number of child and adolescent well-child/well-care visits, and increase the number of children and adolescents receiving annual dental visits. The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

Technical Methods of Data Collection

AHCCCS established a process for selection and validation of clinical and nonclinical focused PIP topics that is based on *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019.[A-3] Table A-2 describes the nine protocol activities and the specific tasks that AHCCCS performed to complete each activity.

Table A-2—Protocol Activities Performed for Validation of PIPs

For this protocol activity,	AHCCCS completed the following activities:
Activity 1:	**Select the Topic**
	PIP topics shall be selected to improve clinical and/or nonclinical services. Selected topics shall reflect the characteristics of AHCCCS members in terms of demographics, prevalence of disease, and potential consequences of the disease. Project topics and performance indicators used to assess each project are identified through data collection and analysis of member needs, care, and services. The selection of PIP topics shall consider: • Performance on standardized performance measures established by CMS, NCQA, the Substance Abuse and Mental Health Services Administration (SAMHSA), etc. • Feedback from members or providers • Care of special populations or high priority services, including behavioral health, children with special healthcare needs, LTSS, preventive care, continuity or coordination of care, etc. • Alignment with priority areas identified by CMS
Activity 2:	**Define the Aim statement**
	The PIP aim statement shall identify the focus of the PIP as well as establish the framework for data collection and analysis. The aim statement shall also be answerable and measurable. The aim statement shall clearly and concisely outline: • The improvement strategy • Population • Time period

[A-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct. 27, 2022.

For this protocol activity,	AHCCCS completed the following activities:
Activity 3:	**Identify the Population**
	The PIP may be inclusive of the Contractor's entire enrolled population (based on the LOB) or a subset of the population. The included population shall be clearly defined by the following (as applicable): • Age • Length of enrollment • Diagnoses • Procedures • Other characteristics
Activity 4:	**Use Sound Sampling Methods**
	For PIPs which require a sampling methodology, appropriate sampling methods are required to ensure the collection of information produces valid and reliable results. PIP indicators which align with standardized performance measures shall adhere to the sampling methodology outlined within the measure's associated technical specifications. The sampling methodology shall: • Outline the sampling frame that contains a complete, recent, and accurate list of the target population • Consider and specify the true or estimated frequency of the event, the confidence interval utilized, and the acceptable margin of error • Contain a sufficient number of members • Assess the representativeness of the sample according to subgroups (e.g., age, geographic location, health status) • Include valid sampling techniques utilized to protect against bias
Activity 5:	**Select the Indicators**
	The selected PIP indicator(s) shall: • Be objective, clearly defined, and time-specific • Reliably measure/answer the PIP aim statement • Be available to measure performance and track improvement over time For PIP indicators that are based on standardized performance measures, the indicators shall: • Assess an important aspect of care that will have meaningful impact on members' health or functional status • Be appropriate based on the availability of data and resources to collect the data • Be based on current clinical knowledge or health services research

For this protocol activity,	AHCCCS completed the following activities:
	• Monitor performance at a point in time • Track performance over time • Compare performance over time • Inform the selection and evaluation of quality improvement activities The following shall also be considered when selecting PIP indicator(s) based on standardized performance measures: • The measure addresses accepted clinical guidelines relevant to the PIP question • The measure addresses an important aspect of care or operations that was meaningful to members • The available data sources allow for the reliable and accurate calculation of the measure • The criteria utilized in the measure were defined clearly • The measure captures changes in member satisfaction or experience of care
Activity 6:	**Collect Valid and Reliable Data**
	Data collection procedures shall ensure that the data utilized to measure performance are valid and reliable. To ensure the validity and reliability of the PIP data collected, the data collection procedures shall specify: • The systematic method for collecting valid and reliable data that represents the population, • The frequency of data collection • The data sources • The data elements to be collected The data collection plan shall link to the data analysis plan to ensure that appropriate data are available for the PIP. Additionally, the data collection instruments shall allow for consistent and accurate data collection over the studied time periods. For PIP indicators which utilize qualitative data collection methods, the methods shall be well-defined and designed to collect meaningful and useful information from respondents.
Activity 7:	**Analyze Data and Interpret Results**
	PIP data analysis includes measurements at multiple points in time and tests for statistical significance. Interpretation of the PIP results shall involve an assessment of performance. The PIP methodology shall ensure the analysis: • Is conducted in accordance with the data analysis plan • Includes baseline and repeated measurements of project outcomes • Assesses the statistical significance of any differences between the initial and repeat measurements

For this protocol activity,	AHCCCS completed the following activities:
	• Accounts for factors that may influence the comparability of initial and repeat measurements • Accounts for factors that may threaten the internal or external validity of the findings • Compares the results across multiple entities (e.g., MCOs, member subgroups/subpopulations, provider sites, etc.), as applicable PIP results and findings shall be presented in a concise and easily understood manner. To promote continuous quality improvement, the analysis and interpretation of PIP data shall include lessons learned and opportunities for improvement.
Activity 8:	**Review Improvement Strategies**
	Based on the data analysis and interpretation of PIP results, the improvement strategies implemented as part of the PIP shall be reviewed. The selected improvement strategies shall be: • Evidence-based (i.e., based on existing evidence that the test of change would be likely to lead to the desired improvement in processes or outcomes) • Designed to address root causes or barriers identified through data analysis and quality improvement processes • Culturally and linguistically appropriate Plan-Do-Study-Act (PDSA) cycles shall be utilized to test the selected improvement strategy. In addition, the implementation of the improvement strategy shall be designed to account or adjust for any major variables that could have an obvious impact on the PIP outcomes. Based on the findings from data analysis and interpretation of results, the PIP shall assess the extent to which the improvement strategy was successful and include potential follow-up activities.
Activity 9:	**Assess Whether Significant and Sustained Improvement Occurred**
	A PIP is intended to result in significant and sustained improvement in healthcare delivery processes and outcomes, rather than a short-term or random change. The PIP results shall be assessed to determine if the PIP resulted in statistically significant changes over time that could reasonably be attributed to the improvement strategy implemented as part of the PIP. In order to assess if significant and sustained improvement occurred, repeated measurements that utilize the same methodology as the baseline measurement are required. Tests of statistical significance are also required to assess if statistically significant improvement is demonstrated. The assessment shall consider:

For this protocol activity,	AHCCCS completed the following activities:
	• The quantitative evidence of improvement in processes or outcomes of care • If the reported improvement is likely to be a result of the selected intervention • Statistical evidence/significance tests that the observed improvement is a result of the intervention • If sustained improvement was demonstrated through repeated measurements over time

Description of Data Obtained

Typically, PIPs include one intervention year; however, to account for the impact of the COVID-19 PHE, the *Breast Cancer Screening* PIP (ALTCS-EPD Program) and the *Back to Basics* PIP (ALTCS-DD Program) each include two intervention years within its design in which Contractors will implement strategies and interventions to improve performance, with CYE 2019 serving as the baseline year, unless otherwise indicated. AHCCCS will then conduct annual measurements to evaluate Contractor performance, with remeasurement years aligning with CYs: the first remeasurement year reflective of 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).

In CY 2022, each Contractor submitted the PIP Intervention Year Attachment form to AHCCCS. The form described each intervention the Contractor implemented during the intervention year, along with the intervention status, focus, and rationale for changes or discontinuation of the intervention for the following year. Specific intervention information for each Contractor can be found in Section 5. ALTCS-EPD Program Contractor-Specific Results and Section 6. ALTCS-DD Program Results.

Table A-3 shows the indicators, numerators, and denominators that will be used to measure the baseline of the *Breast Cancer Screening* PIP.

Table A-3—*Breast Cancer Screening* PIP Indicator

PIP Indicator: *Breast Cancer Screening*	
Indicator: 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 A-4 through Table A-6 show the indicators, numerators, and denominators that will be used to measure the baseline of this PIP.

Table A-4—*Back to Basics* PIP Indicator 1

PIP Indicator 1: *Well-Child Visits in the First 30 Months of Life* (*W30 Rate 1*)	
Indicator 1: Percentage of children who turned 15 months old during the MY and who had six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life. (*Not applicable for DES/DDD*)	**Numerator:** The total number of members receiving six or more well-child visits, on different dates of service, with a PCP during their first 15 months of life.
	Denominator: The eligible population.

*For indicator 1, the full measure includes two rates: one rate that evaluates well-child visits at 15 months and one rate that evaluates well-child visits at 30 months. For the purposes of this PIP, Contractors were focused only on the first rate, which evaluates well-child visits at 15 months (*W30 Rate 1*).

Table A-5—*Back to Basics* PIP Indicator 2

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

Table A-6—*Back to Basics* PIP Indicator 3

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

Evaluation of Contractor performance on the selected PIP indicators is based on systematic, ongoing collection and analysis of accurate, valid, and reliable data, as collected and reported by AHCCCS or as validated by the AHCCCS' EQRO. For Contractor self-selected PIPs that are not based on standardized performance measures, the Contractor shall ensure collected data are accurate, valid, and reliable through internal processes.

How Data Were Aggregated and Analyzed

AHCCCS-mandated PIPs typically begin on a date that corresponds with a calendar year. Table A-7 presents the timeline for the *Breast Cancer Screening* PIP.

Table A-7—ALTCS-EPD Timeline for *Breast Cancer Screening* PIP

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

AHCCCS-mandated PIPs typically begin on a date that corresponds with a calendar year. Table A-8 presents the timeline for the *Back to Basics* PIP.

Table A-8—ALTCS-DD Timeline for *Back to Basics* PIP

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

Baseline data are collected and analyzed at the beginning of the PIP. During the Intervention Year[A-4], 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 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 (Remeasurement Year 1, Remeasurement Year 2, as well as any subsequent Remeasurement Years necessary for the Contractor to meet the required criteria for PIP closure) are utilized to evaluate Contractor performance. AHCCCS may require 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.

[A-4] To account for the impact of the COVID-19 PHE, the *Breast Cancer Screening* PIP and *Back to Basics* PIP, which began in CYE 2019, each include two intervention years within its design.

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 reviews Contractors' submissions to verify adequate participation in the PIP until Contractors demonstration of significant and sustained improvement is shown, as outlined below.

How Conclusions Were Drawn

AHCCCS ensures the validity and reliability of data submissions through verifying:

- Measurement of performance using objective quality indicators
- Evaluation of the effectiveness of the interventions based on indicators collected as part of the PIP

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

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Contractors, HSAG assigned each of the components reviewed for PIP validation to one or more of the three domains (i.e., Quality, Timeliness, and Access). While the focus of a Contractor's PIP may have been to improve performance related to healthcare Quality, Timeliness, or Access, PIP validation activities were designed to evaluate the validity and quality of the Contractor's process for conducting valid PIPs. Therefore, HSAG assigns all PIPs to the Quality domain. In addition, PIP topics are also assigned to other domains as appropriate. This assignment to domains is shown in Table A-9.

Table A-9—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Breast Cancer Screening PIP	✓		
Back to Basics PIP	✓		✓

Compliance Review

Objectives

AHCCCS' objectives for conducting compliance reviews are as follows:

- 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)
- 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 compliance reviews
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures
- Determine Contractor compliance with commitments made during the request for proposal (RFP) process
- 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 the annual EQR technical report as described in 42 CFR §438.364

Technical Methods of Data Collection

To assess for the Contractors' compliance with regulations, AHCCCS conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[A-5] Table A-10 describes the five protocol activities and the specific tasks that AHCCCS performed to complete each activity.

Table A-10—Protocol Activities Performed for Assessment of Compliance with Regulations

For this protocol activity,	AHCCCS completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	• AHCCCS determined the timing and scope of the reviews, as well as scoring strategies.

[A-5] 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: Aug 10, 2021.

For this protocol activity,	AHCCCS completed the following activities:
	• AHCCCS developed monitoring tools and templates, agendas, and set review dates. • AHCCCS conducted training for all reviewers to ensure consistency in scoring across the Contractors.
Activity 2:	**Perform Preliminary Review**
	• AHCCCS notified the Contractors in writing of the request for desk review documents via email delivery of the compliance monitoring tool and an agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. • Prior to the review, the Contractors provided data files from which AHCCCS chose samples to be reviewed, including grievances, appeals, and denials. AHCCCS provided the final samples to the Contractors via AHCCCS' secure file transfer protocol (FTP) site. Prior to the scheduled review, the Contractors provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The AHCCCS review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation, as needed, and an interview guide to use during the webinar.
Activity 3:	**Conduct the Review**
	• During the review, AHCCCS met with groups of the Contractors' key staff to obtain a complete picture of the Contractors' compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the Contractors' performance. • AHCCCS requested, collected, and reviewed additional documents, as needed. • At the close of the review, AHCCCS may provide the Contractors' staff with a high level overview of how the overall review process went.
Activity 4:	**Compile and Analyze Findings**
	• AHCCCS used a compliance report template to compile the findings and incorporate information from the compliance review activities. • AHCCCS analyzed the findings and calculated scores based on pre-determined scoring strategies.

For this protocol activity,	AHCCCS completed the following activities:
	• AHCCCS determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.
Activity 5:	**Report Results**
	• AHCCCS populated the report template. • AHCCCS submitted the draft report to the Contractors for review and comment. • AHCCCS considered the Contractor's requests for reconsideration, as applicable, and finalized the report. • AHCCCS included a CAP template with the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score less than 95%). • AHCCCS distributed the final report, scores, and CAP template to the Contractor.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with the Contractors' key staff

How Data Were Aggregated and Analyzed

The AHCCCS compliance review is organized into Focus Areas. Each Focus Area consists of several standards designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard. Within each standard are specific scoring detail criteria worth defined percentages of the standard's total possible score.

Focus Areas include standards articulated at 42 CFR Part 438 as well as additional contractual requirements. In addition, there may be Focus Areas based solely on contract requirements.

AHCCCS included the following Focus Areas in its compliance review. Table A-11 includes a list of each Focus Area cross-walked with the related federal requirements found in 42 CFR Part 438.

Table A-11—Crosswalk of AHCCCS Focus Areas, Standards, and Federal Requirements

Focus Areas	Federal Requirements Included
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
CC	438.242, 438.608, 438.610, 455.1, 455.17, 455.100-106, 455.436
CIS	433.135, 434.6, 438.242, 438.600
DS	438.12, 438.102, 438.206, 438.207, 438.214, 438.242
GA	164.530, 438.3, 438.224
GS	438.10, 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.420, 438.424
MCH	441.56, 441.58
MM	438.62, 438.114, 438.136, 438.208, 438.210, 438.228, 438.230, 438.236, 438.240, 438.330, 438.404, 456.125-133
MI	438.10, 438.100, 438.206, 438.207, 438.208, 438.406
QM	438.3, 438.66, 438.206, 438.214, 438.228, 438.230, 438.402, 438.406, 438.408, 438.416, 438.330, 479.98, 476.160
QI	438.330, 438.240, 438.242
RI	This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.
TPL	This Focus Area reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.
ISOC	This Focus Areas reflects the Contractor's fulfillment of State requirements or regulations outside of CFR §438.

AHCCCS conducts a review of Contractor information systems as part of its PMV process; therefore, there is not an IS requirements are not presented in the OR. 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 CY 2020, AHCCCS transitioned to using Contractor-calculated performance measure rates that are validated by the Arizona EQRO. The EQRO PMV activities (detailed in Section 5. ALTCS-EPD Program Contractor-Specific Results and Section 6. ALTCS-DD Program Results) included a review of the Contractors' information systems.

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.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by each Contractor. HSAG then identified common themes and the salient patterns that emerged across Contractors related to the compliance activity conducted.

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

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services, AHCCCS assigned each of the components reviewed for assessment of compliance with regulations to one or more of the three domains (i.e., Quality, Timeliness, and Access). Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality and timeliness of, or access to care and services provided by the Contractors.

Table A-12 depicts assignment of the standards to the domains of care for both the ALTCS EPD Program and ALTCS DD Program.

Table A-12—ALTCS Program Assignment of Focus Areas to the Quality, Timeliness, and Access Domains

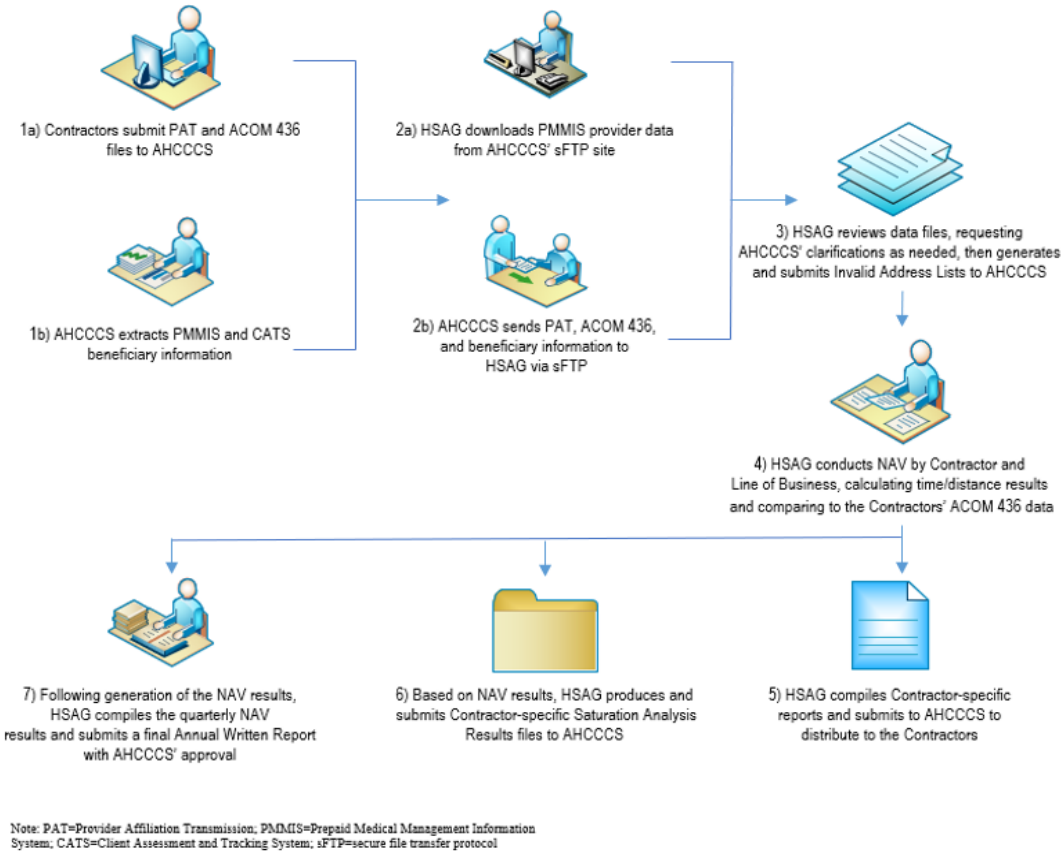
Focus Areas	Quality	Timeliness	Access
CM	✓		✓
CC	✓		✓
CIS			✓
DS		✓	✓
GA		✓	✓
GS	✓	✓	✓

Focus Areas	Quality	Timeliness	Access
MCH		✓	✓
MM	✓	✓	✓
MI	✓		
QM	✓		
QI	✓		✓
RI	✓		
TPL	✓	✓	✓
ISOC	✓		✓

Network Adequacy Validation

CYE 2022 is the fourth year in which AHCCCS contracted with HSAG to support biannual analysis and validation of healthcare provider networks subcontracted to AHCCCS' ALTCS-EPD Program Contractors and ALTCS-DD subcontracted health plans.[A-6] HSAG's biannual NAV considered each ALTCS-EPD Program Contractor's compliance with 12 AHCCCS-established time/distance standards each ALTCS-DD subcontracted health plan's compliance with 11 AHCCCS-established time/distance standards during the CYE 2022 measurement period.[A-7] Figure A-1 summarizes the biannual network adequacy data process and reporting products.

Figure A-1—CYE 2022 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

[A-6] 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.

[A-7] 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.

HSAG conducted biannual validation between the ALTCS-EPD Program Contractors' and the ALTCS-DD subcontracted health plans' self-reported ACOM 436 results and HSAG's time/distance calculations for all Contractors in each quarter that data could be compared.

Objectives

The NAV activities, in anticipation and release of the CMS protocol, were designed to help AHCCCS meet the NAV requirements once the EQR protocol is released. HSAG used data supplied by AHCCCS to calculate the number and percentage of AHCCCS-EPD and ALTCS-DD members within a defined time or distance from up to 12 types of AHCCCS-defined providers. As Table A-13 describes, these time/distance standards vary by provider type and county, and some standards may not apply to every Contractor or subcontracted health plan.

Table A-13—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[3]	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]	All members	90 percent of members within 15 minutes or 10 miles	Not Applicable
Cardiologist, Adult[3]	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[3]	Members younger than 21 years	90 percent of members within 60 minutes or 45 miles	90 percent of members within 110 minutes or 100 miles
Dentist, Pediatric	Members younger than 21 years	90 percent of members within 15 minutes or 10 miles	90 percent of members within 40 minutes or 30 miles
Hospital	All members	90 percent of members within 45 minutes or 30 miles	90 percent of members within 95 minutes or 85 miles
Nursing Facility[2]	All members currently residing in their own home	90 percent of member within 45 minutes or 30 miles	90 percent of members within 90 minutes or 30 miles

Provider Type	Member Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
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[3]	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[3]	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 ALTCS-EPD Program Contractors.
3. Services identified as eligible for a telehealth standard modification only require 80 percent of a county's membership to meet the time and distance standards where telehealth services are available for that provider category.

Technical Methods of Data Collection

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

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. Scoring is as follows:
     - 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
     - An asterisk (*) identifies standards with fewer than 10 members included in HSAG's 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 biannual PAT file for each applicable time/distance standard scored as Not Met

Description of Data Obtained

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 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 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 A-14 shows the effective dates for the data files supplied to HSAG in each measurement period.

Table A-14—Effective Dates for AHCCCS-Supplied Network Adequacy Data by Quarter and Data Type

Data Source	CYE 2022 Q2	CYE 2022 Q4
Measurement Period	April 2022	October 2022
PMMIS Providers	April 2022	October 2022
AHCCCS Members	April 2022	October 2022
Contractor-Specific PAT Providers	April 2022	October 2022
Contractor-Specific ACOM 436 Submissions	April 2022	October 2022

How Data Were Aggregated and Analyzed

HSAG used the Quest Analytics Suite software, version 2022.1 (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 A-12. 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.

How Conclusions Were Drawn

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

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

- CYE 2022 Q2: January 1–March 31, 2022
- CYE 2022 Q4: July 1–September 30, 2022

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

HSAG deemed that all NAV activities were related to both the Access and Timeliness domains.

Analytic Considerations

AHCCCS does not define the software or process by which each ALTCS 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.[A-8] Table A-15 describes each ALTCS Contractor's self-reported methods for calculating the ACOM 436 results, as of September 2022.

Table A-15—ALTCS-EPD Program Contractors' ACOM 436 Calculation Methods, as of September 2022

Contractor	ACOM 436 Calculation Method
BUFC LTC	Calculates time/distance results based on driving distances using Quest version 2021.4
Mercy Care LTC	Calculates time/distance results based on driving distances using Quest version 2022.2
UHCCP LTC	Calculates time/distance results based on driving distances using Quest version 2022.1

Table A-16 describes the ALTCS-DD Program DES/DDD subcontracted health plan's self-reported methods for calculating the ACOM 436 results, as of September 2022.

Table A-16—ALTCS-DD Program DES/DDD Subcontracted Health Plan's ACOM 436 Calculation Methods, as of September 2022

Contractor	ACOM 436 Calculation Method
Mercy Care DD	Calculates time/distance results based on driving distances using Quest version 2022.2
UHCCP DD	Calculates time/distance results based on driving distances using Quest version 2022.1

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 section presents, by LOB, the biannual validation results for Contractors' county-specific time/distance network standards. However, HSAG's time/distance calculations included all available provider locations noted in Contractors' PAT data files, without considering potential barriers to new patient acceptance or appointment availability at individual provider locations.

[A-8] 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.

Additionally, HSAG's time/distance calculations did not include some facilities available to American Indian members enrolled with an ALTCS 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, Indian Health Service (HIS) 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' ALTCS 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.

Aggregating and Analyzing Program-Level Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the Quality, Timeliness, and Access to care furnished by each MCO, as well as the program overall. To produce AHCCCS' Annual Technical Reports, HSAG performed the following steps to analyze the data obtained and draw program-level conclusions about the Quality, Timeliness, and Access to care and services provided by the Contractors:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each Contractor to identify strengths and opportunities for improvement in each domain of Quality, Timeliness, and Access to services furnished by the Contractor for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall Quality, Timeliness, and Access to care and services furnished by the Contractor.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of, Quality, Timeliness, and Access to care and services furnished by the Contractor.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the Quality, Timeliness, and Access to care for the program.

Appendix B. Acknowledgments and Copyrights

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