Quality Strategy

July 1, 2024

AHCCCS Quality Strategy

Executive Summary 3

1. AHCCCS Overview 4

1.1 AHCCCS Strategic Plan Goals 4

1.2 Background 4

1.3 AHCCCS Organizational Overview 5

1.4 Investigations - QM/OIG Relationship 6

1.5 AHCCCS Programs 6

2. Population Management 8

2.1 State Procedures for Identifying and Reporting Race, Ethnicity, and Primary Language of Each Member 8

2.2 Disability Status 9

2.3 Health Equity 9

2.4 Transition of Care 11

2.5 AHCCCS Initiatives and Best Practices 12

2.6 Integrated Health Care 12

2.7 Long Term Care Supports and Services 16

2.8 Centers of Excellence 19

2.9 Residential Facilities and Oversight 20

2.10 Prevention Efforts and Attention to the Overuse of Opioids 20

2.11 Foster Care Youth 21

2.12 Justice Population 22

2.13 Suicide Prevention in Arizona 23

2.14 System of Care Oversight 24

2.15 Grants Administration 25

2.16 Housing 25

2.17 Workforce Development 27

2.18 Employment Support 28

3. AHCCCS Quality Strategy and Evaluation 29

3.1 Quality Strategy Scope and Objectives 29

3.2 Methods and Processes for Quality Strategy Development 30

3.3 Community and Stakeholder Engagement 30

3.4 Quality Strategy Evaluation 33

3.5 Enhanced Quality Strategy Goals and Objectives 34

4. MCO Program Requirements 40

4.1 State Verification that Sub-Part E Provisions of the Managed Care Regulations are Included in Medicaid Contract Provisions 40

4.2 Quality Management/Performance Improvement (Quality Assessment and Performance Improvement) Requirements 41

4.3 Assessment of Quality and Appropriateness of Care/Services for Routine and Special Health Care

Needs Members 42
4.4 Member Information Requirements 43
4.5 Evidence-Based Clinical Practice Guidelines 45
4.6 Sharing Best Practices 45
4.7 Sanction Philosophy and Notice to Cure 45
5. MCO Performance Monitoring 47
5.1 Performance Measurement 47
5.2 Performance Measures 47
5.3 Performance Improvement Projects (PIPs) 48
5.4 Regular Monitoring and Evaluation of MCO Performance 48
5.5 Improvement/Interventions 52
5.6 External Quality Review (EQR) 53
6. Network Adequacy 54
6.1 Provider Network Development and Management Plan (Network Plan) 54
6.2 Minimum Network Requirements Verification 55
6.3 Appointment Availability Monitoring and Reporting 55
6.4 Material Changes to the Provider Network 55
6.5 Provider Changes Due to Rates Reporting 56
7. Payment Reform 56
7.1 Alternative Payment Models 57
7.2 Differential Adjusted Payments (DAP) 58
7.3 State Directed Payment CMS Quality Criteria and Framework 59
7.4 Targeted Investments Program 59
8. Enabling Infrastructure: Data and Technology Systems 60
8.1 Pre-paid Medical Management Information System 60
8.2 Data Warehouse 61
8.3 Health Information Exchange (HIE) 61
8.4 Telehealth 61
9. Conclusion 62
10. References & Works Cited 63
10.1 Links to Related Documents 63
10.2 Works Cited 64
Appendix A 65
Appendix B 67

Executive Summary

In accordance with Code of Federal Regulations (CFR) 42 CFR 438.340 et. seq., the Arizona Health Care Cost Containment System (AHCCCS) Quality Strategy was first established in 2003. It has since 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, quality of care, and service delivery. In addition, the Quality Strategy supports the identification and documentation of issues related to those standards.

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS. The agency's Quality Strategy has shifted emphasis from process measurements to more comprehensive outcome-based measurements and innovative delivery system design. The Quality Strategy provides a framework for improving or maintaining members' health statuses, 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.

Through internal and external collaborations with partners, the agency is able to develop and implement key initiatives and address identified issues. As a result of continued collaboration with stakeholders to optimize both the experience and health outcomes of Arizonans accessing Medicaid managed care, AHCCCS has established the following Quality Strategy goals:

Quality Strategy Goals

Quality Strategy Goals	
Goal 1	Improve the Member's Experience of Care Related to Quality and Satisfaction
Goal 2	Improve the Health of AHCCCS Members
Goal 3	Limit Avoidable Growth in Healthcare Costs While Enhancing Member Access to Quality Care and Services that Address Whole Person Care
Goal 4	Promote Improvement in the Care and Services Provided to Members by Enhancing Data System and Performance Measure Reporting Capabilities

For additional information related to the Quality Strategy goals and objectives, including the methodology for measuring progress towards the identified goals, please refer to the *Enhanced Quality Strategy Goals and Objectives* section of this report.

AHCCCS Quality Strategy

1. AHCCCS Overview

As a delivery system that serves more than 2.2 million Arizonans with a budget of more than $20 billion, it is critical that AHCCCS pursue a broad array of strategies that are focused on creating a sustainable program while maintaining its member-centered focus. AHCCCS has established the following to demonstrate its commitment to serving members and providing high quality care and services:

AGENCY MISSION:

Reaching across Arizona to provide comprehensive, quality health care for those in need.

AGENCY VISION:

Shaping tomorrow's managed care . . . from today's experience, quality, and innovation.

AGENCY VALUES:

Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership, and Courage.

AGENCY CREDO:

Our first care is your health care.

1.1 AHCCCS Strategic Plan Goals

The AHCCCS Strategic Plan identifies three critical goal areas. These are:

Strategic Goal 1: Provide equitable access to high quality, whole-person care.

Strategic Goal 2: Implement solutions that ensure optimal member and provider experience.

Strategic Goal 3: Maintain core organizational capacity, infrastructure, and workforce planning that effectively serve AHCCCS operations.

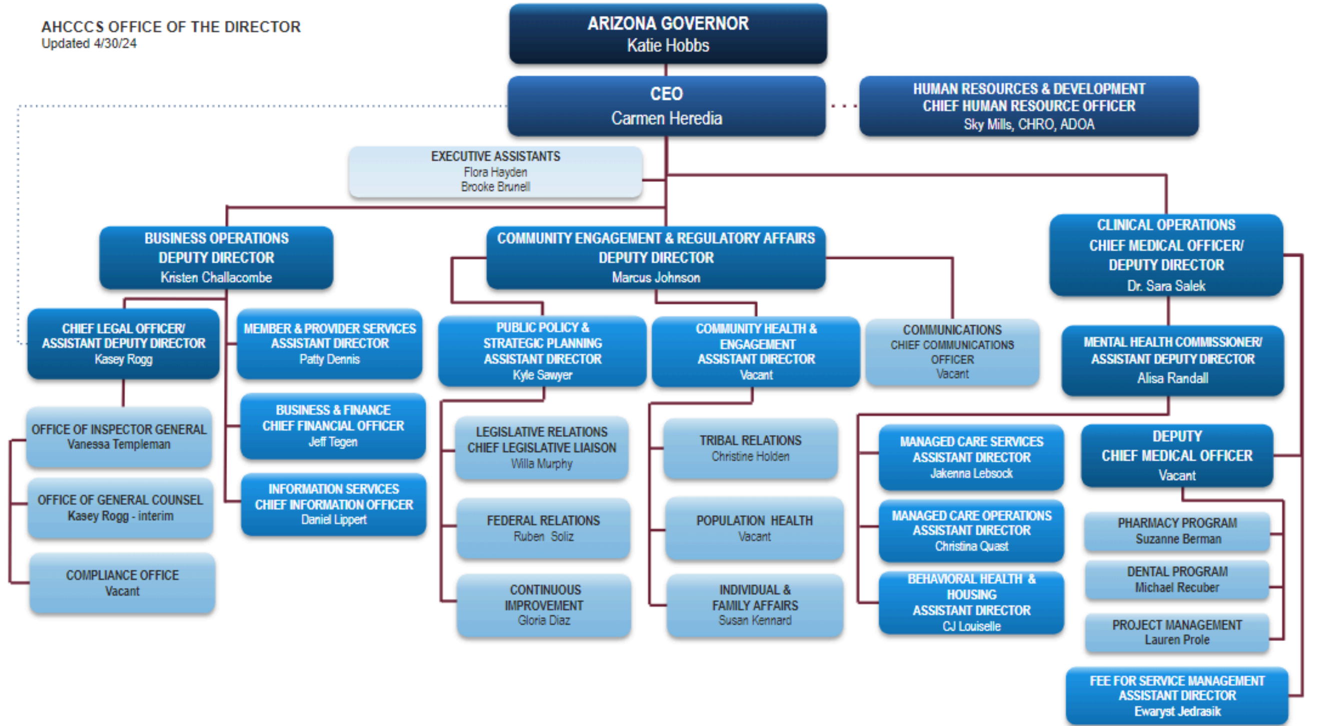
1.2 Background

Since 1982, AHCCCS has been delivering high-quality, cost-effective health care services to Arizonans. The State of Arizona has the unique distinction of being the first state in the country to operate under a statewide managed care 1115 Waiver, and the only state to have done so from the start of its Medicaid program. This public-private partnership ensures that members receive high-quality care and that the agency maximizes efficiency and contains costs. In 1988, the 1115 Waiver was amended to add the Arizona Long Term Care System (ALTCS) program, a fully integrated, managed care health plan for physical and behavioral health services, Long Term Services and Supports (LTSS), serving individuals with intellectual and/or developmental disabilities, as well as those who are elderly and/or have a physical disability. AHCCCS believes that this health care delivery system design is essential to providing quality care that improves members' health outcomes while eliminating barriers to care and containing costs. By integrating physical and behavioral health services under a single MCO, AHCCCS is better able to address the whole health needs of the state's Medicaid population, reduce fragmentation within the system, and simultaneously improve service delivery to members. On October 1, 2018, AHCCCS fully integrated physical and behavioral health managed care contracts for 1.5 million managed care members. AHCCCS promotes integration at the provider level as well, supporting efforts to deliver integrated services through primary care, integrated clinics, health homes, and other models, and using innovative reimbursement models to improve health outcomes. Most recently, the Centers for Medicare and Medicaid Services (CMS) approved a five-year extension of this 1115 waiver, continuing many long-standing authorities and programs and also including new innovative programs such as Targeted

Investments 2.0 and Housing and Health Opportunities (H2O) to further advance member health outcomes.

1.3 AHCCCS Organizational Overview

The AHCCCS organizational structure is designed to effectively implement and oversee various programs that serve its members. The AHCCCS Executive Management Team, and specifically the Chief Medical Officer (CMO), oversees the Division of Managed Care Services (DMCS) and its implementation of the Quality Strategy, as outlined in the agency administration and management organizational chart below.



- AHCCCS Cabinet Executive Officer and Executive Deputy Director and the Executive Management Team: The AHCCCS Cabinet Executive Officer and Executive Deputy Director has overall responsibility for ensuring that the agency meets the established goals of its Strategic Plan and maintains the administrative infrastructure to meet its needs. The AHCCCS Cabinet Executive Officer and Executive Deputy Director leads the Executive Management and leadership teams in managing business operations, developing and implementing administrative policies and procedures, and supporting the delivery of quality health care services for Arizona's Medicaid members.
- Clinical Operations Chief Medical Officer/Deputy Director: The CMO is a key position within AHCCCS, working collaboratively across divisions, providing oversight and guidance of the quality and delivery of health care services as well as developing and approving medical policy.
- Division of Managed Care Services: The DMCS is responsible for developing policy, procuring MCO contracts, and overseeing and monitoring MCOs. All units within the DMCS play a role in developing and adhering to the agency's Quality Strategy. Key units include: Clinical,

Performance Strategy/Quality Improvement, Program Initiatives, Project Management, and Targeted Investments.

1.4 Investigations - QM/OIG Relationship

The AHCCCS Office of Inspector General (OIG) coordinates with the DHCS on different aspects of the Quality Strategy. Any potential quality of care issues are forwarded from the OIG to the DHCS, Quality Management (QM) unit for its review. The OIG also receives referrals for any matters that QM identifies, which may indicate fraud, waste, or abuse. Furthermore, the OIG coordinates with the DHCS for any areas of concern, operational reviews (ORs) of the MCO for program integrity requirements, and MCO compliance with technical assistance.

Should OIG identify a need to take an action against a provider such as a suspension and/or termination, OIG notifies the QM unit and shares specific information needed for evaluation. The QM unit contacts each MCO with the information that is needed to evaluate an action against a provider. These contacts work to gather various pieces of information such as how many members are assigned to and/or receiving services from the provider, MCO-specific conditions AHCCCS should be aware of, etc. MCOs are also inquired about network capacity to transition members to an appropriate provider that can meet their needs as well as the anticipated time frames for safe member transition. It is expected that MCOs respond to these inquiries within the time frames specified by AHCCCS to complete evaluations. AHCCCS QM tracks all MCO notifications and member transitions; the OIG and QM unit provide bi-directional updates throughout the process. OIG also coordinates the same questions and processes through the Division of Fee for Service Management (DFSM) for populations not served by the MCOs.

Additional MCO requirements for fraud, waste, or abuse, program integrity, and contractual obligations can be found in AHCCCS Contractor Operations Manual (ACOM) 103 and by visiting the OIG's web page.

1.5 AHCCCS Programs

a. AHCCCS Complete Care (ACC)

The ACC program provides physical and behavioral health care services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members, including adults with General Mental Health and Substance Use needs and children, including those with Special Health Care Needs (SHCN) (e.g., members with a Children's Rehabilitation Services [CRS] designation). To qualify:

- Individuals must be a citizen or qualified immigrant,
- Individuals must provide a social security number or apply for one,
- For Title XIX, individuals must be aged 19-64, without Medicare, with income at or below 106% of the FPL (Adults </= 106%),
- For Title XXI, individuals must be under 19 years of age and live in a household with an income between 133% and 225% of the federal poverty level (FPL), and
- For adults only, individuals must apply for all cash benefits that one may be entitled to, such as pensions or Veteran Assistance benefits.

b. ACC-RBHA

The ACC-RBHA program provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members who qualify for ACC, as well as individuals determined to have an SMI designation (i.e., ACC-RBHA program members). Individuals who qualify for an SMI designation:

- Must be age 18 and older, and

- Must have a Serious Mental Illness (SMI) designation that results in either:[1]
    - An inability to live independently without adequate support,
    - A risk of serious harm to self or others,
    - A dysfunction in role performance, or
    - A risk of deterioration if adequate supports and services are not provided.

SMI eligibility evaluations and designations are available to individuals regardless of AHCCCS eligibility, and a co-occurring substance use disorder does not automatically disqualify an individual from receiving a SMI evaluation and/or designation.

c. Arizona Long Term Care System (ALTCS)

ALTCS provides long-term care services and supports to financially and medically eligible Arizona residents who are elderly, blind, have a disability, or those who have an intellectual/developmental disability. Financial eligibility compares the individual's income to 300% of the Federal Benefit Rate (FBR) and involves a resources test. To qualify for ALTCS, in addition to meeting financial and medical eligibility criteria, the individual must:

- Be in need of a nursing home level of care as determined by AHCCCS,
- Be a citizen or qualified immigrant,
- Provide a social security number or apply for one,
- For adults only, apply for all cash benefits that one may be entitled to, such as pensions or Veteran Assistance benefits, and
- Live in an approved setting, such as one’s own home, an AHCCCS certified nursing facility, or assisted living facility.

d. AHCCCS Fee-for-Service (FFS)

While the vast majority of the AHCCCS populations are managed under a MCO, approximately 12% of AHCCCS membership is under FFS management. The DFSM is responsible for the clinical, administrative, and claims functions of the FFS population of more than 280,000 members. This includes American Indians enrolled in the American Indian Health Program (AIHP) for integrated acute physical and behavioral health services, members enrolled with the Tribal Regional Behavioral Health Authorities (TRBHAs) for behavioral health care coordination services, members enrolled with the Tribal Long Term Care programs (Tribal ALTCS), and individuals in the Federal Emergency Service (FES) program.

AHCCCS American Indian Health Program (AIHP)

AIHP is a FFS program that provides medically necessary physical and behavioral health services. Enrolled members may receive health care services from IHS/638 health programs and Urban Indian health clinics and from other AHCCCS-registered providers. Members are not limited to a network and may switch their enrollment between the AIHP and an MCO at any time; however, a member can change from one MCO to another only once a year. AIHP members must meet the same eligibility requirements in either sections a or b as outlined above.

[1] The above criteria must be met for 12 months OR be present for six months with an expected continued duration of an additional six months.

Tribal ALTCS
Tribal ALTCS is a FFS program that provides medically necessary physical health, behavioral health, and long term care services. An AI/AN member will be enrolled with a Tribal ALTCS Program if he/she lives on or lived on a reservation prior to admission into an off-reservation facility. Enrolled AI/AN members may receive health care services from IHS/638 health programs and Urban Indian health clinics and from other AHCCCS-registered providers. Members must meet the same eligibility requirements as outlined in section c above.

Federal Emergency Services (FES)
AHCCCS provides emergency health care services through the FES program for qualified and nonqualified individuals, as specified in 8 USC 1611 et seq. who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship. All services for FES must undergo a medical review conducted by DFSM.

The DFSM contracts with a Pharmacy Benefits Manager (PBM) for its FFS programs. In April 2019, Indian Health Service (IHS) and Tribal 638 (IHS/638) pharmacies began submitting their claims through the PBM, which provides AHCCCS with more data on American Indian/Alaska Native (AI/AN) members filling a prescription with an IHS/638 facility, including both FFS and MCO enrolled AI/ANs. AHCCCS is also able to implement point of sale safety edits, as well as perform concurrent and retrospective utilization review, to assist in ensuring coordination of care and best practices in prescribing for FFS members and comply with the opioid drug utilization review provisions.

AHCCCS has started to evaluate the FFS program for potential inclusion in key quality improvement activities to support new federal requirements.

2. Population Management

Population management looks at the structures and processes in place to enhance clinical health outcomes through improved care coordination and member engagement. As part of the agency's population management efforts, the agency has implemented the following:

2.1 State Procedures for Identifying and Reporting Race, Ethnicity, and Primary Language of Each Member

AHCCCS receives member race, ethnicity, and primary language information through the eligibility screening process, which collects such information at the time of application. This information, along with other demographics, is systematically updated on the AHCCCS member record file and transmitted daily to the MCOs on the member enrollment roster. Changes to this information are also updated and transmitted to the MCOs. MCOs are responsible for providing any updated information to AHCCCS that differs from the initial documentation provided for each member and AHCCCS updates the member information, as appropriate. Member information is included on the data exchange file received from the Social Security Administration. If any information is missing, the system will default to unknown or unspecified categories. If the member does not provide or does not wish to provide this information, the member will be designated as unknown or unspecified categories.

Currently, there are codes for 40 languages that can be captured electronically. AHCCCS periodically assesses the language data to determine any need to expand possible language categories. In addition, AHCCCS evaluates prevalent languages for the AHCCCS populations at the state and MCO levels.

AHCCCS is exploring many avenues to enrich collection and reporting of member demographic data in a standardized format consistent with Federal guidance and Arizona's needs. First and foremost, AHCCCS will seek to align with updated specifications and categories expected to be announced in the near future such as race and ethnicity categories (Office of Management and Budget, expected Summer 2024) and geographic strata (i.e., the United States Department of Agriculture's Rural Urban Community Area Codes, expected Fall 2024). AHCCCS will assess, with community feedback, federal guidance on collecting new demographic dimensions such as sexual orientation and gender identity (CMCS, guidance provided November 2023). AHCCCS is considering supplemental sources to enrich data collected through the eligibility application, such as reports from the Arizona Department of Health Services Vital Records (i.e., birth and death certificates) and hospital discharge databases and the Health Information Exchange (HIE). AHCCCS will maximize these efforts by requiring outpatient providers participating in the Targeted Investments 2.0 Program to collect these data from patients that choose to provide it and share these data through the HIE. Once reports are received, AHCCCS will evaluate data discrepancies collected through eligibility, SSA, and these supplemental sources to determine improvement opportunities.

2.2 Disability Status

AHCCCS utilizes its Medicaid Management Information System records of eligibility to identify disability status. Individuals defined by the state as having a disability include the following:

- A person who has been determined to have a qualifying disability by the Social Security Administration or the Department of Economic Security (DES), Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E),
- A person who has been determined to meet the criteria for blindness by the Social Security Administration or the DES, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2),
- A person who is determined by an authorized entity contracted with AHCCCS to have a serious mental illness (SMI) as defined in Arizona Revised Statutes (A.R.S.) § 36-501,
- A person who at the time of a regularly scheduled continuing disability review is determined by the DES, Disability Determination Services Administration to no longer have a qualifying disability, but continues to have a severe medically determinable impairment, as determined under Social Security Act section 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI),
- A person who is determined eligible for services by the DES/Division of Developmental Disabilities (DDD) and determined by AHCCCS through a Pre-Admission Screening assessment to be at immediate risk of institutionalization in either a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and
- A person who is determined by AHCCCS through a Pre-Admission Screening assessment to be at immediate risk of institutionalization in either a nursing facility or an ICF/IID.

2.3 Health Equity

AHCCCS seeks to identify, understand, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

a. AHCCCS Health Equity Committee

Formally established in July 2020, the Health Equity Committee is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS members. The committee is

responsible for overseeing and managing health equity considerations as they relate to policy, data, MCO oversight, and emerging health care innovation strategies for over 2 million Arizonans.

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

This committee is responsible for identifying health disparities among AHCCCS-eligible individuals and members by using AHCCCS utilization and quality improvement data to advance policy and/or contracting strategies to improve the health equity of AHCCCS' populations and programs. This committee will communicate existing health equity strategies currently being implemented by the agency, identify needed improvements to existing strategies (if appropriate), develop and/or evaluate key metrics, and articulate future interventions aimed at eliminating health disparities.

Two sub-committees facilitate specific functions. The Communications Subcommittee is responsible for developing internal and external-facing communication related to AHCCCS' health equity initiatives and increasing understanding of the committee's work and impact. The Data Subcommittee is responsible for improving member demographic data collected, stored, and reported; conducting multivariate statistical analyses to identify factors significantly correlated with a community's disproportionately poor health outcomes, and identifying policy levers that can address these disparities.

b. Health Disparity Summary & Evaluation Report and NCQA Health Equity Accreditation

Beginning CYE 2021, MCOs are required to submit a Health Disparity Summary & Evaluation Report annually intended to provide:

- An analysis of the effectiveness of implemented strategies and interventions in meeting health equity goals and objectives during the previous calendar year,
- A detailed overview of the MCO's identified health equity goals/objectives for the upcoming calendar year, and
- Targeted strategies/interventions planned for the upcoming calendar year to achieve health equity goals.

In addition to the Health Disparity Summary & Evaluation Report, MCOs shall be required to earn NCQA Health Equity Accreditation by October 1, 2025.

c. Targeted Investments 2.0 Program

The Targeted Investments 2.0 Program (TI 2.0), an 1115 Waiver program approved by CMS October 14, 2022, aims to assist outpatient primary care and behavioral health providers address inequities within their patient populations. Participating organizations will be required to:

- Collect and report member demographic data willingly provided by the patient,
- Stratify outcomes (e.g., well-gap reports) by a demographic dimension,
- Identify health outcome inequities and create plans to address them,
- Routinely evaluate the its health equity plan and revise it to maximize impact,
- Earn NCQA Health Equity Accreditation (optional), and
- Meet performance measure targets on demographically-weighted or stratified NCQA HEDIS® measures.

With partners at Arizona State University, AHCCCS will support participating providers as well as interested Accountable Care Organizations, Clinically Integrated Networks, and contracted Managed Care Organizations by:

- Enriching demographic data supplied by AHCCCS with external sources,
- Creating stratified NCQA HEDIS® measure dashboards specific to each entity's population, and
- Conducting multivariate statistical analyses and process audits to identify root causes contributing to inequities.

2.4 Transition of Care

AHCCCS has a Member Transition policy that applies to all AHCCCS MCOs and FFS programs. The policy provides detailed requirements to ensure that member access to services remains consistent throughout the transition process. Requirements for member transitions are identified for the following:

- Transitions between MCOs and FFS programs and FFS members,
- Transitions between ALTCS and non-ALTCS MCOs (ACC, ACC-RBHAs),
- Transitions between ALTCS Elderly and Physical Disabilities (ALTCS-EPD) and ALTCS Developmental Disabilities (ALTCS-DD),
- Transitions across Geographic Service Areas (GSAs), and
- Transition age youth to adult delivery systems.

Contractors are required to have policies and procedures to address transitions for members with special circumstances including, but not limited to:

- Pregnancy,
- Major organ or tissue transplantation services that are in process,
- Chronic illness, for members in a high-risk category, currently hospitalized or place in nursing or other facilities,
- Significant medical or behavioral health conditions,
- Chemotherapy or radiation therapy,
- Dialysis,
- Members with ongoing needs (e.g., ventilator, pain management, durable medical equipment, and prescriptions),
- Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), and
- Members with an SMI designation.

MCOs are required to ensure that care is coordinated between MCOs and FFS programs, as well as providers that are involved in member care. MCOs and providers are expected to provide appropriate notifications of enrollment changes via a standardized Enrollment Transition Information (ETI) form which includes information, such as pending authorizations for services or medications, treatments members are receiving, providers, and disposition of medical equipment and supplies. AHCCCS provides an Electronic Transfer for capturing key pieces of information for the transition process. AHCCCS also shares Medicaid claims data from IHS and Tribal facilities for AI/AN members enrolled with the MCOs

and requires that each MCO employ a Tribal Liaison in order to work through any continuity of care issues that may arise.

2.5 AHCCCS Initiatives and Best Practices

AHCCCS participates in several initiatives and best practices aimed at building a more cohesive and effective health care system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology, and working with private sector partners to further innovation to the greatest extent. These efforts show a committed focus to stakeholder engagement and system accountability with the ultimate goal of improving member experiences and health outcomes. AHCCCS highlights current, ongoing initiatives on the AHCCCS Initiatives and Best Practices web page that includes links to more detailed information.

2.6 Integrated Health Care

AHCCCS continues to integrate the care delivery systems and align incentives that are designed to transform the structure of the Medicaid program, improve health outcomes, and better manage limited resources. To that end, MCOs are required to administer and ensure delivery of services consistent with the following values, principles, and goals:

- Timely access to care,
- Culturally competent and linguistically appropriate care,
- Identification of the need for and the provision of comprehensive care coordination for physical health and behavioral health service delivery,
- Integration of clinical and non-clinical health care related services,
- Education and guidance to providers on service integration and care coordination,
- Provision of disease/chronic care management including self-management support,
- Provision of preventive and health promotion and wellness services,
- Adherence with continuing education and guidance to physical health and behavioral health providers on the Adult Behavioral Health Service Delivery System-Nine Guiding Principles, and the Arizona Vision-12 Principles for Children Behavioral Health Service Delivery as specified in ACOM Policy 100 and AHCCCS Medical Policy Manual (AMPM) Policy 100,
- Promotion of evidence-based practices through innovation,
- Expectation for continuous quality improvement,
- Improvement of health outcomes,
- Containment and/or reduction of health care costs without compromising quality,
- Engagement of the member and family members at all system levels,
- Collaboration with the greater community,
- Maintenance, rather than delegation of, key operational functions to ensure integrated service delivery,
- Commitment to system transformation,

- Implementation of HIT to link services and facilitate improved communication between treating professionals, and between the health team, the member, and member caregivers, and
- Integration of the delivery of physical and behavioral health care as an essential part of improving the overall health of members.

a. AHCCCS Complete Care

The ACC program was implemented October 1, 2018 to ensure that MCOs deliver integrated physical and behavioral health services to address whole health needs of AHCCCS members and improve member experience. ACC and ACC-Regional Behavioral Health Agreement (ACC-RBHA)[2] Contractors are responsible for providing services under the ACC Program. The MCOs are expected to continuously add value to the program by demonstrating they recognize:

- The importance of an integrated delivery system for physical and behavioral health services and demonstrates focused strategies and approaches to assure coordinated service delivery to members,
- Members do not have equitable access to care and work proactively to eliminate disparities in the provision of health care services,
- The critical importance of care coordination through organizational design and operational processes,
- Medicaid members are entitled to care and assistance navigating the service delivery system and demonstrate special effort throughout its operations to assure members receive necessary services,
- Medicaid members with SHCN or chronic health conditions require care coordination and provide that coordination,
- Health care providers are an essential partner in the delivery of physical and behavioral health care services and operate the Health Plan in a manner that is efficient and effective for health care providers as well as the Contractor,
- Performance Improvement (PI) is both clinical and operational in nature and self-monitors and self-corrects as necessary to improve Contract compliance and/or operational excellence,
- The program is publicly funded, is subject to public scrutiny, and operates in a manner that promotes cost containment and efficiency, and
- The importance of the Arizona Vision-12 Principles for Children Behavioral Health Service Delivery and Adult Behavioral Health Service Delivery System-Nine Guiding Principles.

b. ACC-RBHA

Members enrolled in managed care that are not eligible for the ALTCS program and who have an SMI designation receive all their physical and behavioral health services through select ACC Contractors with a Regional Behavioral health Agreement (ACC-RBHA). ACC-RBHA Contractors provide services to those eligible under AHCCCS Complete Care as well as members with an SMI designation. ACC-RBHAs are required to embed the additional following principles in the design and implementation of an integrated health care service delivery system serving members with an SMI designation:

[2] ACC-RBHA Contractors provide services to those eligible under AHCCCS Complete Care as well as members with an SMI designation. See ACC-RBHA subsection below for additional information.

- Physical, behavioral, peer, and family support providers shall share the same mission to place the member's whole-health needs above all else, as the focal point of care,
- All aspects of the member experience, including engagement, treatment planning, service delivery and customer service shall be designed to promote recovery and wellness as defined by the member,
- Member input shall be incorporated into developing individualized treatment goals, wellness plans, and services,
- Peer and family voice shall be embedded at all levels of the system,
- Recovery is personal, self-directed, and shall be individualized to the member,
- Family member involvement, community integration and a safe affordable place to live are integral components of a member's recovery and shall be as important as any other clinical intervention, and
- The Contractor's overarching system goals for individual members are to improve whole health outcomes and reduce or eliminate health care disparities between members and the general population in a cost-effective manner.

c. ALTCS

Since its inception in 1989, the ALTCS-EPD program has been fully integrated. ALTCS-EPD members receive all services through their MCOs, and many are aligned to receive their Medicare benefits through the MCOs' D-SNP plans, which allows for enhanced care coordination. The ALTCS MCO for individuals with intellectual and developmental disabilities has a partially integrated health program by sub-contracting with health plans to provide physical and behavioral health services, CRS, and limited LTSS while maintaining the responsibility for the provision of the majority of LTSS, including case management support coordination. In serving ALTCS members, the MCOs and their case managers shall promote the values of choice, dignity, independence, individuality, privacy, and self-determination, and adhere to the following guiding principles:

- Member-centered case management,
- Member directed options,
- Person-centered service planning,
- Consistency of services,
- Accessibility of network,
- Most integrated setting, and
- Collaboration with stakeholders.

d. Medicare and Medicaid Dually Eligible Members

As of October 1, 2015, dually eligible members (individuals eligible for both Medicaid and Medicare) enrolled in managed care but not eligible for the ALTCS program began receiving behavioral health services from their enrolled ACC Program MCO[3]. In addition to integration of Medicaid services, AHCCCS promoted extensive alignment efforts between Medicaid and Medicare. As of December 2023, approximately 47% of full benefit dually enrolled members are in aligned plans.

e. American Indian Medical Home (AIMH)

[3] The ACC Program is served by both ACC and ACC-RBHA Contractors.

Arizona is home to over 350,000 AI/AN individuals, approximately half of whom are enrolled in AHCCCS. Significant health disparities exist for the AI/AN population. For instance, the AI/AN population has higher death rates and the lowest average life expectancies compared with other populations in the U.S., experiencing higher death rates from preventable diseases. Whereas the American Indian population accounts for approximately 3% of the national population and 6% of the Arizona population, it accounts for approximately 8% of the AHCCCS population as of January 2024. Recognizing its unique role in addressing the health needs of Arizona's AI/AN population, in 2017 AHCCCS launched a new program to improve the health outcomes of tribal members by identifying critical population needs and collaborating with Tribes, tribal health partners, community organizations, and state and federal agencies to enhance care coordination.

To that end, CMS approved Arizona's State Plan Amendment for the American Indian Medical Home (AIMH) program for the AI/AN members enrolled in the AIHP. The AIMH program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for the AIHP enrolled members. The AIMHs help address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. IHS/638 facilities that choose to become an AIMH must obtain Primary Care Medical Home (PCMH) status through an appropriate accreditation body, in addition to providing 24-hour telephonic access to the care team. The AIMH program is a voluntary program. AIHP enrolled members can select an AIMH site by accessing a participating AIMH provider or by contacting AHCCCS Member Services, where they will be empaneled through the AHCCCS online portal. The AIMH Member Sign-Up forms are available at AIMH sites and on the AHCCCS website and are processed by AHCCCS on a monthly basis. The AIMH member sign-up form identifies benefits of the program, the right to disenroll or select a different AIMH provider at any time, and any other information required by federal and state regulations including 42 CFR 438.54(c)(3). As of February, 2024, approximately 29% of AIHP members are empaneled in an AIMH.

f. Targeted Investments (TI) Program

The Targeted Investments (TI) Program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated and/or coordinated care to meet the individual's whole-person care needs. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. The original TI Program (FFY2017-FFY2022) aimed to:

- Reduce fragmentation between acute primary care and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs by improving integration at the provider level, and
- Improve health outcomes for members with physical health and behavioral health needs.

The renewed TI 2.0 Program (FFY 2023 - FFY 2027) expands upon the original program by encouraging providers to thoughtfully develop infrastructure and protocols to optimize coordination of services designed to meet the members' acute, behavioral, and health-related social needs and address identified health inequities amongst their patient populations.

AHCCCS will achieve this goal by supporting providers throughout the state to develop and enhance care coordination processes with healthcare and community based organizations and provide guidance, tools, and technical assistance for internal population health analyses. This will be achieved by:

- Promoting point of care integration and coordination systems that include enhanced capabilities to successfully identify and address social risk factors for each member,

- Developing and supporting strategies for effective and efficient use of technology including the health information exchange (HIE) and closed loop referral systems (CLRS) that facilitate the information sharing needed to provide whole person care and to identify and address social determinants of health,
- Identifying and addressing health inequities by leveraging features of EHR systems, the HIE, CLRS, and real-time dashboards with stratified performance measurement to assess health equity efforts within the organizations and inform protocols to provide culturally competent services,
- Engaging stakeholders from community based organizations, managed care organizations, and public and private sector subject matter experts to provide input on systems and strategies that enable comprehensive and coordinated whole person care integration opportunities, strategies, and implementation. This cross sector collaboration will help leverage resources to standardize data collection, storage, and analysis to effectively address health inequities and promote health equity,
- Supporting provider and other stakeholder peer learning and sharing of best practices and process improvement strategies through a quality improvement/learning collaborative, and
- Incorporating emerging evidence-based practices into program participant requirements and aligning with current AHCCCS and community initiatives.

2.7 Long Term Care Supports and Services

a. Long Term Care Case Management

Each member enrolled in ALTCS receives case management services provided by a qualified case manager. ALTCS case managers utilize a person-centered approach and maximize member/family self-determination while promoting the values of choice, dignity, independence, individuality, and privacy. Case managers conduct regular on-site, face-to-face visits with members to:

- Ensure quality services are provided without gaps,
- Determine the services necessary to meet members' needs,
- Provide member-specific education to members and their families, and
- Introduce alternative models of care delivery, when appropriate.

The person-centered planning meetings conducted by the case managers are intended to result in a mutually agreed upon, appropriate, and cost-effective individualized, person-centered service plan that meets the medical, functional, social, and behavioral health needs of the member in the most integrated and least restrictive setting. The following are examples of how case managers execute the roles and responsibilities included above:

- Member-Directed Options Information: Case managers regularly inform members about member-directed options and assist members and their families to make informed decisions about the service delivery model of care.
- Cost Effectiveness Analysis: Case managers assess the continued suitability, appropriateness, and cost effectiveness of the member's in-home services. Home and Community Based Services (HCBS) placement is the goal for ALTCS members, as long as cost effectiveness standards and the member's medical, functional, social, and behavioral health needs can be met in that setting. The case manager regularly assesses the cost of the HCBS and compares them to the estimated cost of institutionalized care. HCBS placement is considered cost-effective if the cost of Home

and Community Based Services for a member does not exceed 100% of the net cost of institutional care.

- Non-Medicaid Service Coordination: Case managers identify and integrate non-ALTCS covered community resources/services as appropriate, based on the member's needs.
- End of Life (EOL) Care: Case managers are required to educate members and/or their families on EOL care which encompasses all health care and support services provided at any age or stage of an illness. EOL care goals focus on comfort and quality of life. Services include advance care planning, palliative care, supportive care, and hospice.
- Goal Development: Case managers assist members to develop meaningful and measurable goals, including personal and independent living goals. Case managers also provide members with information about local resources to help them transition to greater self-sufficiency in the areas of housing, education, and employment, as well as identify goals and preferences around the areas of recreation, friendships, and family relationships.
- Person-Centered Service Planning (PCSP): In an effort to enhance the person-centered approach and further maximize member/family self-determination, AHCCCS initiated a process to:
    - Create alignment of practices, forms, and monitoring of the PCSP approach and personal goal development,
    - Support members to have the information and supports to maximize member-direction and determination, and
    - Document health and safety risks, and safeguard against unjustified restrictions of member rights, in accordance with the Home and Community Based Settings Rules (HCBS Rules).

b. Home and Community Based Services

AHCCCS has maintained a consistent trend of Home and Community Based Services member placements even when considering increases in population. For example, the placement rates have held constant in the past three years (CYE 2020-2022) 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 activities available which demonstrates the program's commitment to advancing initiatives which result in serving members in the least restrictive setting.

The Home and Community Based Settings Rules (HCBS Rules) afford Arizona the opportunity to reinforce the priority of serving members in the least restrictive setting while formalizing a new priority to ensure members are actively engaged and participating in their communities. On January 16, 2014, CMS released final rules regarding requirements for HCBS operated under section 1915 of the Social Security Act. The rules mandate certain requirements for residential and non-residential settings where Medicaid members receive long-term care services and supports. Specifically, the rules establish requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living. In Arizona, these requirements impact ALTCS program members receiving services in the following residential and non-residential settings:

Residential

- Assisted Living Facilities,
- Group Homes, and

- Adult and Child Development Homes.

Non-Residential

- Adult Day Health Programs,
- Day Treatment and Training Programs,
- Center-Based Employment Programs, and
- Group-Supported Employment Programs.

In 2015, AHCCCS began working with a wide range of stakeholders representing the long-term care community to assess the State's compliance with the HCBS Rules and identify further opportunities to enhance member integration experience and outcomes by building off Arizona's long-standing history of the provision of Home and Community Based Services. AHCCCS submitted Arizona's Systemic Assessment and Transition Plan to CMS in October 2015. Subsequently, a number of iterations of the Transition Plan have been updated and informed by stakeholder input, with AHCCCS receiving final approval of the Arizona Transition Plan on January 20, 2023. CMS' approval of the Transition Plan solely addressed the State's compliance with applicable Medicaid authorities and the State's process for assessing setting compliance, including settings that meet the criteria for Heightened Scrutiny. CMS' review of settings submitted for Heightened Scrutiny and subsequent determinations are separate and distinct from final approval of the Transition Plan. If States want to preserve settings that are presumed institutional in nature and the State asserts the setting complies with the HCBS Rules, the States must submit evidence to CMS to make a final determination. CMS determines whether the evidence supports that the setting is or can become compliant with the HCBS Rules. The Assessment and Transition Plan is available on the AHCCCS Home and Community Based Settings web page.

In March 2021, Contractors began assessing all HCBS settings for compliance at least annually. A tool was developed for the Contractors to report their audit progress to AHCCCS. AHCCCS used this data to report progress to stakeholders and CMS, including compiling the list of settings that meet the criteria for Heightened Scrutiny. AHCCCS held two rounds of public comment for Heightened Scrutiny settings in February and June of 2022, providing transparency into and giving stakeholders the opportunity to provide input on the settings that met criteria for Heightened Scrutiny and the assessment findings. Public comments received were incorporated into the Arizona State Transition Plan Addendum found on the AHCCCS Home and Community Based Settings web page. AHCCCS created and posted the Transition Plan Addendum to provide an update on the plan's progress and, more specifically, provide information on the findings in the first round of site specific assessments to support CMS' final approval of the Transition Plan.

Given the March 17, 2023, deadline has passed and CMS has just recently requested evidentiary documentation packages for a sampling of settings meeting Heightened Scrutiny, a Corrective Action Plan (CAP) was warranted to afford CMS more time to review the state's assessment documentation and either affirm the State's findings or require remediation for identified settings. The CAP allows for a 12-month remediation period should CMS have any findings when they complete their review. The CAP is available on the AHCCCS Home and Community Based Settings web page.

Looking forward, it is important to ensure members are served by applying the guiding principles of the ALTCS program including, but not limited to, member-centered case management practices, person-centered planning that safeguards against unjustified restrictions, and stakeholder collaboration. It is equally important AHCCCS continues to monitor for compliance to HCBS Rules and ensures that members experience the changes brought about by the HCBS Rules in their day-to-day lives. AHCCCS

continues to hold monthly meetings with the Contractor Quality Management staff to answer questions and provide technical assistance to support their efforts to assess settings for compliance.

c. Electronic Visit Verification (EVV)

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (i.e., attendant care, personal care, homemaker, habilitation, and respite), and for in-home skilled nursing services (i.e., home health). The EVV system must, at a minimum, electronically verify the:

- Type of service performed,
- Individual receiving the service,
- Date of the service,
- Location of service delivery,
- Individual providing the service, and
- Time the service begins and ends.

AHCCCS' goals for instituting EVV include:

- Helping to make sure that members get the services they need, when they need them, through the use of scheduling, contingency planning, and reporting,
- Supporting provider business choices and reducing administrative burden associated, and
- Preventing, detecting, and recovering improper payments due to fraud, waste, and abuse.

AHCCCS implemented EVV on January 1, 2021 (for both personal care and home health services) with the statewide EVV vendor and data aggregator through Sandata Technologies. On March 3, 2022, AHCCCS' EVV system received certification from CMS. Beginning January 1, 2023 (following a two year soft edit claim period), AHCCCS required EVV data in order for claims to be paid. AHCCCS continues to meet with several provider cohorts and MCOs as needed to discuss operational issues. AHCCCS is currently prioritizing the analysis of the EVV data to develop performance measures to evaluate and incentivize provider compliance and monitor access to care.

2.8 Centers of Excellence

Starting October 1, 2015, AHCCCS required all contracted MCOs to develop approaches for identifying and contracting with Centers of Excellence (COEs). The Centers are facilities that are recognized as providing the highest levels of leadership, quality, and service. They align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Designation as a COE is based on criteria, such as procedure volumes, clinical outcomes, treatment planning, and coordination. Each MCO was required to submit a report identifying why it selected a procedure or condition, how it identified and selected providers to address them, how the MCO would drive utilization to the providers, and any barriers or challenges in the development of the COE.

AHCCCS continues to evolve its approach to COEs. MCOs are now required to address and report on the extent to which COEs focus on interventions related to social risk factors and health equity. One MCO requires its COEs to utilize billing codes that track members' social determinants of health as a way of addressing inequities. The same MCO uses the 'hub and spoke' model, where a central hub is linked to satellite campuses, in its COEs to ensure members residing in rural areas have access to services.

Once an MCO has designated a COE, the MCO takes steps to ensure the COE maintains quality standards. In addition to employing techniques to address social determinants of health and social risk factors,

MCOs adopt quality monitoring programs. For example, one MCO established standardized criteria for all its COEs that included staffing models, clinical outcomes, key performance indicators, satisfaction surveys, and community engagement and leadership. The process includes the development of COE agreement templates which outline the COE model and expectations of service delivery, and development of marketing strategies and steerage efforts that will take place once COEs are established. This allows the MCOs to trend performance across providers and over time.

2.9 Residential Facilities and Oversight

AHCCCS monitors residential facilities in a variety of ways. One way is to provide oversight of MCO adherence to network standard requirements, as outlined in the AHCCCS Contractor Operations Manual (ACOM) Policy 436. Another way is to ensure a general assessment of network adequacy for member service needs. AHCCCS has partnered with MCOs to undertake a network analysis in order to identify the specialized treatment and program options for various populations to better understand the capacity for treating individuals with complex needs. The network is validated by AHCCCS' External Quality Review Organization (EQRO). AHCCCS also closely evaluates monitoring of treatment settings for clinical and quality performance. Additionally, AHCCCS regularly monitors MCO prior authorization requirements and issues requests to MCOs with specific requirements for auditing and reporting.

AHCCCS collaborates with the Arizona Department of Health Services (ADHS) to further enhance monitoring efforts for facilities licensed by the ADHS. AHCCCS has continued to engage with MCOs to better clarify the expectations around treatment provided within residential facilities and to align with licensure requirements by the ADHS.

The AHCCCS Office of Human Rights (OHR) and the Office of Individual Family Affairs (OIFA) both engage with community members on an ongoing basis. It is through this work that many system concerns are identified. Once identified, these issues are brought forward for review and resolution within the appropriate AHCCCS division.

2.10 Prevention Efforts and Attention to the Overuse of Opioids

Arizona, like most states in the country, has witnessed the rising tide of opioid-related deaths. In 2018, more than three Arizonans died each day due to opioid-related causes, with a quadrupling in the number of deaths due to heroin since 2012. In an effort to combat the opioid epidemic, AHCCCS developed an Opioid Strategic Plan in 2016 and has been implementing three major strategies with MCOs, providers, and community champions across several impacted sectors. The overarching goals of the AHCCCS Opioid Initiative are as follows:

- Enhance harm reduction strategies to prevent overdose,
- Enhance access to Medications for Opioid Use Disorder (MOUD) for individuals with opioid use disorder (OUD), and
- Promote responsible prescribing and dispensing policies and practices.

The implementation plan includes a blend of objectives designed to increase coordinated and integrated care, recovery support services, and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths. The project approach includes developing and supporting state, regional, and local level collaborations, as well as service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency. Strategies to combat opioid abuse include:

- **Increase access to Naloxone:** Conduct community-based education and naloxone distribution; encourage co-prescribing of Naloxone for all members prescribed MOUD and for any situations involving combinations of opioids and benzodiazepines.
- **Increase access, participation, and retention in MOUD:** Increase provider capacity among Opioid Treatment Programs (OTPs), Office Based Opioid Treatment (OBOT) providers, and Residential settings that allow all three forms of MOUD increase 24/7 access to care sites through identified 24/7 Access Points, previously known as Centers of Excellence; increase navigation to treatment and retention in treatment through expansion of peer supports and care coordinators; increase the ability to identify and assist with the navigation of justice-involved individuals, pregnant and parenting women to MOUD.
- **Promote responsible prescribing and dispensing policies and practices:** Reduce the number of opioid-naïve members unnecessarily started on opioid treatment by limiting initial opioid fills for first acute episodes to no more than five (5) days; promoting the Arizona Opioid Prescribing Guidelines and opioid prescribing education; non-opioid best practices for effective pain management; use of mental health, trauma, and substance use screenings prior to prescribing opioids; and opioid risk education materials for members; improve care processes for chronic pain and high-risk members by using data to identify problematic prescribing patterns and coordinating provider education; using data to identify high-risk members and coordinating to appropriate care; use of the Controlled Substance Prescription Monitoring Program; promote e-prescribing of controlled substances; increase access to non-opioid methods for managing chronic pain; incentivize for integrated behavioral health and pain management; increase options for complex case consults.

2.11 Foster Care Youth

AHCCCS is committed to providing comprehensive, quality health care for children in foster, kinship, and adoptive care. Children in foster/kinship placements are eligible for medical and dental care, behavioral health, and other services through the Department of Child Safety Comprehensive Health Plan (DCS CHP)[4]. Adoptive children are typically AHCCCS eligible and are enrolled into an integrated health plan, similar to any Medicaid-eligible child. On April 1, 2021, physical and behavioral health were integrated under DCS CHP as the single sub-contractor providing services to members in DCS CHP.

System improvements include availability of frequently asked questions documents and behavioral health and crisis services flyers for foster and kinship caregivers, as well as the streamlining of MCO deliverables. AHCCCS created a dashboard to track and trend utilization for children in foster care. This dashboard report is posted to the AHCCCS website. AHCCCS has worked closely with the Department of Child Safety (DCS) to monitor and expand licensed Therapeutic Foster Care capacity, and to develop incentive programs for providers to deliver and sustain the model. AHCCCS is also partnering with DCS to implement quality monitoring efforts utilizing standardized criteria.

AHCCCS ACOM Policy 449: Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children, was developed to implement House Bill 2442 (also known as Jacob’s Law) legislative requirements. Additionally, a dedicated web page hosts helpful information and resources to support the families, community, and providers involved in the care and treatment of foster and adoptive children. Jacob’s Law mandates include the following:

[4] Formerly known as Comprehensive Medical and Dental Program (CMDP) prior to April 2021.

- Designated points of contact for each MCO and AHCCCS (e.g., as it applies for Children's Service Liaisons and customer care service lines depending on health plan enrollment),
- Foster parents self-referral option for an evaluation, including rapid response,
- An assessment of the child must be conducted within 72 hours after being notified that a child has been placed out of home, if a behavioral health need has been identified,
- A mobile team assessment within two hours, as indicated, in the event of a crisis or urgent need,
- An initial evaluation of the child completed within seven calendar days after a referral or request for services,
- Health plan response to a request for residential placement due to threatening behavior within 72 hours,
- If a foster child is moved to a different county, they may continue to receive treatment in the previous county or seek treatment in the new county, and
- An initial behavioral health appointment provided within 21 calendar days after the initial evaluation.

In the event the initial behavioral health appointment is not provided within 21 calendar days, the out of home placement or adoptive parent must notify the health plan and AHCCCS, and the guardian may access the service directly from any AHCCCS-registered provider regardless of whether the provider is contracted with the health plan. The AHCCCS Behavioral Health Community Liaison also conducts Jacob's Law training sessions for the public.

2.12 Justice Population

Approximately 120,000 individuals are released from Arizona jails and prisons each year and over 70% have a substance use and/or mental health disorder. The volume of complex needs within this population makes it difficult to provide high-touch care to all who need it. Despite the challenges, AHCCCS is actively engaged with the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) and most of Arizona's county jails, including Maricopa and Pima, in a data exchange process which suspends health plan enrollment upon incarceration, instead of terminating AHCCCS coverage. This data exchange agreement allows the ADCRR and county jails to electronically transmit custody dates for AHCCCS members, which simplifies the process of transitioning members directly back into care following release. Additionally, AHCCCS MCOs (including RBHAs) are required to provide "reach-in" care coordination to identify incarcerated members with complex health needs and connect them with case managers, prerelease, to provide information and schedule appointments with Primary Care Physicians (PCP) and behavioral health providers, as appropriate.

AHCCCS has agreements with the Arizona Department of Juvenile Corrections (ADJC) to coordinate reach-in for juvenile members. This process ensures that the same pre-release activities can be provided to juvenile members transitioning out of detention. AHCCCS participates in a manual data exchange process with ADJC to ensure that a member's benefits are appropriately suspended and/or reinstated upon knowledge of a youth entering or exiting a detention facility.

AHCCCS has intergovernmental agreements implemented with the ADCRR and most Arizona counties, to provide services to incarcerated individuals temporarily admitted into an inpatient hospital setting outside the correctional institution. This process involves the correctional institution, or its designee, assisting the incarcerated individual with submitting an application for temporary AHCCCS coverage and an expedited review from specialized units which determine eligibility and the specific period of the

hospital stay. When determined eligible, the medical services performed during the hospital stay will be covered by AHCCCS.

AHCCCS has additional agreements with the ADCRR and most Arizona counties, including Maricopa and Pima, granting special permissions in the AHCCCS online application portal [Health-e-Arizona Plus (HEAplus)] to assist uninsured individuals in applying for AHCCCS coverage prior to release. The application is submitted in HEAplus approximately 30 days prior to release and will be reviewed by a specialized eligibility unit. The eligibility determination process is expedited to help ensure that qualified individuals who need critical care may be enrolled in AHCCCS immediately following release. Incarcerated individuals at risk of needing an institutional level of care upon release may receive a Pre-admission Screening assessment while incarcerated and, when eligible, may apply for ALTCS upon release.

Through the Targeted Investments Programs, AHCCCS provides guidance and financial incentives for outpatient clinics to co-locate with probation or parole officers. Co-location increases the convenience of receiving culturally-sensitive primary care and behavioral health services as returning citizens attend their supervision appointments, which are critical for individuals with other reentry-related priorities. Participating clinics are required to assess an individual's primary care, behavioral health, and health-related social needs; reliably provide a suite of primary care and behavioral health services on site; ensure access to MOUD services within 24-hours; and leverage forensic peer and family recovery support specialists. Thirteen clinics, partnering with six county probation departments and ADCRR, participated in the original TI program (TI 1.0). Over 55 clinics in nine counties are participating in the renewal program (TI 2.0) through September 30, 2027. These clinics will prioritize completing activities related to reach-in and release planning, coordinate referral protocols with community partners that can address identified health related social needs (HRSNs), identify and address health inequities within their patient populations, and offer tobacco cessation programming.

2.13 Suicide Prevention in Arizona

In 2020, suicide was the 12th leading cause of death for all ages in the United States, changing from the 10th leading cause in 2019 due to the emergence of COVID-19 and increases in deaths from chronic liver disease and cirrhosis. In 2022, there were 1,599 certified deaths attributed to suicide among its residents. Arizona's rate of suicide per 100,000 of population was 45% higher than that of the U.S. in 2022. Suicide has continued to remain a major threat to public health over the last decade. In 2021, suicide prevention programming moved from AHCCCS to the Arizona Department of Health Services (ADHS).

ADHS has published the 2024-2026 Arizona Suicide Prevention Action Plan, building upon prevention efforts outlined in the 2021-2025 Arizona Health Improvement Plan (AzHIP) Mental Wellbeing and Pandemic Recovery & Resiliency action plans. Suicide Prevention research into best practices has been incorporated into the proposed prevention action plan, as well as guidance from national authorities such as the Centers for Disease Control and Prevention (CDC), the Suicide Prevention Resource Center (SPRC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The 2024 - 2026 SPAP aims to add to the progress of the previous plan by sustaining successful initiatives, maintaining data transparency and greatly expanding partnerships and collaboration.

AHCCCS works with the ADHS Suicide Prevention team to disseminate information and resources regarding suicide prevention and supports suicide prevention activities and best practices through its Arizona crisis system. Additionally, all MCOs are required to address suicide prevention in their policies and to provide suicide prevention training to their front-line staff. The Suicide Prevention team includes a

suicide prevention specialist, an epidemiologist, and two grant-funded positions. One grant specialist works with the Arizona Department of Education (ADE) on the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Project AWARE (Advancing Wellness and Resiliency in Education). The five-year grant targets school districts with suicide prevention and behavioral health resources. The second grant-funded position works on a SAMHSA-funded suicide prevention/domestic violence project in Pima County.

2.14 System of Care Oversight

The System of Care team is responsible for oversight of AHCCCS MCO adherence to contract and policy requirements to ensure services are delivered in line with the Arizona Vision (12 Principles and Adult Service Delivery System and 9 Guiding Principles), 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.

a. Fidelity Review

The Western Interstate Commission for Higher Education (WICHE), a national expert in the four SAMHSA evidence-based practices (EBP), conducts annual fidelity monitoring of services provided to individuals with an SMI designation. These reviews focus on four service types: Assertive Community Treatment, Supported Employment, Supportive Housing, and Peer and Family Services. Fidelity reviews include fidelity scales and review of all EBP materials including interview guides, scoring protocols and forms, fidelity report templates, provider notification, and preparation letters. These tools continue to be utilized. Key activities related to fidelity reviews are listed below:

- Reviews are conducted in a team of two reviewers. Each team has a lead reviewer in charge of preparation correspondence, provider scheduling, and writing the report.
- Following the one-to-four-day reviews, each team member completes individual scores, and the team then consolidates final consensus scores.
- A detailed fidelity report with scoring rationale and recommendations is drafted by the review team.
- Following discussion and any needed input from respective expert consultant(s), the report with the fidelity scale score sheet is delivered to providers.
- A follow-up call with providers and the RBHA may be scheduled to discuss the review findings and answer specific questions regarding the report upon request by the provider.

Mercer Government Human Services Consulting (Mercer) conducts an annual quality service review (QSR) and conducts an annual service capacity assessment to evaluate the quality and availability of services for 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. The Service Capacity Assessment evaluates network sufficiency of four prioritized mental health services (Assertive Community Treatment, Peer Support, Supported Employment, and Supported Housing) and identifies unmet member needs. Mercer conducts the QSR and Service Capacity Assessment of the targeted services using a number of evaluation techniques such as medical chart review, claim utilization review, surveys, and focus groups.

b. Behavioral Health Clinical Chart Audit

The Behavioral Health Clinical Chart Audit has historically been utilized to audit provider charts, with the focus on processes related to initial and ongoing assessment and service planning. Prior to 2018, each of the RBHAs conducted its audits utilizing its own unique tool that comported with required AHCCCS policies. However, the use of distinct audit tools did not allow for data analysis at a statewide level. Therefore, beginning in 2018 and with the advent of the ACC plans, AHCCCS began working with the RBHAs and ACC plans to develop a unified tool for utilization throughout Arizona by all MCOs. The audit tool was formally implemented on October 1, 2019 and the first round of results was reported as of April 2020, but further auditing was suspended due to the COVID-19 Public Health Emergency (PHE). Audits were reinitiated in early 2023 with a revision of the tool and development of new audit instructions that included feedback from MCOs to ensure audit regulatory requirements were met based on AHCCCS policy and contract. A newly developed behavioral health audit portal was released by AHCCCS for use by the MCOs in mid-May 2023 that will allow MCOs to input audit data in real-time as well as create predefined reports that can be used to facilitate more in-depth analysis of providers' processes and care. AHCCCS intends to continue evaluation of the Behavioral Health Chart Audit process to ensure a more focused view of the outcomes of members who have received behavioral health services.

2.15 Grants Administration

The Grants Administration team has applied for, and been awarded, several key grants that help achieve the agency's mission and vision for individuals who are either under or uninsured. The federal grants received by AHCCCS have a narrowly defined purpose for a demonstrated need. The current grants focus on substance use disorders (SUDs), mental health, homelessness, OUD, 988 crisis and suicide prevention, and ongoing prevention and treatment for adolescents and adults.

2.16 Housing

AHCCCS recognizes the importance of housing as a social risk factor to health and is working to integrate housing strategies into its larger health management strategies. Housing is currently one of the three primary focus areas in AHCCCS' Whole Person Care Initiative (WPCI) to address social risk factors to health. Additionally, AHCCCS provides housing subsidies and supports for individuals with an SMI designation [and a smaller number of members with general mental health/substance use (GMHSU) needs] through Non-Title XIX/XXI funds and Title XIX/XXI funding for those support services which are Medicaid compensable. To implement its housing strategies, AHCCCS follows the Permanent Supportive Housing (PSH) model endorsed by SAMHSA, Housing and Urban Development (HUD), and CMS.

Under the PSH model, there are two components to an effective housing strategy: provision of safe, appropriate, and affordable housing that meets the member's/resident's need, and the availability of effective, individualized wrap-around supportive services to assist the individual or household attain and maintain their housing placement while addressing other service plan goals. These services are provided to help a member secure appropriate housing and stay housed in a stable environment.

In addition to Title XIX/XXI funding, AHCCCS receives a state funded annual allocation of approximately $28 million for non-Medicaid compensable housing subsidies and supports. Since 2014, AHCCCS utilizes housing funds in all Arizona GSAs and uses a small portion of housing funds to serve persons diagnosed as GMHSU. AHCCCS prioritizes housing subsidies for persons experiencing homelessness. At present, AHCCCS housing funds provide housing subsidies to an average of 2,800 households statewide each month. Housing funds also support operating expenses for an additional 1,500 individuals with an SMI designation and who were experiencing homelessness but now reside in HUD Continuum of Care subsidized PSH units. AHCCCS housing funding is currently awarded to a single Statewide Housing Administrator based on the submission and approval of an annual Housing Spending Plan that

documents statewide housing needs, waitlists, projects to be funded, service coordination strategies, and an annual housing budget. The Statewide Housing Administrator must provide monthly utilization/vacancy and housing inventory reports, as well as other ad hoc reports as required in contract, which are used to monitor housing performance.

AHCCCS utilizes the ACC-RBHA and ACC contracts for the provision of individualized wrap-around supportive services to assist individuals with obtaining and maintaining housing stability. Contracts require each MCO to employ at least one Housing Liaison who serves as an expert for the plan and identifies additional resources for members while supporting Housing Specialists at the provider level with technical assistance and training around SAMHSA's Evidence Based Practice for PSH.

Additionally, the Arizona State Legislature allocates $2 million annually to a SMI Housing Trust Fund. With these dollars, AHCCCS awards housing developers and providers funds in order to purchase and renovate properties (with some limitations) for individuals with a SMI designation. Properties purchased or renovated with these dollars are limited to the use of those individuals with an SMI designation through Covenants, Conditions, and Restrictions (CC&Rs) on the funded projects for a period ranging from 15-30 years.

Statewide, Arizona is in the midst of an affordable housing crisis. Arizona's dramatically increasing population, limited development of affordable units, and a strong job market, has left rental vacancies at historic lows. Some cities report less than a 3% vacancy rate for all units. This has put upward pressure on rents. In Maricopa County, according to the HUD Office of Policy Development and Research, Fair Market Rents for an efficiency unit have increased over 25% (from $744 to $933 a month) and one-bedroom rates have increased almost 19% (from $868 to $1,032). This is more complicated in Arizona's rural communities that may lack traditional rental units or where affordable housing may not be near other necessary resources. AHCCCS works closely with ACC-RBHAs, ALTCS providers, and MCOs to ensure adherence to follow national best practices regarding assessment and connection to resources for persons experiencing homelessness. MCOs are required to work with their providers to use the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) to assess a member's housing needs and rank members accordingly on a housing wait list. Priority is given to persons experiencing homelessness. Housing staff are expected to be familiar with the Housing Quality Standard (HQS) inspection process to make sure members are being housed in safe environments. The Statewide Housing Administrator, ACC-RBHAs, and ACC plans work closely with landlords and with developers to ensure available housing units are matched with members. Once matched, the member is provided supportive services to help keep him/her successfully housed. For chronically homeless individuals, the first 30 days are critical for supportive services to prevent eviction. The ACC-RBHAs and ACC plans work with other community housing providers when possible, including local Public Housing Authority, the three Arizona HUD approved Continua of Care, and other state agencies to secure both housing subsidies, as well as to develop additional affordable housing units for AHCCCS members.

AHCCCS continued efforts to expand housing resources available for eligible members through the 1115 waiver expansion called Health and Housing Opportunities (H2O). In October of 2022, CMS approved Arizona's request for a five-year extension, which includes approval of the H2O program. Through this program, AHCCCS will be able to cover health related social needs interventions for eligible populations, this includes outreach, access to Enhanced Shelter, temporary rental assistance, home modification and remediation services, and pre-tenancy/tenancy support services. AHCCCS is in the process of establishing a protocol and implementation plan in order to begin these services effective October 1, 2024.

2.17 Workforce Development

Workforce Development (WFD) is the process of recruiting, selecting, developing, deploying, and retaining a sufficiently staffed, qualified, and capable workforce. Within the AHCCCS system, the WFD function is described in ACOM Policy 407. The policy differentiates the responsibilities of the three types of organizations (AHCCCS, MCOs, and providers) comprising the system and describes the collaborative approach to WFD:

- Providers directly acquire, develop, deploy, and retain a qualified and capable workforce,.
- MCOs monitor and ensure that providers maintain a workforce that possesses the required qualifications, staffing capacity, and skill capability needed to deliver AHCCCS services. In addition, MCOs must develop detailed WFD plans to strengthen the workforce capacity and capability of providers within their networks. These network specific plans often include details on assistance MCOs provide to their provider organizations. MCOs also participate in joint WFD planning with AHCCCS and other MCOs designed to address statewide WFD challenges, and
- AHCCCS analyzes current and future healthcare workforce trends, forecasts and describes workforce requirements, and generates policies to manage the development and deployment of the healthcare workforce.

Monitoring the activities and intended accomplishments described in the Annual WFD Plan is the primary way AHCCCS evaluates the productivity and success of the MCOs' WFD programs. Workforce development directly affects the health care members receive, as well as the health outcomes they experience. Services must be provided by a workforce that is sufficiently staffed, skilled and committed to meeting members' needs in the most interpersonally, clinically, and culturally appropriate manner possible. AHCCCS, MCOs, and leaders from the provider community and industry groups are working collaboratively to strategize, develop measures and methods for analyzing the needs, and action planning on how to attract and retain the desired workforce. Specifically, AHCCCS is working towards:

- Increasing its capacity to collect workforce data, analyze workforce trends, facilitate workforce planning, and mobilize human, educational, and community resources needed to both attract and prepare qualified workers to deliver contracted services. Since beginning this effort in 2022, AHCCCS contracted with Myers and Stauffer for consultation and technical assistance in designing and building a workforce database and decision support system,
- AHCCCS contracted with Pipeline AZ to develop an innovative career exploration, planning and job acquisition platform called the "Arizona Health Care Careers Hub". One of AHCCCS's ARP initiatives, the Hub went live in June of 2023 and already has over 5000 users and several hundred health care provider organizations routinely using the platform to explore healthcare careers and find employment with health care providers.
- Enabling MCOs to better assist providers to enhance their WFD programs by strengthening the internal relationship and collaboration between networks, quality, customer service, and culturally competent units, and
- AHCCCS has contracted with the Center for the Future of Arizona (CFA) to facilitate the development of collaborative partnerships with other state and local agencies, community economic development authorities , industry groups, and colleges, high schools and career and technical education programs to develop regional approaches to developing talent pools and pipelines to strengthen the HCBS workforce. CFA will also produce a plan for sustaining these collaborative partnerships. The long term goal of these partnerships is to increase the recruitment of talented individuals (including current AHCCCS members), to join the integrated

healthcare workforce and thereby prevent, reduce or eliminate health professional shortages in key areas of the state.

- One major workforce development goal has been to improve the efficacy of the state's education, training, and development programs By developing Intergovernmental Agreements (IGAs) with community colleges throughout the state and using funds from the American Rescue Plan (ARP) Act, AHCCCS has been able to offer over 2000 community college students scholarships with which to pursue health care degrees and certificates in areas that align with the workforce needs of HCBS providers. The result of this initiative will be an increase in the pool of candidates for HCBS jobs. These candidates will stand out as better prepared to perform the critical, unlicensed jobs offered by HCBS providers with less need for extensive post-hire, initial in-service training.

  Because HCBS providers must still offer both initial post-hire and advanced in-service training, in addition to the scholarship program, AHCCCS was able to secure the assistance of the community college's curriculum development and instructional design team to create or update both initial in-service and advanced training curricula for Direct Care Workers, Behavioral Health Case Managers , Peer Recovery Support Specialists and Supervisors.

- With the increase in the availability of various workforce development tools such as the Health Care Career Hub, Scholarships, and improved in-service training programs, AHCCCS also identified the need to provide upskilling opportunities for trainers, human resources development specialists (HRDS), health plan workforce development professionals and members of provider executive leadership teams. Using ARP funds, AHCCCS contracted with the Association for Talent Development (ATD) to provide their internationally renowned certificate programs in Integrated Talent Management and Training and Facilitation that, to date, over 300 Trainers and HRD specialists from the HCBS provider community have utilized. In addition, ATD developed two tailored training programs. One program is for the health plan Workforce Development Administrators in workforce development best practices such as workforce assessment, data analysis, and planning. The second tailored program is intended for the executive leadership teams from the HCBS provider community; this program includes "Ted Talk"-like sessions that will focus on emerging and established approaches to successful workforce recruitment and retention.

2.18 Employment Support

AHCCCS believes that every person should have the opportunity to work competitively in the community when the right kind of job and work environment is identified, and appropriate supports are present. Competitive Integrated Employment is work that is performed on a full-time or part-time basis for which an individual is: compensated at or above minimum wage and comparable to the customary rate paid to persons without disabilities performing similar duties and with similar training and experience; receiving the same level of benefits provided to other employees without disabilities in similar positions; at a location where the employee interacts with other individuals without disabilities; and presented opportunities for advancement similar to other employees without disabilities in similar positions. Self-employment, in many cases, is also considered Competitive Integrated Employment.

The RBHAs are required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties include employment and rehabilitation-related activities, such as meaningful community involvement activities. AHCCCS tracks the utilization of covered services.

For individuals with an SMI designation, AHCCCS and the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) [which includes the State Vocational Rehabilitation (DES/VR) program], have an established Interagency Service Agreement (ISA) to provide specialty employment services and supports. AHCCCS provides funds toward this agreement that the ADES/RSA uses as a state match to draw down additional federal monies. The overall funding is used toward client services, staffing, and training. VR submits quarterly deliverables that include client progress statuses and staffing capacity. Some of the special requirements within the ISA are:

- Vocational Rehabilitation Counselors (VRCs) have specialized caseloads consisting of individuals with psychiatric disabilities. DES/VR counselors are cross-trained in the area of psychiatric disabilities to effectively serve the individual needs of the clients,
- The federally mandated, 60-day eligibility requirement for ADES/VR applicants is modified to 30-days; ADES/VR Counselors and RBHA provider employment staff have weekly consultations regarding the progress of mutual program participants, and
- The ISA also requires quarterly ISA Advisory Committee meetings with AHCCCS, ACC-RBHAs, and RSA/VR and bi-annual regional ISA Coordination meetings for collaboration with all stakeholders in efforts to enhance program delivery methods and increase successful employment outcomes. The AHCCCS contract with the RBHA mandates its adherence to the ISA.

AHCCCS has expanded employment requirements beyond the ACC-RBHAs by including employment requirements for MCOs more generally. AHCCCS has also educated MCOs on the usage of Medicaid covered employment services. For the ALTCS and DCS CHP contracts, plans are required to employ staff designated as the subject matter expert (SME) on employment and employment services. Their role is to assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options, including employment. For ACC (effective October 1, 2018), the integrated MCOs are required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties are to include employment and rehabilitation-related activities. Employment-related deliverables are included within the ACC contract.

AHCCCS has also begun efforts to help transform the employment system by coming into compliance with the CMS HCBS Rules specific to employment services (Center-Based Employment and Group Supported Employment). The purpose of the rule is to ensure that individuals receiving home and community-based services are integrated into their communities and have full access to the benefits of community living, including employment settings. The HCBS Rules became effective on March 17, 2023, and authorizes all members having the opportunity to seek competitive employment in the most integrated setting and to the same degree of access as individuals not receiving home and community-based services.

3. AHCCCS Quality Strategy and Evaluation

The following section outlines Quality Strategy scope and objectives, methods and processes, and the evaluation of the Quality Strategy. As a result of the evaluation and analysis, AHCCCS identified and updated new goals and objectives for the Quality Strategy as detailed below.

3.1 Quality Strategy Scope and Objectives

The AHCCCS Quality Strategy is developed utilizing a coordinated, comprehensive, and proactive approach designed to drive quality throughout the AHCCCS delivery system. AHCCCS achieves the goals outlined in the Quality Strategy through:

- Combined methods of partnership with and regulatory oversight of contracted MCOs,
- Value-based program development, and
- Focus on outcomes and optimized member health.

AHCCCS clearly outlines expectations for quality care and service delivery, and has structured a multi-faceted approach for monitoring compliance with expectations that includes member and stakeholder feedback/engagement and numerous MCO oversight activities.

The scope of the Quality Strategy is designed to incorporate the requirements outlined in 42 CFR 438.340 and 42 CFR 457.1240(e). AHCCCS requires transparency for the quality of health care and services it provides to its members, the community, and its stakeholders. AHCCCS has developed quality initiatives and strategies for evidence-based outcomes that:

- Reward quality of care, integrated service delivery, member safety, and member satisfaction outcomes,
- Support best practices in disease management and chronic care,
- Provide feedback to MCOs and providers on quality and outcomes, and
- Provide comparative information to potential members, members, and stakeholders.

The agency's Quality Strategy is focused on continuous quality improvement based on the Triple Aim framework of healthcare developed by the Institute for Healthcare Improvement (IHI) in 2008. The Triple Aim has been widely adopted by governmental and commercial organizations as a mechanism to improve both member and population health simultaneously. In order to achieve the Triple Aim, AHCCCS has formulated strategies intended to improve member experience of care, improve member and population health, enhance system performance, and reduce costs.

3.2 Methods and Processes for Quality Strategy Development

The Quality Strategy is reviewed, at a minimum, once every three years or as needed, based on significant program changes. Significant changes would include revisions to delivery system models, fundamental shifts in quality approaches, and/or changes that significantly impact the manner in which members receive care and services. Typically, the review process includes an evaluation and analysis of the previous three years (or less, if significant changes are experienced). AHCCCS' executive leadership team (or "executive management") provides essential guidance and feedback related to the structure and contents of the document, serving as the Quality Strategy authority. The Quality Strategy updates are submitted to CMS for comment and feedback prior to adopting the changes. In addition, this document is posted on the AHCCCS Quality Strategy web page and made available in accordance with 42 CFR 438.340 and 42 CFR 457.1240(e).

3.3 Community and Stakeholder Engagement

Quality is a community process and AHCCCS strives to ensure that the voice of the community is heard. AHCCCS interfaces with Medicaid beneficiaries and their families, community members, tribal leaders, as well as federal and state stakeholders to ensure that all perspectives and voices are considered in the health care policy and service delivery decision-making process. AHCCCS provides education on what Medicaid is and how it works, and seeks to receive feedback, input, and consultation on how to best serve its beneficiaries and stakeholders. AHCCCS ensures agency transparency and incorporates community feedback into its Quality Strategy development through engagement with and support from the following mechanisms and structures:

a. Public Information

The AHCCCS Communications team disseminates information to the public about the agency's programs, policies, and initiatives using mass communication techniques, including press releases, website content, public and media relations, email newsletters, and social media. In addition, the Communications team fields formal public records requests and communicates with stakeholders including businesses, providers, students, and AHCCCS members.

AHCCCS employs a social media strategy to increase public access to information, generate positive public relations, interface with the media, support MCO community efforts, gather information to increase business intelligence, and bolster employee recruiting efforts. AHCCCS uses several official social media channels to amplify external messages, support partner organizations, answer member questions, and drive traffic to the AHCCCS website.

b. Office of Individual and Family Affairs (OIFA)

The Office of Individual and Family Affairs (OIFA) is staffed by peers and family members of persons receiving services in Arizona's behavioral health system. They bring their lived experiences to the forefront when making decisions, incorporating recovery and resiliency into all aspects of service delivery. OIFA provides regular community education and outreach activities through its One-Pager Empowerment Tools, weekly newsletters, and monthly meetings including System Navigation, AHCCCS Hot Topics, Community Policy, and Jacob's Law Training. Moreover, OIFA:

- Builds partnerships with individuals, families of choice, youth, communities, and organizations to promote recovery, resiliency, and wellness,
- Collaborates with key leadership and community members in the decision-making process at all levels of the behavioral health system,
- Advocates to end stigma,
- Ensures member and family member voice is included in system design,
- Provides educational resources,
- Ensures peer support and family support is available to all persons receiving services and their families, and
- Assists with navigating the health care system.

c. Office of Human Rights (OHR)

The Office of Human Rights (OHR) is the State Advocacy Office, established by the A.A.C., R9-21-104, that focuses on direct advocacy to a population that meets Special Assistance criteria. Special Assistance is a clinical designation that occurs when a member cannot participate effectively in his/her own treatment planning processes due to a cognitive or intellectual impairment and/or medical condition. OHR also provides advocacy to individuals with an SMI designation. Staff provide assistance to help members understand and learn how to protect and exercise their rights, facilitate self-advocacy through education, and obtain access to behavioral health services within Arizona's publicly funded system. Currently in Arizona, there are approximately 4,000 members who receive Special Assistance.

d. Arizona State Medicaid Advisory Committee (SMAC)

The State Medicaid Advisory Committee (SMAC) reviews and advises on the operations, programs, and planning for Arizona's Medicaid program. The Committee advises the AHCCCS Cabinet Executive Officer and Executive Deputy Director of AHCCCS on policy, operations, and administrative issues of the Medicaid program, including issues of concern to the community. The SMAC operates in accordance with 42 CFR 431.12 and the Medicaid State Plan. The bylaws for the committee were created in September

1992 and are reviewed annually, or as needed. The Committee is comprised of the AHCCCS Cabinet Executive Officer and Executive Deputy Director, the Deputy Director of the Arizona Department of Health Services (ADHS) or a designee, the Deputy Director of the Arizona Department of Economic Security (DES) or a designee, and no less than 17 health care professionals/providers and public members with a direct interest in the AHCCCS program. Members are appointed for two-year terms with appointments made on a staggered basis with half the public and professional/provider members completing their terms annually. After serving three consecutive terms, members must wait 24 months before re-applying for a committee position. The SMAC meets quarterly and is chaired by the AHCCCS Cabinet Executive Officer and Executive Deputy Director and SMAC Liaison. Meetings are open to the public with a call to the public at the end of each agenda.

e. Behavioral Health Planning Council

As a requirement of receiving Community Mental Health Block Grant (MHBG) funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), states are required by 42 U.S. Code § 300x–3 to establish a Behavioral Health Planning Council (BHPC). Arizona's BHPC takes the form of a combined Mental Health Block Grant and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) advisory council. BHPC membership reflects Arizona's geographic and cultural diversity and includes behavioral health system recipients, family members, advocates, state agencies, and community providers. The council and its committees meet monthly, either in-person or online, as appropriate.

One of the primary duties of the BHPC is to review Arizona's annual Combined MHBG and SUPTRS BG Application and Plan for children and adults. This review must occur before it is submitted to the United States Department of Health and Human Services (DHHS).

The BHPC members' additional duties are to serve as advocates for people with mental illness including adults with Serious Mental Illness (SMI), and children and adolescents with Severe Emotional Disturbance (SED) and to monitor, review, and evaluate the adequacy of mental health services in the state.

f. ALTCS Advisory Council

The ALTCS Advisory Council meets on a quarterly basis and is composed of ALTCS members and their family members/representatives. Additionally, representatives from ALTCS Contractors, providers, State agencies, and advocacy agencies serve on the Council. Council Members advise AHCCCS on activities aimed at making system improvements. Individual Council members are asked to provide input and feedback on ALTCS program activities from their personal or professional experience, expertise, or perspective. ALTCS Advisory Council members are encouraged to identify topics for discussion as well as provide input on topics that AHCCCS brings forward to solicit stakeholder input from members.

g. Tribal Consultation

AHCCCS acknowledges and respects the unique government-to-government relationship that exists between the 22 Tribal Nations in Arizona and federal and state governments. As part of this recognition, AHCCCS conducts quarterly and ad hoc tribal consultations to strengthen this special relationship and ensure meaningful engagement with Tribal Nations.

The primary goal of these consultations is to ensure that AHCCCS provides reasonable notice and the opportunity for consultation with Tribal Nations prior to implementing policy changes that may directly affect tribal communities, their members, or the relationship between the State of Arizona and Tribal Nations, or the distribution of responsibilities between the State of Arizona and Tribal Nations. To

facilitate this process, AHCCCS has a designated tribal liaison who serves as the primary point of contact for tribal issues.

In recent months, AHCCCS has made several changes to enhance the tribal consultation process and foster more meaningful engagement with Tribal Nations as defined by the Tribes. Firstly, consultations have been expanded from four-hour sessions to full dedicated days, held once per quarter, allowing for more comprehensive discussions and dialogue. Secondly, AHCCCS has introduced a hybrid approach, giving participants the flexibility to attend consultations either in-person or virtually. This change aims to increase accessibility and encourage broader participation from tribal stakeholders, including Tribal leaders and key representatives from the IHS, Tribal health programs, and Urban Indian Health Programs (I/T/U). Additionally, there is a concerted effort to prioritize hosting these sessions on tribal lands or in tribal venues, ensuring accessibility and fostering a sense of inclusivity and partnership. Thirdly, the agency has modified the tribal consultation format to include dedicated time for a Tribal leadership open mic and has reduced the number of AHCCCS slides to facilitate more open and fluid dialogue. Lastly, AHCCCS is actively coordinating visits with Tribes to further strengthen the partnership between the agency and Tribal Nations.

h. Liaison to Independent Oversight Committees (IOC)

The Independent Oversight Committees (IOCs) were created by the Arizona Legislature to assist AHCCCS, DES/DDD, and the ACC-RBHAs in promoting and protecting the rights of children and adults diagnosed with special health care conditions [i.e., members with intellectual and developmental disabilities (I/DD)] and/or who receive publicly funded behavioral health services. The committees provide independent oversight to ensure members' rights are protected.

The IOCs are composed of volunteers with an array of expertise, including providers, members, family members, tribal representatives, advocates, I/DD professionals and/or mental health professionals, and representatives from state agencies. The IOCs review, monitor, and evaluate the adequacy of relevant services as well as agency handling of significant incidents and quality of care concerns.

i. MCO Meetings

Throughout the 2024 Quality Strategy Workgroups effort, AHCCCS engaged and solicited feedback from external stakeholders and, when possible, incorporated the feedback offered into the development, review, and revision efforts used to finalize the AHCCCS 2024 Quality Strategy. In addition, AHCCCS involved the MCOs throughout the Quality Strategy development process via discussion at various meetings which included:

- **Quality Management/Medical Management/Maternal Child Health (QM/MM/MCH) Contractor Meeting:** meetings conducted in collaboration with the AHCCCS QM, MM, MCH and Quality Improvement staff that involve ongoing participation of the MCO quality-focused staff members.
- **AHCCCS Medical Directors Meeting**: meetings conducted quarterly with the AHCCCS MCO CMOs; topics vary with each meeting and include updates by agency area leads to proposed topics from the medical directors.

3.4 Quality Strategy Evaluation

As part of the Quality Strategy updates, AHCCCS utilizes a Quality Strategy Evaluation workgroup to determine the effectiveness of the previous AHCCCS Quality Strategy by conducting an evaluation of the goals, objectives, and agency performance. This evaluation serves to highlight efforts conducted by the agency and identify potential areas of improvement to inform the next Quality Strategy.

a. Methods and Processes for Quality Strategy Evaluation Development

As part of the Quality Strategy Evaluation, AHCCCS collects data and conducts analyses, in addition to other evaluation activities, to assess the value of the strategies described in the Quality Strategy. The analyses include trending and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and PIPs, as well as other data reported by MCOs, such as quality of care concerns. The results of these efforts are documented in a formal Quality Strategy Evaluation report posted on the AHCCCS Quality Strategy web page and made available in accordance with 42 CFR 438.340 and 42 CFR 457.1240(e).

b. Quality Strategy Effectiveness

Data within the Quality Strategy Evaluation is used to assess the efficacy of current goals and strategies, provide a roadmap for potential changes, and develop new goals/strategies, as needed and applicable. Quality Strategy effectiveness, progress, and updates are also reported as part of the agency's:

- 1115 Waiver Quarterly Report,
- Annual report submissions to CMS, as required by the state's 1115 Waiver, and
- External Quality Review (EQR) Annual Technical Reports.

For additional information related to EQR, please refer to the *External Quality Review* section of this report.

c. 2021 Quality Strategy Evaluation Findings

The Quality Strategy Evaluation workgroup conducted a robust evaluation of the 2021 AHCCCS Quality Strategy to determine the effectiveness of the included goals and inform updates and enhancements to the 2024 AHCCCS Quality Strategy. As part of these evaluation activities, the following opportunities for improvement were identified:

- Member satisfaction with their MCO and the care and services they receive,
- Preventive care and services received by members and the promotion of improved health outcomes, and
- Processes for performance measure data capture, calculation, reporting, and analysis.

The Quality Strategy workgroup and executive leadership team considered the evaluation findings as well as community and stakeholder feedback received as part of the 2024 Quality Strategy update process. For additional information related to the community and stakeholder feedback comments received, please refer to *Appendix A* of this report.

Based on the evaluation findings identified above and the stakeholder feedback received, the 2024 Quality Strategy was updated to include the following enhancements:

- Updates to the Quality Strategy goals and objectives,
- Methods by which to measure and evaluate the stated goals, and
- A summary of the stakeholder feedback and public comments received, including an indication of how this feedback was addressed and/or incorporated within.

3.5 Enhanced Quality Strategy Goals and Objectives

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS as the agency continues to collaborate with stakeholders to optimize both the experience and health outcomes of Arizonans

receiving care and services through the Arizona Medicaid managed care system. Utilizing the concepts and strategies described within this section, along with the findings of the most recent Quality Strategy Evaluation, AHCCCS enhanced the Quality Strategy goals and objectives to serve as the agency's roadmap beginning in 2024.

Quality Goal 1: Improve the Member's Experience of Care Related to Quality and Satisfaction
Objectives
Enriching the member experience through an integrated approach to service delivery and using strategies and approaches to assure coordinated service delivery.
Driving the improvement of member-centered health outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on implementation of clinical best practices and measurable improved health outcomes (as funding allows).
Measuring member satisfaction with quality of and access to health care services through the implementation of nationally recognized surveys.
Increasing AHCCCS' understanding of survey trends, members' cultural preferences, key drivers of member satisfaction, and opportunities to improve member experience by engaging the community.
Measurement
In order to demonstrate improvement in the member's experience of care related to quality and satisfaction, AHCCCS intends to monitor and evaluate performance for the following member experience surveys with the intent of meeting the following improvement targets:
By the end of the evaluation period, increase the percentage of CAHPS® member satisfaction survey individual and composite scores rated at or above three stars to 20%. **Rationale:** AHCCCS analyzed its 2023 CAHPS® survey results, serving as the baseline for which improvement will be measured, to evaluate member satisfaction with their MCO, as well as in the care and services they receive. As part of this analysis, AHCCCS identified that 17.9% of the 2023 CAHPS® Survey individual and composite measure results were rated 3 stars or above. As a result, this measurement was determined to be a valuable indicator of member experience and will promote the overarching goal and objectives included as part of Goal 1.
Implement the National Core Indicators - Aging and Disabilities (NCI-AD™) survey in CYE 2024, followed by the establishment of baseline performance in CYE 2025 and the initiation of trending and analysis activities. **Rationale:** AHCCCS remains committed to understanding members' experience of care (including independence, community engagement, decision-making, and other key focus areas that may not be captured through the CAHPS® survey) from the perspective of older adults and members with physical disabilities. The implementation of the NCI-AD™ Survey followed by an evaluation of the results to establish baseline performance and associated opportunities for improvement will promote the overarching goal and objectives included as part of Goal 1.
By the end of the evaluation period, AHCCCS will establish an AHCCCS MCO and Provider Advisory

Committee (AM-PAC), comprised of various MCO and provider representatives, that will be responsible for developing an action plan to enhance communication between MCOs and providers, including enhanced education and support pertaining to quality improvement related activities and initiatives.

> **Rationale:** AHCCCS recognizes the impact providers have on the members' overall experience of care and remains committed to addressing concerns raised related to quality improvement transparency at all levels of the health care system (including the agency, MCOs, and providers). As such, AHCCCS recognized a need to establish the AM-PAC to support the development and implementation of an action plan intended to enhance MCO and provider communication, including education and support as it pertains to quality improvement, thereby, promoting the overarching goal and objectives included as part of Goal 1.

Quality Goal 2: Improve the Health of AHCCCS Members
Objectives
Increasing members' access to integrated care that meets the members' individual needs within their local communities.
Supporting innovative reimbursement models, such as APMs, while promoting increased quality of care and services.
Building upon prevention and health maintenance efforts through targeted medical management: ▪ Emphasizing disease and chronic care management, ▪ Improving functionality in activities of daily living, ▪ Planning patient care for special needs populations, ▪ Identifying and sharing best practices, and ▪ Expanding provider development of COEs.
Expanding access to specialized treatment providers across the state.
Increasing care coordination between providers, MCOs, AHCCCS, community health workers, community based organizations, and other entities involved with the member's care.
Enhancing accessibility of a high-quality, culturally-sensitive provider network for AHCCCS members by collaborating with MCOs.
Promoting member engagement in managing their care.
Measuring health outcomes and comparing them to national benchmarks, at the aggregate or community level, as appropriate and applicable..
Measurement
In order to demonstrate improvement in the health of AHCCCS members, AHCCCS intends to monitor and evaluate performance with the intent of meeting the following improvement target(s):
During the evaluation period, increase the percentage of the targeted preventive care (TPC) measure rates meeting or exceeding the associated NCQA Medicaid Mean to 35%.

Rationale: AHCCCS selected the TPC measures to drive improvement in the preventive care and services received by members and to promote improved health outcomes. AHCCCS analyzed the CY 2021 TPC measure rates, which serves as the baseline for which improvement will be measured. As part of this analysis, AHCCCS identified that 25% of the CY 2021 TPC measure rates met or exceeded the associated NCQA Medicaid Mean. As a result, this measurement was determined to be a valuable indicator by which to: ▪ Measure improvement in the health of the AHCCCS populations, and ▪ Promote the overarching goal and objectives included as part of Goal 2. For a list of performance measures included within the TPC measure set, please refer to *Appendix B* of this report.
By the end of CY 2024, increase the percentage of children served within 21 days of a referral from a school to an outpatient behavioral health provider (for behavioral health services) within three local education agencies (LEAs) tracking districts to 55%. **Rationale:** AHCCCS understands the impact referrals from schools to outpatient behavioral health providers may have on member health outcomes. AHCCCS conducted an analysis of referral data as of August 2023 and identified that 0 children were referred for behavioral health services to outpatient behavioral health providers due to the beginning of the school year. This metric is focused on improving the health of Medicaid enrolled children by increasing access to quality care and services, directly promoting the overarching goal and objectives included as part of Goal 2.

Quality Goal 3: Limit Avoidable Growth in Healthcare Costs While Enhancing Member Access to Quality Care and Services that Address Whole Person Care
Objectives
Developing 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 for at-risk and vulnerable populations, ▪ Build capacity in rural and underserved areas to address both professional and paraprofessional shortages, and ▪ Streamline requirements and monitoring efforts.
Evaluating new and existing agency initiatives, services, and processes that have, or are expected to, increase cost to determine if they enhance member access to quality services that address whole member care.

Identifying opportunities to streamline administrative functions related to healthcare, such as care management, through process improvement techniques (e.g., process mapping, root cause analyses, PDSA) and collaboration with national SMEs through the Targeted Investments Programs and other applicable AHCCCS programs.
Evaluating current processes related to network oversight and preparing for network system improvements to align with new CMS access to care enhancements.
Measurement
To limit avoidable growth in healthcare costs while enhancing member access to quality care and services that address whole person care, AHCCCS will monitor and evaluate performance with the intent of meeting the following improvement target(s):
During the evaluation period, AHCCCS will annually compare its spending growth per enrollee with the national Medicaid spending growth per enrollee. In cases where AHCCCS' spending growth exceeds the national Medicaid spending growth per enrollee, AHCCCS will evaluate the appropriateness of spending in relation to the services provided.[5] **Rationale:** AHCCCS aims to limit the growth in its overall healthcare costs while remaining committed to enhancing member access to quality care and services. AHCCCS utilizes the national Medicaid spending growth per enrollee as a benchmark. By comparing its spending growth per enrollee with the national Medicaid spending growth per enrollee, AHCCCS is supporting the overarching goal and objectives included as part of Goal 3.
By the end of the evaluation period, increase the number of monthly referrals to 800 referrals per month made through CommunityCares to address members' health-related social needs. **Rationale:** AHCCCS understands the impact health-related social needs have on member health outcomes and has implemented a Statewide Closed-Loop Referral System, known as CommunityCares, which is an electronic tool that allows health care providers to screen and refer AHCCCS members for health-related social need services. The baseline number of cumulative referrals made as of October 2023 was 2,845. This metric is focused on limiting the growth of healthcare costs while enhancing member access to quality care and services by addressing health-related social needs and providing whole person care, directly promoting the overarching goal and objectives included as part of Goal 3.

Quality Goal 4: Promote Improvement in the Care and Services Provided to Members by Enhancing Data System and Performance Measure Reporting Capabilities
Objectives
Increasing analytical capacity to make more informed clinical and policy-making decisions, as well as driving continuous delivery system performance through advanced data analytics and disparity analyses.

[5] AHCCCS spending growth per enrollee will be calculated based on managed care spending and enrollees

Initiating implementation of a new data system infrastructure.
Meeting CMS Core Set mandatory reporting requirements by: ▪ Identifying and proposing potential solutions for system and process limitations that impact performance measure reporting and analysis capabilities, and ▪ Enhancing data capture of member demographic criteria such as race, ethnicity, primary language, etc.
Leveraging various data sources to produce comprehensive and reliable data by: ▪ Collaborating with external stakeholders to facilitate access to supplemental data sources such as the Health Information Exchange (HIE), and ▪ Exploring means for collecting and reporting performance measure data utilizing electronic health record (EHR) and Electronic Clinical Data Systems (ECDS) methodologies.
Increasing transparency by developing and implementing a CMS-compliant quality rating system, as well as enhancing public-facing dashboards and report cards.
Collaborating with the Health Equity Committee: Data Subcommittee (HEC:DS) SMEs to conduct multivariate analyses that identify poor health outcomes and specific policy levers to address them.
Measurement
To promote improvement in the care and services provided to members, AHCCCS will enhance its data system and performance measure reporting capabilities with the intent of meeting the following improvement target(s):
By the end of the evaluation period, enhance the process for calculating the Screening for Depression and Follow-Up Plan measure in alignment with technical specification requirements and develop an action plan to improve the data capture of depression screenings. **Rationale:** As part of AHCCCS' preparation for mandatory reporting of the CMS Child Core Set and the behavioral health measures in the CMS Adult Core Set, AHCCCS identified barriers in capturing the depression screening data utilized to calculate the Screening for Depression and Follow-Up Plan (CDF) measure. AHCCCS identified this measure as an area of opportunity to promote improvement in the care and services provided to members as well as improve member outcomes. Enhancing the process for calculating the CDF measure in alignment with the technical specifications requirements and developing an action plan to improve data capture, will promote the overarching goal and objectives included as part of Goal 4.
By the end of the evaluation period, develop an action plan to enhance the calculation and reporting capability of ECDS measures in alignment with technical specification requirements by successfully reporting a minimum of one ECDS measure as part of the CY 2024 performance measure validation activities. **Rationale:** Many of the newly redesigned ECDS performance measures include a focus on member outcomes, shifting the focus from processes to follow up activities conducted. Developing an action plan to enhance the calculation and reporting capability of ECDS measures will provide AHCCCS better insight into the care and services members are receiving and assist in the identification of improvement opportunities. Additionally, the successful reporting of ECDS measures will promote the overarching goal and objectives included as part

of Goal 4.
By the end of the evaluation period, develop an action plan to address actionable disparities identified based on a review and analysis of select measures included within the CY 2023 TPC measure rate set. **Rationale:** AHCCCS remains committed to identifying and addressing health disparities among its members. Conducting disparity analyses on select measures included within the CY 2023 TPC measure rate set will allow AHCCCS to identify and develop an action plan to address actionable disparities related to preventive care services. The development of a measure-focused action plan to address actionable disparities identified will promote the overarching goal and objectives included as part of Goal 4.

4. MCO Program Requirements

The purpose of the contract between AHCCCS and the MCOs is to delineate MCO requirements. The MCOs shall be responsible for the performance of all contract requirements as it implements and operates the ACC, ALTCS-DD, ALTCS-EPD, DCS CHP, and/or SMI-Designated programs pursuant to A.R.S. and 42 CFR 438 Managed Care.

4.1 State Verification that Sub-Part E Provisions of the Managed Care Regulations are Included in Medicaid Contract Provisions

In its contracts with MCOs, AHCCCS incorporates the CFR requirements regarding MCO establishment and implementation of ongoing comprehensive Quality Management/Performance Improvement (QM/PI) programs for services provided to members. The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, quality measurement, and quality improvement. The AMPM, the ACOM, and other AHCCCS policies and manuals are incorporated by reference as part of the MCO contracts and provide more detailed standards, information, and requirements. MCO contract provisions require all MCOs to:

- Establish and implement an ongoing comprehensive QM/PI Program,
- Implement mechanisms to assess the quality and appropriateness of care furnished to members with SHCN, as defined by the state in the Quality Strategy,
- Conduct PIPs,
- Collect and submit performance measurement data,
- Implement mechanisms to detect both underutilization and overutilization of services,
- Collect data from providers in standardized formats (to the extent feasible and appropriate), including secure information exchanges/technologies utilized for state Medicaid quality improvement and care coordination efforts,
- Track and trend member and provider issues, and
- Implement written policies regarding member rights and responsibilities.

In addition to the requirements outlined above, contract provisions for MCOs providing LTSS require the MCO to:

- Implement mechanisms to assess the quality and appropriateness of care provided to members utilizing LTSS, including the assessment of care between care settings as well as a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable, and
- Participate in efforts by the state to prevent, detect, and remediate critical incidents.

4.2 Quality Management/Performance Improvement (Quality Assessment and Performance Improvement) Requirements

Within its MCO contracts, AHCCCS outlines QM/PI Program requirements. The MCOs' QM/PI Program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement (in the areas of clinical and nonclinical care) which is expected to have a favorable effect on health outcomes and member satisfaction. These QM/PI Program requirements include, but are not limited to:

- Implementation, monitoring, evaluation, and compliance with applicable program requirements,
- Provision of quality care and services to eligible members, regardless of payor source and eligibility category,
- Contractor written policies and training regarding preventing abuse, neglect, and exploitation, ensuring incident stabilization [member(s) immediate health and safety is secured and immediate care and recovery needs are identified and provided], reporting incidents, and conducting investigations,
- Monitoring for provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation,
- Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN,
- Demonstration of improvement in the quality of care and services provided to members through established QM/PI processes,
- Analysis of the effectiveness of implemented interventions, including targeted interventions, to address the unique needs of populations and subpopulations served,
- Participation in community initiatives, events, and/or activities, as well as implementation of specific interventions to address overarching community concerns,
- Written policies regarding member rights and responsibilities,
- Protection of medical records, any other personal health, and enrollment information that identifies a particular member, or subset of members, in accordance with federal and state privacy requirements,
- Development and maintenance of mechanisms to solicit feedback and recommendations from key stakeholders, subcontractors, members, and family members to monitor service quality, and develop strategies to improve member outcomes and quality improvement activities related to quality of care and system performance,
- Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation, and unexpected deaths,

- QM/PI Program monitoring and evaluation activities, which include Peer Review and Quality Management Committees that are chaired by the MCO's local CMO, and
- Performance measurement and PIPs.

MCOs are required to develop a written QM/PI Program Plan that specifies the objectives of the MCOs' QM/PI Programs and addresses the MCOs' proposed approaches to meet or exceed the performance standards and requirements specified in the contract and AHCCCS policy. The QM/PI Program Plans (inclusive of program narrative, work plan, and work plan evaluation) are submitted annually and describe how program activities shall improve the quality of care, service delivery, and satisfaction for members.

4.3 Assessment of Quality and Appropriateness of Care/Services for Routine and Special Health Care Needs Members

The MCOs are required by contract to identify children and adults with special health care needs (SHCN). The qualifying criteria is defined in the contract as, "Members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally." A member is considered as having SHCN if the medical condition simultaneously meets one or more of the following criteria including but not limited to:

- Actively engaged in a transplant process plus one-year post transplant,
- ALTCS-DD,
- ALTCS-EPD,
- Autism/at risk for Autism,
- Arizona Early Intervention Program (AzEIP),
- Mercy Care DCS CHP and up to one year after transition from Mercy Care DCS CHP,
- CRS,
- Early Childhood Service Intensity Instrument (ECSII)/Child and Adolescent Level of Care Utilization System score of 4 or higher,
- High needs and high costs,
- HIV/AIDS,
- Members who are pregnant and postpartum (especially pregnant women who are high risk or in their third trimester)
- Severe Combined Immunodeficiency (SCID),
- SED/Neonatal Abstinence Syndrome (NAS), or
- An SMI designation.

a. Identification

Members with SHCN are identified through a review of utilization data to identify diagnoses, services, and medications specific to a member with SHCN, new member health risk assessments, concurrent review, prior authorization, and/or a review of Early and Periodic Screening Diagnostic and Treatment (EPSDT) Clinical Sample Templates or equivalent forms. The identification (not available for all categories

of SHCN) that designates a member as having SHCN is entered into the Pre-paid Medical Management Information System (PMMIS) mainframe database.

b. Assessment

MCOs are required to comprehensively assess each member identified as having SHCN, in order to identify any ongoing special conditions of the member that require a course of treatment, regular care management, or transition to another AHCCCS program [42 CFR 438.208(c)(2) and 42 CFR 438.240(b)(4)]. The assessment mechanisms must use health care professionals with the appropriate expertise [42 CFR 438.240(c)(2) and 42 CFR 438.208(c)(2)]. The MCO must share the results of its identification and assessment of that member's needs with other entities providing services to that member to avoid unnecessary duplication of effort [42 CFR 438.208(b)(4) and 42 CFR 438.208(c)(3)].

The MCO must ensure that members with special health care needs have an individualized clinical and behavioral treatment or service plan. Furthermore, the MCO shall conduct multidisciplinary staffing for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3)].

c. Access to Care

Recognizing that Medicaid members with SHCN or chronic health conditions require care coordination, AHCCCS requires MCOs to provide appropriate coordination. The contracts between AHCCCS and its MCOs require and define standards for access to specialists (e.g., through a standing referral or an approved number of visits), and structure of programs and operations in order to serve members' conditions and identified needs in accordance with 42 CFR 438.208(c)(4). Additionally, the MCOs must have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these members.

In an effort to improve maternal and child health outcomes and increase access to life-saving health care services, AHCCCS was able to extend postpartum coverage for a full year, effective April 1, 2023. Under previous Medicaid requirements, AHCCCS coverage ended after 60 days postpartum when a member was eligible solely based on a pregnancy. The American Rescue Plan Act of 2021 gave states the option to increase postpartum coverage to 12 months; this state option was codified permanently in the Consolidated Appropriations Act of 2022, and approved in the Arizona state budget in June 2022. AHCCCS covers more than half of all births in the state, meaning that this change in coverage has high potential to reduce health disparities among birthing people and their infants.

d. Monitoring

AHCCCS monitors quality and appropriateness of care and services for members, including members with SHCN, through annual MCO ORs, sharing of health risk assessments, review of required MCO deliverables set forth in contract, program specific performance measures, and PIPs. AHCCCS tracks and trends member grievances to identify potential access to care issues and/or the need for corrective actions and monitors the outcomes of required corrective actions.

4.4 Member Information Requirements

AHCCCS requires MCOs, as specified in the contract and in AHCCCS policy, to provide members with information including, but not limited to the following:

- Covered services,
- How to obtain services,
- How to choose a provider,
- A member's rights with respect to grievances and state fair hearings,

- Prior authorization processes and requirements,
- Advance directives,
- What constitutes an emergency,
- Language and cultural competency requirements, and
- Member financial responsibilities.

This information is required to be included in each MCO Member Handbook.

The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, and quality measurement and improvement. The AMPM and ACOM, as well as other AHCCCS Policies and Manuals, are incorporated by reference as part of the MCO contracts and provide more detailed standards information and requirements.

Requirements for enrollee information dissemination (42 CFR 438.10 and 42 CFR 457.110) as set forth for both AHCCCS and its MCOs are required to be adhered to; moreover, AHCCCS processes and protocols ensure that:

- The Application for Benefits complies with the information requirements for potential enrollees,
- The eligibility staff has access to the provider listing by MCO for their Geographic Service Area (GSA) and will share the MCOs' websites with the applicant,
- All enrollees and potential enrollees are informed of their enrollment rights as they pertain to their specific GSA and circumstances, and
- The beneficiary support system is available for all enrollees and potential enrollees to assist in making an informed decision when selecting their MCOs.

When enrollees and potential enrollees need help selecting a health plan, they may:

- Visit www.azahcccs.gov/choice, or
- Speak to a Beneficiary Support Specialist by calling 602-417-7100 or 1-800-334-5283.

AHCCCS also provides links to the AHCCCS MCO websites, member handbooks, provider searches, and drug formularies. This enables applicants to view the MCO networks from the AHCCCS website.

A variety of language assistance services, as well as auxiliary aids and related services, are available to individuals at no cost. Written materials for the AHCCCS program are available in both English and Spanish. In addition, bilingual staff are employed throughout AHCCCS to assist individuals who speak Spanish, to answer their questions, and provide information. AHCCCS also utilizes a vendor to provide oral interpretation services for all languages. Additional communication accommodations, such as large print eligibility letters, are provided for applicants and members who have visual, auditory, and/or other impairments. All vital materials include taglines, printed in a conspicuously visible font size, in a variety of the most common non-English languages spoken in the state. Vital documents also provide information about the availability of written translation and oral interpretation services, how to request auxiliary aids and services, and how to obtain information in alternative formats.

With regard to MCOs, AHCCCS imposes stringent requirements regarding availability of language assistance services and auxiliary aids and services at no cost. Written materials that are critical to obtaining services are made available in each prevalent non-English language in the MCOs' service area(s), and oral interpretation services are available in all languages. Tagline documents and

information describing availability of auxiliary aids and services are also mandatory requirements for MCOs.

4.5 Evidence-Based Clinical Practice Guidelines

AHCCCS requires MCOs (as specified in the contract) to develop, manage, and monitor provider use of the Evidence Based Programs and Practices (EBPP), including but not limited to the following:

- Intake, assessment, engagement, treatment planning, harm reduction efforts, data and outcome collection, and post discharge engagement,
- EBPPs used by all providers for the treatment of SUD and MOUD integrated into services as appropriate,
- Trauma informed care,
- Gender-based treatment,
- Lesbian, Gay, Bisexual, Transgender, and/or Queer/Questioning (LGBTQ),
- Culturally appropriate,
- Criminal involvement,
- Adolescent specific, and
- Development and use of promising practices, if no EBPP is available.

AHCCCS requires MCOs, as specified in AHCCCS AMPM Policy 1020, to develop or adopt and disseminate practice guidelines for physical and behavioral health services that are based on valid and reliable clinical evidence, consider the needs of the MCOs' members, and adopt in consultation with MCOs and National Practice Guidelines. MCOs must disseminate EBPP to all affected providers upon request to members/Health Care Decision Makers and potential members upon request. AHCCCS requires MCOs to annually evaluate the guidelines through the Medical Management Committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards [42 CFR 457.1233(c) and 42 CFR 438.236(b)(4)].

4.6 Sharing Best Practices

AHCCCS actively seeks to identify local, state, and national evidence-based best practices that promote and support member health outcomes. This includes programs and practices as identified by AHCCCS or self-reported by the MCOs annually via the Contractor Best Practices & Follow Up on Previous Year's EQR Report Recommendations submissions.

The MCO representatives are invited to share best practices at the QM/MM/MCH Contractor Meetings to facilitate discussion and system wide process improvement efforts within the practice area being addressed. In addition, AHCCCS routinely invites external SMEs to present information and best practices that pertain to key AHCCCS initiatives. Technical assistance is offered upon MCO request or upon AHCCCS direction based on MCO performance.

4.7 Sanction Philosophy and Notice to Cure

AHCCCS collaborates closely with its MCOs to ensure compliance with contractual and policy requirements and provides technical assistance whenever necessary to educate and train MCOs on specific requirements. AHCCCS does have the authority to issue administrative actions, including sanctions, to an MCO for failing to demonstrate compliance with contractual requirements. Each occurrence of non-compliance is evaluated for possible administrative action. Administrative actions may

include issuing of any of the following: Notice of Concern, mandated Corrective Action Plan (CAP), Notice to Cure, and/or Sanctions.

With few exceptions, the AHCCCS Compliance Committee evaluates recommendations for proposed sanctions, considers relevant factors, and determines the appropriate sanction to be imposed. The Compliance Committee may also consider less severe administrative actions that do not include a sanction, such as a Notice of Concern, a Notice to Cure, or a requirement of a CAP as part of their review process. ACOM Policy 408, Administrative Actions, describes the types of sanctions and subsequent monetary penalties or other actions that may result if an MCO fails to adhere to the provisions of the Medicaid managed care program or contract requirements. The policy also identifies the committee membership and considerations for determination of appropriate sanctions.

AHCCCS may impose monetary sanctions, suspend any or all further member enrollment, and/or suspend, deny, refuse to renew, or terminate a contract in accordance with A.A.C., R9-22-606, and the terms of the contract and applicable federal or state regulations. Written notice is provided to the MCO specifying the sanction to be imposed, the grounds for the sanction, and either the length of suspension or the amount of capitation to be withheld. The MCO may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed for, but are not limited to, the following actions:

- Substantial failure to provide medically necessary services that the MCO is required to provide to its enrolled members under the terms of its AHCCCS Contract,
- Imposition of premiums or charges in excess of the amount allowed under the 1115 Waiver,
- Discrimination among members based on their health status or need for health care services,
- Misrepresentation or falsification of information furnished to CMS or AHCCCS,
- Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider,
- Failure to comply with the requirement for physician incentive plan as delineated in contract,
- Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information,
- Failure to meet quality of care and quality management requirements,
- Failure to meet AHCCCS encounter standards,
- Violation of other applicable state or federal laws or regulations,
- Failure to fund the accumulated deficit in a timely manner,
- Failure to increase the Performance Bond in a timely manner, and
- Failure to comply with any other contract provisions.

AHCCCS may impose the following types of intermediate sanctions:

- Civil monetary penalties,
- Appointment of temporary management of an MCO,
- Allow members the right to terminate enrollment without cause and notify affected members of their right to disenroll,

- Suspension of all new enrollment, including auto assignments,
- Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur, and
- Additional sanctions to allow under statute or regulation that address areas of noncompliance.

5. MCO Performance Monitoring

AHCCCS provides regulatory oversight and conducts performance monitoring of its MCOs through a variety of methods as outlined below.

5.1 Performance Measurement

AHCCCS utilizes performance standards and benchmarks that are based on national standards (e.g., NCQA National Medicaid Mean and/or CMS Medicaid Median data), whenever possible. AHCCCS and MCOs regularly evaluate metrics and other performance monitoring tools in order to promote effective and meaningful performance improvement for populations served.

5.2 Performance Measures

AHCCCS utilizes performance measures to monitor MCO compliance in meeting contractual requirements related to the delivery of care and services to members and evaluate whether MCOs are fulfilling key contractual obligations. Additionally, performance measures are an important element of the agency's approach to transparency in health services and Value Based Purchasing (VBP). MCO performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies, other community organizations, and other stakeholders.

AHCCCS considers the goals of the "Triple Aim'' when selecting and monitoring performance measures, as AHCCCS' performance measures are integral to each MCO's QM/PI Program [42 CFR 438.330(c)(1)(ii)]. Performance measure selection and the associated calculation methodologies align with those outlined in the CMS Adult and Child Core Set Lists and associated technical specifications. AHCCCS may utilize other performance measures and/or methodologies, such as National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), or develop methodologies for measurement that are reflective of the Arizona system of care delivery model.

MCOs are required to report performance measures identified in AHCCCS contracts and are expected to achieve the established performance measure standards. MCOs that provide LTSS shall also include LTSS-specific performance measures that examine, at a minimum, members' quality of life as well as rebalancing and community integration outcomes. AHCCCS compares MCO performance with Contract requirements, the national NCQA Medicaid Means and the CMS Medicaid Medians, which serve as the performance target for each contractually required performance measure for the associated measurement period. Performance measures are also evaluated based on a number of demographics in order to identify and reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. MCOs are expected to implement interventions aimed to improve performance and develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvements.

5.3 Performance Improvement Projects (PIPs)

Each MCO is required to conduct PIPs (in clinical and/or non-clinical areas) that are expected to have a favorable impact on health outcomes and member satisfaction. AHCCCS mandates that MCOs participate in PIPs selected by the agency; in addition, MCOs are required to identify and implement additional PIPs based on self-identified opportunities for improvement, as supported by root cause analysis, external/internal data, surveillance of trends, or other information available to the MCO. PIPs are developed according to 42 CFR 438.330 and are designed to correct significant systemic issues and/or achieve significant improvement in member health outcomes as well as member satisfaction. It is expected that the significant improvement is sustained over time, through the:

- Measurement of performance using objective quality indicators,
- Implementation of interventions to achieve improvement in access to and quality of care,
- Evaluation of the effectiveness of the interventions based on the performance measures, and
- Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)].

AHCCCS-mandated PIP topics are selected through the analysis of internal and external data/trends and may include MCO input. Topics take into account comprehensive aspects of member needs, care, and services for a broad spectrum of members or a focused subset of the population, including those members with special health care needs or receiving LTSS [42 CFR 438.330]. AHCCCS may also mandate that a PIP be conducted by one MCO, or a group of MCOs, according to a standardized methodology developed by AHCCCS. In consultation with states and other stakeholders, CMS may specify standardized performance measures and topics for PIPs to include alongside state-specified performance measures and PIP topics within state contracts [42 CFR 438.330(a)(2)].

For each AHCCCS-mandated PIP, AHCCCS develops a standardized methodology to measure performance, collect data, and conduct analysis. Utilizing various data (e.g., financial, population, disease-specific) and input from the MCOs, AHCCCS selects the project indicator(s) to measure MCO and aggregate level improvement. AHCCCS-mandated PIPs are posted on the AHCCCS Quality & Performance Improvement web page with applicable populations for each PIP defined within the associated PIP methodology. MCO-specific PIP interventions and results are outlined within the Annual EQR Technical Reports located on the AHCCCS Health Plan Report Card web page.

5.4 Regular Monitoring and Evaluation of MCO Performance

AHCCCS monitors and evaluates MCO compliance through ORs, the review and analysis of periodic reports as required in contract, program specific performance measures, and PIPs. Objectives of MCO monitoring and evaluation include:

- Determine if the MCO satisfactorily meets AHCCCS requirements as specified in contract, AHCCCS policies, A.R.S., A.A.C., and 42 CFR 438 Managed Care,
- Increase knowledge of the MCOs' operational encounter processing procedures,
- Provide technical assistance and identify areas where improvements can be made and to identify areas of noteworthy performance and accomplishments,
- Review progress in implementing recommendations made during prior reviews,
- Determine if the MCO is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures,

- Perform MCO oversight required by CMS in accordance with the AHCCCS 1115 waiver, and
- Provide information to an EQRO for its use as described in 42 CFR 438.364.

a. Operational Reviews

AHCCCS conducts administrative ORs of each contracted MCO at least once every three years, utilizing the 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 Contract requirements, AHCCCS policies, and additional federal and state requirements. AHCCCS establishes standards for operational, programmatic, and clinical focus areas. To evaluate an MCO's compliance with each standard, AHCCCS reviews the MCO's policies, procedures, records, reports, and information systems, as well as interviews key staff. Additionally, AHCCCS staff reviews the progress of implementing the recommendations made during prior ORs, determines each MCO's compliance with its own policies and procedures, and evaluates its effectiveness. Agency staff from the DHCS, the Office of the General Counsel (OGC) , the Division of Business and Finance (DBF), the Division of Grants and Innovation (DGI), OIG, and OIFA review the operations of the MCO, conduct file reviews, and interview key health plan staff.

To maintain compliance with regulatory requirements and AHCCCS contract standards, AHCCCS reviews the following focus areas (as applicable) at least every three years:

- Case Management,
- Corporate Compliance,
- Claims and Information Systems,
- Delivery Systems,
- General Administration,
- Grievance System,
- Adult, EPSDT, and Maternal Child Health,
- Medical Management,
- Member Information,
- Quality Management,
- Reinsurance,
- Third Party Liability,
- Quality Improvement, and
- Integrated Systems of Care.

Upon completion of an OR, MCOs are required to submit CAPs in any areas receiving a score of less than 95%. AHCCCS expects the vast majority of these CAPs to be implemented and closed within six months of AHCCCS' acceptance of the CAP. MCOs are required to submit a CAP update along with documentation demonstrating compliance to close each CAP.

AHCCCS may choose to review specific areas more frequently depending on identified needs. AHCCCS also uses the OR to increase its knowledge of each MCO's operational procedures, provide technical assistance, identify areas for improvement, and identify areas of noteworthy performance and accomplishment.

As a condition of the 1115 Waiver, AHCCCS performs extensive data validation. Known as encounter data, records of services provided are submitted to AHCCCS for all covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. AHCCCS also performs annual validation studies on MCO data to ensure that the data has been reported in a timely manner and is accurate and complete; sanctions may be imposed on the MCO based on the results of the data validation studies. AHCCCS provides technical assistance and training to the MCOs to support the MCOs' ability to meet AHCCCS requirements. OR and data validation results are reported to CMS in accordance with the 1115 Waiver's terms and conditions.

b. Grievance and Appeals

One of many critical objectives of the agency's grievance and appeals system is to advance and improve the quality, accessibility, and timeliness of health care services for AHCCCS members. AHCCCS has developed robust contractual requirements, which have been refined over time to ensure compliance with the agency's grievance and appeals system requirements. Contracts dictate member-focused standards designed to support the timely provision of medically necessary health care services by MCOs, focusing on improvements in members' health and well-being. In addition to detailed contractual requirements that promote these objectives, AHCCCS also promulgated specific administrative regulations and clarified policies to which MCOs must adhere.

The OGC is responsible for oversight of AHCCCS' Grievance and Appeals system. The OGC continually engages in the review of hearing cases resulting from appeals of adverse benefit determinations from managed care beneficiaries. Not only does AHCCCS monitor the number of beneficiary hearing requests filed against each MCO on a monthly basis, AHCCCS also reviews the categories of adverse benefit determinations to identify trends, outliers, and whether additional scrutiny of the MCOs service authorization process may be warranted. As mandated by 42 CFR 438.402, MCOs are permitted only one level of appeal.

Routinely, the agency's medical management department receives a listing of beneficiary requests for hearing from the OGC to review the adequacy of service authorization notices sent to beneficiaries pursuant to 42 CFR 438.404. Each substantive hearing case resulting from the appeal of an adverse benefit determination is individually reviewed to evaluate MCO compliance from both a procedural standpoint and a clinical perspective. This scrutiny includes consideration of the MCOs' handling of grievances and appeals pursuant to 42 CFR 438.406 to ensure beneficiary access, meaningful participation, and effective MCO review. When deficiencies or concerns are identified, including those that pertain to quality, accessibility, and timeliness of service, or the adequacy or timeliness of the MCO notifications pursuant to 42 CFR 438.404 and 42 CFR 438.408, they are identified in the hearing decision or presented for follow-up through other mechanisms to achieve compliance.

Deficiencies and areas of concern are communicated to the appropriate divisions within the agency to be addressed. As a result, compliance actions may be instituted against MCOs, and corresponding policies and guidance may be developed or clarified. All hearing matters that present quality of care concerns regarding service delivery, accessibility, or timeliness are referred to the agency's quality management department for thorough investigation. In addition, findings from OGC reviews of MCO hearing cases and member concerns directed to OGC are communicated within quarterly meetings to executive management and staff across the agency. These quarterly meetings are convened to evaluate MCO performance in a variety of operational areas. As part of the agency's continuing scrutiny of MCO quality, timeliness, and accessibility of health care delivery to members, OGC staff members participate in ongoing ORs of each MCO's grievance and appeals system which evaluates, in part, MCO compliance with member Grievance and Appeals requirements.

A meaningful recordkeeping system is vital and fundamental to an effective grievance and appeals system. Thus, consistent with 42 CFR 438.416, each MCO must comply with detailed recordkeeping requirements for all grievances and appeals in order to inform its ongoing monitoring processes and the continual refinement of its quality strategies. Through its ORs and oversight activities, AHCCCS assesses each MCO's recordkeeping system to determine its efficacy.

c. Ongoing Review and Analysis of Deliverables

To monitor compliance with rules, regulations, contracts, and policies on an ongoing basis, AHCCCS requires MCOs to submit a number of contract deliverables. Contract deliverables are due weekly, monthly, quarterly, annually, and on an ad hoc basis depending on the individual deliverable requirement. A chart of contract deliverables is included in the MCO contract; these deliverables may vary depending on the program. AHCCCS teams/units are responsible for reviewing submitted deliverables, specific to their respective areas, as part of the agency's ongoing MCO oversight efforts.

d. Program Plans

AHCCCS requires the MCOs to submit annual Program Plans, which delineate the implementation of a comprehensive approach, utilized to support high-quality and cost-effective services for all Medicaid members within Arizona, including those with special health care and behavioral health needs. The distinct set of annual Program Plans summarize general QM/PI, maternity and family planning, and medical management strategies, as well as population-specific requirements for EPSDT services (including dental services).

Each MCO is required to submit separate Program Plans for EPSDT, dental, maternity and family planning, medical management, and QM/PI. Each Program Plan must include a narrative, a prospective work plan, and a work plan evaluation. The narrative must identify operational and structural elements intended to achieve contractually required clinical, quality, and performance standards for its members. Prospective work plans focus on goals and methods for achieving performance and quality standards for the upcoming calendar year. Work plan evaluations offer an analysis of the previous year's activities related to quality and performance goals and strategies.

e. Performance Measure Monitoring Reports

MCOs are required to submit Performance Measure Monitoring Reports to the AHCCCS Quality Improvement Team. These deliverables provide self-reported MCO data for contractually required performance measures. Each MCO utilizes its prospective Work Plan to identify performance goals/objectives and related interventions. Within the Performance Measure Monitoring reports, the MCOs include an indication whether performance goals were met, an analysis of the results, identified barriers, and opportunities for improvement, if applicable.

In an effort to align MCO reporting across lines of business, the Performance Measure Monitoring Report template, attachment, and associated instructions provide essential guidance to effectively compare performance. In addition, a consolidated reporting format was created to efficiently facilitate the AHCCCS Quality Improvement team's review of Performance Measure Monitoring report submissions.

f. Meetings and Staffings

AHCCCS routinely conducts quality-driven meetings that facilitate staff education and/or the wide-spread dissemination of quality-related information specific to MCO performance. These meetings include, but are not limited to, the following:

- **Clinical Oversight Committee:** quarterly meetings facilitated and managed by the clinical unit (which includes the AHCCCS Cabinet Executive Officer and Executive Deputy Director, executive

management, and representatives across divisions), conducted to review and discuss MCO clinical and quality performance, and review clinical initiatives.

- **Operations Oversight Committee:** quarterly meetings facilitated and managed by the operations unit (which include the AHCCCS Cabinet Executive Officer and Executive Deputy Director, executive management, and representatives across divisions) and conducted to review MCO operational and financial performance.
- **Quarterly Quality Management/Medical Management/MCH/EPSDT Contractor Meeting:** quarterly meetings facilitated by the clinical unit (which include representatives from MCO quality management, medical management, MCH/EPSDT, behavioral health teams, and agency staff), to review quality objectives, policies and procedures, and provide resources and guest speakers who support overall quality efforts.
- **Quarterly Operations MCO Meetings:** quarterly meetings facilitated by the operations unit, for which over the course of a year, two of the annual meetings (including only the DHCS representation) and the other two meetings(including attendance by the AHCCCS Cabinet Executive Officer and Executive Deputy Director, executive management, and cross divisional representation) are conducted. The MCOs provide overall updates on their operations, including clinical updates and updates on strategic initiatives.
- **AHCCCS MCO Quality Improvement Workgroup Meetings:** monthly meetings facilitated by the Quality Improvement Team (which includes MCO and cross divisional representation), conducted to review and discuss matters pertaining to quality improvement including but not limited to Performance Measures, PIPs, and current initiatives.

5.5 Improvement/Interventions

To promote operational and quality improvement at the MCO level, AHCCCS requires MCOs to participate in technical assistance or training sessions when opportunities for improvement are identified. MCOs are also encouraged to request technical assistance when questions arise. Additionally, AHCCCS conducts quality improvement and quality management related training at the quarterly Quality Management/Medical Management, Maternal Child Health and EPSDT (QM/MM/MCH/EPSDT) meetings. AHCCCS has also established the following MCO requirements:

a. Review and Analysis of Program-Specific Performance Measures and Performance Improvement Projects

AHCCCS reviews performance measure and PIP data on a regular basis at the AHCCCS aggregate level, population level, and MCO level and compares the results with established performance standards specified in contract to identify trends, strengths, and opportunities for improvement. Appropriate action is conducted based on the analysis findings, which includes requiring MCOs to implement CAPs and/or AHCCCS providing technical assistance to MCOs.

b. Accreditation

As of October 1, 2023, AHCCCS requires MCOs to achieve Medicaid Health Plan Accreditation from the NCQA. MCOs serving the ALTCS-EPD population shall also obtain the NCQA Long-Term Services and Supports (LTSS) Distinction by October 1, 2024 or October 1, 2025, as applicable. DES/DDD is required to obtain NCQA Case Management (CM)-LTSS Accreditation by October 1, 2025. Additionally, all MCOs are also required to obtain NCQA Health Equity Accreditation by October 1, 2025.

MCOs are required to provide copies of their most recent Accreditation review documents to AHCCCS, in accordance with managed care regulation and Contractual requirements. Should the MCO renew or lose

its Accreditation (either due to non-renewal or revocation), the MCO shall provide AHCCCS written notification (in the case of losing its accreditation) or a copy of the renewal certificate, as applicable, within 15 calendar days of notification or receipt from the accrediting entity. Information regarding MCO Accreditation is available on the AHCCCS Health Plan Report Card web page.

AHCCCS reserves the right to assess Administrative Actions for an MCO that receives provisional or denied Accreditation status for a renewal survey.

For additional information related to the MCO NCQA Accreditation activities, please refer to the *Nonduplication Efforts* section of this report.

c. Quality Rating System

In accordance with the November 2020 updates to 42 CFR 438.334, AHCCCS intends to implement a Quality Rating System (QRS). Currently, AHCCCS utilizes its AHCCCS Health Plan Report Card to provide a comparison of MCOs by program related to the quality of care received by members enrolled in each MCO, members' satisfaction with their MCO, and how well the members' MCO met their expectations.

The AHCCCS Health Plan Report Card undergoes enhancements based on internal and external stakeholder feedback, as well as provides easy access to specific MCO related quality documents and information. AHCCCS looks forward to engaging with CMS in its development of mandatory measures and the associated methodology to be applied for its Medicaid QRS.

5.6 External Quality Review (EQR)

Through the procurement process, AHCCCS ensures the qualifications of its CMS-required EQRO for both competence and independence as outlined in 42 CFR 438.354. AHCCCS' EQRO is tasked with conducting an independent review of the MCOs in alignment with the CMS EQR Protocols. This review provides an independent analysis and assessment of the MCOs' performance, including associated strengths, opportunities for improvement, and recommendations to improve the MCOs' performance, as it pertains to the:

- Validation of state-required performance measures,
- Validation of state-required PIPs,
- Review of MCO compliance with specified standards for quality program operations, and
- Validation of MCO compliance with network adequacy requirements.

a. Nonduplication Efforts

42 CFR 438.360 allows the use of information from a Medicare or private accreditation review of an MCO to provide information for the annual EQR, in lieu of the EQRO conducting one or more of the EQR activities. As part of the agency's direction in requiring its MCOs to obtain NCQA Accreditation, AHCCCS is reviewing and evaluating which activities are considered deemable (whether in full or in part) and may be used for the purposes of providing information for the annual EQR. In addition, AHCCCS will retain the right to reinstate any monitoring activity considered "deemed" for any oversight process.

For additional information related to NCQA Accreditation, please refer to the *Accreditation* section of this report.

b. EQR Annual Technical Reports

EQR results (including strengths and opportunities for improvement) are presented within the Annual Technical Report(s) which summarizes findings on access to and quality of care. The EQR Annual Technical Reports include:

- A description of EQR activities,
- An overview of the AHCCCS program history and a summary of AHCCCS' Quality Strategy goals and objectives,
- An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs,
- Performance measure results and analysis,
- Results and analysis of member satisfaction surveys, as applicable
- Performance improvement project results and analysis,
- Organizational assessment and structure results and analysis,
- Network adequacy results and analysis, and
- Information related to nonduplication efforts, as applicable.

EQR Annual Technical Reports are posted on the AHCCCS website and made available in accordance with 42 CFR 438.364. The EQR Annual Technical Reports are considered companion documents to the Quality Strategy, as they are utilized to further assess the effectiveness of the current quality goals, objectives, and strategies, as well as provide a roadmap for potential updates.

6. Network Adequacy

In order to ensure MCO network adequacy, AHCCCS has developed a number of network adequacy and availability of services standards to address the requirements of 42 CFR 438.68 and 42 CFR 438.206, as outlined below:

6.1 Provider Network Development and Management Plan (Network Plan)

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

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

- A formal attestation of the MCO's network adequacy,
- An evaluation of the previous contract year's network plan,
- How services are provided promptly and reasonably accessible in terms of location and hours of operation,
- How the MCO ties network implications from its Cultural Competency Plans to ensure cultural and linguistic needs are met,

- A summary and review of the MCO's VBP initiatives and COE programs, and
- The MCO's process for identifying and publicizing providers that offer reasonable accommodations for members such as physical access, accessible equipment, and culturally competent communications.

6.2 Minimum Network Requirements Verification

Every six months, the MCOs submit a completed Minimum Network Requirement Verification Report (Verification Report). In the Verification Report, MCOs describe their compliance with minimum network requirements, including time and distance requirements. These requirements identify 13 provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards specific to all MCOs, as well as some standards specific to RBHA and ALTCS EPD MCOs. Moreover, some standards are measured against specific member populations and the standards vary by county. These standards, as well as other minimum network requirements that define network access, are identified in ACOM Policy 436.

AHCCCS validates the Verification Report submissions by conducting an independent time and distance analysis of the MCOs' compliance. This analysis is completed through a contract with AHCCCS' EQRO. Each quarter, AHCCCS provides its EQRO with each MCO's Verification Report submission, the MCO's Provider Affiliation Transmission (PAT) file, the MCO's enrolled membership, and a file of all AHCCCS-registered providers. For each MCO, AHCCCS' EQRO produces a report comparing the Verification Report submissions with its validation.

6.3 Appointment Availability Monitoring and Reporting

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

6.4 Material Changes to the Provider Network

AHCCCS has established reporting requirements for when a significant change is made to an MCO's provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires MCOs to evaluate changes made to their provider networks for materiality. A material change to provider network is defined as any change in the composition of, or payments to, the MCO's provider network that would cause or is likely to cause more than 5% of its members in a GSA to change where they receive services, or any change impacting fewer than 5% of members but involves a provider or provider group who is the sole source of a service, or operates in an area with limited alternate sources.

When the MCO identifies a material change to the provider network, the MCO submits an assessment of the impact of the change, how it will transition members, a communication plan regarding the change, and how the MCO will monitor the impact of the change after transition. After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status of transitioning members.

6.5 Provider Changes Due to Rates Reporting

The MCOs must identify when a provider leaves or reduces services due to rates, regardless of whether the change has a material impact on the provider network. Specifically, ACOM Policy 415 includes an attachment where plans report the name, type, whether the provider is a PCP, the region served, and number of members assigned to any provider leaving the network or reducing or diminishing their scope of services due to sufficiency of rates. The MCO must also conduct an analysis to determine if the loss is a material change to its network and requires more in-depth reporting under ACOM Policy 439.

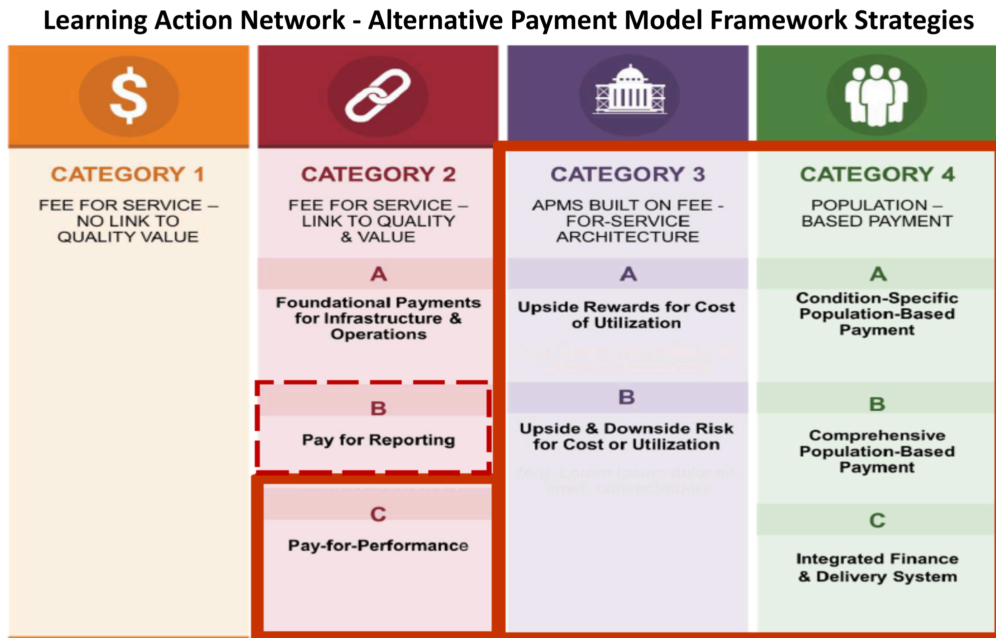
7. Payment Reform

AHCCCS is pursuing the implementation of long-term strategies that bend the cost curve while improving member health outcomes. A critical tool in achieving this strategic priority is VBP. 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 Payments (DAP), State Directed Payments, and Targeted Investments (TI). A critical tool in achieving payment reform is Value Based Purchasing which includes Withhold and Quality Performance Measure Incentives, Alternative Payment Models (APMs), and Performance Based Payments. The graphic display below outlines the long-term strategy AHCCCS employs to move along the continuum of APMs.

Learning Action Network - Alternative Payment Model Framework Strategies



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 paying for volume instead of quality.

AHCCCS has identified the following guiding principles for its VBP strategy:

- Engagement with stakeholders,

- Movement along the LAN-APM continuum,
- Balance prescriptive requirements while preserving MCO flexibility, and
- Data-driven decision making.

Through VBP, AHCCCS hopes to work toward achieving the following goals:

- Pay for value,
- Align payer and provider incentives,
- Innovate through competition,
- Improve quality, and
- Demonstrate results.

7.1 Alternative Payment Models

a. LAN-APM Target Requirements

AHCCCS is a committed partner in the Health Care Payment (HCP) Learning and Action Network (LAN) which strives to accelerate the health care system's adoption of effective APMs. Using LAN-APM Target Requirements, AHCCCS encourages contracted MCO activity in the area of quality improvement, specifically the development of initiatives conducive to improved health outcomes and cost savings.

AHCCCS has established contractually required targets for MCOs to contract with providers at a selected percentage of overall medical spend under VBP/APM arrangements. Furthermore, AHCCCS has specified the sub-requirement for the proportion of those VBP/APM arrangements that must be under HCP LAN-APM Framework Categories 3 and 4. There is a LAN-APM Target Requirement and sub-requirement specific to each AHCCCS program. For example, the acceptable APM for MCOs includes pay for performance, shared savings, bundled payment, and capitation.

b. Performance Based Payments

AHCCCS employs its APM Performance Based Payments (PBP) Initiative to encourage MCOs to develop initiatives designed to improve health outcomes and achieve cost savings by incentivizing providers to participate in APMs. PBPs are payments to providers for meeting certain performance measure targets that support LAN-APM initiatives. PBPs work to align incentives between MCOs and providers to increase the quality and efficiency of care by rewarding providers for improving performance across various quality measures to achieve cost savings and improve outcomes. MCOs are also able to pay out PBP based on providers' meeting Medical Loss Ratio (MLR) targets if linked to quality.

c. Withhold and Quality Measure Performance Incentive

The APM-Withhold and Quality Measure Performance (QMP) Incentive strives to encourage MCO activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the MCO and providers through APM strategies. AHCCCS implements this initiative under 42 CFR 438.6(b)(2) and 42 CFR 438.6(b)(3).

AHCCCS withholds 1% of each MCO's prospective gross capitation. MCOs are then evaluated on AHCCCS-selected NCQA-HEDIS® performance measures where the MCOs are able to earn back their withhold amounts, as well as an additional incentive payment if eligible.

MCOs are evaluated on the following two items:

- Relative performance on NCQA HEDIS® performance measures to other MCOs, and

- Performance on NCQA HEDIS® performance measures compared to benchmarks based on NCQA Quality Compass percentile data.

AHCCCS may consider including a health equity component to the Withhold and QMP Incentive in future years.

7.2 Differential Adjusted Payments (DAP)

Through DAP, AHCCCS is able 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 FFS rates and MCOs' contracted rates. DAP aims to distinguish providers that 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 last seven years has grown the program to support a variety of providers across the Arizona health care delivery system, including:

- Hospitals subject to All Patients Refined Diagnosis Related Groups (APR-DRG) reimbursement, excluding critical access hospitals,
- Critical access hospitals,
- Other hospitals and inpatient facilities,
- Freestanding emergency departments
- IHS/638 tribally owned and/or operated facilities,
- Nursing facilities,
- Integrated clinics,
- Behavioral health outpatient clinics,
- Behavioral health residential facilities
- Physicians,
- Physician Assistants,
- Registered Nurse Practitioners,
- Dental providers, and
- HCBS providers.

Each DAP is time-limited for one year only, although a similar DAP may be implemented in the subsequent year. Providers must re-qualify for a DAP each year even when the DAP criteria remain the same. Examples of DAP criteria include: increasing the percent of dental services that occur on the weekends, meeting or falling below the national average for the pressure ulcers performance measure for long-term care hospitals, and encouraging the distribution of naloxone for patients at risk of opioid overdose in emergency departments and hospital settings. AHCCCS MCOs are required to pass DAP increases through to their contracted providers, maintaining rates to match the corresponding AHCCCS FFS rate increase percentages.

7.3 State Directed Payment CMS Quality Criteria and Framework

42 CFR 438.6(c)(1)(iii)(B) provides AHCCCS with the flexibility to implement delivery system and provider payment initiatives under its MCO contracts. AHCCCS uses this federal authority to implement several state directed payment initiatives for AHCCCS managed care programs.

State directed payments occur when AHCCCS directs its MCOs to pay specific amounts to providers under their managed care contracts. The state directed payments work to advance delivery system reforms and/or performance improvement initiatives.

AHCCCS' state directed payments focus on advancing the goals and objectives of AHCCCS' Quality Strategy to improve performance and provide high-quality services to AHCCCS members. AHCCCS is required to identify quality criteria and a framework for each payment arrangement. AHCCCS uses the goals and objectives outlined in AHCCCS' Quality Strategy to determine how each state directed payment will be evaluated. When selecting performance measures for AHCCCS' state directed payments, AHCCCS maintains its efforts to support the agency's Quality Strategy. AHCCCS works across divisions, as well as with external stakeholders through workgroups, when selecting performance measures to ensure that facilities required to report the data are able to do so.

Annually, AHCCCS is responsible for preparing CMS preprints for each of its state directed payments for the following payment arrangements:

- Access to Professional Services Initiative (APSI),
- Differential Adjusted Payments (DAP),
- Hospitals Enhanced Access Leading to Health Improvements Initiative (HEALTHII),
- Nursing Facilities Supplemental Payments (NF)
- Pediatric Services Initiative (PSI),
- Safety Net Services Initiative (SNSI), and
- Targeted Investments (TI).

7.4 Targeted Investments Program

Integrating and increasing coordination amongst physical health, behavioral health, and health related social services is essential to reducing delivery system fragmentation and addressing individuals' whole person care needs. The TI Programs provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, MCOs are required to pass-through financial incentives to eligible Medicaid providers who meet certain benchmarks. The original TI Program (TI 1.0) aimed to increase integration at point of care and improve coordination of primary care and behavioral health services for high-risk individuals from FFY 2017 - FFY 2022. The renewed TI 2.0 Program (FFY 2023 - FFY 2027) expands on this foundation to include coordination with community service providers to address HRSN and identifying and addressing health inequities within each program participants' patient populations. TI participants are organized into the following areas of concentration: adult primary care, adult behavioral health, pediatric primary care, pediatric behavioral health, justice-involved adults, and hospitals (TI 1.0 only).

Financial incentives are paid on an annual basis to participating provider organizations based on requirements that vary over the five-year span of the TI Program.

At the end of Year One of the TI 2.0 Program (October 1, 2022 through September 30, 2023), participating providers were eligible to receive payment following acceptance into the program. For

Years Two and Three, directed incentive payments will be tied to completing core components and annual milestones including systems and process requirements related to the program initiatives. For Years Four and Five, payments will be based on meeting or exceeding performance improvement targets for specified quality measures. The core components include the systems and process requirements that are intended to help further coordination with other primary care, behavioral health, dental, and community service providers to address each individuals' needs and address health outcome inequities.

The core components and milestones for TI 2.0 program participants focus on: identifying anxiety and depression of new caregivers; identifying health related social needs of the member and their family; building referral and communication protocols with primary care, behavioral health, dental, and community service providers to address each individual's needs and inequities within their patient populations. For example, core components common to several areas of concentration include establishing health-related social needs policies with specific procedures delineating how a practice will: determine if a patient needs to be screened for HRSN, completing the screening with a tool including required domains, educating the patient on the impact of HRSN on the individual's quality of life, confirming if the individual wants a referral for an identified need, making a referral to a nearby community service provider that is available to address the HRSN, confirming the outcome of the referral, documenting the results in a closed-loop referral system, and documenting all related activities in the member's electronic medical record. In the fourth and fifth program years, TI 2.0 participants' payments will be based on their performance on clinical outcome measures that are aligned with AHCCCS' Quality Strategy, nationally recognized stewards and programs (e.g., NCQA HEDIS®), MCO withholds, CMS Core Sets, measures with significant evidence of inequitable outcomes, stakeholder feedback, and other measures as suggested by CMS.

8. Enabling Infrastructure: Data and Technology Systems

AHCCCS performs extensive data validation of managed care data. Records of services provided (encounter data) are submitted to the agency for all covered services, including institutional, professional, dental, and medication/pharmacy services. These encounter data are submitted in standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) and National Council for Prescription Drug Programs (NCPDP) formats and are subject to extensive data standards as well as extensive data quality editing. AHCCCS also performs annual validation studies on MCO encounter data to ensure that the data has been reported in a timely manner, is accurate, and is complete.

8.1 Pre-paid Medical Management Information System

AHCCCS operates the Pre-paid Medical Management Information System (PMMIS), a mainframe database processing system made up of multiple subsystems, each with distinct functions supporting managed care as well as FFS processes. In 2020, AHCCCS began a modernization effort for its aging mainframe system by adding a vendor-hosted provider management system to integrate with the mainframe. This new "modular" approach, first proposed by CMS in 2016 as a way of improving systems, is the future of the AHCCCS PMMIS, where individual subsystems will be replaced by external modules until eventually the mainframe can be fully retired.

AHCCCS collects encounter data from all MCOs. An encounter is a record of a covered Medicaid service rendered by a registered AHCCCS provider to an AHCCCS member who is enrolled with a MCO on the date of service. MCOs are required to submit encounters for services provided to AHCCCS members for paid services, services eligible for processing with no financial liability (e.g., Medicare and third-party payer), prior period coverage (PPC), and administrative denials. Complete, accurate, and timely reporting of encounter data is critical for the program's success. AHCCCS encounter formats follow national

industry standards and code sets for encounter submissions and editing (837P/I/D and NCPDP PAH). All submitted encounters are subject to AHCCCS-specific requirements, as well as approximately 500 edits/audits, including federal coding standards (e.g., correct coding and medically unlikely edits). Data validation occurs in both a structured/formal process and on an ad hoc basis, as well as includes review by certified coders to ensure that encounter data is complete, accurate, and timely. Actuaries perform ad hoc analysis at least as often as each rate-setting period. In addition, operational/actuarial reports measure MCO encounter throughput by date of service and date of submission.

8.2 Data Warehouse

The AHCCCS Data Warehouse provides a timely and flexible way to monitor and analyze performance measure data. Utilization data may be reviewed by multiple characteristics, such as diagnosis, service, age, gender, or other characteristic types. The Data Warehouse is maintained on a regular basis by an in-house team of programmers and configuration specialists. The Information Services Division (ISD) fields requests for system changes, additions, and maintenance, and completes additions or changes according to policy, legislative, CMS, or other requirements.

8.3 Health Information Exchange (HIE)

Since 2006, AHCCCS providers and MCOs have supported a single statewide HIE now called Contexture. Contexture is an integral part of AHCCCS' Quality Strategy and, as of April 2024,has grown to include 1,119 participating organizations representing laboratories, physical health and behavioral health providers, state agencies, 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. For a complete list of participants, visit Contexture's website at www.contexture.org.

AHCCCS and MCOs are using the clinical data that is available at Contexture to support health care coordination and care management operations. Based on member panels provided to Contexture, a variety of HIE alerts are distributed to advise of certain test results, hospital admissions, discharges, transfers, and other inpatient clinical events. Additionally, Contexture participates in the national Patient Centered Data Home (PCDH) and, based on zip code mapping, can provide alerts when a member has been seen at a facility outside of Arizona.

Contexture supports multiple AHCCCS programs, including the DAP program, the TI Program, and the agency's WPCI. Working strategically with AHCCCS, the HIE sets exchange standards and data sets for its participants that can be used to improve the quality of the data that is available at Contexture for AHCCCS providers and MCOs.

As of the Spring of 2024, Contexture is in the midst of migrating to a new HIE platform. Once completed, Contexture will be able to expand its services to participants and to AHCCCS, with the addition of electronic Clinical Quality Measures reporting and greater support for electronic Performance Measure Management.

8.4 Telehealth

Telehealth is the use of digital technology, such as computers, telephones, smartphones, and tablets, to access health care services remotely. AHCCCS members who cannot travel to an office can use these devices from their homes to attend health care appointments with their providers. Telehealth can make access to health care more convenient, saving time and transportation costs. It allows people in rural communities, people with limited mobility, people in high-risk populations, and people with limited time or transportation to have options to access their PCPs, medical specialists, and behavioral health

services, thereby eliminating barriers to care. It also helps to improve communication and coordination of care among members of the health care team and their patients.

AHCCCS covers all major forms of telehealth services, including telemedicine (real-time), asynchronous (store and forward), remote patient monitoring, and teledentistry. Telemedicine involves interactive audio and video in a real-time, synchronous conversation. It allows health care delivery, diagnosis, consultation, treatment, and transfer of medical data through interactive audio and video communications that occur in the physical presence of the patient. Asynchronous occurs when services are not delivered in real-time, but are uploaded by providers and retrieved, often through a secure online portal. Telephonic services (audio-only) use a traditional telephone to conduct health care appointments. AHCCCS also covers telehealth for 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. Conclusion

Improving and/or maintaining every member's health status, as well as increasing the potential for the resilience and functional health status of 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. Although AHCCCS has experienced significant quality improvements and successes, the agency and its MCOs continuously strive for:

- Improved performance by MCOs as a result of incentives, such as comparative reporting and financial incentives,
- Members who are better informed and who understand the value of preventive care,
- The ability for members with chronic diseases to maintain or improve their health,
- A physician community that is increasingly vested in the prevention of disease,
- Systematic research and sharing of best practices and lessons learned both locally and nationally,
- A significant reduction in the costs associated with treating disease and adverse health outcomes, and
- Broader participation in collaborative community efforts to improve the health status of Arizonans.

Built on a system of competition and choice, 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. Keeping a member-centered focus, AHCCCS will continue to work with partners and collaborate to advance innovative ideas that drive continuous improvement.

10. References & Works Cited

10.1 Links to Related Documents

AHCCCS Contracts and Manuals

AHCCCS Contractor Operations Manual (ACOM)

AHCCCS Contracts

AHCCCS Medical Policy Manual (AMPM)

AHCCCS Reports

AHCCCS 1115 Waiver 2016-2021

AHCCCS Strategic Plan: 2023-2027

AHCCCS Quality & Performance Improvement – Performance Measures and Performance Improvement Projects

Annual and Quarterly Reports to CMS

External Quality Review Organization Reports

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Appendix A

The Quality Strategy workgroup and executive leadership team considered community and stakeholder feedback received as part of the 2024 Quality Strategy update process. The table below includes a summary of community and stakeholder feedback received, whether the feedback was considered during the Quality Strategy Update activities, whether the feedback was incorporated into the Quality Strategy Update, and AHCCCS' response, action taken, or action proposed for each.

Community and Stakeholder Feedback Received (As of 3/30/2024)	Feedback Considered	Feedback Incorporated	AHCCCS Response, Action Taken, or Action Proposed
Are the goals tribal specific? Can there be information included that is tribal specific?	✔		In alignment with Managed Care Regulations, the Quality Strategy is intended to serve as a written strategy for assessing and improving the quality of health care and services furnished by the Managed Care Organizations; however, AHCCCS has elected to include information pertaining to Fee-for-Service, when feasible, throughout the document.
What will AHCCCS do with suggestions?	✔		AHCCCS evaluates and includes suggestions, where possible, when aligned with the requirements and intent of the Quality Strategy document. Feedback that does not align with the requirements and intent of the Quality Strategy document may be captured in other agency quality-based documents or efforts.
What information on social determinants of health is included?	✔	✔	Information on social determinants of health is incorporated into the Quality Strategy document by way of reference and a newly included Quality Strategy goal specific to the Closed Loop Referral System. For additional information related to social determinants of health, please refer to sections 2.6, 2.8f, and 3.4.
Will AHCCCS consider including an appendix to document stakeholder feedback received and highlight changes made/not made based on the feedback received?	✔	✔	AHCCCS now includes an appendix that summarizes the feedback received through community and stakeholder engagement activities.
Recommendation to update "COE" to spell out as Centers of Excellence	✔	✔	AHCCCS ensures to spell out acronyms prior to their use in the document.
Recommendation to include a focus on or mention of Fraud, Waste, and Abuse efforts.	✔	✔	Information pertaining to Fraud, Waste, and Abuse is included within subsection 1.4 Investigations - QM/OIG Relationship.

Community and Stakeholder Feedback Received (As of 3/30/2024)	Feedback Considered	Feedback Incorporated	AHCCCS Response, Action Taken, or Action Proposed
Recommendation(s) to enhance focus on provider education, support, and transparency as it pertains to MCO quality improvement activities and initiatives, including a mechanism for providers to give feedback on quality improvement related items.	✔	✔	AHCCCS included a quality strategy goal specific to to enhance communication between MCOs and providers, including enhanced education and support pertaining to quality improvement related activities and initiatives.
Can AHCCCS consider including information on innovative MCO projects and initiatives related to Community Reinvestment dollars?	✔		AHCCCS will review this recommendation outside of the Quality Strategy update to determine alternative approaches for sharing more details specific to MCO projects/initiatives related to the Community Reinvestment Program.
Will AHCCCS consider adding a health equity goal or objective?	✔	✔	AHCCCS included a health equity related goal in the 2024 Quality Strategy update.
Recommendation(s) to enhance workforce development activities as a tool for leveraging quality improvement for the ALTCS population.	✔		AHCCCS is engaged in a number of workforce development initiatives outside of the current Quality Strategy update that focus on the recruitment and retention of a workforce that supports access to and quality of care. For additional information pertaining to current workforce developmental goals and activities, please refer to the *Workforce Development* section of this report.
Recommendation(s) to enhance case management activities as a tool for leveraging quality improvement.	✔		AHCCCS will review this recommendation outside of the current Quality Strategy update to determine how case managers may be further utilized to promote quality improvement.
Recommendation(s) to include a subset of goals for ALTCS, specific to the long term care population.	✔	✔	AHCCCS included a quality strategy goal specific to the ALTCS-EPD population.
Recommendation(s) to improve the uniform assessment tool (UAT) to help track and improve outcomes, identify the needs for specialty care, and improve network adequacy.	✔		AHCCCS will review this recommendation outside of the Quality Strategy update to determine the timing for the next UAT update and additional means for stakeholder engagement.

Appendix B

In order to demonstrate improvement in the health of AHCCCS populations, AHCCCS intends to monitor and evaluate performance of the following measures included as part of the Targeted Preventive Care (TPC) measure set.

Targeted Preventive Care (TPC) Measure Set[1]
Antidepressant Medication Management: Effective Continuation Phase Treatment
Asthma Medication Ratio
Breast Cancer Screening
Cervical Cancer Screening
Child and Adolescent Well-Care Visits
Childhood Immunization Status: Combo 3
Controlling High Blood Pressure
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9.0%)[2]
Immunizations for Adolescents: Combo 2
Lead Screening in Children
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing
Oral Evaluation, Dental Services
Prenatal and Postpartum Care: Postpartum Care
Prenatal and Postpartum Care: Timeliness of Prenatal Care
Topical Fluoride for Children
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity
Well-Child Visits in the First 30 Months of Life (15 Months)
Well-Child Visits in the First 30 Months of Life (30 Months)

*Measures in **bold** text utilize the hybrid methodology*

[1] *Measures may be updated based on changes to the CMS Adult and Child Core Set Lists*

[2] *Lower rates indicate better performance*