AHCCCS Quality Strategy Evaluation
CYE 2021 - CYE 2023

March 2024

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1. Introduction

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

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

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

2. Population Management

One of the primary strategic goals of AHCCCS is to reduce system fragmentation and develop systems of care that are easy for members to navigate. Since 2013, and culminating in 2022, AHCCCS has been implementing a delivery system reform effort that allows members to access physical and behavioral health services through a single integrated delivery system model. This new integrated system is intended to treat all aspects of members' healthcare needs and encourages greater coordination between providers within the same network which can lead to better health outcomes for members.

Table 1-1 includes an enrollment summary for the following AHCCCS programs:

- AHCCCS Complete Care (ACC),
- Regional Behavioral Health Authority (RBHA)/AHCCCS Complete Care - Regional Behavioral Health Agreement (ACC-RBHA),[1,2]
- Department of Child Safety Comprehensive Health Plan (DCS CHP) - formerly known as Comprehensive Medical and Dental Program (CMDP) prior to April 2021,
- Arizona Long Term Care System Developmental Disabilities (ALTCS-DD), and
- Arizona Long Term Care System Elderly and Physical Disabilities (ALTCS-EPD).

[1] Effective October 1, 2022, AHCCCS expanded three ACC contracts to include RBHA services, thus furthering integration efforts, under the ACC-RBHA line of business (LOB).
[2] 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).

Table 1-1. Managed Care Organizations and Enrollment Summary

Line of Business	Plan Type	Sep 30, 2021 Enrollment	Sep 30, 2022 Enrollment	Sep 30, 2023 Enrollment
ACC/ACC-RBHA: ACC Population				
Arizona Complete Health - Complete Care Plan (AzCH)	ACC-RBHA	368,172	400,687	360,347
Banner-University Family Care (BUFC)	ACC	279,130	305,566	271,774
Care 1st Health Plan (Care 1st)	ACC-RBHA	80,460	85,718	75,194
Health Choice Arizona (HCA)	ACC	227,113	242,559	212,961
Mercy Care	ACC-RBHA	393,221	419,811	368,598
Molina Healthcare	ACC	45,334	49,431	42,517
UnitedHealthcare Community Plan (UHCCP)	ACC	442,366	474,631	416,385
RBHA/ACC-RBHA: SMI Designated Population[1]				
Arizona Complete Health - Complete Care Plan (AzCH)	ACC-RBHA	14,368	13,192	12,098
Care 1st Health Plan (Care 1st)[2]	ACC-RBHA	—	—	5,432
Health Choice Arizona (HCA)[3]	RBHA	6,309	6,590	—
Mercy Care	ACC-RBHA	26,923	29,838	27,831
Department of Child Safety Comprehensive Health Plan				
Department of Child Safety Comprehensive Health Plan	DCS CHP	13,566	12,621	10,098
Arizona Long Term Care System Developmental Disabilities (ALTCS-DD)				
Division of Developmental Disabilities	DES/DDD	37,147	38,818	40,940
Arizona Long Term Care System Elderly and Physical Disabilities (ALTCS-EPD)				
Banner-University Family Care (BUFC)	ALTCS	6,409	6,726	6,849
Mercy Care	ALTCS	11,033	10,760	10,467
UnitedHealthcare Community Plan (UHCCP)	ALTCS	8,583	8,472	8,587

[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).

[2] Care 1st began serving the ACC-RBHA SMI Designated population effective 10/1/2022.

[3] Health Choice no longer serves the RBHA SMI Designated population effective 10/1/2022.

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

3. AHCCCS Quality Strategy

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS. As part of its 2021 Quality Strategy, AHCCCS established the following quality goals and objectives:

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

Objectives:

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

Quality Goal 2: Improve the health of AHCCCS populations.

Objectives:

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

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

Objectives:

- Increase analytical capacity to make more informed clinical and policy making decisions, and
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:

    - Strategic partnerships to improve access to health care services and affordable health care coverage,
    - Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues,
    - Effective medical management of at-risk and vulnerable populations, and
    - Capacity building in rural and underserved areas to address both professional and paraprofessional shortages.

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

Objectives:

- Evaluate current data system infrastructure,
- Identify system and process limitation impacting performance measure reporting and analysis,
- Leverage various data sources to produce comprehensive reliable data, and
    - Collaborate with external stakeholders to facilitate access to supplemental data sources, and
    - 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.

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

4. Quality Strategy Evaluation

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

4.1 Evaluation Methodology

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

In order to evaluate the Quality Strategy goals, AHCCCS:

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

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

4.2 Evaluating the Quality Strategy Goals

During the Quality Strategy evaluation period [Contract Year Ending(CYE) 2021 - CYE 2023], AHCCCS conducted activities and implemented initiatives to achieve the CYE 2021 Quality Strategy goals and objectives, as outlined below.

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

- Continued its efforts to monitor and evaluate performance on current AHCCCS-mandated PIP indicators. In addition, AHCCCS identified and implemented new PIPs based on monitoring of performance measure data trends and External Quality Review Organization (EQRO) improvement recommendations,
- Initiated efforts to implement the National Core Indicators - Aging and Disabilities (NCI-AD™) member experience survey for its ALTCS-EPD population,
- Continued its efforts to work with tribal partners to establish IHS/Tribal 638 facilities as American Indian Medical Homes (AIMH). To date, there are eight AIMHs with nearly 29% of American Indian Health Program (AIHP) members empaneled with an AIMH,
- Children in foster care began receiving integrated physical and behavioral health services through DCS CHP effective April 1, 2021,
- Integrated physical and behavioral health services for AIHP members with a Serious Mental Illness (SMI) designation effective October 1, 2022, and
- Continued various State Directed Payments focused on improving members' care experience.

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

- Implemented validation of members' access to care through a third party via appointment availability surveys,
- Received approval for a $350 million Targeted Investments Program (TIP), helping facilitate integration at approximately 500 provider sites across the state,
- Implemented several strategies to combat the opioid epidemic, including: overdose prevention through a variety of fentanyl and opioid overdose public education campaigns and naloxone

distribution, increasing access to medication-assisted treatment through innovative approaches such as 24/7 access points providing opioid treatment services 24 hours a day, 7 days per week, enhancing workforce quality through ongoing provider training, and supporting improved referral pathways to recovery support services through provider collaboration and networking,

- Collaborated with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) [formerly known as the Department of Corrections (DOC)] and county justice partners resulting in over 10,000 incarcerated individuals becoming eligible for AHCCCS prior to release,
- Implemented member level data collection requirements through updates to AHCCCS Medical Policy Manual (AMPM) 1022 to enable AHCCCS to verify reach-in and begin conducting outcomes analysis. Additionally, AMPM 1022 was revised to require reach-in at 20 days instead of 30 days,
- Renewed focus on enrollment suspense activities for justice-involved Medicaid members to allow AHCCCS to engage in data-sharing with more counties and create additional linkages for members who are releasing to rural communities,
- Extended postpartum coverage for members who are eligible solely based on pregnancy from 60 days to 12 months. This includes full coverage of all AHCCCS-covered services, including both physical and mental health screening and treatment,
- Included postpartum depression screening for caregivers at the infant's 1, 2, 4, and 6 month Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits to the list of covered services on the basis that treatment of depression benefits both the individual as well as their child and family. Individuals with positive screens are provided with resources and connected with treatment through their health plan,
- Included adolescent suicide screening as a routine covered service at EPSDT visits beginning at 10 years of age, in response to children's mental health crisis,
- Funded the Arizona Perinatal Psychiatry Access Line (APAL) through partnership with the University of Arizona. This access line allows providers of any specialty from across the state to connect with a perinatal psychiatrist that can provide consultation to assist with treatment decisions for people who are pregnant or postpartum, and
- Continued various State Directed Payments focused on improving members' health outcomes.

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

- Integrated APMs in order to reduce costs and increase quality of care for members. Through VBP, AHCCCS is committing resources to leverage the State's successful managed care model to address inadequacies of the current health care delivery system such as fragmentation, and to continue to lead efforts to bend the health care cost curve to sustainable levels,
- For the period of CYE 2021 through CYE 2023, the overall weighted average capitation rate increase was 1.98% for lines of business included in the AHCCCS budget, which continues the overall trend for capitation rate growth of below 3% for the program. This is less than the rate increase from 2018 through 2020,
- Implemented updated provider identification of specialization in serving various populations of individuals (i.e. Autism Spectrum Disorder, Substance Use, etc.) to ensure streamlined process for referrals and access to care, and
- Continued various State Directed Payments focused on reducing the cost of care.

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

- Required provider types Integrated Clinic (IC), 77, and 05 to include the provider who rendered the service on the claim/encounter in the claim note field (box 19) when the clinic is the servicing and billing provider, effective July 1, 2023,
- Collaborated with the State Health Information Exchange (HIE), Contexture, as a data source for enriching system data. Initial activities have included leveraging HIE data to enhance member contact information related to the COVID-19 Public Health Emergency (PHE) unwinding, enhance race and ethnicity reporting, and supplement performance measure rate reporting for the *Comprehensive Diabetes Care HBA1c Poor Control* performance measure related to a directed payment program,
- Developed a Medicaid Enterprise System Roadmap and initiated the build out of systems integrator (SI) platform and Enterprise Workflow System (ServiceNow),
- Relocated on-premise workloads, including file shares, Virtual Machine environment, server environment, cybersecurity platforms, single sign-on system, and miscellaneous applications to the cloud,
- Continued adoption and support of the State HIE,
- Transferred the DataWarehouse from the legacy version of Oracle to Azure SQL, and
- Relocated the HEAplus eligibility system to the cloud.

e. 2022 Year in Review

In 2022, AHCCCS enhanced health care service delivery, increased its use of technology to serve customers, and received national recognition for innovative work to address health related social needs. During Calendar Year (CY) 2022, AHCCCS:

- Obtained 1115 Waiver renewal, sustaining historic innovations like managed care and the provision of Home and Community Based Services (HCBS) while extending the Targeted Investments program to offer incentive funding to providers who meet specific integrated care milestones and implementing the Housing and Health Opportunities (H2O) demonstration,
- Received 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,
- Received CMS approval of the American Rescue Plan Act (ARP) spending plan to allocate $1.5B to improving HCBS programs,
- Implemented the AHCCCS Complete Care Regional Behavioral Health Agreement (ACC-RBHA) line of business serving individuals with an SMI designation, including integration of the national 988 suicide and crisis hotline; a single, statewide crisis line (1-844-534-4673); and a crisis text line (4HOPE),
- Integrated 424 American Indian and Alaska Native (AI/AN) individuals with an SMI designation into AIHP 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 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% 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 Medicaid Enterprise System (MES) to continue. The MES handles functions such as claims payment, provider enrollment, and electronic visit verification, and
- Engaged more than 50,000 members, families, and providers in stakeholder events, launched AHCCCS Explains video series featuring employees, and enhanced social media platforms to increase reach by 71%.

The 2020 Year in Review and 2021 Year in Review documents are also available on the AHCCCS website.

f. Current AHCCCS Initiatives and Best Practices

AHCCCS continually evaluates and innovates its service delivery in order to build a more integrated, cohesive, and effective health care system. This is done by reducing fragmentation, incentivizing quality outcomes, leveraging health information technology, and thinking about how whole person care can optimize health outcomes. Some current AHCCCS projects include:

- Implementing the Housing and Health Opportunities (H20) program to increase positive health and wellbeing outcomes for target populations,
- Using ARP funds to increase HCBS and supports,
- Increasing access to behavioral health services in schools,
- Incentivizing whole person care outcomes with Targeted Investments 2.0,
- Enhancing the closed loop referral system, and
- Leveraging telehealth services to better serve members and improve healthcare outcomes.

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

g. Home and Community Based Services

AHCCCS has maintained a consistent trend of HCBS member placements even when considering increases in population. For example, the placement rates have held constant in the past three years (CYE 20-22) with 72% of members living in their own home, 19% residing in an alternative residential setting, and 9% served in an institutional setting. These placement rates are largely attributable to the service options and HCBS Rules activities available which demonstrates the program's commitment to advancing initiatives which result in serving members in the least restrictive setting.

h. System of Care Oversight

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

Additionally, the System of Care team engages with community partners and other state agencies to ensure quality of, and access to, care for AHCCCS members. Over the past three years, this has included expanded efforts to identify referral pathways, coordination of care amongst systems, and alignment of definitions and policy requirements. Efforts have included partners, such as the Arizona State Hospital (ASH), Arizona Department of Education (ADE), and the Administrative Office of the Courts.

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

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

i. Justice System

As an important component of AHCCCS' Whole Person Care and Health Equity initiatives, AHCCCS has developed collaborative partnerships with a growing number of Arizona's justice system stakeholders in efforts to divert individuals from entering the justice system when appropriate and to provide efficient

and cost effective health care resources in support of men, women, and children attempting to successfully transition out of the justice system.

- In 2023, AHCCCS accomplished the following:
  - Assembled a list of all county active enrollment IGA numbers and active hospitalization IGAs to assess and verify that IGAs are in place. Counties that do not have an IGA in place for either of these functions are being contacted by AHCCCS to explore these opportunities,
  - Compiled new contact information for many counties where contact information was outdated,
  - Identified a strategy to track progress made towards counties who are sending booking and release information to AHCCCS in an automation file,
  - At the beginning of 2023, there were four counties using the automated booking/release process (Maricopa, Coconino, Pinal, and Yavapai). ADCRR is also using this process to notify AHCCCS of incarceration for citizens expected to be incarcerated for 12 months and less. By the end of 2023, AHCCCS was nearing implementation for Apache, Gila, Mohave, and Navajo Pima counties to be added to the list of automated receipt of booking/release files,
  - Collaborated with ISD to define a process to automate the hospitalization and hospital discharge of members so that members can be automatically enrolled into Fee-For-Service (FFS) during a hospital stay,
  - Worked with ADCRR to begin sending a file for long-term incarcerations (greater than 12 months) to automate the booking/release process, and
  - Worked with ADCRR to automate bookings and releases of juvenile incarcerations.

j. American Rescue Plan (ARP) Act Initiatives

On July 12, 2021, AHCCCS submitted a spending plan for the implementation of the American Rescue Plan Act of 2021, Section 9817. Arizona leveraged this unprecedented opportunity to implement initiatives that enhance and strengthen HCBS services while simultaneously promoting ongoing access to care and paths to self-sufficiency. Arizona has identified two priorities for HCBS funding: (1) strengthening and enhancing Arizona's home and community-based system of care, and (2) advancing technology to support greater independence and community connection. Both of these critical priorities have a number of member-centric strategies that will serve as a roadmap for Arizona's use of funding. These strategies are designed to support transformational change of Arizona's care delivery system, leading to improvements for individuals who are accessing general mental health and substance use disorder (SUD) services. In addition, Arizona has identified four key populations at the center of its efforts to enhance and strengthen HCBS services: seniors, individuals with disabilities, individuals with an SMI designation, and children with behavioral health needs. The key populations, strategies, and priorities are detailed in Table 2-1.

Table 2-1. HCBS Funding Priorities

<table>
<tr><th colspan="2">HCBS Funding Priorities for
Arizona's Seniors, Individuals with Disabilities, Individuals Living with Serious Mental Illness, and Children with Behavioral Health Needs</th></tr>
<tr><th>Strengthening and Enhancing Arizona's Home and Community Based System of Care</th><th>Advancing Technology to Support Greater Independence and Community Connection</th></tr>
<tr><td>(1) Empowering parents and families to provide care and meet the needs of their children.</td><td>(1) Utilizing new technology to promote care coordination and seamless communication.</td></tr>
<tr><td>(2) Funding local initiatives and community-specific programming to improve member health.</td><td>(2) Creating tools that strengthen quality monitoring and prevent abuse and neglect.</td></tr>
<tr><td>(3) Assessing member engagement and satisfaction to better understand needs, prevent abuse and neglect, and identify opportunities for improvement.</td><td rowspan="3">(3) Supporting individual self-sufficiency by connecting members to technological tools and resources that promote independence.</td></tr>
<tr><td>(4) Expanding access to care from a well-trained, highly skilled workforce.</td></tr>
<tr><td>(5) Promoting stabilization, access to supportive services, and workforce retention/consistency to improve member outcomes.</td></tr>
</table>

AHCCCS developed the spending plan with a wide array of stakeholder groups, including individual members, community advocates, providers, health plans, associations, and state policymakers. As of January 19, 2022, AHCCCS received conditional approval of the spending plan by CMS, and subsequently received spending authority from the Arizona State Legislature to implement the spending plan approved by CMS. AHCCCS continues to work with CMS to monitor and oversee the HCBS ARP Spending Plan on a quarterly basis. Since approval of the spending plan, AHCCCS has worked to implement and operationalize the priorities listed above. These include the following activities:

- Releasing one-time, directed payments to providers for the purposes of strengthening their workforce and enhancing HCBS. To support the release of these directed payments, AHCCCS will monitor outcomes related to diabetes management in an effort to promote ongoing access to care and enhance the quality of care delivered to its members,
- Working with community colleges to develop partnerships to assist with the implementation of workforce development activities, including tuition assistance and curriculum development for direct care workers (DCWs) and behavioral health technicians/behavioral health professionals (BHT/BHP) providers,

- Developing a Caregiver Career Development Pathway (Pathway) program designed to encourage individuals to begin a career as a DCW and guide them through their ideal career path, in partnership with Pipeline AZ,
- Implementing a differential adjusted payment (DAP) to providers for the development of a workforce plan to allow providers to proactively identify and mitigate potential gaps in the workforce,
- Reviewing the state's Client Assessment and Tracking System and Quality Improvement System through a partnership with a third party vendor. AHCCCS will work with a vendor to conduct an assessment of potential upgrades needed to streamline reporting of key quality metrics, such as the HCBS core set measures,
- Administering ARP Program Awards which will allow providers to make key program and infrastructure investments that will enhance the quality of care delivered to AHCCCS members,
- Upgrading the AHCCCS Health-e-Arizona Plus (HEAplus) system to support members' ability to upload documentation and access correspondence stored in the system, as well as to access translation of member screens to Spanish, in partnership with a third-party vendor,
- Making targeted investments for the Pre-Admission Screening and Resident Review (PASRR) System Portal that allow for greater efficiencies for PASRR application review,
- Implementing the first National Core Indicators - Aging and Disabilities (NCI-ADTM) survey in the state to solicit insight on member experiences and on opportunities for system improvements; and
- Reviewing remote technology options, how members receive HCBS across state agencies, and data sources used to assess progress for the Arizona Olmstead Plan.

More information on the Agency's ARP spending plan, including quarterly progress reports and updates, can be found on the AHCCCS website.

k. Workforce Development

As part of the overall effort to improve member's experiences with receiving health care services as well as to improve their health outcomes, the Office of Health Care Workforce Development, in collaboration with the workforce development operations of all contracted health plans, undertook several initiatives designed to strengthen the capacity and capability of the provider workforce.

- **Assisted the provider community adopt and use workforce development best practices:** Implemented three Differential Adjusted Payment (DAP) incentive programs for providers in 2021 and 2022. Program 1 incentivized providers to develop and implement Workforce Development (WFD) Plans as a means of improving the provider's recruitment, selection, training, deployment and staff support strategies. Program 2 incentivized the collection and reporting of workforce data and. Program 3 incentivized providers to create a presence on a newly developed career exploration and job acquisition platform called the Arizona Health Care Career Hub (the Hub), and use the Hub as a means to interact with job seekers, students, members of the community, and other job placement resources to increase the number of applicants for direct service positions in long term care and behavioral health.
- **Increased the number of health care career oriented applicants seeking employment in Arizona's health care provider system:** AHCCCS contracted with Pipeline AZ (PAZ) to build the Arizona Healthcare Careers platform (https://pipelineaz.com/hubs/healthcare). The Hub is a

skills mapping technology and career exploration platform connecting students, incumbent workers, and job seekers to career paths, jobs, education, training, and other resources needed to begin or grow a career in the health care field. By creating a presence on the platform, Arizona's health care providers can interact with Hub users and demonstrate how they can offer job seekers employment, but also be a pathway into starting or growing the job seekers career.

- **Developed and implemented a workforce database and decision support system:** AHCCCS lacked reliable sources of workforce data that could be used to inform policy development or decision making about quality and access to care, as well as information about turnover, retention, and time to fill critical positions in the provider community. Using consultation from Myers & Stauffer, and in collaboration with all of the health plans, AHCCCS is building and implementing a comprehensive workforce database and policy decision support system by 2024.
- **Developed and implemented a statewide partnership with Arizona's community colleges:** This partnership consists of three components that together, intend to reduce the time required for HCBS providers to onboard, train, and deploy newly hired staff by increasing the skills and knowledge of the talent pool from which HCBS providers typically hire. The first component is academic curriculum alignment; community college districts are aligning key aspects of their curriculum with the skills and information that closely align with the duties and requirements of various positions. Along with being equipped with the skills that are relevant to the jobs they seek, graduates of degree and certificate programs will also become more familiar with the AZ health care structure, approach to managed care, and other administrative requirements that may often limit new staff. The second component is a financial assistance program called AHCCCS Scholarships which fund over 50 health care degree and certificate programs in nearly all of Arizona's community colleges. Additional information about AHCCCS Scholarships can be accessed on the ARP Scholarships AHCCCS web page. The third component is in-service curriculum development. AHCCCS is using the curriculum development, testing, and instructional design expertise of community college faculty and staff to upgrade the initial, ongoing, and advanced in-service training curricula used by providers to train the behavioral health and long term care workforces. While intended for use by the provider community, these training programs will also be used by the colleges to align their academic course curricula with the requirements of HCBS providers.

4.3 External Quality Review

In accordance with 42 CFR 438.358, AHCCCS' EQRO conducts an annual EQR that includes:

- Validation of performance measures,
- Validation of PIPs,
- A review conducted within the previous three-year period to determine compliance with the standards [Operational Reviews (ORs)], and
- Validation of network adequacy.

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

As part of the Quality Strategy Evaluation process, the information presented within the EQR Annual Technical Reports is reviewed and utilized as a roadmap for the Quality Strategy Evaluation to identify potential changes and develop new goals/strategies, as needed. The EQR Annual Technical Reports

outline AHCCCS, line of business, and MCO-specific recommendations for improvement in key areas. AHCCCS reviews these recommendations annually and as part of the Quality Strategy Evaluation process in order to identify Quality Strategy strengths and areas for improvement.

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

a. Performance Measures

MCOs that did not meet performance standards for the CY 2021 performance measures (child and adult) were required to submit a corrective action plan (CAP) to AHCCCS outlining root causes, new or enhanced interventions implemented to improve performance, and the methods for monitoring progress toward achieving performance goals. As part of the CAP, MCOs were required to conduct root cause analysis, as well as examine and report potential barriers.

b. Performance Improvement Projects

PIPs are mandated by AHCCCS; however, the MCOs are also required to identify and implement self-selected PIPs meaningful to the population served, based on self-identified opportunities of improvement. As part of the AHCCCS-Mandated and MCO Self-Selected PIP reporting, MCOs are required to conduct a root cause and barrier analysis, as well as implement interventions to promote improvement in performance. AHCCCS and/or AHCCCS' EQRO review and provide feedback for MCO PIP submissions, identifying items that do not meet the associated requirements (e.g., CMS EQR PIP Validation protocols and state-specific requirements). MCOs are required to incorporate the deliverable submission feedback in future PIP submissions or resubmit the PIP report, per AHCCCS' direction. In addition, AHCCCS encourages (and, at times, requires) MCO participation in technical assistance sessions, to facilitate MCO compliance in meeting AHCCCS' expectations as it pertains to performance measures, PIPs, and CAPs.

c. Operational Reviews

In accordance with 42 CFR 438.358(b)(iii), AHCCCS utilizes ORs to evaluate MCO operations and performance related to compliance with federal and state laws, rules and regulations, as well as AHCCCS contracts and policies. AHCCCS offers technical assistance sessions to MCOs for any findings in the OR that may be of concern. The MCO may request a technical assistance session or AHCCCS staff may offer it based on the outcomes of the OR. In addition, AHCCCS has a number of venues to share lessons learned with MCOs. Lessons learned are often discussed at each of the MCO's exit interviews following completion of the OR onsite process.

d. Network Adequacy

AHCCCS provides assistance and offers several tools to assist MCOs in meeting AHCCCS standards and submitting accurate network data analysis. AHCCCS takes appropriate compliance action when necessary.

Specifically, as part of the time and distance network validation process, AHCCCS provides MCOs with a list of AHCCCS-registered providers not contracted with the MCO for use in network-building to bring them into compliance with standards. When MCOs cannot meet network standards, AHCCCS permits them to request a network exception. The exception process includes submission requirements designed to demonstrate the MCO has exhausted all efforts to expand their network, and how they will monitor access going forward. Currently, AHCCCS has approved two network exceptions.

Additionally, AHCCCS offers tools to assist MCOs in identifying and addressing issues in MCO data. First, AHCCCS provides files of MCO-submitted provider addresses that do not meet the United States Postal Service (USPS) address standards. The validation reports are posted to a website along with the MCO-submitted scores and are made available to the MCOs to assist in researching any discrepancies identified by the validation process. AHCCCS maintains a testing environment to assist MCOs in identifying and addressing any issues with the data submissions used in the validation process. Finally, AHCCCS also provides technical assistance with MCOs on these submissions.

AHCCCS also formally addresses and takes action when MCOs do not comply with data accuracy requirements. During Operational Reviews, AHCCCS reviews each MCO's processes for developing and submitting network data through two standards. One standard looks at the MCO's process for conducting the time and distance analysis, and a second examines a selection of MCO provider directory data for consistency with the data reported during this validation process. Any area found non-compliant results in a CAP. Finally, AHCCCS issued a letter of concern to one MCO for the continued submission of poor provider data, implemented a CAP, and closed it when the MCO demonstrated compliance.

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

4.4 Responsibility for Quality Monitoring

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

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

a. AHCCCS Quality Steering Committee

In CYE 2019, AHCCCS established the Quality Steering Committee inclusive of the executive management team, representatives from the AHCCCS clinical teams, and agency project teams. This committee continued to meet regularly to discuss quality initiatives, including performance measures and other quality improvement activities.

b. AHCCCS Clinical Oversight Committee

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

5. Performance Monitoring Results

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

As part of the agency's commitment to continuous quality improvement, AHCCCS developed a performance metric to monitor the improvement of performance measure rates at the AHCCCS statewide[3] level. AHCCCS also monitors and evaluates MCO and aggregate level performance on current AHCCCS-mandated PIP indicators, and conducts member experience surveys to monitor improvement in the members' experience of care, including quality and satisfaction. Additionally, AHCCCS conducts ORs of each contracted MCO at least once every three years, utilizing the OR process to meet the requirements of the Medicaid managed care regulations (42 CFR 438.358) and to determine the extent to which each MCO meets AHCCCS contractual and policy requirements, as well as additional federal and state requirements.

5.1 Performance Measures

AHCCCS utilizes CMS Core Set measures, the National Committee of Quality Assurance (NCQA) Health Effectiveness Data and Information Set (HEDIS)® measures, and other measures (when appropriate) to monitor MCO compliance in meeting contractual requirements related to the delivery of care and services to members. In addition to monitoring MCO performance, AHCCCS evaluates performance on CMS Core Set measures at the statewide level and utilizes the statewide data for CMS reporting. The results are analyzed and compared with previous year performance to identify trends, including strengths and opportunities for improvement, as well as to inform the selection of PIP topics, VBP strategies, and other improvement activities. Performance measures are also an important element of AHCCCS' approach to transparency in health services and VBP as performance is publicly reported on the AHCCCS website as well as via other means, such as the sharing of information with other state agencies, other community organizations, and stakeholders.

5.2 Performance Measure Analysis and Benchmark Comparison

AHCCCS conducted an analysis of its performance measure results utilizing several national benchmarks for comparison. This included comparison with the CMS Medicaid and CHIP Means, CMS Scorecard data, and NCQA Medicaid Means for the associated measurement period(s).

a. CMS Medicaid and CHIP Mean Comparison

As part of the Quality Strategy Evaluation, AHCCCS conducted an analysis of the CY 2020 and CY 2021 performance measure data reported to CMS. This analysis included all measure data reported and compared the AHCCCS reported performance measure rates with the associated CMS Medicaid Median, as well as evaluated performance by Core Set domain. AHCCCS identified an overall increase in the percentage of measures meeting or exceeding the CMS Medicaid Median in CY 2021 when compared to CY 2020.

[3] Statewide rates are reflective of Managed Care enrolled members meeting continuous enrollment criteria within the Arizona Medicaid program (Title XIX and Title XXI).

Table 3-1. Percent of All Reported Measures Meeting or Exceeding the CMS Median

CMS Core Set	CY 2020	CY 2021	Trend
Child Core Set Measures	50%	47%	?
Adult Core Set Measures	34%	52%	?
Total Measures	42%	49%	?

Strengths

Based on CY 2021 performance, AHCCCS demonstrated strength in the following domains as at least 50% of the reported measure rates included within the domain met or exceeded the associated CMS Medicaid Median.

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

AHCCCS demonstrated the strongest performance in the Behavioral Health Care domain for both CMS Child and Adult measures as 100% of the Child Core Set and 76% of the Adult Core Set measures reported exceeded the CMS Medicaid Median. AHCCCS continues to monitor and promote initiatives to further advance behavioral health care for members.

Opportunities

Based on CY 2021 performance, AHCCCS identified the following domains as areas for improvement as less than 50% of the reported measure rates included within the domain met or exceeded the associated CMS Medicaid Median.

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

AHCCCS identified the greatest opportunity for improvement in the Maternal and Perinatal Health domain. To promote improvement for measures included within this domain, AHCCCS implemented the Prenatal and Postpartum Care PIP and included the *Prenatal and Postpartum Care: Timeliness of Prenatal Care* measure as part of its quality measure performance incentive initiatives. In addition, AHCCCS required all MCOs to implement a CAP for any measure that did not meet or exceed national

benchmarks. As part of the CAP(s), MCOs were required to conduct root cause analysis, implement targeted interventions, and provide routine updates for each included measure.

b. CMS Medicaid and CHIP Scorecard Comparison

Statewide performance measure data are compared to the CMS Medicaid and CHIP Scorecard and associated CMS Median data and reported as part of the agency Scorecard. AHCCCS developed the following metric to monitor and improve statewide performance for CMS Core Set measures included within the CMS Scorecard:

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

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

Table 3-2. Percent of Measures Meeting or Exceeding the CMS Median

Measurement Year	Percentage	Trend
CYE 2018 (Baseline)	61.5%	–
CYE 2019	66.7%	?
CY 2020	61.9%	?
CY 2021	60.9%	?

In CYE 2021, AHCCCS reported statewide data for 100% of the measures included within the CMS Scorecard. Of the 23 measures included, 14 met or exceeded the CMS Medicaid Median resulting in 60.9 of measures meeting or exceeding the CMS Scorecard Medicaid Median. When compared to baseline, AHCCCS identified an overall decline in the percent of CMS Scorecard measures meeting or exceeding the Medicaid Median; however, the number of measures AHCCCS reported increased from 13 measures in CYE 2018 to 23 measures in CY 2021. As a result, AHCCCS implemented various strategies to promote improvement in performance, including additional data analysis to identify strengths and areas of opportunity as well as requiring its MCOs to implement CAP. Additionally, AHCCCS conducted an analysis on the decline noted between CYE 2019 and CY 2020, identifying that the decrease could be reasonably attributed to the reporting of hybrid measure data (new for CY 2020) and the impacts of the COVID-19 PHE.

Strengths

For measures included as part of the CMS Scorecard, AHCCCS demonstrated strength in several measures included within the Behavioral Health domain as well as in the *Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)* measure. Performance for the *Follow-Up After Hospitalization for Mental Illness (7 Day)* measure for ages 6 to 17 years and ages 18 years and older exceeded the Medicaid

Median by 24.1 percentage points and 21.0 percentage points, respectively. The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total Initiation* measure also exceeded the Medicaid Median by 4.5 percentage points and demonstrated a 2.0 percentage point improvement between CY 2020 and CY 2021.

Of note, the *Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)* measure did not meet or exceed the Medicaid Median in CY 2020; however, in CY 2021, the measure met the Medicaid Median and demonstrated a 4.0 percentage point improvement.

Opportunities

For measures included as part of the CMS Scorecard, AHCCCS identified opportunities for improvement for three measures. AHCCCS noted improvement in the *Prenatal and Postpartum Care: Postpartum Care* measure between CY 2020 and CY 2021; however, the measure did not meet or exceed the Medicaid Median in either years. As a result, AHCCCS implemented a Prenatal and Postpartum Care PIP aimed to improve performance for both of the Timeliness of Prenatal Care submeasures. Additional information related to this PIP can be found in section 5.8.

AHCCCS also identified an opportunity for improvement in the *PQI 01: Diabetes Short-Term Complications Admission Rate* measure as performance for this measure did not meet or exceed the Medicaid Median. Diabetes-related complications are associated with elevated Hemoglobin A1c levels (Sherwani, Khan, Ekhzaimy, Masood, & Sakharkar, 2016). As a result, beginning in CY 2020, AHCCCS included the *Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0)* measure as part of its VBP initiatives.

Additionally, AHCCCS is currently evaluating the *Controlling High Blood Pressure* measure as a potential area for improvement. While performance for the measure did not meet or exceed the Medicaid Median in CY 2020 or CY 2021, AHCCCS noted a 5.8 percentage point improvement between the two years. AHCCCS intends to continue monitoring this measure and collaborate with MCOs to promote continued improvement.

b. NCQA Medicaid Mean Comparison

As part of the Quality Strategy Evaluation, AHCCCS also conducted an analysis of the Statewide CY 2021 performance measure data that was calculated based on NCQA methodology and age stratifications. These data were compared to the NCQA Medicaid Mean to further evaluate performance and promote improvement.

Strengths

Based on an analysis of CY 2021 data, AHCCCS identified ten measures that exceeded the NCQA Medicaid Mean by 5 percentage points or more, with five measures exceeding by at least 10 percentage points. Notably, performance on the *Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase* submeasure exceeded the NCQA Medicaid Mean by 20.3% and the *Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase* submeasure exceeded by 19.2%.

Opportunities

AHCCCS identified the *Antidepressant Medication Management* measure as an area of opportunity. The *Antidepressant Medication Management - Effective Acute Phase Treatment* submeasure was included as part of its VBP initiatives beginning in CY 2021. AHCCCS intends to continue monitoring this measure and collaborate with MCOs to promote improvement.

5.3 Performance Measure Data Dashboard

AHCCCS developed a performance measure dashboard inclusive of a selected set of performance measures that are reported based on line of business and at the statewide level. The dashboard offers greater transparency to AHCCCS system performance and is a key point of reference for stakeholders. The dashboard compares the line of business aggregate rates with the associated NCQA HEDIS® Medicaid Mean and percentile data or the CMS Medicaid Median and quartile data (as appropriate to the methodology utilized to calculate the measure) for a prioritized group of measures selected through stakeholder feedback. Appendix A outlines the selected set of performance measures for each line of business included within the performance measure dashboard. AHCCCS intends to expand the list of selected performance measures as well as enhance the dashboard as future year performance measure data becomes available and additional stakeholder feedback is received. The Performance Measure Data Dashboard is made available on the AHCCCS website.

5.4 Childhood Immunization Reports

Since 1993, AHCCCS has regularly measured the immunization status of children two years old. AHCCCS publishes a report that evaluates the performance of MCOs, individually and overall, in accordance with state law (A.R.S. section 36-2904), which requires a biennial status of immunization completion rates for children two years of age served by AHCCCS. The most current Childhood Immunizations Report is made publicly available on the AHCCCS Quality & Performance Improvement web page. This report provides additional information related to the results, analysis, and associated MCO recommendations for improvement. For additional information related to child and adolescent immunization rates, please refer to Appendix A.

5.5 Form CMS-416

Annually, AHCCCS calculates and reports Form CMS-416 data for its Medicaid population utilizing the standardized methodology published by CMS. Additionally, AHCCCS calculates Form CMS-416 data for its Children's Health Insurance Program (CHIP) population (i.e., KidsCare) to monitor EPSDT and dental services.

While AHCCCS met the specified standards for T-MSIS and T-MSIS Analytic Files (TAF) data quality and completeness, and had the option to allow CMS to generate its FFY 2020, FFY 2021, and FFY 2022 Form CMS-416 reporting, AHCCCS elected to submit State-generated reports.

AHCCCS analyzes the aggregate CMS-416 data on an annual basis by conducting significance testing, evaluating the percentage point difference, and assessing the relative percent of change from the prior year's reporting. Following this analysis, AHCCCS may require the MCOs to implement interventions/ activities (i.e., CAPs) or participate in mandatory workgroup activities when statistically significant declines in the Medicaid and/or KidsCare aggregate rates are identified.

Table 3-3. Form CMS-416 Performance Summary Trends

Form CMS-416	FFY 2020 Rate	FFY 2021 Rate	FFY 2022 Rate[1]	FFY 2020 - FFY 2021 Change[2]	FFY 2021 - FFY 2022 Change[2]	FFY 2020 - FFY 2022 Change[2]
Title XIX Aggregate						
EPSDT Participation	43.2%	45.9%	47.3%	6.3%	3.1%	9.5%

Form CMS-416	FFY 2020 Rate	FFY 2021 Rate	FFY 2022 Rate[1]	FFY 2020 - FFY 2021 Change[2]	FFY 2021 - FFY 2022 Change[2]	FFY 2020 - FFY 2022 Change[2]
Total Eligibles Receiving Preventive Dental Services	42.0%	44.8%	45.4%	6.7%	1.3%	8.1%
Total Eligibles Receiving Any Dental Services	43.6%	46.2%	46.9%	6.0%	1.5%	7.6%
Title XXI Aggregate						
EPSDT Participation	52.4%	51.6%	51.6%	-1.5%	0.0%	-1.5%
Total Eligibles Receiving Preventive Dental Services	45.6%	47.7%	47.7%	4.6%	0.0%	4.6%
Total Eligibles Receiving Any Dental Services	48.5%	50.3%	50.5%	3.7%	0.4%	4.1%

[1] AHCCCS calculates and reports this measure in alignment with Form CMS-416 timelines. As a result, FFY 2022 data were available and included within this evaluation.
[2] Data within this column represents the relative percent of change.

Prior to the COVID-19 PHE, Form CMS-416 rates demonstrated improvement for both the Medicaid (Title XIX) and KidsCare (Title XXI) populations with the exception of EPSDT Participation for the KidsCare population. Based on an analysis of the FFY 2020 data, the COVID-19 PHE negatively impacted the Form CMS-416 rates, most notably for EPSDT Participation; however, when comparing FFY 2020 rates with FFY 2022 rates, the Title XIX population demonstrated statistically significant improvement in its EPSDT Participation rate.

To promote improvement with children and adolescents receiving well-child/well-care visits, AHCCCS implemented the Back to Basics PIP with a baseline measurement year of CYE 2019. Additionally, AHCCCS facilitated the implementation of a statewide Back-to-School campaign in collaboration with the AHCCCS MCOs. The Back-to-School campaign launched in June 2023 and aimed to increase the number of AHCCCS members ages 3-19 years old who completed a well-care visit; eligible members who completed a well-care visit during the campaign period earned a $25 gift card. Lastly, AHCCCS has included the *Well-Child Visits in the First 30 Months of Life (Rate 1: Well-Child Visits in the First 15 Months)* and the *Child and Adolescent Well-Care Visits* performance measures as primary measures for the ACC MCOs participating in the Withhold and Quality Measure Performance Incentive APM initiative since CYE 2020. The purpose of this initiative is to encourage MCO activity in the area of quality improvement by aligning the incentives of the MCOs and their providers through APM strategies.

5.6 AHCCCS Surveys

AHCCCS obtains survey feedback on its MCOs' membership and/or providers. The results of AHCCCS conducted surveys may become public information and available to all interested parties on the AHCCCS Surveys web page.

a. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey

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

Due to the COVID-19 PHE, AHCCCS delayed the administration of the 2020 CAHPS® Surveys; however, AHCCCS initiated its CAHPS® Survey administration for its ACC, KidsCare, DCS CHP, and RBHA-SMI integrated populations in 2021 and its KidsCare population in 2022. CAHPS® Survey results are made available within the Health Plan Report Card web page by population on the AHCCCS website.

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

b. National Core Indicators - Aging and Disabilities (NCI-AD™)

AHCCCS initiated efforts to implement the NCI-AD™ member experience survey for its ALTCS-EPD population in 2022. The NCI-AD™ survey aims to measure members' experience with several focus areas such as service planning, care coordination, community inclusion, and safety, among others.

c. Provider Survey

AHCCCS conducts surveys to receive feedback from providers contracted with MCOs regarding their satisfaction with MCO performance. The most recent provider survey was conducted in 2021 and measured provider satisfaction with MCO claims processing, resolution of claims issues, provider services staff, credentialing processes, and prior authorization processes. Survey results are used by AHCCCS to support ongoing MCO monitoring and quality improvement processes. Survey results are made available on the Provider Surveys web page of the AHCCCS website.

5.7 Performance Improvement Projects

AHCCCS requires that MCOs participate in PIPs selected by AHCCCS, as well as PIPs mandated by CMS. AHCCCS-Mandated PIP topics are selected through analysis of internal and external data/trends, and may include MCO input. Topics take into account the comprehensive aspects of member needs, care, and services for a broad spectrum of members, or a focused subset of the population, including those members with special health care needs, such as members receiving Long-Term Care Services and Supports (LTSS). AHCCCS may also mandate that a PIP be conducted by an MCO or group of MCOs, according to standardized methodology developed by AHCCCS. AHCCCS-Mandated PIP methodologies and reports (interim and final) are made available on the AHCCCS Quality & Performance Improvement web page. Additional information related to AHCCCS-Mandated PIP results can be found within the EQR Annual Technical Reports located on the AHCCCS Health Plan Report Card web page.

In addition, MCOs are also required to identify and implement Contractor Self-Selected PIPs based on self-identified opportunities for improvement, as supported by root cause analyses, external and internal data, surveillance of trends, or other information available to the MCOs.

Generally, the AHCCCS-Mandated PIPs are designed to include one intervention year in order to provide an opportunity for MCOs to develop strategies, implement interventions, and promote improvement. To account for the impacts of the COVID-19 PHE, AHCCCS included two intervention years within the Back to Basics, Breast Cancer Screening, and Preventive Screening PIP designs. In order to continue monitoring the progress of these PIPs, AHCCCS required the MCOs to provide an intervention year update in CY 2022 that included a description of the current and planned interventions, the intervention status, the intent of the intervention, and the rationale for any intervention changes or discontinuations from the previous year for each applicable AHCCCS-Mandated PIP. A summary of these interventions can be found within the EQR Annual Technical Reports located on the AHCCCS Health Plan Report Card web page; the most common interventions across MCOs included targeting members and providers for outreach and education related to the associated PIP focus.

a. Back to Basics

Population(s): ACC and ACC-RBHA (ACC Population), ALTCS-DD, and DCS CHP

The purpose of this PIP is to increase the number of child and adolescent well-child/well-care visits for eligible members. The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, followed by sustained improvement for one consecutive year.

Table 3-4. Back to Basics Performance Improvement Project

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

[1] CY 2022 rates anticipated to be available in early 2024.
[2] Year to Year Change is not yet available.

b. Breast Cancer Screening

Population(s): ALTCS-EPD

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

Table 3-5. Breast Cancer Screening Performance Improvement Project

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

[1] CY 2022 rates anticipated to be available in early 2024.
[2] Year to Year Change is not yet available.

c. Preventive Screening

Population(s): ACC-RBHA (SMI Designated Population)

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

Table 3-6. Preventive Screening Performance Improvement Project

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

[1]CY 2022 rates anticipated to be available in early 2024.
[2] Year to Year Change is not available.

5.8 Newly Implemented Performance Improvement Projects

In addition, AHCCCS has implemented the additional PIP outlined below with a baseline year of CY 2022 (January 1, 2022 to December 31, 2022)[4]:

a. Prenatal and Postpartum Care

Population(s): ACC and ACC-RBHA (ACC Population), ACC-RBHA (SMI Designated Population)

The purpose of this PIP is to improve health outcomes for members and infants by increasing the number and percent of members with live birth deliveries that 1) received a prenatal care visit, and 2) received a postpartum visit.

[4] The exception being Care 1st ACC-RBHA SMI Designated population, which began serving the SMI Designated population effective 10/1/2022. The baseline year for the Care 1st ACC-RBHA SMI Designated population is CY 2023.

It is anticipated that data for this PIP will be included within a future Quality Strategy Evaluation. Until that time, the Prenatal and Postpartum Care PIP data will be made available within upcoming EQR Annual Technical Reports posted on the AHCCCS Health Plan Report Card web page.

5.9 Operational Review

In CYE 2021, AHCCCS conducted a comprehensive OR inclusive of 13 standard areas for each RBHA MCO. Each standard area was inclusive of standards designed to measure each MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Division of Grants Administration: 4 standards
- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 16 standards
- General Administration: 3 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 18 standards
- Medical Management: 36 standards
- Member Information: 10 standards
- Quality Management: 13 standards
- Reinsurance: 4 standards
- Third-Party Liability: 8 standards
- Quality Improvement: 10 standards

In CYE 2021, AHCCCS also conducted a comprehensive OR inclusive of 13 standard areas for the ALTCS DES/DDD MCO. Each standard area was inclusive of standards designed to measure the MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Case Management: 23 standards
- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 14 standards
- General Administration: 3 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 19 standards
- Medical Management: 34 standards
- Member Information: 10 standards
- Quality Management: 13 standards
- Reinsurance: 4 standards

- Third-Party Liability: 8 standards
- Quality Improvement: 10 standards

In CYE 2022 and 2023, AHCCCS also conducted a comprehensive OR inclusive of 13 standard areas for the ACC MCOs. Each standard area was inclusive of standards designed to measure the MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 14 standards
- General Administration: 5 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 16 standards
- Medical Management: 23 standards
- Member Information: 9 standards
- Quality Management: 14 standards
- Reinsurance: 4 standards
- Third-Party Liability: 8 standards
- Quality Improvement: 6 standards
- Integrated System of Care: 21

In CYE 2023, AHCCCS also conducted a comprehensive OR inclusive of 13 standard areas for the DCS CHP MCO. Each standard area was inclusive of standards designed to measure the MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 14 standards
- General Administration: 5 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 16 standards
- Medical Management: 22 standards
- Member Information: 9 standards
- Quality Management: 14 standards
- Reinsurance: 4 standards
- Third-Party Liability: 8 standards
- Quality Improvement: 6 standards

- Integrated System of Care: 18

In CYE 2023, AHCCCS also conducted a comprehensive OR inclusive of 14 standard areas for the ALTCS-EPD MCOs. Each standard area was inclusive of standards designed to measure the MCO's performance and compliance. The standard areas and associated number of applicable standards are as follows:

- Case Management: 21 standards
- Corporate Compliance: 5 standards
- Claims and Information Systems: 10 standards
- Delivery Systems: 14 standards
- General Administration: 5 standards
- Grievance Systems: 17 standards
- Adult, EPSDT, and Maternal Child Health: 16 standards
- Medical Management: 21 standards
- Member Information: 9 standards
- Quality Management: 16 standards
- Reinsurance: 4 standards
- Third-Party Liability: 8 standards
- Quality Improvement: 6 standards
- Integrated System of Care: 21

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

Additional information related to the OR findings and corrective actions can be found on the AHCCCS Operational Review web page and within the EQR Annual Technical Reports located on the AHCCCS Health Plan Report Card web page.

In CYE 2022, AHCCCS conducted a comprehensive Readiness Review process for each ACC-RBHA MCO in preparation for the CYE 2023 ACC-RBHA contract implementation. The Readiness Review process included assessing the ACC-RBHA MCOs' readiness to perform and maintain compliance based upon an in depth review of the following areas:

- Administration staffing and staff training,
- Policy development/revision,
- Delivery systems,
- Provider and member communication,
- Grievance and appeals process,

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

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

5.10 Administrative Actions

In the event a MCO fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose an administrative action. Administrative actions may include issuance of any or all of the following: Notice of Concern, Notice to Cure (NTC), a mandate for a CAP, and sanctions. With few exceptions, the AHCCCS Compliance Committee evaluates recommendations for proposed sanctions and determines the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee may also review administrative actions that do not include a sanction, such as a Notice of Concern, NTC, or requirement of a CAP. Information related to Administrative Actions is made available on the AHCCCS website. Appendix D outlines the administrative actions issued to MCOs from CYE 2021 through CYE 2023.

6. MCO Accreditation

AHCCCS' managed care contracts require its MCOs to obtain Health Plan Accreditation by October 1, 2023 and LTSS Distinction by October 1, 2024; October 1, 2025 for DES/DDD, through NCQA. Additionally, AHCCCS is requiring MCOs to obtain NCQA Health Equity Accreditation by October 1, 2025. In February 2022, AHCCCS refocused its efforts regarding MCO accreditation and formed workgroups internally, and in collaboration with the MCOs, to promote discussion as MCOs worked through their gap analysis in preparation for their NCQA Survey. The goal of the workgroups is to compare the NCQA Accreditation standards, NCQA Medicaid Managed Care Toolkit, as well as current contractual and policy requirements, to ensure maximum alignment of regulatory oversight, increase opportunities for non-duplication as permitted by 42 CFR 438.360, and to leverage data validation tools. To date, these efforts have resulted in the revision of 22 AHCCCS medical and operational policies and the identification of four MCO contract deliverables as duplicative of NCQA's Accreditation review. AHCCCS' MCOs are simultaneously prioritizing initial NCQA MCO accreditation efforts and collaborating with the agency to raise questions and considerations as they work through their Accreditation review processes.

7. Network Adequacy

AHCCCS regularly receives reports from MCOs on compliance for network standards and follows up with MCOs on areas for improvement, as necessary. Additional information related to network adequacy findings are included within the EQR Annual Technical Reports located on the AHCCCS Health Plan Report Card web page. Findings are also submitted annually to CMS through the Network Adequacy and Access Assurances Report.

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

a. Appointment Availability

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

Table 4-1. PCP, Specialist, and Dental Provider Appointment Availability (CYE 2022 Quarter 4 Example)

PROVIDER REPORT		URGENT				ROUTINE CARE			
PROVIDER TYPE		SURVEYS	PASS	FAIL	COMPLIANCE PERCENTAGE	SURVEYS	PASS	FAIL	COMPLIANCE PERCENTAGE
PCP	New	1921	1875	46	97.61%	1923	1894	29	98.49%
	Established	1935	1912	23	98.81%	1933	1915	18	99.07%
Specialist	New	2001	1920	81	95.95%	2001	1995	6	99.70%
	Established	2000	1912	88	95.60%	2000	1987	13	99.35%
Dental	New	428	424	4	99.07%	424	421	3	99.29%
	Established	457	454	3	99.34%	455	453	2	99.56%

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

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

In September 2022, AHCCCS issued a Notice of Concern to an MCO for consistent failure to demonstrate an adequate network through poor provider appointment timeliness. On July 30, 2023, AHCCCS closed the CAP submitted by the MCO based upon its sustained improvement under this reporting.

AHCCCS contracted with its EQRO to conduct validation surveys for several of the providers in this standard. AHCCCS will use the validation findings to inform plan oversight, as well as to prepare for CMS rule changes impacting provider appointment surveys.

b. Time and Distance

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

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

Table 4-2. Percentage of Members within Minimum Time and Distance Requirements in Mohave County for ACC MCOs (CYE 2022 Quarter 4 Example)

	MCO 1				MCO 2			
Minimum Network Requirement	**CYE 2021 Q2**	**CYE 2021 Q4**	**CYE 2022 Q2**	**CYE 2022 Q4**	**CYE 2021 Q2**	**CYE 2021 Q4**	**CYE 2022 Q2**	**CYE 2022 Q4**
Behavioral Health Outpatient and Integrated Clinic, Adult	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%
Behavioral Health Outpatient and Integrated Clinic, Pediatric	99.9%	99.8%	99.8%	100%	100%	99.9%	100%	99.9%
Cardiologist, Adult	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%
Cardiologist, Pediatric	100%	100%	100%	100%	100%	100%	100%	100%
Dentist, Pediatric	98.5%	99.0%	99.0%	98.9%	98.8%	99.5%	99.4%	99.3%
Hospital	99.9%	99.9%	99.9%	99.9%	100%	100%	100%	100%
Obstetrics/ Gynecology (OB/GYN)	100%	100%	100%	100%	100%	100%	100%	100%
Pharmacy	98.8%	98.9%	98.9%	98.9%	98.8%	99.1%	99.3%	99.2%

	MCO 1				MCO 2			
Minimum Network Requirement	**CYE 2021 Q2**	**CYE 2021 Q4**	**CYE 2022 Q2**	**CYE 2022 Q4**	**CYE 2021 Q2**	**CYE 2021 Q4**	**CYE 2022 Q2**	**CYE 2022 Q4**
PCP, Adult	98.8%	98.9%	98.9%	98.9%	99.6%	99.9%	99.9%	99.9%
PCP, Pediatric	99.1%	98.7%	99.0%	99.0%	98.9%	99.7%	99.9%	99.9%

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

c. Improvement Opportunities

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

d. Network Exceptions

AHCCCS Contractor Operations Manual (ACOM) Policy 436 includes a process for MCOs to request an exception from any minimum network standard that cannot be met after all efforts are exhausted. AHCCCS reviewed criteria identified in the policy to determine if an exception will be allowed. These criteria include, but are not limited to, the number of providers available in the area, provider willingness to contract with an MCO, the availability of IHS/638 facilities to serve the American Indian population, and the availability of alternate service delivery mechanisms. MCOs are then required to monitor member access to the services covered by the exception while the exception is in place. In CYE 2023, there were two MCO exemptions in place, both for Pediatric Dentists in La Paz County, where there is only one AHCCCS-registered dentist in the County.

8. Payment Reform

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

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

Payment reform encompasses a variety of initiatives such as Differential Adjusted Payment (DAP), E-Prescribing initiative, and Directed Payments. A critical tool in achieving payment reform is Value Based Purchasing which includes Withhold and Quality Measure Performance Incentives, Alternative Payment Models (APMs), and Performance Based Payments.

8.1 Value Based Purchasing - Alternative Payment Model

AHCCCS was an early adopter of Value Based Purchasing strategies to reward providers for providing high-quality care to members through financial incentives tied to improving health outcomes while reducing the cost of care. AHCCCS continues to improve on these strategies by facilitating stakeholder workgroups to solicit input and by working collaboratively with the MCOs to better support provider efforts to successfully implement APM arrangements.

a. Withhold and Quality Measure Performance Incentive

AHCCCS has established an incentive arrangement where MCOs may receive additional funds for performance on a select subset of AHCCCS performance measures. The purpose of the quality measure performance incentive arrangement is to encourage MCO activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings. An incentive pool is determined by the portion of the withhold that is not returned to the MCOs under the terms of the withhold arrangement. The policy governing this incentive arrangement changed for CYE 23. For instance, the policy will still use a ranked score to distribute available incentive dollars by AHCCCS performance measure, but the MCOs will not be ranked if they did not earn either a performance achievement score or a performance improvement score for that measure. Additional changes to the incentive arrangement structure include measuring MCO performance on specific established NCQA performance measures and providing an opportunity for MCOs to achieve a portion of the withheld incentive payout for most measures for demonstrating statistically significant performance improvement from the last measurement year. MCOs may still obtain a portion of measure-specific incentives based on their annual performance. In addition, AHCCCS has been involved in developing and implementing new MCO deliverables to improve AHCCCS' oversight and understanding of MCOs' APM contracts with providers. AHCCCS continues to evaluate opportunities for improvement of the Withhold and Quality Measure Performance Incentive arrangement. The following tables are the ACC and ALTCS-EPD VBP Withhold and Quality Measure Performance Scores for CYE 2021 which were calculated using the calendar year 2021 performance measure rates validated by AHCCCS' External Quality Review Organization.

Table 5-1. CYE 2021 ACC VBP Withhold and Quality Measure Performance Scores

ACC MCO	PPC: Timeliness of Prenatal Care	BCS	W30: 15 Months (Rate 1)	WCV	FUH: 7 Day Rate
AzCH	77.9%	51.5%	60.6%	41.5%	41.1%
BUFC	63.2%	50.8%	57.2%	39.9%	34.9%
Care 1st	82.7%	37.0%	59.4%	46.6%	49.7%
HCA	77.6%	39.6%	51.9%	38.9%	41.7%
Molina	75.4%	39.6%	44.8%	34.2%	33.2%
Mercy Care	84.2%	52.0%	64.3%	49.7%	44.0%
UHCCP	86.4%	55.6%	63.3%	47.9%	44.8%

ACC MCO	PPC: Timeliness of Prenatal Care	BCS	W30: 15 Months (Rate 1)	WCV	FUH: 7 Day Rate
ACC Aggregate	**79.4%**	**49.4%**	**59.8%**	**44.9%**	**42.5%**

Table 5-2. CYE 2021 ALTCS-EPD VBP Withhold and Quality Measure Performance Scores

ALTCS-EPD MCO	HDO	BCS	CDC
BUFC	9.3%	38.6%	62.1%
Mercy Care	12.8%	32.1%	21.9%
UHCCP	11.4%	38.3%	29.7%
ALTCS-EPD Aggregate	**11.9%**	**35.4%**	**33.0%**

b. Strategies and Performance-Based Payments Incentive

Performance Based Payments (PBP) are payments from MCOs to providers for meeting certain quality measures that support the Health Care Payment Learning and Action Network (LAN)-APM initiatives. The purpose of PBP is to align incentives between the MCOs and providers to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality to achieve cost savings and improved outcomes. Care management, care coordination, case management, and infrastructure costs are excluded from PBP reimbursement. AHCCCS has established contractually required targets for MCOs to contract with providers at a selected percentage of overall medical spend under VBP/APM arrangements. AHCCCS has specified the sub-requirement for the proportion of those VBP/APM arrangements that must be under the LAN-APM Framework Categories 3 and 4. Each year AHCCCS typically increases its LAN-APM target requirements for MCOs. The tables below show the progression of increased targets by line of business since CYE 2016. As a result of stakeholder feedback, the CYE 2023 targets were reduced to re-focus efforts on improving quality outcomes and emphasize the role of APMs in supporting and rewarding providers' efforts to meet quality benchmarks. AHCCCS intends to evaluate the minimum LAN-APM target thresholds annually using a data-driven approach.

Table 5-3. LAN-APM Percent of Overall Medical Spend Target

Year	ACC & ACC-RBHA[1]	EPD/DSNP	SMI-Integrated	RBHA Non	DDD Sub	DDD LTSS	CHP Sub
CYE 2019	50%	50%	50%	20%	35%	10%	N/A
CYE 2020	60%	60%	50%	25%	50%	20%	0%
CYE 2021	65%	65%	60%	30%	60%	35%	0%
CYE 2022	65%	65%	60%	30%	60%	35%	0%
CYE 2023	45%	45%	35%	N/A	35%	15%	15%

[1] *CYE 2019 through CYE 2022 data are reflective of ACC only.*

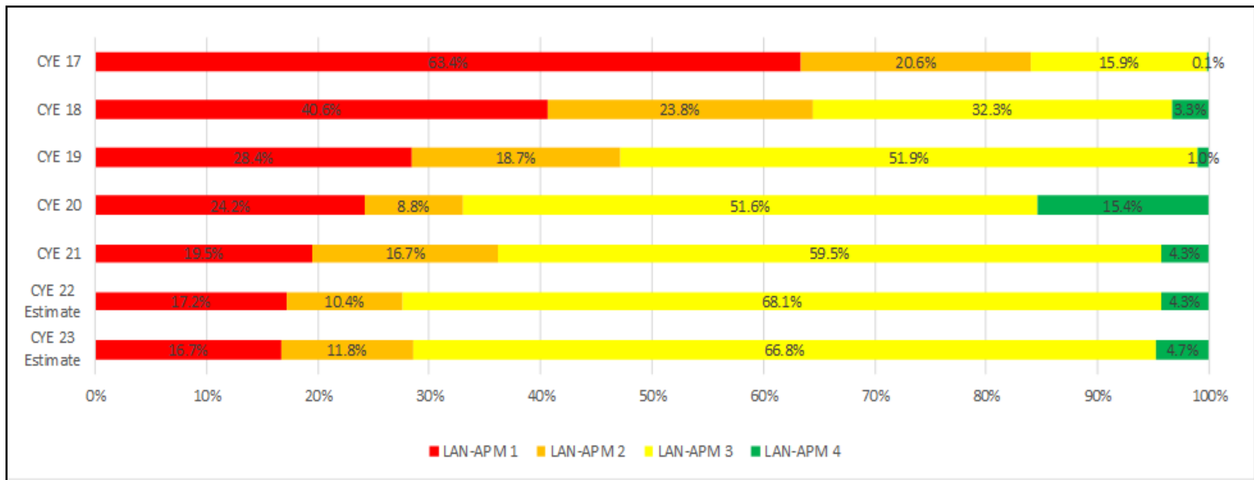
Table 5-4. LAN-APM Category 3 & 4 Sub-Requirement Percent of LAN-APM Spend Target

Year	ACC & ACC-RBHA[1]	EPD/DSNP	SMI-Integrated	RBHA Non	DDD Sub	DDD LTSS	CHP Sub
CYE 2019	40%	25%	10%	10%	40%	5%	N/A
CYE 2020	50%	35%	20%	20%	50%	10%	0%
CYE 2021	55%	40%	30%	25%	55%	15%	0%
CYE 2022	55%	40%	30%	25%	55%	15%	0%
CYE 2023	35%	N/A	N/A	N/A	N/A	N/A	N/A

[1] *CYE 2019 through CYE 2022 data are reflective of ACC only.*

From CYE 2017 to CYE 2021, these contractual requirements have been successful in moving AHCCCS VBP efforts along the LAN-APM continuum. Over the last five years, there has been a significant increase in medical spend in VBP/APM arrangements (LAN Categories 2-4), from 36.6% to 80.5%, and an increase in the proportion of spend in LAN-APM Categories 3 or 4 from 16.0% to 63.8%, as shown in the graph below. By providing the PBP incentive, AHCCCS was able to drive the progression shown in the graph below into LAN Categories 2 and 3. MCOs used PBPs as a way to incentivize providers to enter into value-based contracts with additional funding available.

Table 5-5. Progress Along LAN-APM Continuum



8.2 E-Prescribing Initiative

E-Prescribing is a recognized and proven effective tool to improve members' health outcomes and reduce costs. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to, reduced medication errors, reductions of drug and allergy interactions, and therapeutic duplication, patient adherence, and increased prescription accuracy. As part of the Payment Reform - E-Prescribing Initiative, MCOs are required to increase their E-Prescribing rate of original prescriptions and meet or exceed the goal established for each line of business. Table 5-6

demonstrates that over the last three years, there has been a significant increase in E-Prescribing across all lines of business.

Table 5-6. Value Based E-Prescribing Rates

MCO	CYE 2020	CYE 2021	CYE 2022
ACC	**79.9%**	**81.4%**	**85.2%**
AZ COMPLETE HEALTH CARE	82.2%	82.5%	83.8%
BANNER UNIV FAMILY CARE	83.5%	84.2%	95.8%
CARE1ST HEALTH PLAN	80.5%	81.6%	86.0%
HEALTH CHOICE ARIZONA	79.6%	80.0%	83.1%
MERCY CARE PLAN	74.8%	79.1%	81.8%
MOLINA COMPLETE CARE	74.0%	77.7%	79.7%
UNITEDHEALTHCARE	84.4%	84.5%	86.3%
DCS CHP	**61.3%**	**81.0%**	**83.3%**
ALTCS-DD	**83.2%**	**86.4%**	**88.2%**
ALTCS-EPD	**60.3%**	**63.5%**	**77.7%**
BANNER - UNIVERSITY LTC	60.9%	64.0%	91.4%
MERCY CARE PLAN - LTC	60.8%	64.8%	72.5%
UNITEDHEALTHCARE LTC	59.2%	61.7%	69.3%
RBHA	**83.2%**	**85.6%**	**87.1%**
AZ COMPLETE HEALTH CARE	83.9%	85.2%	86.3%
HEALTH CHOICE ARIZONA	85.0%	87.4%	89.2%
MERCY CARE PLAN	80.6%	84.3%	85.6%

8.3 State Directed Payments

State Directed Payments to providers are critical to ensuring timely access to high-quality care.

a. Access to Professional Services Initiative (APSI)

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

Table 5-7, 5-8, and 5-9 includes results for all providers affiliated with any designated hospitals, other than those affiliated with a free-standing children's hospital.

Table 5-7. Access to Professional Services Initiative (APSI) Any Designated Hospital

All Cause Readmission (PCR-AD)[1]				
Provider	**Baseline CYE 2017**	**Year Three Results CYE 2020**	**Year Four Results CYE 2021**	**Year Five Results CYE 2022**
Banner Health	12.9%	9.4%	12.7%	7.8%
Dignity Health	15.3%	15.2%	15.2%	15.2%
Valleywise	8.0%	7.4%	8.0%	7.5%
Phoenix Children's Hospital	11.7%	11.5%	10.8%	10.6%
Abrazo[2]	7.1% (CYE 2021)			6.6%
Tucson Medical Center	11.2%	11.5%	10.5%	10.4%

[1] *Lower rate indicates better performance.*
[2] *Abrazo did not join the APSI program until CYE 2021.*

Table 5-8. Access to Professional Services Initiative (APSI) Any Designated Hospital

Tobacco Use: Screening and Cessation Intervention (Prev-10)				
Provider	**Baseline CYE 2017**	**Year Three Results CYE 2020**	**Year Four Results CYE 2021**	**Year Five Results CYE 2022**
Banner Health	16.2%	73.2%	59.9%	81.2%
Dignity Health	85.9%	93.0%	81.2%	96.7%
Valleywise	85.4%	85.6%	87.8%	86.4%
Abrazo[1]	90.0% (CYE 2021)			98.0%
Tucson Medical Center	94.7%	94.3%	95.2%	94.7%
Banner Health	16.2%	73.2%	59.9%	81.2%

[1] *Abrazo did not join the APSI program until CYE 2021.*

Table 5-9. Access to Professional Services Initiative (APSI) Any Designated Hospital

Screening for Depression and Follow-Up Plan (Prev-12)				
Provider	Baseline CYE 2017	Year Three Results CYE 2020	Year Four Results CYE 2021	Year Five Results CYE 2022
Banner Health	36.9%	56.9%	90.1%	91.8%
Dignity Health	39.5%	50.0%	61.8%	83.3%
Valleywise	67.3%	40.9%	48.7%	53.5%
Abrazo[1]	76.0% (CYE 2021)			77.0%
Tucson Medical Center	58.1%	59.4%	59.3%	60.8%
Banner Health	36.9%	56.9%	90.1%	91.8%

[1] *Abrazo did not join the APSI program until CYE 2021.*

The Results: For the *All Cause Readmissions* measure, AHCCCS has observed the desired decreases during this time period for all hospitals. Overall, AHCCCS has seen improvement on both of these measures for each of the providers. There has been some slight fluctuation, but most hospitals are performing better than baseline for all measures.

The strategic partnerships with the hospitals will increase access to care, address underserved needs for specific specialties, and improve prevention and health maintenance efforts. Over time, AHCCCS would expect to see cost reductions as underserved specialties and subspecialties become available within the state of Arizona. Table 5-10 includes results for all providers affiliated with a free-standing children's hospital.

Table 5-10. Access to Professional Services Initiative (APSI) Pediatric Hospital

Phoenix Children's Hospital				
Measure	Baseline CYE 2017	Year Three Results CYE 2020	Year Four Results CYE 2021	Year Five Results CYE 2022
Childhood Immunization Influenza Vaccination	57.5%	69.5%	55.1%	48.8%
Diabetes-Patient Education	36.0%	79.0%	82.0%	87.0%

The Results: AHCCCS has seen a general improvement in the children's hospital measures over the past five years. Tracking and improving influenza vaccination rates ensures that patients receive low-cost preventive care services to avoid significant future health care costs (in this case the costs of contracting the flu and the associated complications that arise in a vulnerable population). However, families have

gravitated away from vaccinations and/or have chosen COVID-19 vaccination over influenza vaccination based on their own priority. This has been the experience of many Children's Hospitals nationally.

Educating parents and children about Type 1 Diabetes will reduce the growth in health care costs and lower the costs per person by providing critical information to families about how to manage this illness. Proper management and health behaviors reduces the risk of costly and debilitating complications arising from the disease, and thereby lowers costs for the system.

b. Pediatric Services Initiative (PSI)

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

PSI supports AHCCCS' goal to increase member access to integrated care that meets the member's individual needs within their local community. Freestanding children's hospitals meet a unique subspecialty need through pediatric specialties, and are critical to AHCCCS' ability to provide the full spectrum of care to its pediatric members. Table 5-11 includes results for hospitals that are measured on the following performance measures.

Table 5-11. Pediatric Services Initiative (PSI)

Phoenix Children's Hospital				
Measure	**Baseline CYE 2019**	**Year One Results CYE 2020**	**Year Two Results CYE 2021**	**Year Three Results CYE 2022**
Unplanned Readmissions[1]	12.0%	11.5%	10.8%	10.6%
Antibiotic Stewardship Indications for Antibiotic Use with Order	0.5%	4.9%	89.7%	99.9%
Safe Transition Appointment	0.6% (CYE 2018)	1.3%	1.9%	1.1%

[1] *Lower rate indicates better performance.*

The Results: The performance measure results continue to show improvement for the pediatric population compared to the baseline results. The development of access points throughout Maricopa County have improved access to and integration of care both in and out of the hospitals.

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

The Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) provides uniform percentage increases for payments to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid managed care services.

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

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

Table 5-12. HEALTHII Directed Payment

HEALTHII		
Measure	**Baseline CYE 2019**	**Year One Results CYE 2021**
Influenza Vaccination Coverage Among Health Care Personnel	90.5%[1]	88.4%[2]
HBIPS-2 Hours of Physical Restraint Use[3]	0	0
HBIPS-3 Hours of Seclusion Use[3]	0.01	0.03
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)[3]	0%	0.7%
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure[3]	0.2%	0.2%
Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	100%	100%
Successful Implementation of Antibiotic Stewardship Program	89.3%	94.0%
Median Time from ED Arrival to ED Departure for Discharged ED Patients (average minutes)[3]	107.1	115.6
Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite[3]	0.10%	0.09%
Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)[3]	0.0%	1.7%
Pediatric All-Condition Readmission Measure[3]	2.7%	2.2%
Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)	83.5%	83.1%

[1] The Baseline measurement period for *Influenza Vaccination Coverage Among Healthcare Personnel* was based on the date range of 10/01/2019 to 3/31/2020.
[2] The Year One Result measurement period for *Influenza Vaccination Coverage Among Healthcare Personnel* was based on the date range of 10/01/2021 to 3/31/2022.
[3] Lower rate indicates better performance.
Note: The *Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)* baseline statistics is zero due to numerator data being unavailable for Freestanding Rehabilitation Hospitals and Long-Term Acute Care Hospitals.

The Results: Six of the twelve performance measures selected for HEALTHII maintained or improved performance within the first measurement period. The *Successful Implementation of Antibiotic Stewardship Program*, *Pediatric All-Condition Readmission* measure, and *Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite* measures improved from baseline results. *HBIPS-2 Hours of Physical Restraint Use, National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome measure,* and *Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function* measures maintained the same performance as the baseline results. The *Influenza Vaccination Coverage Among Healthcare Personnel, HBIPS-3 Hours of Seclusion Use, Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay), Median Time from ED Arrival to ED Departure for Discharged ED Patients, Hospital-Wide All-Cause Unplanned Readmission (HWR),* and *Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)* measures declined in performance compared to the baseline results. Notably, the PHE had an impact on rates overall during the measurement period. In addition, caution should be exercised when analyzing the results of measures with limited numerator data.

d. Nursing Facilities Directed Payment

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

This payment arrangement advances the goals and objectives of the AHCCCS Quality Strategy by 1) ensuring access to quality care and thus improving member experience of care, and 2) improving health outcomes. Table 5-13 includes results for nursing facilities that are measured on the following performance measures.

Table 5-13. Nursing Facilities Directed Payment

Measure	Baseline CYE 2017	Year Three Results CYE 2020	Year Four Results CYE 2021	Year Five Results CYE 2022
Skilled Nursing Facility (SNF) Ownership Changes/Closures[1]				
Ownership Changes	35	Urban: 5 Rural: 0	Urban: 1 Rural: 0	Urban: 7 Rural: 0
Closures	0	Urban: 5 Rural: 0	Urban: 1 Rural: 0	Urban: 1 Rural: 0
Percent of High-Risk Residents with Pressure Ulcers (Long Stay)[1]				
Average Arizona	5.6%	8.3%	9.0%	9.3%
National Average	5.6%	7.3%	8.2%	8.1%
Percent Long Stay Residents with UTI[1]				
Average Arizona	Urban 2.3% Rural 1.9%	Urban 1.3% Rural 2.0%	Urban: 1.6% Rural: 1.5%	Urban: 0.9% Rural: 1.1%

[1] *Lower rate indicates better performance.*

The Results: AHCCCS has seen significant progress in reducing the number of ownership changes for nursing facilities, with the exception of CYE 22. There also has been a decrease in the number of closures of nursing facilities since 2020. By reducing the number of ownership changes and closures each year, members are able to receive a more stable, consistent level of care. AHCCCS has seen an increase in the Percent of High-Risk Residents with Pressure Ulcers (Long Stay). The impacts of COVID-19, staffing shortages, and an increase in member acuity may have contributed to the increased rate for this metric. AHCCCS has seen a general improvement in the Percent Long Stay Residents with UTI.

e. American Rescue Plan Directed Payment (ARP)

In 2021 the federal Government passed, ARP Act of 2021. In its ARP HCBS spending plan, AHCCCS received federal approval to provide uniform percentage provider payment increases to recruit and retain a knowledgeable and well-trained workforce. These time-limited payments will be made in State Fiscal Years (SFY) 2022, 2023, and 2024. The directed payment is intended to advance the goals and objectives to ensure ongoing access to care for Medicaid managed care enrollees in light of the difficulties caused by the PHE. Tables 5-14 and 5-15 include the quality measures used to evaluate the directed payment.

Table 5-14. American Rescue Plan Directed Payment (ARP)

Measure	Baseline CYE 2019	CYE 2020	CYE 2021	CYE 2022
Provider Network Adequacy (ALF): Number of ALFs in Network NQF# NA	1,492	1,474	1,591	1,647
Average HCBS Hours Utilized per Member NQF# NA	1,771	1,742	1,825	1,901

Table 5-15. American Rescue Plan Directed Payment (ARP)

Measure	Baseline CY 2020	Year One Results CY 2021
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) - NQF # 0059[1]	99.6% (CYE 2021)	99.3% (CYE 2022)
National Core Indicators - Staff Stability Survey: Average Turnover Rate for Direct Service Professionals - NQF# NA[1]	36.6%	42.3%
National Core Indicators - Staff Stability Survey: Percentage of vendors using Direct Service Professionals career ladder to retain highly skilled workers - NQF# NA	34.2%	37.6%
National Core Indicators - Member and Family Survey: Percentage of members who are receiving services that help lead a good life - NQF # NA	97.7%	96.0%

[1] *Lower rate indicates better performance.*

The Results: AHCCCS has seen an increase in the Number of ALFs in Network and the Average HCBS Hours Utilized per Member. For the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control* measure, results were limited due to the inability to obtain lab specific data. For context, Arizona's statewide CY 2021 rate was 41.2% and line of business results were as follows: ACC at 42.1%, ALTCS-EPD at 33.0%, RBHA SMI at 38.0%, and ALTCS-DD at 21.8%. The National Core Indicator measures had mixed results. The data for the three National Core Indicators metrics included the entire ALTCS-DD provider network. The unavailability of the CY 2022 National Core Indicators survey results is a noted limitation. Arizona intends to utilize future data results to assess the impact of the directed payment arrangement.

f. Targeted Investments

The Targeted Investments Program (TI) aligns with AHCCCS' strategic plan and Arizona's Section 1115 Waiver. TI 1.0 and 2.0 support and incentivize providers to develop and enhance comprehensive whole person care systems that effectively address the social risk factors that adversely affect health. Eligible Medicaid provider organizations that meet certain benchmarks will receive financial incentives through managed care plans for developing infrastructure and protocols to optimize coordination of services designed to meet the member's acute, behavioral, and health-related social needs (HRSN) and address identified health inequities among their patient population. The full evaluation report for TI 1.0 is due 18 months after the waiver period ends (March 30, 2024), and will include the final evaluation results for the TI 1.0 program.

8.4 Differential Adjusted Payments

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

AHCCCS began DAP in CYE 2017 and over the past seven years has expanded the program to over 32 provider types including, but not limited to: hospitals, IHS and 638 Tribally Owned and/or Operated Facilities, nursing facilities, behavioral health providers, physicians, behavioral health outpatient clinics, integrated clinics, HCBS providers, therapeutic foster homes, and dental providers. AHCCCS posts a Preliminary DAP Public Notice outlining the potential DAP for the upcoming contract year. Stakeholders, including providers and MCOs, are able to comment and provide feedback on the proposed DAP as well as recommend new DAPs for consideration. AHCCCS then reviews the comments and incorporates the feedback into its Final DAP Public Notice. This process allows stakeholders to be involved in which DAPs are implemented and/or retired each year.

DAP providers were evaluated in the following areas to advance the Quality Strategy goals and objectives:

- Number of AHCCCS registered Integrated Clinics,
- Number of providers registered in the Health Information Exchange (HIE), and
- Select performance measures, such as:
  - Sepsis (SEP-1) - Hospital,
  - Pressure Ulcer - Long Term Hospital,

- Pressure Ulcer - Inpatient Rehabilitation,
- Dental Sealants for Children Ages 5-15,
- Quality Reporting Program (IPFQR) - Psychiatric Hospitals,
- Urinary Tract Infection - Nursing Facility,
- Electronic Prescriptions, and
- Enrollees receiving Behavioral Health Services in an Integrated Clinic/Behavioral Health Outpatient Clinic.

Table 5-16. DAP Results for Registered Integrated Clinics

Registered Integrated Clinics			
Baseline CYE 2017	Year Four Results CYE 2021	Year Five Results CYE 2022	Year Six Results CYE 2023
79	196	234	259

Table 5-16 shows that over the last three years, there has been a significant increase in registered Integrated Clinics. Increasing the number of Integrated Clinics will help achieve AHCCCS' strategic goal to improve the member's experience of care. Prior to the DAP, AHCCCS had very few providers registered with AHCCCS under this provider type. By applying a DAP specific to the Integrated Clinic provider type, AHCCCS has encouraged more providers to move to this category and thus offer our members more choices of integrated providers.

Table 5-17. DAP Results for Participants Registered in the HIE

Participants Registered in the HIE			
Baseline CYE 2017	Year Four Results CYE 2021	Year Five Results CYE 2022	Year Six Results CYE 2023
350	923	1,064	1,119

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

Table 5-18. DAP Quality Measure Results

DAP Measures (CYE aligns with DAP Payment Year)				
Performance Measure	**Baseline CYE 2018**	**Year Three Results CYE 2020**	**Year Four Results CYE 2021**	**Year Five Results CYE 2022**
Sepsis (SEP-1) - Hospital	47.0%	47.0%	50.0%	51.0%
Pressure Ulcer - Long Term Hospital (Number of Hospitals Qualified)[1]	0.60	3.10	2.15	1.32
Pressure Ulcer - Inpatient Rehabilitation (Number of Hospitals Qualified)[1]	0.40	1.03	1.25	1.09
Quality Reporting Program (IPFQR) - Psychiatric Hospitals (Number of Hospitals Qualified)	39%	90%	100%	100%
Urinary Tract Infection - Nursing Facility[1]	Urban: 2.3% Rural: 2.1%	Urban: 1.3% Rural: 1.4%	Urban: 1.6% Rural: 1.5%	Urban: 1.1% Rural: 0.88%
Dental Sealants for children ages 5-15	58,799	50,799	55,516	59,095
Electronic Prescriptions	70.4%	78.9%	73.8%	80.3%
Enrollees receiving Behavioral Health Services in an Integrated Clinic/Behavioral Health Outpatient Clinic	12.8%	13.8%	13.8%	13.2%

[1] *Lower rate indicates better performance.*

The Results: Rates for *Sepsis (SEP-1)* compliance in the Hospital setting increased 4% from the baseline statistic. The number of stage III or IV pressure ulcers or unstageable (secondary diagnosis) pressure ulcers per 1,000 discharges among surgical or medical patients ages 18 or older decreased in both the long-term hospital and inpatient rehabilitation settings. For the *Quality Reporting Program (IPFQR) - Psychiatric Hospitals*, the number of hospitals qualified for IPFQR has maintained a rate of 100% since year four of the DAP. The percentage of long-stay residents with a urinary tract infection has decreased in both the urban and rural settings compared to the baseline statistic. The number of *Dental Sealants for children ages 5-15* has increased by 3,579 since the previous year. Improvement was also seen with the percentage of *Electronic Prescriptions,* which increased nearly 7% over baseline performance in year five. Lastly, the number of *Enrollees receiving Behavioral Health Services in an Integrated Clinic/Behavioral Health Outpatient Clinic* has slightly decreased from the previous year, but has surpassed the baseline statistic by 0.4%. In conclusion, six of the eight DAP measures have experienced an increase in performance compared to the baseline statistics from CYE 2018. *Pressure Ulcer - Long*

Term Hospital (Number of Hospitals Qualified) and *Pressure Ulcer - Inpatient Rehabilitation (Number of Hospitals Qualified)* have been targeted for upcoming DAP initiatives.

9. Health Information Technology

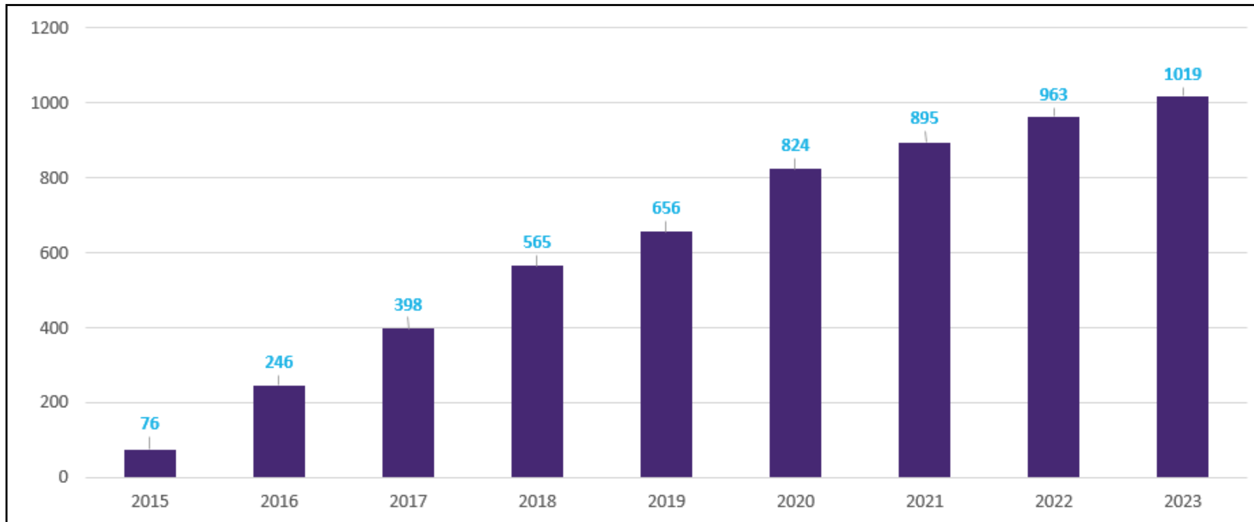
Since 2006, AHCCCS providers and MCOs have been supporting a single statewide HIE, now called Contexture. Contexture has become an integral part of AHCCCS' Quality Strategy and has grown to include 1,019 participating organizations representing laboratories, physical health and behavioral health providers, state agencies, 42 other HIEs, and other payers, such as Accountable Care Organizations and for-profit health plans. These organizations represent thousands of healthcare practitioners and delivery sites across Arizona.

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

9.1 Health Information Exchange

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

Figure 1. Active HIE Participants



Active HIE Participants as of August 2023; chart provided by Contexture.

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

Figure 2. Contexture HIE Participants

As of August 2023; chart provided by Contexture.

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

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

  Within two weeks of then-Arizona Governor Ducey's emergency proclamation, Contexture launched real-time clinical lab results alerts to participating health care organizations who submitted lists of patients they wished to receive alerts on. Real-time alerts were scaled over the first month to include both positive and negative test results, as well as an option for receiving a batch report of COVID-19 tests across an entire list of patients. These alerts were shared by the HIE with all of the patient's treating providers, rather than just the provider that ordered or conducted the test. This included hospitals, primary and specialty care, behavioral health facilities, emergency response providers, and others. Access to test results for COVID-19 allowed providers to both monitor virus status within their patient population as well as ensure the safety of staff by arranging personal protective equipment (PPE) for upcoming appointments with known positive patients or referring the appointment to a telehealth delivery platform. Subsequently Health Current developed a "dynamic" version of COVID-19 lab results specifically for hospital emergency departments that provided a real-time result at the time an individual registers at the emergency department's front desk.

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

- **Visibility into the status of the pandemic among vulnerable Medicaid populations:** Over the past several years, Contexture has worked closely with AHCCCS on a variety of initiatives to ensure deep penetration of HIE use and connections among Medicaid providers. Contexture coordinated with each Medicaid health plan to obtain complete member lists and used these lists to run extract reports that profiled positive COVID-19 test status by health plan, as well as those positive Medicaid members with chronic conditions that placed them at greater risk of serious outcomes. AHCCCS used these reports and data to support care management and outreach programs for affected members.
- **Using HIE technology to relieve hospital burden related to mandatory COVID-19 reporting:** A final area where Contexture maximized its extensive network of connections to support pandemic response in Arizona centered on relieving hospital burden associated with mandatory COVID-19 reporting requirements from the CDC. A key component of the daily CDC reporting is managing hospital bed capacity, including Intensive Care Unit (ICU) and staffed inpatient beds. Since April 2020, hospitals have been required to report total beds available and beds occupied by patients with COVID-19 or COVID-19-like symptoms. Contexture worked with the State's largest hospital systems and the Arizona Department of Health Services (ADHS) to develop a real-time reporting interface using electronic data already submitted to the HIE via admission, discharge, and transfer (ADT) alerts. Using the existing alert interface between hospitals and the HIE allowed Contexture to update the ADHS Central Registry database in real-time for the number of available and occupied beds.

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

The table below reflects the increased use of the HIE via some of its operational metrics from 2016 to 2023. The HIE monitors these metrics as a way to demonstrate an increase in use of its HIE services and infrastructure.

Table 6-1. Contexture Progress Review - Data Exchange & Utilization

Activity	December 31, 2016	December 31, 2020	August 1, 2023
Active Portal Users	359	2,202	3,454
Total Patients in the Master Patient Index (MPI)	7.6 M	14.6 M	13.9 M
Total Participants with Clinical Data	6.9 M	12.9 M	13.07 M
Health Level 7 V2 Transactions Received Monthly	9.8 M	26.1 M	27.4 M
Continuity of Care Documents Received Monthly	121 K	2.1 M	2.5 M

Alerts Received Monthly	51 K	10.4 M	10.8 M
Participating Acute Inpatient Discharges	83%	97%	97%
Participating ED Visits	91%	99%	99%

As of August 2023, as provided by Contexture
In the table above, M refers to million and K refers to thousand

9.2 Telehealth

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

These flexibilities included:

- Expanded the set of covered CPT and HCPCS codes that could be performed via telehealth with over 150 additional covered codes added,
- Created a temporary telephonic code,
- Created the AHCCCS telehealth web page,
- Created an online COVID-19 FAQs for providers, which includes a section specific to telehealth and telephonic services,
- Ensured that rates for telehealth and telephonic services are not discounted when compared to rates for "in-person" services,
- Required MCOs to reimburse at the same rate for services provided "in-person" and services provided via telehealth and/or telephonically, and cover all contracted services via telehealth modalities,
- Permitted FQHCs and Rural Health Clinics (RHCs) to bill for telehealth and telephonic services at the Prospective Payment System (PPS) rate, when the service is within the scope of the FQHC/RHC services; for services covered outside of the FQHC/RHC benefit, AHCCCS reimbursed telehealth and telephonic services provided by the FQHC/RHC at the AHCCCS FFS Rate, and
- Established specific billing guidance for IHS/638 providers billing for telehealth and telephonic services during the PHE.

With the end of the PHE, AHCCCS continues to evaluate telehealth and telephonic flexibilities; information is posted on the AHCCCS Telehealth web page.

10. Conclusion

Improving and/or maintaining members' health status, as well as increasing the potential for resilience and functional health status for members with chronic conditions, is at the core of the Quality Strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration, as well as through its strong partnerships with MCOs and stakeholders. AHCCCS is a leader among the nation's Medicaid programs, operating a high-quality, cost-effective program with an average per enrollee, per year expense of only $8,711 in CYE 2022.

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

Appendix A: Performance Measure Data Dashboard

Line of Business/ Population	Performance Measure
ACC	Breast Cancer Screening: Total
	Child and Adolescent Well-Care Visits
	Childhood Immunization Status: Combination 3
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	Developmental Screening in the First Three Years of Life: Ages 0-3
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 & 30 Days: Total
	Follow-Up After Emergency Department Visit for Mental Illness within 7 & 30 Days: Total
	Follow-Up After Hospitalization for Mental Illness within 7 & 30 Days: Total
	Immunizations for Adolescents: Combination 1
	Immunizations for Adolescents: Combination 2
	Prenatal and Postpartum Care: Timeliness of Prenatal Care and Postpartum Care
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17
	Well-Child Visits in the First 30 Months of Life: 15 Months (Rate 1)
DCS CHP	Child and Adolescent Well-Care Visits
	Childhood Immunization Status: Combination 3
	Developmental Screening in the First Three Years of Life: Ages 0 to 3
	Immunizations for Adolescents: Combination 1
	Immunizations for Adolescents: Combination 2
ALTCS-DD	Breast Cancer Screening: Total
	Child and Adolescent Well-Care Visits
	Childhood Immunization Status: Combination 3
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)
	Immunizations for Adolescents: Combination 1

Line of Business/ Population	Performance Measure
	Immunizations for Adolescents: Combination 2
ALTCS-EPD	Breast Cancer Screening: Total
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)
	Follow-Up After Hospitalization for Mental Illness within 7 & 30 Days: Total
SMI Designated	Breast Cancer Screening: Total
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	Child and Adolescent Well-Care Visits
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 & 30 Days: Total
	Follow-Up After Emergency Department Visit for Mental Illness within 7 & 30 Days: Total
	Follow-Up After Hospitalization for Mental Illness within 7 & 30 Days: Total
	Prenatal and Postpartum Care: Timeliness of Prenatal Care and Postpartum Care
Statewide	Breast Cancer Screening: Ages 50 to 64
	Child and Adolescent Well-Care Visits
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 & 30 Days: Ages 18-64
	Follow-Up After Emergency Department Visit for Mental Illness within 7 & 30 Days: Ages 18-64
	Follow-Up After Hospitalization for Mental Illness within 7 & 30 Days: Ages 18-64
	Follow-Up After Hospitalization for Mental Illness within 7 & 30 Days: Ages 6-17
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17
	Well-Child Visits in the First 30 Months of Life: 15 Months (Rate 1)

Appendix B: Statewide Performance Measure NCQA Medicaid Mean Comparison

Performance Measure	CY 2020 Rate	CY 2021 Rate	Performance Target Met
Adherence to Antipsychotic Medications in Adults with Schizophrenia	57.7%	55.8%	No
Adults' Access to Preventive/Ambulatory Health Services	74.1%	72.5%	No
Annual Dental Visits	50.0%	53.4%	**Yes**
Antidepressant Medication Management - Effective Acute Phase Treatment	45.0%	50.9%	No
Antidepressant Medication Management - Effective Continuation Phase Treatment	26.1%	29.1%	No
Asthma Medication Ratio	66.0%	64.7%	No
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	—	52.9%	No
Breast Cancer Screening	47.6%	44.8%	No
Cervical Cancer Screening	48.8%	51.5%	No
Child and Adolescent Well-Care Visits (Total)	43.0%	45.0%	No
Childhood Immunization Status - Combo 10	32.8%	32.7%	No
Childhood Immunization Status - Combo 3	67.1%	61.3%	No
Childhood Immunization Status - Diphtheria, Tetanus, Acellular Pertussis (DTAP)	72.2%	66.6%	No
Childhood Immunization Status - Haemophilus Influenza Type B (HiB)	85.2%	81.5%	No
Childhood Immunization Status - Hepatitis A (HEP A)	84.2%	78.8%	No
Childhood Immunization Status - Hepatitis B (HEP B)	85.9%	83.2%	No
Childhood Immunization Status - Inactivated Polio Virus (IPV)	86.3%	82.6%	No
Childhood Immunization Status - Influenza	41.8%	41.2%	No
Childhood Immunization Status - Measles, Mumps, Rubella (MMR)	85.7%	80.6%	No
Childhood Immunization Status - Pneumococcal Conjugate (PCV)	73.7%	67.6%	No
Childhood Immunization Status - Rotavirus (RV)	69.7%	67.2%	No
Childhood Immunization Status - Varicella (VZV)	85.0%	80.2%	No

Performance Measure	CY 2020 Rate	CY 2021 Rate	Performance Target Met
Chlamydia Screening in Women	48.8%	47.9%	No
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Poor Control (>9.0%)[1]	45.2%	41.2%	**Yes**
Controlling High Blood Pressure	47.5%	53.3%	No
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication	76.2%	77.3%	No
Follow-Up After ED Visit for AOD Abuse or Dependence - 30 Day	26.8%	25.1%	**Yes**
Follow-Up After ED Visit for AOD Abuse or Dependence - 7 Day	19.6%	18.3%	**Yes**
Follow-Up After ED Visit for Mental Illness - 30 Day	64.9%	63.3%	**Yes**
Follow-Up After ED Visit for Mental Illness - 7 Day	53.2%	50.9%	**Yes**
Follow-Up After Hospitalization for Mental Illness - 30 Day	74.4%	74.3%	**Yes**
Follow-Up After Hospitalization for Mental Illness - 7 Day	58.0%	57.8%	**Yes**
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	71.1%	70.3%	**Yes**
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	61.7%	58.9%	**Yes**
Immunizations for Adolescents - Combo 2	43.0%	39.4%	**Yes**
Immunizations for Adolescents - Human Papillomavirus (HPV)	44.7%	40.7%	**Yes**
Immunizations for Adolescents - Meningococcal (MCV4)	87.4%	86.3%	**Yes**
Immunizations for Adolescents - Tetanus, Diphtheria Toxoids, Acellular Pertussis (TDAP)	88.5%	87.0%	**Yes**
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD (Total)	15.8%	17.2%	**Yes**
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD (Total)	45.5%	47.3%	**Yes**
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	33.7%	40.3%	**Yes**
Plan All-Cause Readmissions - Observed Readmissions[1]	10.1%	10.3%	No
Prenatal and Postpartum Care - Postpartum Care	64.6%	65.1%	No
Prenatal and Postpartum Care - Timeliness of Prenatal Care	77.3%	79.3%	No
Use of First-Line Psychosocial Care for Children and Adolescents	70.3%	67.4%	**Yes**

Performance Measure	CY 2020 Rate	CY 2021 Rate	Performance Target Met
on Antipsychotics			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index (BMI) Percentile Documentation	58.4%	63.9%	No
Well-Child Visits in the First 30 Months of Life: 15 Months	56.5%	56.8%	**Yes**
Well-Child Visits in the First 30 Months of Life: 30 Months	67.1%	62.1%	No

[1] *Lower rate indicates better performance.*

Appendix C: Summary of Operational Review Compliance

CYE 2021 Operational Reviews	AzCH-CCP RBHA		Mercy Care RBHA		HCA RBHA		DES/DDD	
Standard Area[1]	**Score**	**CAPs**	**Score**	**CAPs**	**Score**	**CAPs**	**Score**	**CAPs**
Case Management (CM)	N/A	N/A	N/A	N/A	N/A	N/A	82%	13
Division of Grants Administration (DGA)	90%	3	94%	1	96%	0	N/A	N/A
Corporate Compliance (CC)	90%	1	100%	0	100%	0	87%	1
Claims & Information Systems (CIS)	90%	3	100%	0	99%	1	88%	4
Delivery Systems (DS)	91%	5	90%	5	85%	6	75%	5
General Administration (GA)	100%	0	100%	0	100%	0	76%	3
Grievance Systems (GS)	95%	2	100%	0	100%	0	100%	0
Adult, EPSDT, and Maternal Child Health (MCH)	87%	5	100%	0	96%	2	28%	17
Medical Management (MM)	98%	3	99%	1	96%	5	64%	19
Member Information (MI)	95%	1	98%	1	98%	1	83%	3
Quality Management (QM)	97%	2	99%	1	100%	0	85%	6
Reinsurance (RI)	100%	0	100%	0	100%	0	100%	0
Third-Party Liability (TPL)	100%	0	100%	0	100%	0	100%	0
Quality Improvement (QI)	100%	0	98%	1	94%	2	65%	8
Total Corrective Actions	**25**		**10**		**17**		**79**	

CYE 2022 & 2023 Operational Reviews	Molina ACC		BUFC ACC		HCA ACC		UHCCP ACC	
Standard Area[1]	**Score**	**CAPs**	**Score**	**CAPs**	**Score**	**CAPs**	**Score**	**CAPs**
Corporate Compliance (CC)	100%	0	100%	0	100%	0	93%	1
Claims & Information Systems (CIS)	92%	3	97%	1	99%	1	99%	1
Delivery Systems (DS)	84%	4	87%	4	98%	1	98%	1
General Administration (GA)	93%	2	96%	1	78%	2	100%	0
Grievance Systems (GS)	99%	1	99%	1	99%	1	100%	0
Adult, EPSDT, and Maternal Child Health (MCH)	76%	7	70%	9	98%	1	95%	2
Medical Management (MM)	93%	6	90%	7	97%	3	97%	2
Member Information (MI)	95%	1	100%	0	94%	1	95%	1
Quality Management (QM)	69%	12	80%	7	75%	12	84%	5
Reinsurance (RI)	100%	0	100%	0	100%	0	100%	0
Third-Party Liability (TPL)	100%	0	100%	0	100%	0	100%	0
Quality Improvement (QI)	89%	3	96%	2	83%	4	100%	0
Integrated System of Care (ISOC)	97%	2	100%	0	98%	1	86%	7
Total Corrective Actions	**41**		**32**		**13**		**13**	

CYE 2023 Operational Reviews	DCS CHP		UHCCP LTC		BUFC LTC		Mercy Care LTC	
Standard Area[1]	**Score**	**CAPs**	**Score**	**CAPs**	**Score**	**CAPs**	**Score**	**CAPs**
Case Management	N/A	N/A	87%	11	93%	5	77%	11
Corporate Compliance (CC)	100%	0	100%	0	100%	0	100%	0
Claims & Information Systems (CIS)	99%	1	99%	1	99%	1	97%	1
Delivery Systems (DS)	7%	13	98%	1	88%	2	97%	1
General Administration (GA)	60%	3	100%	0	100%	0	100%	0
Grievance Systems (GS)	100%	0	100%	0	98%	2	98%	0
Adult, EPSDT, and Maternal Child Health (MCH)	60%	13	90%	4	98%	2	89%	6
Medical Management (MM)	91%	4	96%	1	84%	3	97%	2
Member Information (MI)	94%	1	97%	1	96%	1	97%	1
Quality Management (QM)	77%	12	85%	6	88%	5	84%	7
Reinsurance (RI)	100%	0	100%	0	100%	0	100%	0
Third-Party Liability (TPL)	100%	0	100%	0	100%	0	100%	0
Quality Improvement (QI)	92%	2	100%	0	95%	2	99%	0
Integrated System of Care (ISOC)	100%	0	85%	6	96%	3	98%	2
Total Corrective Actions	**49**		**31**		**26**		**31**	

Appendix D: Administrative Actions

MCO	CYE 2021	CYE 2022	CYE 2023
ACC Plans			
Arizona Complete Health - CCP	Sanction: Member ID Card Issue - $50,000.00	Sanction: Data Validation - $4,328.17	None
	Sanction: TI Payment Issue - $10,00.00	——	——
Banner-University Family Care	Sanction: Pended Encounters - $208,350.00	Sanction: Data Validation - $1,229.23	Sanction: Data Validation - $144,972.27
	Sanction: Pended Encounters - $52,760.00	Sanction: Pended Encounters - $580.00	Sanction: Pended Encounters - $820.00
	——	——	Sanction: Pended Encounters - $1,540.00
Care 1st	None	None	Sanction: Administrative Cost Percentage Issue - $25,000.00
Health Choice Arizona	Sanction: Pended Encounters- $6,920.00	None	Sanction: Pended Encounters- $245.00
	Sanction: Pended Encounters - $320.00	——	——
Magellan/Molina	None	Sanction:Data Validation - $12.84	None
	——	Sanction - Financial Reporting Statement Issue - $10,000.00	——
Mercy Care	Sanction: Pended Encounters - $6,880.00	None	Sanction: Pended Encounters- $3,620.00
UnitedHealthcare Community Plan	None	None	None

MCO	CYE 2021	CYE 2022	CYE 2023
ALTCS Plans			
Banner University Family Care	Sanction: Pended Encounters- $23,830.00	Sanction: Data Validation- $1,579.18	None
	Sanction: Pended Encounters- $15,615.00	Sanction: Pended Encounters- $400.00	——
	Sanction: Pended	——	——

MCO	CYE 2021	CYE 2022	CYE 2023
ALTCS Plans			
	Encounters- $9,205.00		
DES/DDD	None	None	None
Mercy Care	Sanction: Pended Encounters- $470.00	Sanction: Pended Encounters- $295.00	Sanction: Pended Encounters- $355.00
	Sanction: Pended Encounters- $800.00	Sanction: Pended Encounters- $885.00	——
UnitedHealthcare	None	None	None

MCO	CYE 2021	CYE 2022	CYE 2023
RBHA/ACC-RBHA Plans			
Arizona Complete Health - CCP	Sanction: Member ID Card Issues - $50,000.00	None	None
	Sanction: Data Validation- $1,761.68	——	——
Health Choice	Sanction: Pended Encounters- $1,740.00	None	None
	Sanction: Pended Encounters- $160.00	——	——
Mercy Care	None	None	None

Works Cited

Sherwani, S. I., Khan, H. A., Ekhzaimy, A., Masood, A., & Sakharkar, M. K. (2016). Significance of HbA1c Test in Diagnosis and Prognosis of Diabetic Patients. Biomarker insights, 11, 95–104. https://doi.org/10.4137/BMI.S38440