Arizona Health Care Cost Containment System

Contract Year Ending 2019
External Quality Review Annual Report

for

Arizona Long Term Care System (ALTCS) Contractors

July 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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Contents

1. Executive Summary

Overview of the Contract Year Ending (CYE) 2019 External Review

The Code of Federal Regulations (CFR) at 42 CFR §438.3641 [1-1] requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide.

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

- Validation of performance improvement projects (PIPs).
- Validation of performance measures (PMs) required in accordance with §438.330(b)(2).
- A review conducted within the previous three-year period to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Subpart D of §438.

For contracts starting on or after July 1, 2018, and no later than one year from the issuance of the revised external quality review (EQR) protocol, according to requirements set forth in §438.68, the Centers for Medicare & Medicaid Services (CMS) has established validation of MCO, PIHP, or PAHP network adequacy as a mandatory activity.

In accordance with the 42 CFR §438.358(a), the state; its agent that is not an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]); or an EQRO may perform the mandatory and optional EQR-related activities.

As permitted by CMS and incorporated under federal regulation at 42 CFR Part 438, Arizona Health Care Cost Containment System (AHCCCS) elected to retain responsibility for performing the four EQR mandatory activities described in 42 CFR §438.358 (b). AHCCCS prepared Contractor-specific reports of findings related to each of the activities, and, as applicable, required Contractors to prepare and submit their proposed corrective action plans (CAPs) to AHCCCS for review and approval.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG) as its CMS-required EQRO to prepare this annual EQR technical report. This report presents AHCCCS' findings from conducting each activity as well as HSAG's analysis and assessment of the reported results for each Contractor's performance and, as applicable, recommendations to improve Contractors' performance.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 88/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR §438.364 Medicaid Program; External Quality Review, Final Rule.

HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR §438.354. HSAG has extensive experience and expertise in both conducting the mandatory activities and in analyzing information obtained from AHCCCS' reviews of the activities. Accordingly, HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to care and services that AHCCCS' Contractors provide.

To meet the requirements set forth in 42 CFR §438.364, as the EQRO, HSAG used information obtained from AHCCCS to prepare and provide a detailed annual technical report. The report summarizes findings on the quality of, timeliness of, and access to healthcare services, and includes the following:

- A description of the manner in which the data from all activities conducted were aggregated and analyzed.
- For each EQR-related activity conducted:
  - Objectives.
  - Technical method of data collection and analysis.
  - Description of the data obtained.
  - Conclusions drawn from the data.
- An assessment of each Contractor's strengths and weaknesses.
- Recommendations for improving the quality of care furnished by each Contractor including how the State can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.
- Methodologically appropriate comparative information about all Contractors (described in §438.310[c][2]), consistent with guidance included in the EQR protocols.
- An assessment of the degree to which each Contractor has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

HSAG has prepared the annual technical report for AHCCCS for 15 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

This executive summary includes an overview of AHCCCS' EQR activities as provided to HSAG and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the AHCCCS Contractors in complying with the AHCCCS contract requirements and the applicable federal 42 CFR §438 requirements for each activity. In addition, this executive summary includes an assessment of each Contractor's strengths and weaknesses related to the quality and timeliness of, and access to, healthcare services and HSAG's recommendations for improving the quality of services.

Additional sections of this annual EQR technical report include the following:

- Introduction to the Annual Technical Report: An introduction to the annual technical report, including a description of the EQR mandatory activities.

- Overview of the Arizona Health Care Cost Containment System: An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' strategic plan with key accomplishments for CYE 2019, AHCCCS' quality strategy, and waivers and legislative changes impacting AHCCCS' Medicaid programs.
- Quality Initiatives: An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those that are specific to the Arizona Long Term Care System (ALTCS) program for CYE 2019.
- Contractor Best and Emerging Practices: An overview of the Contractors' best and emerging practices for CYE 2019.
- Network Adequacy Update: A presentation of results for the network adequacy validation (NAV) and analysis conducted in 2019 and HSAG's associated findings.
- Organizational Assessment and Structure Performance: A presentation of results for the Contractor-specific operational review (OR) conducted in CYE 2019 and HSAG's associated findings and recommendations.
- Performance Measure Results: A presentation of results for AHCCCS-selected performance measures for each ALTCS E/PD Contractor and the Department of Economic Security/Division of Developmental Disabilities (DES/DDD), as well as HSAG's associated findings and recommendations for CYE 2018.
- Performance Improvement Project Results: A presentation of the CYE 2018 *Developmental Screening* PIP rates for DES/DDD.

Please see appendices A, B, and C for an overview of the AHCCCS methodology for the operational review, performance measure, and performance improvement project activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements.

Appendix D includes the network adequacy validation study methodology and ALTCS E/PD Contractor results by quarter and county. Appendix E includes the complete text of AHCCCS' CYE 2019 Network Adequacy Report.

Contractors Reviewed

During the CYE 2019 review cycle, AHCCCS contracted with the Contractors[1-2] listed below to provide services to members enrolled in the AHCCCS ALTCS Medicaid managed care program. Associated abbreviations are included.

- Banner University Family Care—Long Term Care (BUFC-LTC)

[1-2] Note: Title 42 CFR §438.2 defines "managed care organization (MCO)," in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." CMS designates all AHCCCS Contractors as MCOs. Unless citing Title 42 CFR, this report will refer to AHCCCS' MCOs as Contractors.

- Mercy Care—Long Term Care (MC-LTC)
- UnitedHealthcare Community Plan—Long Term Care (UHCCP-LTC)
- Arizona DES/DDD*

*Note: In March 2017, AHCCCS issued a Notice to Cure to DES/DDD citing violations to Contract YH06-0014 related to DES/DDD's process for identification of qualified vendors to provide timely authorized care and services to members, stating that DES/DDD's failure resulted in significant delays in obtaining necessary services for members. In addition, in April 2017, AHCCCS issued a Notice to Cure to DES/DDD citing violations to Contract YH06-0014 related to the failure of DES/DDD's care coordination processes to address delivery of medically necessary care and services to members. In each case, DES/DDD was required to submit a CAP.

From June 28, 2018, to July 3, 2018, AHCCCS' Division of Health Care Management (DHCM) conducted an on-site audit of DES/DDD in response to identified patterns of noncompliance with quality management requirements. The audit findings identified significant noncompliance with AHCCCS contract and policy requirements, immediate concerns regarding members' health and safety, and fundamental concerns about DES/DDD's quality management structure and operations.

In October 2018, AHCCCS issued a Notice to Cure to DES/DDD citing violations to Contract YH06-0014 for critical and substantial failures identified by AHCCCS during the on-site audit by DHCM of DES/DDD's quality management activities. Specifically, DHCM identified quality incident reports (IRs), including medication errors that DES/DDD had not evaluated, triaged using a clinician, or investigated. DHCM found that, not only had these incidents created a substantial backlog, DES/DDD's failure to timely and thoroughly review these incidents placed the health and safety of members at risk. DES/DDD was required to develop an action plan to address the failures and to hire a third-party agency/consultants, with the appropriate clinical expertise and qualifications, to assist the Contractor in completing the identification and resolution of each IR. In addition, DES/DDD was required to perform tracking and trending of all IRs and develop a comprehensive tracking report. Finally, AHCCCS located its quality manager on-site at DES/DDD for 90 days to be directly responsible for the management and oversight of DES/DDD's quality management unit.

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

The following section provides a high-level summary of HSAG's findings and conclusions about the quality of, timeliness of, and access to care provided to AHCCCS members.

Network Adequacy Validation

Each quarter, each ALTCS E/PD Contractor submits its contracted network and its internal assessment of compliance with the applicable standards to AHCCCS. HSAG's analysis of network adequacy

considered compliance with 12 AHCCCS-established time/distance standards for specific provider types and populations applicable to the ALTCS E/PD Contractors. Quarterly analytic results were assembled for the October 1, 2018, through June 30, 2019, measurement period for all beneficiary coverage areas for each ALTCS E/PD Contractor.

HSAG's quarterly network adequacy validation (NAV) determined that the Contractors' provider networks met AHCCCS' minimum time/distance network requirements. Each of the three ALTCS E/PD Contractors met all applicable minimum network standards during all quarters. Refer to Appendix D for the complete study methodology and ALTCS E/PD Contractor results by quarter and county. Refer to Appendix E for the complete text of AHCCCS' CYE 2019 Network Adequacy Report.

Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for each ALTCS E/PD Contractor during CYE 2019, and monitored the progress of all Contractors in implementing their CAPs. Overall, the strongest performance was in the Corporate Compliance (CC), General Administration (GA), and Reinsurance (RI) standard areas, wherein all ALTCS E/PD Contractors demonstrated compliance (standard area scores of 95 percent or above). Additionally, MC-LTC and UHCCP-LTC achieved full compliance (a standard area score of 100 percent) for five of the standard areas reviewed, and BUFC-LTC achieved full compliance for four standard areas. BUFC-LTC met compliance for seven of the 12 standard areas reviewed, and MC-LTC and UHCCP-LTC met compliance for six standard areas.

Standard areas with greatest opportunity for improvement include Case Management (CM); Adult, Early and Periodic Screening, Diagnostic and Treatment, and Maternal Child Health (MCH); Medical Management (MM); and Quality Management (QM). The ALTCS E/PD Contractors did not meet compliance and incurred the greatest number of CAPs during the CYE 2019 OR for these standard areas.

Overall Compliance Scores for the CYE 2019 OR Review Cycle

AHCCCS conducted a comprehensive OR for the ALTCS E/PD Contractors in CYE 2019. Table 1-1 details the percentage score for each Contractor for each of the 12 standard areas.

Table 1-1—ALTCS E/PD Contractors' Standard Area Scores for the CYE 2019 OR Review Cycle

Standard Area	BUFC-LTC	MC-LTC	UHCCP-LTC
Case Management (CM)	93%	82%	89%
Corporate Compliance (CC)	100%	100%	100%
Claims and Information Systems (CIS)	99%	98%	98%
Delivery Systems (DS)	87%	89%	90%
General Administration (GA)	100%	100%	100%

Standard Area	BUFC-LTC	MC-LTC	UHCCP-LTC
Grievance Systems (GS)	99%	100%	100%
Adult, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and Maternal Child Health (MCH)	72%	93%	75%
Medical Management (MM)	94%	94%	90%
Member Information (MI)	97%	100%	93%
Quality Management (QM)	83%	91%	86%
Reinsurance (RI)	100%	100%	100%
Third-Party Liability (TPL)	100%	87%	100%

As indicated in Table 1-1, all Contractors received 100 percent compliance for three standard areas (CC, GA, and RI) and met the 95 percent compliance threshold for two standard areas (CIS and GS). MC-LTC and UHCCP-LTC both received compliance scores of 100 percent for five standard areas, and BUFC-LTC received standard area scores of 100 percent for four standard areas. BUFC-LTC met the 95 percent compliance threshold on three standard areas, and MC-LTC and UHCCP-LTC both met the 95 percent threshold on one standard area. MC-LTC and UHCCP-LTC both received compliance scores below the 95 percent thresholds for six standard areas, and BUFC-LTC received compliance scores below the 95 percent thresholds for five standard areas.

Table 1-2 summarizes outcomes of the reviews conducted by AHCCCS related to the three Contractors' scores in the 12 standard areas. The table details the number, if any, of standards (within each standard area reviewed) with assigned corrective actions for each Contractor, as well as the total number of standards with assigned corrective actions for all three Contractors.

Table 1-2—CAP Summary per Standard Area by Contractor

Standard Area	BUFC-LTC	MC-LTC	UHCCP-LTC	Total Standards With Required Corrective Actions
Case Management	7	12	8	27
Corporate Compliance	0	0	0	0
Claims and Information Systems	1	1	1	3
Delivery Systems	4	4	2	10
General Administration	0	0	0	0

Standard Area	BUFC-LTC	MC-LTC	UHCCP-LTC	Total Standards With Required Corrective Actions
Grievance Systems	1	0	0	1
Adult, EPSDT, and Maternal Child Health	11	4	8	23
Medical Management	6	5	8	19
Member Information	1	0	2	3
Quality Management	11	8	10	29
Reinsurance	0	0	0	0
Third-Party Liability	0	1	0	1
Total	**42**	**35**	**39**	**116**

Table 1-2 details that, overall, there were 116 standards in which AHCCCS required the three Contractors to complete CAPs. Standard areas with the greatest opportunity for improvement, based on the number of standards with required CAPs, were CM, DS, MCH, MM, and QM. However, of the 27 standards in the CM standard area that AHCCCS assigned CAPs to, MC-LTC was required to complete 12.

Overall Strengths

All ALTCS E/PD Contractors received full compliance (100 percent) standard area scores in the CC, GA, and RI standards. All Contractors scored at or above the 95 percent compliance threshold for the CIS and GS standards. For the MI and TPL standards, only one Contractor scored below the 95 percent compliance threshold.

Overall Opportunities for Improvement and Recommendations

Contractors had the lowest performance in five standard areas (CM, DS, MCH, MM, and QM), as more than one Contractor scored below the 95 percent compliance threshold. The standard areas for which all three Contractors scored below the 95 percent compliance threshold were CM, DS, MCH, MM, and QM (three Contractors). Notably, the QM standard had the greatest number of standards in which scores were below the 95 percent threshold for all three Contractors. However, it is important to note that AHCCCS made extensive changes within its CYE 2019 Contract and Policy revision efforts specific to quality management and quality improvement. As a result of the policy changes, the QM standard area (inclusive of the quality management and quality improvement standards) underwent extensive review and revisions just prior to the CYE 2019 OR review cycle.

Based on the results from the CYE 2019 OR, HSAG makes the following general recommendations to ALTCS E/PD Contractors regarding ORs:

- Contractors should continue to conduct internal reviews of operational systems to identify barriers that affect compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.
- Contractors should continue to regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included when issued in Contractors' policies, procedures, and manuals (if impacted by the updates). Contractors should also continue to ensure that communications to all areas directly and indirectly impacted by these updates (including Contractor staff members, providers, subcontractors, and members) are provided and documented. In addition, Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes and implement periodic assessments of those standards reviewed by AHCCCS for which Contractors are found deficient.
- Contractors should continue to apply lessons learned from improving performance for one category of standards to other categories.

Based on AHCCCS' review of the ALTCS E/PD Contractors' performance in the comprehensive OR in CYE 2019, HSAG recommends the following:

- AHCCCS should consider implementing periodic assessments of those standards for which all Contractors did not meet the 95 percent threshold and providing technical assistance to all Contractors on identified areas of deficiency.
- AHCCCS should consider holding technical assistance meetings with Contractors that scored lowest in the ALTCS E/PD OR standards.
- AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the ALTCS E/PD Contractors' predominant issues and facilitate a group discussion on Contractors' policies and procedures.

Performance Measures

Aggregate Results for CYE 2018

AHCCCS collected data and reported Contractor performance for a set of performance measures for the CYE 2018 measurement period. The following tables display the performance measure rates with established minimum performance standards (MPS). An MPS had not been established for all reported performance measure rates. Contractor-specific results for performance measures with an MPS are

included in Section 8, with additional performance measures (i.e., without an established MPS) included in Appendix B of this report.

Throughout the report, references to "significant" changes in performance indicate statistically significant differences between performance from CYE 2017 to CYE 2018. The threshold for a significant result is traditionally reached when the *p* value is ≤0.05.

Findings

Table 1-3 and Table 1-4 present the CYE 2017 and CYE 2018 aggregate performance measure results with an MPS for the ALTCS E/PD Contractors and DES/DDD. Of note, the ALTCS E/PD aggregate rates include all members who met the enrollment criteria within the ALTCS E/PD line of business. The tables display the following information: CYE 2017 performance; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates; the significance of the relative percentage change, where available; and the AHCCCS MPS. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded the CYE 2018 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Table 1-3—CYE 2017 and CYE 2018 Aggregate Performance Measure Results—ALTCS E/PD Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	30.3%	34.6%	14.2%	P=0.415	85.0%
30-Day Follow-Up	51.0%	52.4%	2.7%	P=0.810	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	66.7	69.9	4.8%	—	80.0

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 1-4—CYE 2017 and CYE 2018 Performance Measure Results—DES/DDD

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	85.8%	87.3%	1.8%	**P<0.001**	75.0%
Annual Dental Visits					
2–20 Years	56.5%	56.9%	0.7%	P=0.444	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	96.2%	100.0%	4.0%	P=0.238	93.0%
25 Months–6 Years	89.2%	87.4%	-2.0%	**P=0.030**	84.0%
7–11 Years	92.1%	92.2%	0.1%	P=0.918	83.0%
12–19 Years	89.6%	89.8%	0.2%	P=0.677	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	43.4%	45.8%	5.5%	**P=0.001**	41.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.4%	55.2%	3.4%	P=0.154	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	45.9%	45.1%	-1.7%	P=0.698	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	16.6%	16.3%	-1.8%	P=0.711	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	39.1	44.0	12.8%	—	43.0

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Conclusions

Compared to the CYE 2018 MPS, the ALTCS E/PD Contractors' aggregate performance in the **quality**, **access**, and **timeliness** areas indicated opportunities for improvement as both *Follow-Up After Hospitalization for Mental Illness* measure indicator rates fell below the MPS.

Performance for DES/DDD within the **quality** area indicated opportunities for improvement, with three of four (75.0 percent) measure rates (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Breast Cancer Screening*; and *Cervical Cancer Screening*) falling below the MPS. *Adolescent Well-Care Visits* was the only performance measure rate within the **quality** area that exceeded the MPS for DES/DDD.

DES/DDD demonstrated positive performance in the **access** area, exceeding the MPS for five of six (83.3 percent) performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services* and all four *Children and Adolescents' Access to Primary Care Practitioners* indicators).

Additionally, the ALTCS E/PD Contractors' aggregate and DES/DDD's performance measure rates in the Utilization domain (*Ambulatory Care [per 1,000 Member Months]*) should be monitored for informational purposes.

Please see Table B-1 in Appendix B for more information about the assignment of performance measures with an MPS to the Quality, Timeliness, and Access areas.

Recommendations

HSAG recommends that AHCCCS work with the ALTCS E/PD Contractors to increase rates for both measure indicators in the Behavioral Health domain that failed to meet the CYE 2018 MPS. AHCCCS and the ALTCS E/PD Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Effective transition of care programs have been shown to reduce readmissions and exacerbation of symptoms related to mental illness by engaging the patient and family members (e.g., structured discharge checklist for accountability, awareness of red flags), establishing clear transition and care plans (e.g., follow-up appointments scheduled prior to discharge), utilizing transition coaches and providers (e.g., visits and phone calls to review illness management and questions), and ensuring effective provider communication (e.g., healthcare professionals' understanding of transition and care plan).[1-3] After the key factors related to the low rates are identified, AHCCCS and the ALTCS E/PD Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care.

Additionally, HSAG recommends that AHCCCS work with DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, AHCCCS and DES/DDD should examine potential barriers to women receiving breast cancer and cervical cancer screenings (e.g., provider misconceptions, lack of education, member anxiety) and implement multicomponent interventions to reduce structural barriers. Evidence suggests multicomponent interventions lead to greater effects when they combine strategies to increase community demand for, and access to, cancer

[1-3] Viggiano T, Pincus HA, and Crystal S. Care Transition Interventions in Mental Health. *Current Opinion in Psychiatry*. Vol. 25. No. 6. Nov. 2012.

screening.[1-4,1-5] AHCCCS and DES/DDD should ensure that members receive screenings in accordance with the United States (U.S.) Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and cervical cancer.[1-6,1-7]

Performance Improvement Projects

In CYE 2015, AHCCCS implemented the *E-Prescribing* PIP for all lines of business. The baseline year for this PIP was CYE 2014. The subsequent year was an "Intervention" year in which each Contractor implemented strategies and interventions to improve performance. AHCCCS conducted annual measurements to evaluate Contractor performance, with the first remeasurement reflective of CYE 2016 and the second reflective of CYE 2017. As of CYE 2017, AHCCCS considers the *E-Prescribing* PIP closed for the ALTCS Contractors.

AHCCCS implemented the *Developmental Screening* PIP for the AHCCCS Complete Care (ACC), Comprehensive Medical and Dental Program (CMDP), and the DES/DDD lines of business. Early identification of developmental delays is important when providing effective interventions. During well-child visits, pediatricians look for potential concerns using both developmental surveillance and discussions with parents about their concerns. If any issues are noted, pediatricians should follow through with a developmental screening. Thus, AHCCCS has approved developmental screening tools that should be utilized for developmental screenings by all participating primary care physicians who care for EPSDT-age members.

The purpose of the *Developmental Screening* PIP is to increase the number of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percentage of children receiving a developmental screening, followed by sustained improvement for one year.

The baseline year for this PIP was CYE 2016. The subsequent year was an "Intervention" year in which each Contractor implemented strategies and interventions to improve performance. AHCCCS conducted annual measurements to evaluate Contractor performance, with the first remeasurement reflective of CYE 2018.

[1-4] The Community Guide. *Cancer Screening: Multicomponent Interventions—Cervical Cancer*. Available at: https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-cervical-cancer. Accessed on: Mar. 12, 2020.
[1-5] The Community Guide. *Cancer Screening: Multicomponent Interventions—Breast Cancer*. Available at: https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-breast-cancer. Accessed on: Mar. 12, 2020.
[1-6] U.S. Preventive Services Task Force. *Breast Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening. Accessed on: Mar. 12, 2020
[1-7] U.S. Preventive Services Task Force. *Cervical Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening. Accessed on: Mar. 12, 2020.

AHCCCS considered that a Contractor demonstrated improvement when it achieved one of the following:

- Met or exceeded the AHCCCS overall average for the baseline measurement if the baseline rate was below the average and the increase was statistically significant.
- Demonstrated a statistically significant increase if its baseline rate was at or above the AHCCCS overall average for the baseline measurement.
- Was the highest-performing plan in any remeasurement and maintained or improved its rate in a successive measurement.

AHCCCS considered that a Contractor demonstrated sustained improvement when it achieved one of the following:

- Demonstrated how the improvement could be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, rather than an unrelated reason).
- Maintained or increased improvements in performance for at least one year after those improvements were first achieved.

Although DES/DDD increased its rate of children receiving a developmental screening, DES/DDD did not demonstrate significant improvement from baseline to Remeasurement Year 1.

Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each activity conducted. Table 1-5 is a summary of the follow-up actions per activity that AHCCCS completed in response to HSAG's recommendations during State fiscal year (SFY) 2017–2018. Some of the Contractors have included rates in their responses to the recommendations. Please note that AHCCCS has not approved or validated these rates.

Table 1-5—HSAG Recommendations With AHCCCS Responses to HSAG Recommendations

HSAG Recommendation	AHCCCS Activities
Operational Review	
AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors that scored lowest in the ALTCS OR standards, including guidance on how to complete a CAP.	Scores can change drastically each OR cycle based upon changes made in the tool related to review criteria. However, AHCCCS does offer Technical Assistance for each individual standard that does not meet the criteria. The MCO may request Technical Assistance or AHCCCS may offer based upon outcomes of the OR score.

HSAG Recommendation	AHCCCS Activities
AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for ALTCS Contractors' issues and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.	AHCCCS has a variety of venues to share lessons learned with Contractors. OR lessons learned are often discussed at each Contractor's Exit Interview when the OR is completed.
Performance Measures	
HSAG recommends that AHCCCS work with the ALTCS Contractors to increase rates for the behavioral health performance measure that failed to meet the CYE 2017 MPS. AHCCCS and the ALTCS Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Effective transition of care programs have been shown to reduce readmissions and exacerbation of symptoms related to mental illness by engaging the patient and family members (e.g., structured discharge checklist for accountability, awareness of red flags), establishing clear transition and care plans (e.g., follow-up appointments scheduled prior to discharge), utilizing transition coaches and providers (e.g., visits and phone calls to review illness management and questions), and ensuring effective provider communication (e.g., healthcare professionals' understanding of transition and care plan). After the key factors related to the low rates are identified, AHCCCS and the ALTCS Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase	AHCCCS Contractors not meeting the MPS set forth in the Contract for CYE 2017 Performance Measures were required to submit a proposed CAP for AHCCCS review and approval. This included the *Follow-Up After Hospitalization for Mental Illness* measure. Contractors are required to conduct root cause analyses as part of its CAP proposal and implement interventions that are aimed at addressing the identified barriers.

HSAG Recommendation	AHCCCS Activities
follow-up visits and improve member transitions of care.	
HSAG recommends that AHCCCS work with DES/DDD to increase preventive screenings for women. To understand the cause of the low rates, AHCCCS and DES/DDD should examine potential barriers (e.g., provider misconceptions, lack of education, member anxiety) to women receiving breast cancer, cervical cancer, and chlamydia screenings. Once the causes are identified, AHCCCS and DES/DDD should ensure that members receive screenings in accordance with USPSTF screening recommendations for breast cancer, cervical cancer, and chlamydia in women.	AHCCCS Contractors not meeting the MPS set forth in the Contract for CYE 2017 Performance Measures were required to submit a proposed CAP for AHCCCS review and approval. This included *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening* measures. Contractors are required to conduct root cause analyses as part of its CAP proposal and implement interventions that are aimed at addressing the identified barriers.
Performance Improvement Projects	
HSAG recommends that AHCCCS continue to encourage the collaboration among Contractors in the e-prescribing workgroup to improve these indicators.	Contractors demonstrate sustained improvement when they maintain, or increase, improvements in performance for at least one year after the improvement is first achieved. CYE 2017 reflected Remeasurement Year 2 data for all lines of business, with the exception of the Regional Behavioral Health Authorities (RBHAs) Contractors. Based on the CYE 2017 Rates, AHCCCS considered the *E-Prescribing* PIP closed for all Contractors with the exception of the before mentioned RBHAs. Therefore, this workgroup did not occur during CYE 2019.

Table 1-6 presents a summary of the follow-up actions per activity that MC-LTC and UHCCP-LTC reported completing in response to HSAG's recommendations included in the CYE 2018 ALTCS Technical Report. BUFC-LTC was not an ALTCS Contractor during the time the recommendations were applicable. AHCCCS did not require Bridgeway Health Solutions (BWY) to submit follow-up actions due to the close out of the Contractor, and DES/DDD was granted an extension to submit follow-up actions resulting in the receipt of the documents occurring outside of the review cycle for this annual report.

To note, all activities specific to the CYE 2016 OR and the *E-Prescribing* PIP for the ALTCS line of business were completed.

Additionally, the text located after each HSAG recommendation box was submitted by the Contractor. (HSAG only completed minor edits where it was appropriate.)

Table 1-6—MC-LTC's Responses to HSAG's Follow-Up Recommendations

MC-LTC
Performance Measures
HSAG Recommendation: Following a member's discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care plan. The ALTCS Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.
MC-LTC implemented new interventions during CYE 2019, including the following: • Elected to utilize it for our self-selected PIP topic. • Implemented interventions aimed at addressing the identified barriers. Additionally, MC-LTC is implementing interventions that are carrying over into CYE 2020. The MC-LTC team has twice weekly Institution for Mental Disease (IMD) meetings where treatment and discharge planning are discussed. The LTC case manager and the IMD staff are instructed to arrange a post-discharge appointment within seven calendar days of discharge. Members discharge from the IMD with a follow-up appointment in hand. The LTC case manager follows up with the member to ensure that the member attends the appointment. MC-LTC will continue to monitor the *Follow-Up After Hospitalization for Mental Illness* measure rates quarterly for statistically significant changes. As needed, MC-LTC will apply the Plan-Do-Study-Act (PDSA) model to assess the need to modify existing interventions or implement new interventions.
Performance Improvement Projects
HSAG Recommendation: • HSAG recommends that MC-LTC conduct a current barrier analysis to determine what interventions might be prioritized to increase performance in both indicators. • HSAG recommends that MC-LTC request a meeting with AHCCCS to reconcile the PIP indicator data.
Although MC's performance was below the AHCCCS aggregate, MC was successful in achieving the goal of increasing the number of prescribers electronically prescribing prescriptions and of increasing the percentage of prescriptions which are submitted electronically in order to improve patient safety. Improvements are evidenced in both the AHCCCS calculated data and the MC internal calculations.

Table 1-7—UHCCP-LTC's Responses to HSAG's Follow-Up Recommendations

UHCCP-LTC
Operational Reviews
HSAG Recommendation: Contractors should continue to conduct internal reviews of operational systems to identify barriers that affect compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations.
UHCCP-LTC adopts policies as needed and reviews said policies and procedures annually or as often as business or regulatory requirements dictate. UHCCP policies and procedures are instrumental in translating the laws and regulations as well as the company's strategies, mission, and values into documented guidelines for management and staff to follow and act upon.
HSAG Recommendation: Contractors should continue to regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included when issued in Contractors' policies, procedures, and manuals (if impacted by the updates). Contractors should also continue to ensure that communications to all areas directly and indirectly impacted by these updates (including Contractor staff members, providers, subcontractors, and members) are provided and documented. In addition, Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes and implement periodic assessments of those standards reviewed by AHCCCS for which Contractors are found deficient.
UHCCP-LTC presents new and substantially revised policies and procedures to the Policy Committee. The Policy Committee recommends approval or denial to Contractor management. If approved by Contractor management, the Policy Committee finalizes approval of the policy and procedure. Policies and procedures are reviewed annually or as often as business needs or regulatory requirements dictate. The Policy Committee is comprised of a cross-functional team designated to provide oversight and to ensure that communication to all areas directly and indirectly impacted by these updates is provided and documented. Policies are then converted to Portable Document Format (PDF) and uploaded to the UHCCP HEART SharePoint, where they can be accessible.
HSAG Recommendation: Contractors should continue to apply lessons learned from improving performance for one category of standards to other categories. Further, Contractors should continue to use opportunities to address and discuss issues identified during ORs.
The UHCCP Quality Management Committee is responsible for reviewing the findings from the AHCCCS OR and for overseeing the internal corrective actions led by the subject matter experts (SMEs) to address deficiencies. Oversight includes discussion and review of best practices as noted in previous ORs as a means to correct policies, procedures, and practices to address deficient standards.

UHCCP-LTC
Performance Measures
HSAG Recommendation: • ALTCS Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). • ALTCS Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care.
UHCCP-LTC conducted a root cause analysis in CYE 2018 and identified the following factors negatively impacting the performance measure: • Long-term care (LTC) members discharged from an acute inpatient facility with a primary discharge diagnosis of "mental illness" are not referred directly to a mental health practitioner unless the discharge orders indicate that the members need further evaluation or treatment. Rather, when the case manager completes the post-hospital assessment (PHA) the member is referred to the assigned primary care physician for follow-up medical services and to coordinate care. • Often, medical conditions or admissions to hospitals may exacerbate mental health conditions, but the underlying issue of a member's admission to a hospital may stem from medical etiology. • Members refuse a referral for behavioral health services (if they are not already established), preferring to seek treatment from their primary care physician or other specialty provider. • Technical specifications do not allow for an outpatient service by a mental health practitioner on the same day of the discharge from the acute inpatient facility. • Due to a change in the National Committee for Quality Assurance (NCQA) technical specifications for this measure, members are no longer considered compliant if the visit by a behavioral health professional occurred on the same day as discharge. National NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[1-8] rates as well as UHCCP rates dropped significantly as a result in this change in technical specification.
HSAG Recommendation: Following a member's discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care plan. The ALTCS Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.
During CYE 2018 and into CYE 2019, UHCCP-LTC implemented the following activities in order to improve the *Follow-Up After Hospitalization for Mental Illness* measure (including performing a follow-up call with the member):

[1-8] HEDIS® is a registered trademark of NCQA.

UHCCP-LTC
• Updated the PHA instructions to expand upon a question in which the case manager asks the member "other reason that caused the member to be hospitalized" to include a question or discussion if the member had been discharged from an acute inpatient facility with a principle diagnosis of mental illness. If the answer is "yes," the case manager refers the member to a mental health practitioner and documents their response. All case managers were trained on the PHA instructions by the LTC management team as well as ensuring the member is referred to a behavioral health professional and this training occurred in August 2018 and new hire training has incorporated this practice and continues today. • Include, in its oversight process, the PHA visit within two days of notification with follow-up with a member that had a principle diagnosis of mental illness upon discharge from an acute inpatient facility to ensure the member had a follow-up outpatient visit with a mental health practitioner. The case manager will document referrals and, if applicable, refusal reasons in the member record. The intervention began in August 2018 and is continuing.
HSAG Recommendation: Although the *Plan All-Cause Readmissions* performance measure rates are considered an area of strength, the rates for all three Contractors and the ALTCS aggregate declined significantly from CYE 2016 to CYE 2017. Despite the high performance for this measure, the Contractors should assess the cause of this decline to ensure that performance stays above the MPS in future years.
UHCCP's *Plan All-Cause Readmissions* measure rate for CYE 2017, as reported by AHCCCS, was 12.2 percent. This rate was below the AHCCCS MPS of 17 percent and below the statewide aggregate rate of 15.9 percent. UHCCP generates an internal report on the LTC performance measures and assesses the plan's performance on each performance measure monthly. In the event UHCCP does not exceed the MPS, an internal CAP is brought forth to the UHCCP Quality Management Committee for review and approval. UHCCP will continue this internal monitoring to ensure the health plan continues to exceed the MPS.
Performance Improvement Projects
HSAG Recommendation: Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
During CYE 2019, UHCCP-LTC continued to monitor the e-prescribing rates of providers.

2. Introduction to the Annual Technical Report

Description of EQR Activities

Mandatory Activities

As permitted by CMS within federal regulation and described in Section 1—Executive Summary, AHCCCS retained the functions associated with the three CMS mandatory activities for its Contractors:

- Validate Contractor PIPs—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- Summary and findings of Contractor's performance in complying with the AHCCCS' contract requirements and the federal Medicaid managed care regulations—review performed by AHCCCS.

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for its Contractors and to prepare this CMS-required EQR annual report of findings and recommendations.

For contracts that started on or after July 1, 2018, and no later than one year from the issuance of the revised EQR protocol, according to requirements set forth in 42 CFR §438.68, CMS is requiring validation of MCO, PIHP, and PAHP network adequacy as applicable.

Optional Activities

AHCCCS' EQRO contract with HSAG required HSAG to:

- Conduct quarterly validation of Contractors' network adequacy.

AHCCCS' EQRO contract with HSAG did not require HSAG to:

- Conduct any other CMS-defined optional activities (e.g., validating encounter data, conducting focused studies of healthcare quality, or assessing information systems capabilities).
- Analyze and report results, including providing conclusions and recommendations based on optional activities that AHCCCS conducted.

AHCCCS has numerous sophisticated processes for monitoring both the Contractors and its own performance in meeting all applicable federal and State requirements, its goals and internal objectives, and its policies and procedures. AHCCCS regularly prepares meaningful, detailed, and transparent reports documenting the results of its assessments. AHCCCS is transparent with performance results, posting to its website both provider performance reports and the required quarterly reports it submits to CMS. AHCCCS uses the information provided in the CMS-required EQR annual reports to honor its

commitment to transparency by posting final reports on its website. The EQR reports provide detailed information about the EQRO's independent assessment process; results obtained from the assessment; and, as applicable to its findings, recommendations for improvement. AHCCCS uses the information to assess the effectiveness of its current strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

Quality, Access, and Timeliness

CMS has identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains.

- **Quality**, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.[2-1]
- **Access**, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements ("standards" for the purpose of this report) defined under §438.68 (Network Adequacy Standards) and §438.206 (Availability of Services). Under §438.206, availability of services means that each state must ensure that all services covered under the state's plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that the MCO, PIHP, and PAHP provider networks for services covered in the contract meet the standards developed by the State in accordance with the network adequacy standards (§438.68). Any state that contracts with an MCO, PIHP, or PAHP to deliver Medicaid services is required by §438.68 to develop and enforce network adequacy standards.[2-2]
- **Timeliness**. Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2-2] Ibid.
[2-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

3. Overview of the Arizona Health Care Cost Containment System (AHCCCS)

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 (Strategic Plan). The description of the Strategic Plan includes the four goals:

- AHCCCS must pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.
- AHCCCS must pursue continuous quality improvement.
- AHCCCS must reduce fragmentation driving toward an integrated healthcare system.
- AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations.

AHCCCS Medicaid Managed Care Program History

Since 1982, AHCCCS, the single state Medicaid agency for Arizona, has operated under the authority of the federal Research and Demonstration 1115 Waiver, which has allowed for the operation of an integrated managed care model. AHCCCS uses State, federal, and county funds to administer pediatric, acute, long-term, and behavioral healthcare programs to the State's Medicaid members. AHCCCS has an allocated budget of approximately $13.8 billion to administer its programs, which provides services for 1.9 million individuals and families in Arizona through a provider network credentialed and contracted by its Contractors. AHCCCS' Acute Care Program was incorporated from its inception in 1982. In 1988, AHCCCS added the ALTCS program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (E/PD) populations. ALTCS provides acute care, behavioral health services, LTC, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for receiving care in a residential setting. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona DES/DDD. The ALTCS members account for less than 4.0 percent of the AHCCCS population, with approximately 21.7 percent of the costs.

In October 1990, AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. The Children's Health Insurance Program (CHIP) was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill (SB) 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors. In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UnitedHealthcare Community Plan (UHCCP). This was done in order to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and

behavioral care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions and enrolled in the ALTCS program, other than in DDD, were fully integrated into their ALTCS Contractors' provided services, including all primary, specialty, long-term, and behavioral healthcare related to the members' CRS conditions.

Before the integration of services into a single health plan that began in April of 2014, a member with SMI had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute health plan; the behavioral health services through the Regional Behavioral Health Authority (RBHA) contracted through the Division of Behavioral Health Services (DBHS); the Medicare system, if the member was also eligible for Medicaid and Medicare; and Medicare Part D for medications. On April 1, 2014, approximately 17,000 members with a serious mental illness (SMI) residing in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs. Since October 1, 2015, AHCCCS has contracted with two additional integrated health plans to provide both physical and behavioral healthcare services for SMI members who do not reside in Maricopa County .

Contracts were awarded on March 13, 2017 to three MCOs throughout Arizona to administer Arizona's integrated long-term care system for individuals who are elderly and/or physically disabled, based on the bidder's proposed approaches for care and treatment of ALTCS individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g., use of health homes, electronic health records [EHRs], coordinated case management, and collaboration between behavioral and physical health). Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly regarding individuals who have been determined to have SMI. The newly awarded long-term care system contracts were implemented on October 1, 2017.

Effective October 1, 2018, AHCCCS implemented a delivery system reform that allows members to access physical and behavioral healthcare services through a single integrated delivery system model ACC with a choice of seven health plans. In addition, on October 1, 2018, service delivery was restructured into three geographic service areas (GSAs): North, Central, and South. Members continue to have a choice of health plans in their geographic service areas and to have access to a network of providers and the same array of covered services. RBHAs continue to provide specific crisis services and to serve members with SMI, children in foster care, and DES/DDD eligible members. American Indian members have the choice of enrolling in an ACC managed care plan or the American Indian Health Program (AIHP) and a Tribal RBHA when available. American Indian members have the same access to Indian Health Service (IHS) providers, Tribal 638 providers, and Urban Indian Health providers.

AHCCCS Waiver Amendment Requests and Legislative Updates

AHCCCS Works Waiver Amendment

Through the 1115 Waiver Amendment, AHCCCS received CMS approval to implement requirements for the community engagement program, titled "AHCCCS Works," which is designed to provide low-income adults with the tools needed to gain and maintain meaningful employment, job training, education, or volunteer service experience.

The AHCCCS Works community engagement requirements will apply to able-bodied adults ages 19 to 49 who are not eligible for one of the following exemptions: pregnant women up to the 60th day of post-pregnancy; former Arizona foster youths up to age 26; members of a federally recognized tribe; individuals determined to have SMI; members with a disability recognized under federal law and individuals receiving long-term disability benefits; individuals who are medically frail or who have an acute medical condition; members who are in active treatment for a substance use disorder; full-time high school, college, and trade school students; survivors of domestic violence; individuals who are homeless; a designated caretaker of a child under the age of 18; a caregiver who is responsible for the care of an individual with a disability; and individuals who receive assistance through Supplemental Nutrition Assistance Program (SNAP), cash assistance, or unemployment insurance, or who participate in another AHCCCS-approved work program.

Members who are required to comply with AHCCCS Works requirements will participate in at least 80 hours of community engagement activities per month and report those hours by the 10th day of the following month. Engagement activities include: employment (including self-employment), less than full-time education, job or life skills training, job search activities, and community service. At the program start date, members will have a three-month period in which to become familiar with requirements and tools available to ensure their success. After that three-month period, members who do not complete at least 80 hours of community engagement in a month will be suspended from AHCCCS coverage for a two-month period, followed by automatic reinstatement.

Arizona has decided to postpone implementation of AHCCCS Works until further notice. This decision is informed by the evolving national landscape concerning Medicaid community engagement programs and ongoing litigation regarding this topic.

Prior Quarter Coverage Waiver Amendment

Through the 1115 Waiver Amendment, AHCCCS received CMS approval to limit retroactive coverage for some applicants to the beginning of the month in which the Medicaid application is filed, consistent with Arizona's historical waiver authority prior to January 2014. Coverage for new Medicaid members will be retroactive to begin the first day of the month in which the Medicaid application is received. Women who are pregnant (up to 60 days postpartum) and children under age 19 are exempt from this

change and may still apply to receive retroactive coverage for the three months prior to the month of application. Changes to retroactive coverage were implemented on July 1, 2019.

AHCCCS Technical Correction Amendment

CMS approved Arizona's request for technical amendments to the language in the Special Terms and Conditions (STCs) to reflect the delivery system changes resulting from the ACC managed care contract award. CMS has issued the following technical corrections, in accordance with Arizona's request:

- Simplified language in Waiver Authority 1, Section II Program Overview, and Historical Context and STCs 26, 29(g), 46, and 72(c).
- Updated STCs 18 and 41 to detail that Arizona Acute Care Program (AACP) beneficiaries receive behavioral and physical healthcare through a single ACC plan.
- Updated STCs 27 and 43 to reflect that CRS beneficiaries receive behavioral and physical healthcare through a single ACC plan.
- Updated STC 42 to reflect how beneficiaries under the ALTCS receive physical, behavioral, and LTC services.
- Updated STC 61, 68, and 69 Table 8 to reflect accurate measures and targets language for the Targeted Investments (TI) Program.

Legislative Updates

The following are the legislative bills, provisions of the SFY budget package, assigned workgroups, and changes to professional scope of practice and reporting requirements that impacted AHCCCS.

- House Bill (HB) 2754/HB2747—Implements appropriations for the following state agencies and programs:
  - Eliminates a mandatory enrollment freeze on the KidsCare program due to declining federal funding participation and fully funds the program.
  - Creates a licensure type for secure behavioral health residential facilities.
  - Provides additional state funds for Graduate Medical Education.
  - Additional funding for LTC providers.
- SB 1296—Aligns the training and testing requirements for direct care workers with the training and testing requirements of assisted living caregivers, allowing for easier transitions for workers between in-home care and caregiving in an assisted living facility.
- SB 1450—Integrates physical and behavioral health under a single plan (the Comprehensive Medical and Dental Program) for foster children across the state.

The fiscal year (FY) 2020 budget package included the following:

- The amount of $527,018,800 for Adult Expansion Services, which includes a decrease of $36,059,100 for formula adjustments on federal matching.
- Total of $9,990,000 for behavioral health services in schools.
- The amount of $100,000 for a suicide prevention coordinator to assist school districts and charter schools in suicide prevention efforts.
- Incorporates a decrease of $85,367,400 to transfer funding and administration of behavioral health services for people with developmental disabilities to the Department of Economic Security.
- The amount of $3 million in General Medical Education funding in health professional shortage areas, as well as one-time funding of $750,000 from the general fund to graduate medical education in community health centers to address healthcare provider shortages in northern Arizona.
- The reductions required by the Bipartisan Budget Act of 2018, which represents reductions in federal Disproportionate Share Hospital (DSH) funding by 31.7 percent in FY 2020 and by 63.4 percent in FY 2021, respectively. The DSH amount is now $117.3 million.

Enacted legislation requires the following new reports:

- On or before January 31, 2022, AHCCCS shall complete a third-party study on the costs and effectiveness of secure behavioral health residential facilities for individuals with an SMI, taking into account the impacts on outcomes related to health, employment, and interactions with the criminal justice system.
- On or before January 2, 2020, requires AHCCCS to submit annual reports on the availability of inpatient psychiatric treatment both for adults and for children and adolescents who receive services from the RBHAs, that include the following:
  - The total number of inpatient psychiatric treatment beds available and the occupancy rate for those beds.
  - Expenditures on inpatient psychiatric treatment.
  - The total number of individuals in this state who are sent out of state for inpatient psychiatric treatment.
  - The prevalence of psychiatric boarding or holding psychiatric patients in emergency rooms for at least 24 hours before transferring the patients to a psychiatric facility.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The strategic plan identifies AHCCCS' mission, vision, and the agency's core values:[3-1]

[3-1] *AHCCCS Strategic Plan State Fiscal Years 2018-2023 Available at*: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdfAccessed on: October 29, 2018.

- AHCCCS Vision: Shaping tomorrow's managed healthcare…from today's experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality healthcare to those in need.
- Core Values:
  - Passion: Good health is a fundamental need of everyone. This belief drives us, inspires and energizes our work.
  - Community: Healthcare is fundamentally local. We consult with, are culturally sensitive to, and respond to the unique needs of each community we serve.
  - Quality: Quality begins as a personal commitment to continual and rigorous improvement, self-examination, and change based on proper data and quality improvement practices.
  - Respect: Each person with whom we interact deserves our respect. We value ideas for change, and we learn from others.
  - Accountability: We are personally responsible for our actions and understand the trust our government has placed on us. We plan and forecast as accurately as possible. Solid performance standards measure the integrity of our work. We tell the truth and keep our promises.
  - Innovation: We embrace change, but accept that not all innovation works as planned. We learn from experience.
  - Teamwork: Our mission requires good communication among interdependent areas inside and outside the agency. Internally, we team up within and across divisions. Externally, we partner with different customers as appropriate.
  - Leadership: We lead primarily in two ways: by setting the standards by which other programs can be judged and by developing and nurturing our own future leaders.

The strategic plan offers four overarching goals:

1. Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.

- Increase use of alternative payment models and AHCCCS fee schedule differentiation for all lines of business.
- Reduce administrative burden on providers while expanding access to care.
- Successfully implement program integrity strategies.
- Modernize 1115 Waiver to provide new flexibilities to the State.

2. Pursue continuous quality improvement.

- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care coordination initiatives to improve health outcomes.
- Develop comprehensive strategies to curb opioid abuse and dependency.

3. Reduce fragmentation driving toward an integrated sustainable healthcare system.

- Establish a system of integrated plans and support provider integration to better serve all AHCCCS members.
- Leverage integrated Health Information Exchange (HIE) to improve outcomes and reduce costs.
- Improve access for individuals transitioning out of the justice system.

4. Maintain core organizational capacity, infrastructure, and workforce planning that effectively serves AHCCCS operations.

- Promote activities that support employee engagement and retention and successful succession planning.
- Strengthen system-wide security and compliance with privacy regulations.
- Continue implementation of the Arizona Management System.

Key Accomplishments for AHCCCS

Following are key accomplishments highlighted by AHCCCS in the AHCCCS Strategic Plan, SFYs 2018–2023:

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding.
- AHCCCS successfully awarded the ALTCS request for proposal (RFP) and transitioned over 9,000 members on October 1, 2017.
- The ALTCS program began implementing a new eligibility system in November 2017.
- The Office of Human Rights eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The Office of Human Rights has 2,504 individuals identified as requiring special assistance and provides direct advocacy via assignment to 702 members.
- AHCCCS implemented a new assessment policy and streamlined demographic reporting to reduce provider and member administrative burdens.
- AHCCCS received approval from CMS to begin the American Indian Medical Home program and has begun the process of implementation.
- AHCCCS received approval for a $300 million Targeted Investments Program, helping facilitate integration at approximately 500 provider sites across the state.
- AHCCCS established new value-based purchasing (VBP) strategies for nursing facilities (NFs) and providers who utilize e-prescriptions.
- AHCCCS completed a rebase of the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology, better aligning inpatient reimbursement with current data.

- AHCCCS Leadership Academy was established, providing an opportunity annually for 30 staff to broaden perspective about the Agency's mission, explore key issues within healthcare, better understand the healthcare delivery system, and build personal networks.
- AHCCCS expanded access to Hepatitis C medication while lowering overall drug costs.
- AHCCCS implemented several strategies to combat the opioid epidemic, including implementing seven-day opioid-naïve fills.
- Cross-agency collaboration between AHCCCS, Arizona Department of Corrections (ADC), and county justice partners resulted in more than six thousand incarcerated individuals having AHCCCS coverage immediately upon their release from incarceration.
- The number of HIE providers increased from 250 to 350.
- AHCCCS increased the funding for physicians who are affiliated with graduate medical education by $40 million.
- AHCCCS implemented a new reimbursement methodology for freestanding emergency departments.
- AHCCCS Office of the Inspector General completed a review by CMS; the results were positive.
- AHCCCS transitioned approximately 130,000 acute members as part of the closures of Phoenix Health Plan and Maricopa Health Plan.
- AHCCCS began registering board-certified behavior analyst (BCBA) providers.
- AHCCCS held four quarterly tribal consultations, which saw the largest turnout in AHCCCS history.
- AHCCCS completed a request for information (RFI), held public meetings, and released the largest procurement in the history of Arizona for AHCCCS Complete Care.
- AHCCCS participated in the Repeal and Replace discussions and published timely analysis of proposed legislation.
- For CYE 2018, the overall weighted average capitation rate increase was 2.9 percent, which continues the overall trend for capitation rate growth of below 3 percent for the program.
- AHCCCS continued to have overall employee engagement scores that far exceeded the statewide average.

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency quality strategy must include all of the following:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.

- The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.
- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.
- A description of the State's transition of care policy.
- The State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.
- Appropriate use of intermediate sanctions for MCOs.
- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.
- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.
- Information relating to non-duplication of EQR activities.
- The State's definition of "significant change" related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

AHCCCS has had a formal quality assessment and performance improvement (QAPI) plan in place since 1994 and AHCCCS' Quality Strategy was first established in 2003. Since that time, AHCCCS has revised the Quality Strategy to reflect AHCCCS' innovative approaches to member care and continuous quality improvement efforts. The AHCCCS quality strategy was set for revision in CYE 2017. However, due to the introduction of proposed changes to the managed care regulations, AHCCCS elected to delay this revision until final publication was posted by CMS. AHCCCS has established an internal workgroup to head the expansive revisions that incorporate AHCCCS goals and initiatives, Contractor oversight, and the new requirements found within the managed care regulations. The revised Quality Strategy draft was completed, submitted to CMS for review and approval, and posted to the AHCCCS website on July 1, 2018.

AHCCCS' Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. AHCCCS designed the Quality Strategy to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. AHCCCS' Quality Strategy identifies, and documents issues related to those standards and encourages improvement through incentives or, when necessary, through regulatory action.

The Quality Strategy aligns with AHCCCS' mission and vision and the Strategic Plan, all of which outline overarching goals that provide direction for SFY 2018–2023. The Quality Strategy outlines AHCCCS' commitment to transparency, stakeholder engagement, and the provision of quality care and

services to members. Since 2003, the emphasis of AHCCCS' Quality Strategy has shifted from process measures to more comprehensive outcomes-based measurement and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status, providing focus on resilience and functional health of members with chronic conditions.

4. Quality Initiatives

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving quality of systems, care, and services. The draft July 1, 2018, Quality Strategy, Assessment and Performance Improvement Report (Quality Strategy); the 2018–2023 strategic plan, and the quarterly quality assurance/monitoring activity reports provided compelling evidence of AHCCCS' vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services, as well as improve member health outcomes.

Quality Initiative Selection and Initiation

AHCCCS has established an objective, systematic process for identifying priority areas for improvement and selecting new performance measures and PIPs. This process involves a review of data from both internal and external sources, while also taking into account factors such as the prevalence of a particular condition and population affected, the resources required by both AHCCCS and Contractors to conduct studies and impact improvement, and whether the areas are current priorities of CMS or State leadership and/or can be combined with existing initiatives. AHCCCS also seeks Contractor input in prioritizing areas for improvement.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- Identified priority areas for improvement.
- Established realistic, outcome-based performance measures.
- Identified, collected, and assessed relevant data.
- Provided incentives for excellence and imposed financial sanctions for poor performance.
- Shared best practices with and provided technical assistance to the Contractors.
- Included relevant, associated requirements in its contracts.
- Regularly monitored and evaluated Contractor compliance and performance.
- Maintained an information system that supported initial and ongoing operations and review of AHCCCS' quality strategy.
- Conducted frequent evaluation of the initiatives' progress and results.

Systemwide Quality Initiatives/Collaboratives

Administrative Simplification and the Integrated Model Update

On October 1, 2018, AHCCCS offered fully integrated AHCCCS Complete Care (ACC) contracts to manage behavioral health and physical health services to children (including children with Children's Rehabilitative Services [CRS] eligible conditions) and adult AHCCCS members not determined to have SMI. AHCCCS also proposed to preserve the RBHAs as a choice option and to provide a mechanism for affiliated Contractors to hold a single contract with AHCCCS for non-ALTCS members.

AHCCCS Complete Care

AHCCCS states that healthcare is most effective and efficient when it treats the patient holistically. Since its inception in 1982 and under the leadership of several directors, AHCCCS has worked to integrate physical and behavioral healthcare service delivery. AHCCCS has found that evidenced-based studies demonstrate mental health and physical health are dependent on each other and that optimal care includes that link. AHCCCS also stated that studies demonstrate the significant cost-savings resulting from integrating care.

Prior to October 1, 2018, most of the 1.8 million AHCCCS members in Arizona were enrolled in at least two managed care health plans—one for physical healthcare services and a second for behavioral healthcare services.

Throughout 2017 and 2018, AHCCCS worked to further this strategic goal of healthcare integration. In March 2018, AHCCCS took a large step toward this goal by awarding integrated managed care contracts to seven AHCCCS Complete Care (ACC) health plans. The seven ACC plans throughout the state will manage a network, provide all covered physical and behavioral health services, and be the only Medicaid payer to the ACC providers. The ACC plans will also provide services for members with CRS conditions. These CRS members had been restricted to a single plan and now have a choice of all ACC health plans offered in their service area.

Success was achieved through a committed team of AHCCCS staff throughout the agency that over the last two years achieved all of the following:

- Obtained stakeholder feedback.
- Conducted community forums.
- Issued and scored a request for proposal.
- Awarded ACC plan contracts without protest.
- Worked with ACC plans to ensure system and plan readiness to serve members.

- Undertook significant information system changes to ensure that members were enrolled correctly for integrated services and ACC plans and that providers had access to information by October 1, 2018.
- Made comprehensive policy and contractual changes as well as provided ongoing communication and education to the community, members, and staff.

The results of the October 1 implementation and transition of members to ACC plans have been incredibly successful. From the contract awards that were not protested, to the health plan and agency system transition on October 1, the reports have been positive.

With the implementation of ACC, more than 1.5 million AHCCCS members now have a single health plan for physical and behavioral healthcare services. A single health plan will be easier for members and providers to navigate, with one network and a single payer. One health plan can streamline care coordination at the health plan and provider levels and work to improve the member's whole health.

Executive Order 2016-06—Prescription of Opioids

On October 24, 2016, the Governor of Arizona, Douglas Ducey, signed Executive Order 2016-06 to address the opioid crisis affecting the nation and, in particular, the state of Arizona. In this order, the Governor indicated that Arizona has the ninth highest rate of opioid deaths in the nation, and that approximately 404 people in the state died of prescribed opioid overdoses in 2015. The State presented alarming statistics showing that during 2013 enough prescription pain medications were dispensed to medicate every adult in Arizona around the clock for two weeks.

The order authorized AHCCCS and the Arizona Department of Administration (ADOA) to adopt policies and rules that impose limitations to initial prescriptions of opioids for no more than seven days and initial and subsequent prescriptions to minors for the same period (seven days), except in cases of cancer and other chronic disease or traumatic injury.

As part of this initiative, the Governor also established the Arizona Substance Abuse Task Force to act as a coalition of leading experts, providers and members, and other community representatives. According to the Governor, this task force will provide recommendations on a variety of substance abuse-related issues, including access to treatment, evidence-based practices, neonatal abstinence syndrome, and medically assisted treatment best practices.

The overarching goal of this initiative is to reduce the prevalence of opioid use disorders (OUDs) and opioid-related overdose deaths. The initiative approach includes developing and supporting state, regional, and local-level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency. Strategies include:

- Increasing access to naloxone through community-based education and distribution as well as a co-prescribing campaign for individuals receiving opioid prescriptions exceeding morphine-equivalent daily doses and receiving combinations of opioids and benzodiazepines.

- Increasing access to and participation and retention in medication-assisted treatment (MAT).
- Reducing the number of opioid-naive members unnecessarily started on opioid treatment.
- Promoting best practices and improving care process models for chronic pain and high-risk members.

The Medication Assisted Treatment—Prescription Drug Opioid Addiction Program (MAT-PDOA) grant, awarded to AHCCCS in September 2016, aims to target states having the highest rates of primary treatment admission for heroin and opioids. The primary goal of AHCCCS' MAT-PDOA program is focused toward engaging individuals diagnosed with OUD and involved with the criminal justice system. Specifically, the intention is to focus on outreaching and screening individuals within four months of their release date to engage them in medication-assisted treatment (MAT) and provide care coordination as they reenter the community. The project also seeks to improve access to MAT services for these individuals by improving infrastructure and collaboration among criminal justice entities and opioid treatment programs (OTPs). Additionally, the project will expand infrastructure and build capacity for State, regional, and local collaborators to implement integrated strength-based treatment planning, screening, and assessment for co-occurring disorders for the target population by increasing participation in MAT services.

To date the MAT-PDOA program has enrolled 168 participants into the program to receive services. Among those enrolled, program outcomes include reductions in crimes committed, nights spent in jail, and drug-related arrests. The program has also produced an increase in gainful employment as well as increased housing acquisition and treatment retention. MAT-PDOA providers have expanded collaboration and engagement efforts with correctional facilities, re-entry centers, parole and probation departments, and drug courts. The program has also expanded services to the Graham County correctional facilities and drug court to assist an area that has been heavily impacted by the opioid epidemic and which, among other counties, has one of the highest overdose rates.

To expand training and education, AHCCCS will host two free MAT symposiums, in Mohave and Graham County, in efforts to display clinically effective prevention and treatment strategies to best serve those impacted by the opioid epidemic. Topics will also include current State initiatives being implemented to combat this rapidly emerging crisis. The content of the symposiums is designed for MAT providers, substance use disorder treatment providers, physical health providers, harm reduction organizations, justice system partners, and interested community members.

The Opioid State Targeted Response (STR) grant will enhance community-based prevention activities and treatment activities—to include offering 24/7 access to care points in "hotspot" areas throughout the state—increasing the availability of peer supports, providing additional care coordination efforts among high-risk and priority populations, and adding recovery supports.

During 2019, the following efforts supporting this initiative were made:

- Arizona opened six 24/7 centers of excellence (COEs) for opioid treatment on demand during year one. The COE is an opioid treatment program in a designated "hotspot" that expanded its hours to be open for intakes around the clock and for warm handoff navigation care post-intake. Arizona has

also opened four medication units in rural Arizona to make MAT more accessible among those communities. In addition, Arizona has added 1,045 certified Drug Addiction Treatment Act (DATA)-waivered practitioners. As of June 30, 2019, more than 17,700 individuals have been connected to OUD treatment through the STR and State Opioid Response (SOR) grants.

- AHCCCS launched a concentrated effort through the STR grant to increase peer support utilization for individuals with OUD. Through the STR grant, additional peer support navigators have been hired in identified hotspots in Arizona; and efforts to include peer support navigation in COEs, jails, EDs, and for first responders at the scene in hotspot areas have increased. Through STR funding, Arizona has launched a real-time auto-dispatch model with the Phoenix Fire Department (PFD); when PFD receives an opioid-related call, a peer support staff member from the 24/7 OTP clinic in Phoenix is also dispatched to arrive on the scene to help navigate individuals to resources. Arizona has also launched its first law enforcement "pre-booking" model in Tucson. Peers are called on scene to provide navigation to the 24/7 OTP as a mechanism for an alternative to incarceration. As of June 30, 2019, over 20,830 individuals have received peer support and recovery services through the STR and SOR grants.
- A total of 125,347 Naloxone kits have been distributed, resulting in 14,908 reported reversals.

Targeted Investments Program

On January 18, 2017, CMS approved Arizona's request to implement the TI Program to support the State's ongoing efforts to integrate the healthcare delivery system for AHCCCS members. The TI Program is AHCCCS' strategy to provide financial incentives to participating AHCCCS providers to develop systems for integrated care. The TI Program will make nearly $300 million available over five years to Arizona providers who assist AHCCCS in promoting the integration of physical and behavioral healthcare, increasing efficiencies in care delivery and improving health outcomes.

Pursuant to 42 CFR §438.6(c), the TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing healthcare delivery systems that improve care coordination and drive better health and financial outcomes. The TI projects will support children and adults with behavioral health needs (including children with or at risk for Autism Spectrum Disorder (ASD) and children engaged in the child welfare system) as well as individuals transitioning from incarceration who are AHCCCS eligible. The TI Program is expected to:

- Reduce fragmentation for both acute and behavioral health programs.
- Increase efficiency in service delivery for behavioral health members.
- Improve health outcomes for the affected populations.

As part of the AHCCCS TI Program initiative, use of the Early Childhood Service Intensity Instrument (ECSII), an incentive-based requirement, was adopted by the providers who volunteered to participate in the program for use with children birth to 5 years of age. The ECSII is a screening tool designed to examine risk and protective factors in the environment of infants and toddlers through the use of six major domains: quality of the relationship between child and caregiver; caregiving environment;

developmental, emotional, or functional status of the child; and degree of safety within the child's environment. Domain scores are used to help both the formal and informal systems of care that surround the child to coordinate services based on intensity of need.

The ECSII tool was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and is designed to identify intensity of services needed to improve early intervention outcomes for at-risk infants and toddlers. The tool promotes a collaborative and integrated approach among the various systems working on behalf of the child (behavioral and physical health, educational, foster care system, and State agencies). The ECSII is based on a child-centered, family, and team-driven approach. It is expected to identify the need for behavioral health intervention sooner than what may otherwise be possible, and to thereby improve outcomes.

To satisfy specific requirements for the TI Program ECSII, providers were required to document the practice's policies and procedures for use of the ECSII, and to attest that the results of the ECSII were in the electronic medical record. By September 30, 2019, providers were required to attest that the practice performed the ECSII 85 percent of the time and incorporated service intensity recommendations into the integrated treatment plan.

The following are highlights of the TI Program implementation activities conducted by AHCCCS during CYE 2019:

- Enhanced the reporting system for TI Program participants to submit attestations of milestone completion and to upload documents for validation.
- Collaborated with Health Current, Arizona's HIE, to onboard TI Program participants in order to ensure that they are able to receive admission, discharge, and transfer (ADT) alerts from the HIE, and to send EHR core data to the HIE.
- Developed resources to support TI participants' work to meet program objectives, including a video of participant experience/success.
- Enabled implementation of a Peer/Family training curriculum to meet a TI milestone for co-located justice clinics that requires training of peer and family support staff members. The TI Program partnered with Maricopa Integrated Health System to develop the first phase of the Peer/Family training curriculum, which is being used to train individuals providing Peer/Family services to justice-involved individuals who are served by the TI co-located justice sites.
- Consulted with the Arizona Department of Child Safety on development of provider participant milestone requirements related to children in foster care.
- Developed and implemented multiple communication avenues for participants and stakeholders, including a detailed and regularly updated TI webpage, direct email, a dedicated TI email address, and social media posts.
- Made numerous presentations on the TI Program to a range of internal and external stakeholders, explaining the integration and whole person care goals and objectives of the TI Program.

- Established an ongoing dialogue between AHCCCS and its MCOs to facilitate alignment between the TI Program guidance on enhanced provider-level integration and the MCOs' provider network integration initiatives, including regular meetings between AHCCCS and MCO medical directors.
- Toured and evaluated the program's following co-located justice sites: Community Health Associates Tucson, Terros, Spectrum, Southwest Behavioral, and Valleywise Health (formerly Maricopa Integrated Health System).
- Instituted participant focus groups to solicit input and feedback on year 3 milestone requirements and potential year 4 performance measure milestones.
- Teamed with Arizona State University to develop a Quality Improvement Collaborative for program participants that provides timely and actionable performance metric information and a performance management system to share best practices and disseminate the practical content needed to enhance program participants' milestone achievement.
- Submitted a Sustainability Plan on March 29, 2019, pursuant to Arizona's 1115 waiver demonstration STC 67. This Sustainability Plan was approved by CMS on August 12, 2019.

American Indian Health Plan Integration

In addition to the implementation of integrated managed care plans with ACC, AHCCCS has worked throughout the last year to integrate physical and behavioral healthcare and services throughout the state for members with CRS conditions who choose to enroll in AIHP.

Eligible American Indians currently have a choice of using managed care or the AHCCCS fee-for-service program, AIHP.

Prior to October 1, 2018, most members enrolled in AIHP were also enrolled in a RBHA or Tribal Regional Behavioral Health Authority (TRBHA) for behavioral health services.

As of October 1, 2018, American Indian members have the choice of integrated care: AIHP or an ACC health plan. AIHP members will also be able to choose care coordination through a TRBHA (when available).

Quality Strategy

During CYE 2018, an internal workgroup was established to lead the most recent overhaul of the AHCCCS Quality Strategy. The Quality Strategy supports the mission and vision of AHCCCS and is aligned with AHCCCS' Strategic Plan, which outlines overarching goals that guide AHCCCS' direction for SFY 2018–2023. The report outlines AHCCCS' commitment to transparency, stakeholder engagement, and ultimately a commitment to the provision of quality care and services to those served through Arizona's Medicaid managed care and fee-for-service system.

Arizona Management System (AMS)

Arizona Governor Doug Ducey has deployed a professional, results-driven management system to transform the way agencies think and do business. AHCCCS has fully embraced this system and is committed to tracking and improving performance daily. Across the agency, AHCCCS employees now meet regularly around huddle boards (approximately 110 across the agency) where staff can monitor performance and hold themselves accountable for results. Leaders routinely observe how the work is completed and assist staff in identifying waste and developing problem-solving skills. AHCCCS continues to gather data and work toward delivering results for the people of Arizona.

Suicide Prevention Plan

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15–29-year-olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4 percent of all deaths worldwide, making it the fifth leading cause of death in 2012.

In Arizona, suicide is a primary public health concern that touches urban and rural communities including people of all ages and backgrounds.

- Among children ages 10–14 in Arizona, suicide is the leading cause of death.
- On average, a suicide occurs every seven hours in Arizona.
- Arizona ranks 12th in the nation for deaths by suicide.
- A total of 1,310 Arizonans died by suicide in 2016—the youngest was 9 years old.
- Among American Indians or Alaskan Natives, the median age of death by suicide is 27 years old (compared to age 51 among Caucasians).

Governor Ducey issued a proclamation declaring September Suicide Prevention Awareness Month in Arizona, encouraging citizens to take part in addressing suicide in communities.

As a member of the Arizona Suicide Prevention Coalition, AHCCCS collaborates with State agencies, organizations, healthcare plans, lawmakers, and other partners to create a community-based plan to end suicide in our state.

Learning Community

AHCCCS developed a "Learning Community" for AHCCCS staff, where SMEs present on issues of topical interest. One such session was a review of the children's system of care. The session reviewed the topic from an historical perspective and considered how it has been modified in response to recent litigation for behavioral health services for children. The session also explored the impact to the new ACC plans as outlined in the contract. The audience was provided tools to use in reviewing contractual

deliverables associated with behavioral health services for children. As part of its commitment to quality improvement, AHCCCS reviews the feedback provided by the attendees to improve future presentations to ensure that the material is pertinent and germane to the mission of the clinical departments.

System Improvements

AHCCCS hosts various meetings to continue to direct system improvements:

- Monthly collaborative meetings with the Department of Children's Services/Comprehensive Medical and Dental Program (DCS/CMDP) to continue efforts to improve service delivery for children in the foster care system and to ensure availability of medically necessary services.
- Quarterly contractor meetings including DCS/CMDP, to review deliverable submissions and foster care data and to discuss system successes and improvements.
- Quarterly cross-divisional operational team meetings to further enhance service delivery efforts.

Through these meetings, various system improvements have been identified:

- Resource Packet—the frequently asked questions (FAQs) document has been expanded and renamed. It now includes more FAQs, information, and resources for foster, kinship, and adoptive parents related to available physical and behavioral health services.
- Behavioral health and crisis services flyers for foster and kinship that are updated annually.

AHCCCS developed a specific policy (AHCCCS Contractor Operations Manual [ACOM] 449), which outlines specific requirements for behavioral health services for children within custody of the Department of Child Safety and for adopted children.

AHCCCS created a quarterly dashboard to track and trend utilization for children in foster care; this dashboard is posted on the AHCCCS foster care webpage.

Long-Acting Reversible Contraceptives (LARCs)

AHCCCS implemented the LARC initiative to allow for LARC devices to be reimbursed outside of regular hospital payment. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their six-week post-partum office visits.

Summary of Activities Designed to Enhance the Medical Record Review Process

AHCCCS has initiated a statewide workgroup designed to develop a consistent behavioral health chart review tool. The tool will be designed to:

- Meet the CFR and State statutory requirements.
- Operate according to AHCCCS contractual guidelines.
- Provide consistency across the state with regard to clinical behavioral health practice.
- Allow for consistency of results in chart analysis and review.
- Allow for data comparisons across geographic service areas using consistent measurement of required chart elements.

Home and Community Based Settings Rules

The purpose of the Home and Community Based Settings (HCBS) Rules is to ensure individuals receiving HCBS are integrated into their communities and have full access to the benefits of community living. These new requirements, from CMS, impact individuals receiving services in residential and non-residential settings such as assisted living facilities, group homes, adult day health, day treatment and training, center-based employment programs, etc. After a public comment period, AHCCCS submitted Arizona's Systemic Assessment and Transition Plan to CMS in October 2015. The systemic assessment conducted by AHCCCS summarized Arizona's current level of compliance for HCBS settings and was approved by CMS in September 2017.

The Transition Plan outlines strategies the State will use to make sure all HCBS settings come into compliance by March 2022. AHCCCS engaged in multiple meetings and/or correspondence with CMS pertaining to the Transition Plan for the period of September 2017–February 2019. The updated Transition Plan referenced below contains revisions to the Transition Plan made in response to CMS feedback during that period. In February 2019, CMS confirmed the current revisions to the Transition Plan to date are satisfactory. CMS will not officially approve Arizona's Systemic Assessment and Transition Plan until after the first round of site-specific assessments have been completed, a public comment period is held, and the State's reports to CMS are satisfactory. In March through May 2019, AHCCCS held a public comment period including stakeholder forums, statewide, to provide information on updates made to the Transition Plan and solicit comments that will be used to help inform the implementation of the Transition Plan.

A copy of Arizona's Systemic and Transition Plan can be found on the AHCCCS website (http://www.azahcccs.gov/HCBS).

Data Stewardship Committee

In November 2018, AHCCCS selected a data governance manager, and one of the first objectives for the manager was to work with divisions to identify the key data owners across the agency and form the Data Stewardship Committee. The committee was formed in August 2019 and meets once a quarter to review progress of any workgroups, data governance monitoring reports, definition approval, and open data discussion. Members of the committee include subject matter experts from all the divisions that work with agency reporting and data, as well as with management. The committee's goals for CYE 2020 will

be to implement the charter and policies to create a solid foundation for upcoming data governance projects such as the data dictionary.

Notable accomplishments of the Data Stewardship Committee during CYE 2019 include:

- Implemented training modules for the agency to expand the agency's knowledge about data governance and stewardship. These trainings were completed by the agency's employees, with the exception of Contractors and temporary staff, and are now required for new employees.
- Started a monthly reporting newsletter to share knowledge, updates, and other important data topics with data users to improve quality and foster open communication.
- Formed workgroups to start working on data governance initiatives for the agency, such as the business glossary and data dictionary, that will standardize definitions and fields to prevent inaccurate results in reports since everyone at the agency will have the same definitions.
- Created a new data request form to help users request data with more business detail along with maintaining quality for the analyst by requiring certain checklist items be done before the report can be sent to the user.
- Implemented change control for report development so all required documentation and quality checks are verified as completed by the report analyst before a request can be closed.

Electronic Visit Verification

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), also known as the 21st Century Cures Act, in order to prevent a reduction in the Federal Medical Assistance Percentage (FMAP), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) and for in-home skilled nursing services (home health). After receiving approval from CMS, AHCCCS is scheduled to implement EVV on January 1, 2021.

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
- Time the service begins and ends

AHCCCS (in partnership with the MCOs) is using EVV to help ensure, track, and monitor timely service delivery and access to care for members, as well as using EVV to help reduce provider administrative burden associated with scheduling and hard copy timesheet processing.

More information on AHCCCS' EVV initiative can be found on the AHCCCS website (http://www.azahcccs.gov/EVV).

Other Systemwide Quality Initiatives/Collaboratives

During the reporting period, AHCCCS participated in the following systemwide quality initiatives. (Note: This is not an all-inclusive list.)

- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*: AHCCCS is revising the Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age guidance document to ensure that the most recent research on appropriate prescribing is provided to providers, children, and families. AHCCCS is also updating tools that provide best practice strategies related to infants and toddlers—including psychotropic prescribing, early childhood mental health intervention, and trauma-informed care. The document content focuses on the most current prescribing practices and psychotherapeutic approaches for use during early childhood, with the recommendation that psychotherapeutic approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention. To further ensure realization of the treatment recommendations within these tools, AHCCCS has begun a statewide Birth to Five initiative to address the unique needs of infants and toddlers. Additionally, AHCCCS is collaborating with CMDP for their Birth to Five learning collaborative.
- Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on ASD: In February 2016, the ASD Advisory Committee (appointed by the Office of the Arizona Governor in spring 2015) published a report of recommendations to strengthen the healthcare system's ability to respond to the needs of AHCCCS members with or at-risk for ASD, including those with co-morbid diagnoses. During 2017, two COEs opened in Maricopa County. ACC, the new contract for AHCCCS and the Contractors, is addressing the recommendation to integrate care for acute members. In addition, AHCCCS is developing a behavioral intervention policy that addresses this issue.
- Summary of Activities Designed to Enhance the Monitoring of Physical Health Providers: Arizona Association of Health Plans (AzAHP), comprised of all AHCCCS Contractors for Medicaid business except CMDP and the Arizona Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), offers a single point of contact for the Contractors and promotes consistency across the system. AzAHP works closely with AHCCCS discussing Contractor concerns, barriers, and challenges Contractors are asked to undertake. It also provides valuable feedback for consideration as the direct link to the care and services being provided. AHCCCS utilizes the AzAHP to provide stakeholder insight and to collaborate and promote new initiatives. AHCCCS has collaborated with AzAHP to provide consistent monitoring of physical health providers. This collaboration has historically allowed for uniform statewide review of primary care practitioners including internists, family practices, and obstetricians. AHCCCS began discussions with AzAHP regarding capacity to also monitor behavioral health providers throughout Arizona. Utilizing AzAHP as a monitoring agent facilitates consistency in quality monitoring and reduces burden on

practitioners because AzAHP serves as the single reviewing entity for multiple MCOs. AHCCCS is currently combining this effort with the development of a consistent tool during meetings conducted with the RBHAs during 2017 and early 2018.

- AHCCCS Quarterly Contractors' Quality Management/Maternal and Child Health Meeting: To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor's Quality Management/Maternal and Child Health Meeting.
- Clinical Integration: The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and Maternal and Child Health and EPSDT units, added a second behavioral health coordinator to support efforts for the entire clinical team. The addition of a behavioral health coordinator enhances the ability for clinical considerations, service delivery, and program and contract development—to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional staff with behavioral health expertise from within its workforce.

  Within the QM, Quality Improvement, and Maternal and Child Health and EPSDT units, other activities designed to enhance integration have involved utilization of performance and quality measurement activities that provide a greater focus on specific aspects of integrated care. Highlights include:
  - Required tracking of performance on the frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.
  - Tracking performance on prenatal and postpartum timeliness of care, with supplemental training provided to contracted health plan staff relative to physical and behavioral health aspects of perinatal mood disorders.
  - Implementation of regular community-based meetings open to AHCCCS membership—with focus on enhancing member and stakeholder involvement and investment in performance as well as on enhancing quality improvement activities for physical and behavioral healthcare.
- Involvement of Stakeholders and Community SMEs: Throughout 2017, AHCCCS continually involved stakeholders and community SMEs as members of AHCCCS committees, quality meetings, policy workgroups, and advisory councils. SMEs provided technical assistance, guidance, and advisement related to various areas and issues (e.g., special needs populations, consumer advocacy, ASD, early intervention, trauma-informed care, behavioral health system best practices, integrated care).
- Medical Director Meetings: AHCCCS involves medical directors from Contractors in quarterly meetings. These meetings are designed to inform medical directors of changes in policy, regulation, billing practices, and current or future system updates. Additionally, these quarterly medical director meetings are designed to provide information on best practices in medical, behavioral care, and/or prescribing practices.
- ADHS Bureau of the U.S. Department of Agriculture (USDA) Nutrition Programs: AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from Contractor education to Women, Infants, and Children (WIC) promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.

- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, is administered by the Division of Developmental Disabilities. Maternal and Child Health staff in the Clinical Quality Management unit at AHCCCS work with AzEIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzEIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. As an ongoing effort to promote care coordination and system clarification the Maternal and Child Health and EPSDT manager undertook extensive efforts to create detailed flow charts that outline the process from multiple points of entry and across many different MCO types and member conditions. These flow charts have been promoted at several stakeholder groups, with collaborative feedback. Once the charts undergo a final review, these tools will be made available on the AHCCCS website.
- The Arizona Partnership for Immunization (TAPI): Maternal Child Health staff attend on-going TAPI Steering Committee meetings and subcommittee meetings concerning community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI's Provider Awareness and Adult and Community Awareness committees continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents, and the community at large. In addition to the website, TAPI provides vaccination handouts. TAPI has a teen vaccination campaign (Tdap, meningococcal and human papillomavirus [HPV] vaccines) that involves provider education as well as parent and teen outreach. Protect Me with 3, a parent-focused campaign, reminds parents that their children still need them to protect them and to help with healthy decisions. Take Control, a teen campaign, addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.
- Health Current (formerly Arizona Health-e Connection): Health Current, a non-profit organization, is a health information exchange organization (HIO) and is the single statewide HIE. Health Current currently has 500 unique participants, which include hospitals, accountable care organizations, health plans, behavioral health providers, laboratories, ambulatory practices, long-term care providers, and more. (For a complete list of participants, Health Current maintains a count on their website: https://healthcurrent.org/hie/the-network-participants/). To improve care coordination, AHCCCS requires all managed care Contractors to join the HIE. Health Current electronically shares hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member's home HIE if that member seeks care outside his or her Arizona or "home" HIE.

  AHCCCS providers from across multiple programs (e.g. ACC, TI, and Differential Adjusted Payments/Value Based Payments) have been recruited and the number of total HIE participants from October 2018 to September 2019 has risen from 538 organizations to 649 organizations (a 21 percent increase). Of the total participants, 75 percent are AHCCCS registered providers.
- ADHS Bureau of Tobacco and Chronic Disease: In collaboration with ADHS, AHCCCS monitors the utilization of and access to smoking cessation drugs and nicotine replacement therapy programs.

AHCCCS members are encouraged to participate in ADHS' Tobacco Education and Prevention Partnership (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.

- Medicare and Medicaid Alignment for Duals: Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 64,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact on plan alignment related to dual-eligible members. The study compared national data for dual-eligible members enrolled in traditional Medicare fee-for-service to data for aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmissions rate.
- Early Reach-In: Contractors are required to participate in the criminal justice system "reach-in" care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff's office; Correctional Health Services; and Arizona Department of Corrections (DOC), including community supervision and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend member eligibility upon incarceration rather than terminating coverage. Upon the member's release, the member's suspension of AHCCCS eligibility is lifted, allowing for immediate care coordination activities. Using the 834 data file to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of MAT-eligible members. The Contractors, with the criminal justice partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointments, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.
- Foster Care Initiative: AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through CMDP and RBHAs. Adoptive children are typically AHCCCS eligible and enroll in an ACC health plan like any Medicaid-eligible child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care.
- Behavioral Health Learning Opportunities: With the advent of administrative simplification, AHCCCS recognized the need to provide learning opportunities for staff lacking behavioral healthcare experience and expertise due to previous historical hiring requirements for medically trained personnel. AHCCCS offers formal meetings as well as informal workshops, and lunch-hour trainings to ensure that staff had ample opportunities to increase behavioral health system

knowledge. Internal behavioral health SMEs, licensed behavioral health practitioners, and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma-informed care, perinatal mood disorders, and adult system-of-care processes for individuals with general mental health needs and SMI.

QM is providing additional behavioral health "Lunch and Learn" trainings for QM and QOC staff especially, with attendance open to other departments based on department need. Topics include the following:

- Regulatory requirements for individuals designated as having an SMI versus having general mental health and/or substance use needs (GMH/SU)
- Grant-based housing for individuals with SMI
- Short-term behavioral health residential services
- Crisis process and requirements
- Diagnostic categories and symptoms
- Best-practice and evidence-based clinical approaches for adults and children
- Mental health awareness
- AHCCCS Waiver process
- Meeting the needs of members with developmental disabilities and behavioral health challenges
- Coordination of benefits (e.g., AHCCCS, Medicare, commercial coverage)

- Workforce Development: Beginning October 1, 2018, AHCCCS instituted a requirement for Contractors to hire a Workforce Development Administrator, maintain a Workforce Development Operation, and as a part of the Network Development and Management Plan, to develop an annual Workforce Development (WFD) Plan. The WFD requirements have been adopted formally into policy in the AHCCCS Contractors Operations Manual, Policy 407, and the scope of the WFD requirements has expanded. Contractors spanning all lines of business are required to maintain an operational infrastructure for workforce policy management. The requirement addresses the Contractors' capacity to collect data, assess workforce development needs of the subcontracted provider network, develop a Workforce Development Plan, and monitor provider adherence to AHCCCS workforce requirements and to directly assist providers with workforce issues if needed. Each Contractor's WFD plan must incorporate required elements such as forecasts of workforce capacity and competency needs, and must identify strategic goals and implement initiatives to address those needs. The flexibility built into the planning process affords Contractors the opportunity to develop a plan responsive to membership and network needs. The Contractors also have the opportunity to jointly develop priorities that address common areas of need. For example, the Contractors' Workforce Development personnel are working in collaboration with AHCCCS' Workforce Development Administrator and the provider industry to create a competency-based training system. This multi-level system consists of a standardized approach to developing curricula for new employee orientation as well as basic, specialized, and advanced job-specific training programs. This virtual training system model is housed within a single learning management system (LMS) provided by Relias Learning. All ACC and RBHA Contractors share a portion of the cost to fund a contract for the LMS services provided by Relias Learning.

ALTCS Quality Initiatives/Collaboratives

During the reporting period, AHCCCS participated in the following quality initiatives. (Note: This is not an all-inclusive list.)

- ADHS Immunization Program and Vaccine for Children (VFC) Program: Ongoing collaboration with ADHS helps ensure efficient and effective administration and oversight of the federal VFC program. The VFC program representatives provide education to Contractors, regular notification to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State Immunization Information System (ASIIS), an immunization registry that can capture immunization data on individuals within the state. Staff also provide monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 Promoting Interoperability (previously meaningful use [MU]) public health requirements.
- Arizona Head Start Association: The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The meetings are attended by families participating in the Head Start program along with AHCCCS staff members and the AHCCCS Contractor Maternal and Child Health and EPSDT coordinators.

5. Contractor Best and Emerging Practices

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

Banner University Family Care-Long Term Care (BUFC-LTC)

- Diabetes Hemoglobin A1c (HbA1c) Control: In CYE 2019, BUFC-LTC worked to get the HbA1c testing to the MPS of 86 percent. The strategies included coordinating with Sonora Quest to track and monitor HbA1c tests and values and to conduct outreach to those members without a test on record or those with HbA1c values greater than 9 percent. BUFC-LTC case managers will assist members with high HbA1c levels (greater than 9 percent) by following up with providers and care givers so that interventions can be done quickly to lower the HbA1c levels. When members' HbA1c levels are out of control and they have only received one HbA1c test, the care managers work to have the test done more often to ensure that the interventions are working and that members are gaining control of their HbA1c levels. This intervention continues until the HbA1c levels are in appropriate range.
- Breast Cancer Screening: BUFC-LTC sends regular mailings to members regarding the importance of mammography with the aim to increase the number of members receiving an annual mammogram. In addition, BUFC-LTC had a breast cancer member gift card campaign that appeared to have improved the measures at least slightly for this population. Further, BUFC-LTC has worked with several imaging clinics and a mobile mammogram vendor to reach rural and hard-to-reach populations.

Mercy Care-Long Term Care (MC-LTC)

- Policy Review: In 2014, AHCCCS assigned a CAP to MC-LTC for noncompliance with timely review following an OR. As a result, MC-LTC established a best practice review process for all policies in accordance with regulatory, contract, and department requirements. The policy library holds policies (both active and retired) and desktops and workflows that are associated with the policies. The database sends out notifications to the policy owner prior to the annual review due date to review and collaborate with other departments and SMEs on updates to the policy and associated desktops. If applicable, automated emails are sent to the appropriate department informing it of the possible changes and/or possible additions to the member handbook or provider manual, prompting the department to conduct a review. Once the initial reviews are completed, the policy is reviewed by the policy review committee at the next scheduled meeting. Once the review process has been completed, and the Chief Medical Officer (CMO) and the Chief Executive Officer have conducted a final review, the policy is uploaded to the database. MC-LTC reports that, since implementing process and database enhancements to monitor and record policy changes and reviews, the process has resulted in a 100 percent compliance in CYE 2019.

- Asthma Medication Ratio (AMR): The NCQA HEDIS measure, AMR, evaluates adherence to asthma controller medications by members with persistent asthma. The measure is calculated at the member level by dividing the number of fills of asthma controller medications by the total number of asthma medications filled during the study period. MC-LTC reports that higher AMRs are associated with improved asthma control and decreased risk of emergency hospital care. MC-LTC set a goal of improving asthma-related QOC and decreasing the frequency of asthma exacerbations in members with an AMR less than 0.5 and a recent history of asthma exacerbations through member, case manager, and provider education provided by a clinical pharmacist.
- Hospital Readmissions Reduction Program (HRRP): HRRP focuses on coordinating care between providers, case managers, and pharmacy as members are discharged from the hospital. Eligible members are identified by a case management referral or by using the Inpatient Census Report. MC-LTC reports that, when care transitions are not provided in a coordinated and seamless manner, members face significant challenges when discharged from the hospital, leaving members (particularly vulnerable members) at risk for negative health outcomes. With the HRRP, MC-LTC aims to reduce hospital readmission rates and it is intended to supplement established case management programs.
- Pharmacy Supported Comorbid Condition Management Program: A clinical program, focuses on coordinating care between members, case managers, and clinical pharmacists to improve medication-related outcomes in complex high-risk members through the completion of a thorough clinical medication review. Per the Centers for Disease Control and Prevention (CDC), as an individual's number of chronic conditions increases, their risk for premature death, hospitalization, and poorly coordinated care also increases. Further, approximately 71 percent of the total healthcare spending in the U.S. is associated with care for individuals with more than one chronic condition. MC-LTC reports that approximately 61 percent of adult Medicaid members have a chronic or disabling condition, and that a significant portion of these members suffer from multiple chronic conditions, leaving members vulnerable to poor health outcomes and substantial healthcare expenditure. MC-LTC identifies members with multiple chronic conditions either through the clinical pharmacist or through case management referrals.
- NF patient discharges: MC-LTC reports that it works with members so they can live in the least restrictive and most integrated setting that will meet their needs. MC-LTC further reports that many members prefer to live at home or in the community; research demonstrates that living at home has many benefits (including increased safety, independence and self-determination, strengthened social network and proximity to friends and family, increased comfort and convenience, and a decrease in expenditures for the payer) and aligns with AHCCCS' plans to increase the number of members living at home or in the community. Therefore, MC-LTC developed and implemented interventions so members would have ongoing funds and could discharge to home or a lower level of care. MC-LTC has identified its target population to include single, NF residents with discharge potential, and whom had zero cost-sharing and had been enrolled with MC for at least two weeks. Case managers discuss discharge plans with members in the cohort, raise their awareness of the possibility of unrealized funds, and provide them with information and resources to assist them in applying for and receiving income for which they are eligible.

UnitedHealthcare Community Plan-Long Term Care (UHCCP-LTC)

- Internal Mortality Review: UHCCP-LTC developed a standardized process to analyze internally generated unexpected death data for all lines of business to identify potential QOC concerns, and track and trend for opportunities for improvement. Mortality data are obtained from claims data for all members receiving UHCCP benefits. To assist the process, a standard operating procedure was developed for the review analysis criteria and for the Mortality Review Committee reporting schedule. Additionally, a standardized template was created for reporting initial mortality reviews to the committee.
- Work Force Development: In CYE 2019, UHCCP's Provider Network Team continued to develop and implement value-based payment models that allow home- and community-based services (HCBS) agencies to earn additional bonus payments by meeting quality targets. The payment models were designed to align with quality metrics relevant to performance measurements and expected outcomes for an improved ALTCS member experience. UHCCP states that participating agencies can utilize this forum as an opportunity to earn incentives for their caregivers and treat shared ideas as both a recruitment strategy and an employee retention strategy.
- The UHCCP Provider Network Team also worked on developing a career ladder—collaborating with local high schools, community colleges, faith-based organizations, and community clinics—to educate on the Direct Care Worker profession. Incentives and assistance are provided to family members and other individuals interested in paraprofessional or nursing career paths. Additionally, UHCCP launched a transportation assistance program for direct care workers (DCWs) in CYE 2019. All DCWs who work for contracted attendant care agencies and provide critical care services to UHCCP-LTC members are eligible for transportation assistance in the event they experience a transportation barrier.
- Silver Alert Monitoring: As a result of a timely identification through a "Silver Alert" of an elopement event in 2018, systemic improvements were implemented. During CYE 2019, various nurses checked the "Silver Alert" website to identify individuals that had left alternative residential living facilities. The names were used to identify (through internal databases and the AHCCCS Eligibility website) if the member was receiving UHCCP-LTC benefits. If the individual was an ALTCS member, UHCCP case management was contacted to obtain information about the facility and if other members were residing there. Once the information was gathered, a health and safety visit was conducted.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

- Centralization of All IRs: In an effort to streamline DDD's IR review process, DDD started moving to a centralized IR system. The system will help DDD to receive, review, and properly distribute IRs quicker through its clinical triage and to decrease turnaround time. Currently IRs are being entered by its entry staff members in the districts, and its clinical triage staff members determine what incidents are identified as QOC and if a health and safety check is required. Incidents that do not

meet the QOC criteria are reviewed and sent back to the districts to address any non-QOC contractual concerns. DDD will monitor the enhanced review process (which began in September of 2019) through regular reporting and updates by staff members. As a result of the process changes, DDD expects quicker response times, while ensuring members' safety, QOC, and the appropriate level of care.

- Peer Review: DDD's peer review committee (a structured joint venture between the medical staff and administration) will review cases that have been reviewed by staff members referred to the committee for further review. The committee will be responsible for providing feedback to the CMO. The committee will also recommend courses of action to facilitate improvement or program services, while continuously looking for educational opportunities for DDD providers. DDD's goal is to ensure providers are held to AHCCCS standards, education is provided when needed, and that DDD members consistently receive quality care.
- Interrater Reliability (IRR) Testing: DDD has implemented a process for testing IRs for IRR between the original investigator and the supervisor. The IRR for each investigator is calculated using the number of times the original investigator and supervisor agreed on the leveling value across all triaged IRs divided by the total number of triaged IRs. A minimum of 10 percent of IRs will be randomly selected for auditing. DDD is working with staff members, providing ongoing training and encouraging feedback from staff members to identify process improvements. Once the review is complete, further discussions will be conducted regarding process improvements and what (if any) education and/or training is needed for staff members.

6. Network Adequacy Update

Beginning in CYE 2019, AHCCCS contracted its EQRO, HSAG, to support the validation and analysis of healthcare provider networks subcontracted to AHCCCS' ALTCS E/PD Contractors.[6-1] HSAG's analysis of network adequacy considers each ALTCS E/PD Contractor's compliance with 12 AHCCCS-established time/distance standards for specific provider types and populations.[6-2]

Each quarter, each Contractor submits its contracted network to AHCCCS along with its internal assessment of compliance with the applicable standards. This report presents quarterly analytic results for the October 1, 2018, through June 30, 2019, measurement period for all beneficiary coverage areas for each ALTCS E/PD Contractor.

In addition to the activities conducted by HSAG to validate the ALTCS E/PD Contractors' compliance with time/distance standards, AHCCCS measures network adequacy through a number of other mechanisms, as outlined in Appendix E.

Table 6-1 presents the total AHCCCS ALTCS E/PD beneficiary enrollment for each county as of July 1, 2019 (i.e., the day after the end of the CYE 2019 Quarter 3 measurement period). The total numbers represent all Contractors with ALTCS E/PD beneficiaries residing in the county.

Table 6-1—AHCCCS' ALTCS E/PD Beneficiary Enrollment by County, as of July 1, 2019

County	ALTCS E/PD Beneficiary Enrollment
Apache	86
Cochise	636
Coconino	220
Gila	271
Graham and Greenlee[6-3]	129
La Paz	51
Maricopa	18,256
Mohave	1,073
Navajo	271

[6-1] Validation of network adequacy is a mandatory external quality review (EQR) activity, and states must begin conducting this activity, described in CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While the protocol has not yet been released as of the publication of this report, HSAG's analysis of the Contractor's time/distance results aligns with current federal regulations.

[6-2] The AHCCCS Contractors Operations Manual (ACOM), Section 436—Network Standards, defines time/distance standards, as well as provider identification and beneficiaries' county assignment criteria. Available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436_Network_Standards.pdf.

[6-3] Due to Health Insurance Portability and Accountability Act (HIPAA) requirements, enrollment data reported for Graham and Greenlee counties have been combined.

County	ALTCS E/PD Beneficiary Enrollment
Pima	4,567
Pinal	922
Santa Cruz	333
Yavapai	1,081
Yuma	940

Table 6-2 presents the counts of ALTCS E/PD Contractors' provider locations identified for each time/distance network standard for CYE 2019 Quarter 3 (i.e., the April 1, 2019, through June 30, 2019, measurement period).

Table 6-2—Summary of ALTCS E/PD Provider Locations by Time/Distance Network Standard and Contractor, Quarter 3

Minimum Network Requirement	Count of BUFC-LTC Provider Locations	Count of MC-LTC Provider Locations	Count of UHCCP-LTC Provider Locations
Behavioral Health Outpatient and Integrated Clinic, Adult	377	404	441
Behavioral Health Outpatient and Integrated Clinic, Pediatric	377	404	441
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	207	221	172
Cardiologist, Adult	1,358	1,698	2,046
Cardiologist, Pediatric	1,502	1,882	2,238
Dentist, Pediatric	2,163	472	1,493
Hospital	162	113	121
Nursing Facility *(Only ALTCS E/PD Contractors)*	114	97	103
Obstetrics/Gynecology (OB/GYN)	1,384	2,212	3,726
Pharmacy	1,079	972	773
PCP, Adult	18,167	25,914	44,774
PCP, Pediatric	14,337	20,888	35,971

HSAG reviewed the ALTCS E/PD Contractors quarterly on 12 time/distance network standards applicable to the ALTCS E/PD line of business, and the ALTCS E/PD Contractors met all standards during each measurement period. Note that, in selected instances, an ALTCS E/PD Contractor reported county-specific time/distance compliance results for a standard in which HSAG's validation did not

identify any beneficiaries meeting the age requirements who would be considered for these standards. Additionally, there were instances when both an ALTCS E/PD Contractor and HSAG were unable to identify any beneficiaries meeting the age requirements who would be considered for these standards. These instances are indicated with an "NR" in the Appendix D tables and primarily occur among standards specific to pediatric beneficiaries (i.e., HSAG identified no pediatric beneficiaries for its time/distance calculation of the specific standard). Refer to Appendix D for results by ALTCS E/PD Contractor, quarter, and county.

Finally, all AHCCCS Contractors are required by state law to only contract with AHCCCS-registered providers. Saturation analyses considered the degree to which each ALTCS E/PD Contractor's provider network reflected available AHCCCS-registered providers when the ALTCS E/PD Contractor was not in compliance with time/distance standards. Following each quarterly NAV, HSAG conducted saturation analyses specific to the ALTCS E/PD Contractors and counties that failed to meet minimum network standards.

As part of the NAV implementation, AHCCCS developed a feedback process for ALTCS E/PD Contractors to review and improve the accuracy of their data submissions. Specifically, AHCCCS supplied each ALTCS E/PD Contractor with a copy of HSAG's quarterly analysis of its network adequacy, the saturation analysis identifying AHCCCS registered providers that could improve their compliance with network standards, a file of provider addresses that could not be mapped under USPS CASS standards, and a copy of the Provider Affiliation Transmission (PAT) file that HSAG used to conduct the analysis. AHCCCS expected ALTCS E/PD Contractors to research instances in which the ALTCS E/PD Contractor's ACOM 436 reporting and HSAG's validation lead to different conclusions regarding compliance with AHCCCS' standards. If an ALTCS E/PD Contractor determined that the differences resulted from its data processing errors, it was expected to make corrections for future PAT data and/or ACOM 436 submissions.

7. Organizational Assessment and Structure Performance

In accordance with 42 CFR §438.358, which describes activities related to EQR, a state Medicaid agency; its agent that is not an MCO, PIHP, PAHP, or PCCM entity; or an EQRO must conduct a review within the previous three-year period to determine the Contractor's compliance with state standards set forth in subpart D of 42 CFR §438 and the QAPI requirements described in 42 CFR §438.330. AHCCCS meets the requirement by conducting ORs of its Contractors' performance in complying with federal and AHCCCS' contract requirements, ensuring that it reviews each requirement at least once every three years.

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' compliance with federal and AHCCCS contractual requirements. As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the activities associated with the federal Medicaid managed care mandatory compliance reviews. In accordance with and satisfying the requirements of 42 CFR §438.364, AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

Conducting the Review

AHCCCS conducted comprehensive ORs for each ALTCS E/PD Contractor in CYE 2019. Details regarding the standard areas reviewed for each Contractor are included in the CYE 2019 findings. Included in this section are the updates on CAPs issued during the review.

For details on the review objectives, methodologies for conducting the review and for scoring, and criteria for requiring Contractors to submit CAPs, please see Appendix A. Validation of Organizational Assessment and Structure Performance Methodology.

Standards

The CYE 2019 OR was organized into 12 standard areas. For the ALTCS E/PD Contractors, each standard area consisted of several standards designed to measure the Contractor's performance and compliance. The following are the standard areas and number of standards involved in each standard area:

- Case Management (CM), 21 applicable standards
- Corporate Compliance (CC), five standards
- Claims and Information Systems (CIS), 10 standards
- Delivery Systems (DS), 14 standards
- General Administration (GA), three standards
- Grievance Systems (GS), 17 applicable standards

- Adult, EPSDT, and Maternal Child Health (MCH), 16 standards
- Medical Management (MM), 27 applicable standards
- Member Information (MI), 10 standards
- Quality Management (QM), 22 applicable standards
- Reinsurance (RI), four standards
- Third-Party Liability (TPL), eight standards

Contractor-Specific Results

For the three year review cycle, AHCCCS conducted an OR for 12 standard areas in CYE 2019 for the following Contractors: BUFC-LTC, MC-LTC, and UHCCP-LTC. Contractor-specific results and CAPs are presented below.

Banner University Family Care-Long Term Care (BUFC-LTC)

AHCCCS conducted an on-site review of BUFC-LTC from February 4, 2019, through February 9, 2019. A copy of the draft version of the report was provided to the Contractor on March 20, 2019. BUFC-LTC was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the three year review cycle, AHCCCS conducted a comprehensive OR considering 12 standard areas in CYE 2019. Table 7-1 presents the total number of standards; the standard area scores; and the total number, if any, of standards with required corrective actions for each standard area reviewed.

Table 7-1 presents compliance results for the 12 standard areas reviewed for the BUFC-LTC OR.

Table 7-1—Standard Areas and Compliance Scores for BUFC-LTC

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards With Required Corrective Actions
Case Management (21)	1,944/2,100	93%	7
Corporate Compliance (5)	500/500	100%	0
Claims and Information Systems (10)	992/1,000	99%	1
Delivery Systems (14)	1,216/1,400	87%	4
General Administration (3)	300/300	100%	0

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards With Required Corrective Actions
Grievance Systems (17)	1,680/1,700	99%	1
Adult, EPSDT, and Maternal Child Health (16)	1,152/1,600	72%	11
Medical Management (27)	2,549/2,700	94%	6
Member Information (10)	966/1,000	97%	1
Quality Management (22)**	1,833/2,200	83%	11
Reinsurance (4)	400/400	100%	0
Third-Party Liability (8)	800/800	100%	0

*Standard area scores, maximum possible scores, and standard area percentage scores were provided by AHCCCS.
**QM 3 was not scored; however, AHCCCS used the feedback from the interviews to assess overall program compliance (e.g., to supplement findings in other QM standards) as well as identify opportunities for improvement and/or best practices for the Contractor.

Strengths for BUFC-LTC

For this OR, AHCCCS reviewed a total of 12 standard areas. For eight of those, BUFC-LTC achieved either full compliance or compliance. Of those eight standard areas, BUFC-LTC was fully compliant, with 100 percent scores, for four standard areas (CC, GA, RI, and TPL). BUFC-LTC also demonstrated strong performance in the CIS, GS, and MI standard areas, with compliance scores between 97 percent and 99 percent.

Full compliance was demonstrated by BUFC-LTC for the CC standard area; BUFC-LTC had an operational corporate compliance program, including a work plan that detailed compliance activities. For the GA standard area, BUFC-LTC demonstrated that training is provided to all staff members on AHCCCS guidelines. BUFC-LTC further demonstrated full compliance for the RI standard area, which included the requirement that the Contractor has policies and procedures for monitoring the appropriateness of the reinsurance revenue received against paid claims data. For the TPL standard area, which involved processes to file liens on total plan casualty cases that exceed $250, BUFC-LTC achieved full compliance.

Although the following standard areas did not meet full compliance, BUFC-LTC performed at or above the "95 percent threshold" established by AHCCCS. BUFC-LTC received 99 percent compliance for both the CIS and GS standard areas. For the CIS standard area, BUFC-LTC demonstrated that the remittance advice to providers contains the minimum required information. BUFC-LTC also demonstrated for the GS standard area that it had a process for the intake and handling of member appeals that are filed orally and ensures that the individuals who make decisions on appeals are appropriately qualified.

For the DS standard area, BUFC-LTC had a process for collecting, maintaining, updating, and reporting accurate demographic information on its provider network. BUFC-LTC also performed well in the MI standard area, which included the requirement to ensure that the Contractor's new member information packets met AHCCCS standards for content and distribution.

Opportunities for Improvement and Required Actions for BUFC-LTC

The results of the OR demonstrated opportunities for improvement as BUFC-LTC received 42 required corrective actions for eight standard areas. BUFC-LTC was less than compliant in five of the 12 standard areas reviewed (CM, DS, MCH, MM, and QM), and although having met overall compliance for three other standard areas (CIS, GS, and MI), BUFC-LTC received required actions for the deficiencies outlined below.

For the CM standard area, AHCCCS conducted record reviews to assess the implementation of policies and procedures. Deficiencies were found in the submitted documentation for the following areas: conducting discharge planning for members in the hospital, conducting needs assessment and care planning, placement and service planning, service plan monitoring and reassessment, providing and monitoring behavioral health (BH) services, and timely initiation of services to existing members in an HCBS (own home) setting.

AHCCCS also found several discrepancies in the DS standard area related to requirements for out-of-network referrals, the provider manual, network analysis requirements, and provider network and material business operation changes.

BUFC-LTC received the lowest compliance score (72 percent) for the MCH standard area. AHCCCS determined that BUFC-LTC did not adequately comply with requirements related to women's, EPSDT, and maternal and child programs and services; oral and dental services; inter-agency coordination; nutritional screenings; and behavioral health records.

For the MM standard area, BUFC-LTC did not demonstrate compliance with requirements related to the following: discharge follow-up, prior authorization request processing, enrollment transition information (ETI), denial of payment for emergency services or disallowance of emergency service limitation, notices of extension, and care management outreach.

For the QM standard area, BUFC-LTC did not adequately demonstrate that BUFC-LTC processed, analyzed, monitored, and provided adequate training on QOC concerns and other QM activities. BUFC-LTC also did not adequately demonstrate that it participated in all applicable community initiatives and interventions to address overarching community concerns.:

Although AHCCCS did not score the standard QM 3, AHCCCS required BUFC-LTC to complete action items related to contract, policy, and program requirements of the QM Program and work processes to support compliance that were not otherwise addressed in other QM standards.

Overall, BUFC-LTC met compliance in the CIS, GS, and MI standard areas; however, deficiencies were identified by AHCCCS. For the CIS standard area, AHCCCS found deficiencies regarding payments of applicable interest on all claims.

For the GS standard area, BUFC-LTC did not adequately demonstrate that claim disputes were resolved and that the Notices of Decision were mailed within the appropriate time frame.

AHCCCS also noted that, for the MI standard area, BUFC-LTC did not demonstrate that member service representatives were trained to appropriately to handle and track member inquiries and grievances.

Corrective Action Plans

In the report generated from BUFC-LTC's OR, AHCCCS required that BUFC-LTC develop 42 CAPs for issues that AHCCCS identified. BUFC-LTC submitted the first CAP submission to AHCCCS by May 1, 2019. AHCCCS accepted 32 CAPs, closed three CAPs, and required that BUFC-LTC submit to AHCCCS by June 12, 2019, an update for the seven CAPs that remained open. On July 9, 2019, AHCCCS accepted all CAPs that BUFC-LTC proposed.

AHCCCS required that BUFC-LTC submit to AHCCCS by January 9, 2020, an update for the CAPs that remained open. With few exceptions, AHCCCS expected all CAP steps to be completed within six months. (The six-month CAP update that BUFC-LTC was required to provide was not available at the time of this report and is, therefore, not included.)

Mercy Care-Long Term Care (MC-LTC)

AHCCCS conducted an on-site review of MC-LTC from April 22, 2019, through April 24, 2019. A copy of the draft version of the report was provided to the Contractor on June 5, 2019. MC-LTC was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2019 review cycle, AHCCCS conducted in CYE 2019 a comprehensive OR considering 12 standard areas. Table 7-2 presents the total number of standards; the standard area scores; and the total number, if any, of standards with required corrective actions for each standard area reviewed.

Table 7-2 presents compliance results for the 12 standard areas reviewed for the MC-LTC OR.

Table 7-2—Standard Areas and Compliance Scores for MC-LTC

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards With Required Corrective Actions
Case Management (21)	1,729/2,100	82%	12
Corporate Compliance (5)	500/500	100%	0
Claims and Information Systems (10)	980/1,000	98%	1
Delivery Systems (14)	1,258/1,400	89%	4
General Administration (3)	300/300	100%	0
Grievance Systems (17)	1,700/1,700	100%	0
Adult, EPSDT, and Maternal Child Health (16)	1,494/1,600	93%	4
Medical Management (27)	2,547/2,700	94%	5
Member Information (10)	1,000/1,000	100%	0
Quality Management (22)**	2,013/2,200	91%	8
Reinsurance (4)	400/400	100%	0
Third-Party Liability (8)	700/800	87%	1

*Standard area scores, maximum possible scores, and standard area percentage scores were provided by AHCCCS.
**QM 3 was not scored; however, AHCCCS used the feedback from the interviews to assess overall program compliance (e.g., to supplement findings in other QM standards) as well as identify opportunities for improvement and/or best practices for the Contractor.

Strengths for MC-LTC

For this OR, AHCCCS reviewed a total of 12 standard areas. For six of those, MC-LTC achieved either full compliance or compliance. Of those six standard areas, MC-LTC was fully compliant, with 100 percent scores, for five standard areas (CC, GA, GS, MI, and RI). MC-LTC also demonstrated strong performance in the CIS standard area, with a compliance score of 98 percent.

For the CC standard area, MC-LTC had an operational corporate compliance program, including a work plan that detailed compliance activities.

MC-LTC had policies and procedures for policy development and the maintenance of records, and provided training to all staff members on AHCCCS guidelines, compliant with the GA standard area. For the GS standard area, MC-LTC complied with all time frame requirements, transferred denied expedited appeal requests to the standard appeal review process, issued a written notice to the member when an extension was taken, and issued appeal decisions as expeditiously as the member's health condition required.

MC-LTC demonstrated compliance in the MI standard area, as MC-LTC's new member information packets met AHCCCS standards for content and distribution, MC-LTC appropriately handled and tracked member inquiries and complaints, and MC-LTC notified affected members timely when a PCP or frequently utilized provider left the network. Full compliance was also demonstrated by MC-LTC for the RI standard area, as MC-LTC had the required policies, procedures, and processes for reinsurance activities.

Although the following standard areas did not meet full compliance, MC-LTC performed at or above the "95 percent threshold" established by AHCCCS for the CIS standard area, which included the requirement to have a process for identifying claims where MC-LTC is or may be a secondary payor prior to payment.

Opportunities for Improvement and Required Actions for MC-LTC

The results of the OR demonstrated opportunities for improvement as MC-LTC received 35 required corrective actions for seven standard areas. MC-LTC was less than compliant in six of the 12 standard areas reviewed (CM, DS, MCH, MM, QM, and TPL), and although having met overall compliance for one other standard area (CIS), MC-LTC received a required action for this standard area.

AHCCCS found several deficiencies when reviewing requirements in the CM standard area (which incurred the lowest score during the review at 82 percent). Deficiencies included inadequate documentation related to the following:

- Discharge planning
- Needs assessments and care planning
- Program and AHCCCS standards
- Action plans and emergency visits
- Referrals for BH evaluation and services
- Plans for addressing chart audit findings
- Timely initiation of services to existing members in an HCBS (own home) setting

Additionally, sufficient evidence was not provided that MC-LTC met all the delivery system requirements in the DS standard area. Deficiencies were noted during AHCCCS' review related to out-of-network referral appointment standards, provider manual requirements, consistency of PAT data file submissions with the online directory, and requirements for evaluating member geographic access to care.

AHCCCS noted for the MCH standard area that MC-LTC did not demonstrate adequate compliance with requirements related to coordination with appropriate agencies and programs and with the Arizona Early Intervention Program (AzEIP), the process for implementing psychotropic medication monitoring activities, and informing members about women's preventive health services.

For the MM standard area, AHCCCS identified that MC-LTC did not fully meet the requirements for post-discharge follow-up appointments, processing prior authorization requests, coordination of services when a member is transitioning between Contractors, interventions preventing the misuse of controlled and non-controlled medications, and end-of-life care and advanced care planning. For the QM standard area, MC-LTC did not adequately demonstrate compliance with the requirements related to the following:

- QOC processes
- Monitoring of residential settings
- Documentation of supervision/clinical oversight
- Best practice documentation
- Participation in all applicable community initiatives and interventions to address overarching community concerns

Although AHCCCS did not score the element QM 3, AHCCCS required MC-LTC to complete action items related to contract, policy, and program requirements of the QM Program and work processes to support compliance that were not otherwise addressed in other QM standards.

During a record review for the TPL standard area, AHCCCS identified noncompliance with requirements for submitting requested claims information to the AHCCCS TPL Contractor (Health Management Systems [HMS]).

Although, overall, MC-LTC met compliance in the CIS standard area, deficiencies were identified by AHCCCS involving incorrect calculation of interest payments

Corrective Action Plans

In the report generated from MC-LTC's OR, AHCCCS required that MC-LTC develop 35 CAPs for issues that AHCCCS identified. MC-LTC submitted the first CAP submission to AHCCCS by July 17, 2019. AHCCCS accepted 28 CAPs and required that MC-LTC submit to AHCCCS by August 28, 2019, an update for the 29 CAPs that remained open. Out of the CAPs accepted from the first CAP submission, six CAPs were closed. On September 16, 2019, AHCCCS accepted all CAPs that MC-LTC proposed during the second submission and closed one CAP.

AHCCCS required that MC-LTC submit to AHCCCS by March 16, 2020, an update for the CAPs that remained open. With few exceptions, AHCCCS expected all CAP steps to be completed within six months. (The six-month CAP update that MC-LTC was required to provide was not available at the time of this report and is, therefore, not included.)

UnitedHealthcare Community Plan-Long Term Care (UHCCP-LTC)

AHCCCS conducted an on-site review of UHCCP-LTC from March 4, 2019, through March 6, 2019. A copy of the draft version of the report was provided to the Contractor on April 17, 2019. UHCCP-LTC

was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2019 review cycle, AHCCCS conducted in CYE 2019 a comprehensive OR considering 12 standard areas. Table 7-3 presents the total number of standards; the standard area scores; and the total number, if any, of standards with required corrective actions for each standard area reviewed.

Table 7-3 presents compliance results for the 12 standard areas reviewed for the UHCCP-LTC OR.

Table 7-3—Standard Areas and Compliance Scores for UHCCP-LTC

Standard Area (Number of Standards Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score*	Number of Standards With Required Corrective Actions
Case Management (21)	1,875/2,100	89%	8
Corporate Compliance (5)	500/500	100%	0
Claims and Information Systems (10)	983/1,000	98%	1
Delivery Systems (14)	1,262/1,400	90%	2
General Administration (3)	300/300	100%	0
Grievance Systems (17)	1,700/1,700	100%	0
Adult, EPSDT, and Maternal Child Health (16)	1,196/1,600	75%	8
Medical Management (27)	2,418/2,700	90%	8
Member Information (10)	930/1,000	93%	2
Quality Management (22)**	1,901/2,200	86%	10
Reinsurance (4)	400/400	100%	0
Third-Party Liability (8)	800/800	100%	0

*Standard area scores, maximum possible scores, and standard area percentage scores were provided by AHCCCS.
**QM 3 was not scored; however, AHCCCS used the feedback from the interviews to assess overall program compliance (e.g., to supplement findings in other QM standards) as well as identify opportunities for improvement and/or best practices for the Contractor.

Strengths for UHCCP-LTC

For this OR, AHCCCS reviewed a total of 12 standard areas. For six of those, UHCCP-LTC achieved either full compliance or compliance. Of those six standard areas, UHCCP-LTC was fully compliant, with 100 percent scores, for five standard areas (CC, GA, GS, RI, and TPL). UHCCP-LTC also demonstrated strong performance in the CIS standard area, with a compliance score of 98 percent.

For the CC standard area, UHCCP-LTC had an operational corporate compliance program, including a work plan that detailed compliance activities.

UHCCP-LTC was fully compliant with the GA standard area, which included the requirement to maintain policies and procedures for policy development and the maintenance of records, and to provide training to all staff members on AHCCCS guidelines. Additionally, UHCCP-LTC complied with all timelines required in the GS standard area, transferred denied expedited appeal requests to the standard appeal review process, issued a written notice to the member when an extension was taken, and issued appeal decisions as expeditiously as the member's health condition required.

UHCCP-LTC further demonstrated full compliance for the RI standard area, which included requirements regarding reinsurance activities. In addition, full compliance was demonstrated by UHCCP-LTC for the TPL standard area, which involved processes to file liens on total plan casualty cases that exceed $250.

Although UHCCP-LTC did not meet full compliance, UHCCP-LTC met the "95 percent threshold" established by AHCCCS for the CIS standard area, which included the requirement to maintain a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.

Opportunities for Improvement and Required Actions for UHCCP-LTC

The results of the OR demonstrated opportunities for improvement as UHCCP-LTC received 39 required corrective actions for seven standard areas. UHCCP-LTC was less than compliant in six of the 12 standard areas reviewed (CM, DS, MCH, MM, MI, and QM), and although having met compliance for one other standard area (CIS), UHCCP-LTC received required actions for this standard area.

For the CM standard area, AHCCCS found several deficiencies regarding the implementation of policies and procedures for the following: conducting placement and service planning; conducting discharge planning for members enrolled with the Contractor during hospitalization; conducting needs assessment and care planning, placement, and service planning, Client Assessment and Tracking System (CATS); providing and monitoring skilled nursing services; monitoring case management caseloads for compliance with AHCCCS standards; and timely initiation of services to existing members in an HCBS (own home) setting.

AHCCCS noted that, for the DS standard area, UHCCP-LTC did not meet all the requirements for provider manual content and network analysis for evaluating member geographic access to care

UHCCP-LTC received the lowest compliance score (75 percent) for the MCH standard area. UHCCP-LTC did not adequately comply with the requirements related to the following:

- PCP communication and staffing for women's, EPSDT, and maternal and child programs and services
- Outreach materials
- Oral and dental services

- Inter-agency coordination
- Implementing nutritional interventions
- Behavioral health records

Child and Family Team (CFT) documentation and the service plan completion For the MM standard area, AHCCCS found that UHCCP-LTC did not demonstrate compliance with requirements related to the following:

- Discharge planning and follow-up
- Policies and procedures for monitoring members with special healthcare needs
- Maintenance of the disease/chronic care management programs
- Coordination of services when a member is transitioning between Contractors and from the justice system
- Enrollment transition information (ETI)
- Referrals to providers specialized in diagnosing autism
- Care management outreach

Collaboration with DCS Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) (AFF) programs AHCCCS also found discrepancies in the MI standard area. UHCCP-LTC did not demonstrate that all information in the New Member Information Packet had been approved by AHCCCS or that affected members were notified in a

UHCCP-LTC received a compliance score of 86 percent for the QM standard area. UHCCP-LTC did not fully comply with requirements for QOC processes and training, and monitoring of residential settings.

Although AHCCCS did not score the element QM 3, AHCCCS required UHCCP-LTC to complete action items related to contract, policy, and program requirements of the QM Program and work processes to support compliance that were not otherwise addressed in other QM standards.

Although, overall, UHCCP-LTC met compliance in the CIS standard area, AHCCCS found deficiencies regarding payments of applicable interest on all claims..

Corrective Action Plans

In the report generated from UHCCP-LTC's OR, AHCCCS required that UHCCP-LTC develop 39 CAPs for issues that AHCCCS identified. UHCCP-LTC submitted the first CAP submission to AHCCCS by May 30, 2019. On June 27, 2019, of the proposed CAPs, AHCCCS accepted 33 CAPs and closed four. The second CAP update submission was received by AHCCCS on July 12, 2019. On August 12, 2019, AHCCCS accepted all CAPs.

AHCCCS required that UHCCP-LTC submit to AHCCCS by February 12, 2020, an update for the CAPs that remained open. With few exceptions, AHCCCS expected all CAP steps to be completed within six months. (The six-month CAP update that UHCCP-LTC was required to provide was not available at the time of this report and is, therefore, not included.)

Strengths

During the comprehensive OR conducted in CYE 2019, all reviewed Contractors demonstrated compliance for the CC, GA, and RI standard areas. Notably, BUFC-LTC met compliance for seven of the 12 standard areas reviewed, and MC-LTC and UHCCP-LTC met compliance for six standard areas. However, both MC-LTC and UHCCP-LTC achieved full compliance for five of the standard areas reviewed and BUFC-LTC achieved full compliance for four standard areas.

Opportunities for Improvement

Opportunities for improvement exist for the CM, MCH, MM, and QM standard areas, as the reviewed Contractors did not meet compliance and incurred the greatest number of CAPs during the CYE 2019 OR for these standard areas.

Overall Recommendations

Please see the Executive Summary for the overall recommendations for BUFC-LTC, MC-LTC, and UHCCP-LTC as a result of the ORs conducted in CYE 2019.

8. Performance Measure Results

Methodology

The following section presents the results for the mandatory performance measure activity conducted during the CYE 2018 reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, AHCCCS required its Contractors to report CYE 2018 data (i.e., October 1, 2017–September 30, 2018). HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), and CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). AHCCCS approved the CYE 2018 rates for inclusion in this report.

For a detailed explanation of the methodology, please see Appendix B.

Required Performance Measures

The performance measures selected by AHCCCS for CYE 2018 were grouped into the following domains of care: Access to Care, Behavioral Health, Medication Management, Pediatric Health, Preventive Screening, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractors and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance.

Table 8-1 and Table 8-2 display the CYE 2018 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for the ALTCS E/PD Contractors and DES/DDD. An MPS had not been established for all reported performance measure rates.

Table 8-1—CYE 2018 Performance Measures for ALTCS E/PD Contractors

Performance Measure	Measure Specification	MPS
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	Adult Core Set	85.0%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	Adult Core Set	95.0%
Medication Management		
*Use of Opioids at High Dosage in Persons Without Cancer***	Adult Core Set	—
Utilization		

Performance Measure	Measure Specification	MPS
*Ambulatory Care (per 1,000 Member Months)—ED Visits—Total**	HEDIS	80.0
Inpatient Utilization—General Hospital/Acute Care—Total—Days per 1,000 Member Months (Total Inpatient)—Total	HEDIS	N/A
Mental Health Utilization—Any Service—Total	HEDIS	—
*Plan All-Cause Readmissions—Total***	Adult Core Set	17.0%±

— Indicates that an MPS had not been established by AHCCCS.
** A lower rate indicates better performance for this measure; therefore, rates must fall at or below the established MPS in order to exceed the CYE 2018 MPS.*
*** For this indicator, a lower rate indicates better performance.*
± Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made.
N/A indicates lower or higher rates are not considered to be an appropriate measure of care for this measure.

Table 8-2—CYE 2018 Performance Measures for DES/DDD

Performance Measure	Measure Specification	MPS
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services—Total	HEDIS	75.0%
Annual Dental Visits—2–20 Years	HEDIS	60.0%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	Child Core Set	93.0%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	Child Core Set	84.0%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	Child Core Set	83.0%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	Child Core Set	82.0%
Medication Management		
*Use of Opioids at High Dosage in Persons Without Cancer***	Adult Core Set	—
Pediatric Health		
Adolescent Well-Care Visits	Child Core Set	41.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Child Core Set	66.0%
Preventive Screening		
Breast Cancer Screening	Adult Core Set	50.0%
Cervical Cancer Screening	Adult Core Set	64.0%
Utilization		
*Ambulatory Care (per 1,000 Member Months)—ED Visits—Total**	HEDIS	43.0

Performance Measure	Measure Specification	MPS
Inpatient Utilization—General Hospital/Acute Care—Total—Days per 1,000 Member Months (Total Inpatient)—Total	HEDIS	N/A
*Plan All-Cause Readmissions—Total***	Adult Core Set	11.0%±

— Indicates that an MPS had not been established by AHCCCS.
** A lower rate indicates better performance for this measure; therefore, rates must fall at or below the established MPS in order to exceed the CYE 2018 MPS.*
*** For this indicator, a lower rate indicates better performance.*
± Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made.
N/A indicates lower or higher rates are not considered to be an appropriate measure of care for this measure.

Performance Measure Results—ALTCS E/PD Contractors

Table 8-3 presents the CYE 2018 performance measure rates with an MPS for each ALTCS E/PD Contractor and the statewide aggregate. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2018 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Table 8-3—CYE 2018 Performance Measure Results—ALTCS E/PD Contractors

Performance Measure	BUFC-LTC	MC-LTC	UHCCP-LTC	Aggregate
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	33.3%	28.9%	45.5%	34.6%
30-Day Follow-Up	61.5%	48.5%	52.7%	52.4%
Utilization				
Ambulatory Care (per 1,000 Member Months)				
*ED Visits—Total**	62.6	68.2	77.6	69.9

** For this indicator, a lower rate indicates better performance.*
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 8-4 presents a comparison of the ALTCS E/PD Contractors' CYE 2017 to CYE 2018 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2017 and CYE 2018 using a Chi-square test of proportions. In cases where the cell size was less than five (i.e., fewer than five people were either numerator positive or numerator negative for either reporting year), a Fisher's exact test was used in place of a Chi-square test. The results of the statistical tests were considered significant when the *p* value was ≤0.05. A green upward arrow (↑) indicates a significant improvement in performance, a red downward arrow (↓) indicates a significant decline in performance, and a dash (—) indicates that the change in performance was not significant.

For some measures, significance testing was not performed, because CYE 2018 was the first year that the measure was required to be reported (i.e., *Use of Opioids at High Dosage in Persons Without*

Cancer), there was a change to the measure specifications and calculation methodology (i.e., *Plan All-Cause Readmissions*), or the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care*, *Inpatient Utilization,* and *Mental Health Utilization*).

Table 8-4—Trend Analysis From CYE 2017 to CYE 2018—ALTCS E/PD Contractors

Performance Measure	BUFC-LTC	MC-LTC	UHCCP-LTC	Aggregate
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	NC	—	—	—
30-Day Follow-Up	NC	—	—	—

↑ *Indicates a significant improvement in the Contractor's rate from CYE 2017 to CYE 2018.*
↓ *Indicates a significant decline in the Contractor's rate from CYE 2017 to CYE 2018.*
— *Indicates no significant difference in the Contractor's rate from CYE 2017 to CYE 2018.*
NC indicates that a comparison of performance between CYE 2017 and CYE 2018 was not appropriate.

Strengths and Opportunities for Improvement

For CYE 2018, the ALTCS E/PD Contractors demonstrated strength for the measure rates within the Utilization domain as all Contractors' rates for *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* exceeded the MPS.

Conversely, all three ALTCS E/PD Contractors and the ALTCS E/PD aggregate demonstrated opportunities for improvement related to *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, with the reportable performance measure rates falling below the MPS by at least 39.5 and 33.5 percentage points, respectively. Research related to hospitalization for mental illness indicates that appropriate discharge planning and follow-up visits are contributing factors to lowering readmission rates.[8-1] The Reducing Avoidable Readmissions Effectively (RARE) Campaign—a collaboration of the Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health—recommends improving care transitions following an inpatient hospital admission by focusing on patient and family engagement, medication management, comprehensive transition planning, care transition support, and transition communications. Patients should have follow-up appointments scheduled prior to discharge, and mental health practitioners should ensure availability to review each patient's progress and care plan within the first seven days post discharge.[8-2] Following a member's discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care

[8-1] Lien, Lars. Are readmission rates influenced by how psychiatric services are organized? *Nordic Journal of Psychiatry.* Vol. 56, No. 1, 2002.
[8-2] Reducing Avoidable Readmissions Effectively. *Recommended Actions for Improved Care Transitions: Mental Illness and/or Substance Use Disorders*. Available at: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf. Accessed on: Mar. 12, 2020.

plan.[8-3,8-4] AHCCCS and the ALTCS E/PD Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.

Performance Measure Results—DES/DDD

Table 8-5 presents the CYE 2017 and CYE 2018 performance measure results for DES/DDD. The table displays the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available; and the significance of the relative percentage change, where available. Performance measure rate cells shaded green indicate that DES/DDD met or exceeded the CYE 2018 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Table 8-5—CYE 2017 and CYE 2018 Performance Measure Results—DES/DDD

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	85.8%	87.3%	1.8%	**P<0.001**
Annual Dental Visits				
2–20 Years	56.5%	56.9%	0.7%	P=0.444
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.2%	100.0%	4.0%	P=0.238
25 Months–6 Years	89.2%	87.4%	-2.0%	**P=0.030**
7–11 Years	92.1%	92.2%	0.1%	P=0.918
12–19 Years	89.6%	89.8%	0.2%	P=0.677
Medication Management				
Use of Opioids at High Dosage in Persons Without Cancer[2,3]				
*Total**	—	8.9%	—	—
Pediatric Health				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.4%	45.8%	5.5%	**P=0.001**

[8-3] Arizona Health Care Cost Containment System. *How A Hospital Discharge Plan Helps AHCCCS Members Return to Good Health*. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/HospitalDischarge.pdf. Accessed on: Mar. 12, 2020.

[8-4] Arizona Health Care Cost Containment System. *AHCCCS Presentation Care Coordination Discharge Planning*. Available at: http://files.constantcontact.com/b108b018001/a0e54380-8b8a-4cda-abfa-464c2a417bbf.pdf. Accessed on: Mar. 12, 2020.

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.4%	55.2%	3.4%	P=0.154
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	45.9%	45.1%	-1.7%	P=0.698
Cervical Cancer Screening				
Cervical Cancer Screening	16.6%	16.3%	-1.8%	P=0.711
Utilization				
Ambulatory Care (per 1,000 Member Months)				
*ED Visits—Total**	39.1	44.0	12.8%	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total[2†]				
Days per 1,000 Member Months (Total Inpatient)—Total	43.4	61.5	41.8%	—

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] An MPS had not been established for this measure.
[3] Due to changes in the technical specifications for this measure, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes or a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Strengths and Opportunities for Improvement

For CYE 2018, DES/DDD exceeded the MPS for six of 11 (54.5 percent) performance measure rates, including six of eight (75.0 percent) rates within the Access to Care and Pediatric Health domains, demonstrating strength. Despite improvement in rates from CYE 2017 to CYE 2018, the performance measure rates for *Annual Dental Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPS by 3.1 and 10.8 percentage points, respectively. AHCCCS and DES/DDD should focus efforts on identifying the factors contributing to low rates for these measures and implementing improvement strategies to increase well-child visits for members 3 to 6 years of age and dental screenings.

Conversely, DES/DDD fell below the MPS for both performance measures within the Preventive Screening domain (*Breast Cancer Screening* and *Cervical Cancer Screening*), demonstrating an opportunity to ensure that women receive appropriate screenings. Research shows that women with intellectual and developmental disabilities (IDDs) experience disparities in timely screening for

preventive diseases and care; yet, women with IDDs develop cancer at the same rate as the general population.[8-5] Women with IDDs have indicated aversion to mammography and Pap tests due to a general lack of understanding of the procedures, inadequate preparation, and increased anxiety.[8-5,8-6] AHCCCS and DES/DDD should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for breast cancer and cervical cancer.

[8-5] Wilkinson JE, Deis CE, Bowen DJ, et al. 'It's Easier Said Than Done': Perspectives on Mammography From Women With Intellectual Disabilities. *Ann Fam Med*. 2011 Mar; 9(2): 142–147.

[8-6] Parish SL, Swaine JG, Son E, et al. (2013). Determinants of cervical cancer screening among women with intellectual disabilities: Longitudinal evidence from medical record data. *Public Health Reports*. 128, 519-526.

9. Performance Improvement Project Results

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

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

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

Conducting the Review

In the AMPM, 980—Performance Improvement Projects, AHCCCS mandates that Contractors participate in PIPs selected by AHCCCS. In addition, with AHCCCS approval, Contractors may select and design additional PIPs specific to needs and data identified through internal surveillance of trends. Mandated PIP topics are selected through AHCCCS' analysis of internal and external data and trends that may include Contractor input. AHCCCS considers topics such as comprehensive aspects of member needs, care, and services for a broad spectrum of members or for a focused subset of the population, including those members with special healthcare needs or receiving LTSS.

AHCCCS may mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS.

In CYE 2016 (October 1, 2015, through September 30, 2016), AHCCCS implemented the *Developmental Screening* PIP for the ACC, CMDP, and DES/DDD lines of business. The CYE 2016 baseline year for this PIP was followed by an "Intervention" year in which each Contractor implemented strategies and interventions to improve performance. AHCCCS conducted annual measurements to evaluate Contractor performance, with the first remeasurement reflective of CYE 2018.

Early identification of developmental delays is important when providing effective interventions. During well-child visits, pediatricians look for potential concerns using both developmental surveillance and discussions with parents about their concerns. If any issues are noted, pediatricians should follow through with a developmental screening. Thus, AHCCCS has approved developmental screening tools

that should be utilized for developmental screenings by all participating PCPs who care for EPSDT-age members.

The purpose of the *Developmental Screening* PIP is to increase the number of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percentage of children receiving a developmental screening, followed by sustained improvement for one year.

Contractor-specific findings for the ALTCS DES/DDD Contractors regarding the *Developmental Screening* PIP are included in the section below.

This annual report includes CYE 2016 baseline measurement data; CYE 2018 Remeasurement 1 data; percentage change from baseline to Remeasurement 1; overall relative percentage changes from baseline data; statistical significance data; qualitative and quantitative analyses, including limitations and lessons learned identified by the Contractors; and interventions.

Contractor-Specific Results

AHCCCS provided HSAG with DES/DDD's CYE 2018 *Developmental Screening* PIP information; including qualitative analysis, with limitations and lessons learned, and interventions.

This section includes DES/DDD's PIP results, as calculated by AHCCCS, along with specific activities conducted during CYE 2018. HSAG has minimally edited the analysis and interventions; otherwise, they appear as provided by DES/DDD.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

Findings

Table 9-1 presents the baseline and Remeasurement 1 results for the *Developmental Screening* PIP for DES/DDD's members. The table also presents relative percentage changes from baseline to Remeasurement 1 and statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 9-1—DES/DDD *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1 Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1	Statistical Significance
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	24.9%	25.1%	0.8%	P=.0.947

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 9-1 shows that, during the baseline period, 24.9 percent of DES/DDD's members from zero to three years of age received a developmental screening. For Remeasurement 1, 25.1 percent of DES/DDD members ages zero to three years received a developmental screening. DES/DDD's Remeasurement 1 rate demonstrated a relative percentage change from baseline of 0.8 percent. DES/DDD did not demonstrate statistically significant improvement in the performance of the indicator for this PIP.

Due to the Notice to Cure issued in 2017, DES/DDD submitted no *Developmental Screening* CYE 2019 PIP Report (detailing DES/DDD's CYE 2018 analyses and interventions) to AHCCCS.

Recommendations for AHCCCS and DES/DDD

Based on the submitted results for the *Developmental Screening* PIP, HSAG offers the following recommendations related to the PIP rates to support progress toward improved PIP outcomes in the future:

- DES/DDD is encouraged to meet with AHCCCS to ensure that accurate data are used for the calculation of the PIP rates.
- DES/DDD should identify and prioritize barriers so as to develop robust strategies and interventions for the PIP.
- DES/DDD is encouraged to monitor the progress of the PIP interventions employed to increase the rate of children receiving a developmental screening, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
- DES/DDD should monitor the outcomes associated with the interventions and systemwide changes.

- AHCCCS may consider working with DES/DDD to ensure the alignment of the screening tools that are allowed by CMS and the tools recognized by AHCCCS.
- AHCCCS may want to use more timely data to support performance improvement activities that can be monitored in real time.

Appendix A. Validation of Organizational Assessment and Structure Performance Methodology

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.

Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR 438.364.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts formal reviews on a schedule that ensures it reviews all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.[A-1]

AHCCCS' methodology for conducting the OR included the following:

- Reviewing activities that AHCCCS conducted to assess the Contractor's performance
- Reviewing documents and deliverables that the Contractor was required to submit to AHCCCS
- Conducting interviews with key Contractor administrative and program staff

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: February 14, 2019.

AHCCCS conducted activities following the review that included documenting and compiling the results of the review, preparing the draft report of findings, and issuing the draft report to the Contractor for review and comment. In the report, each standard area and standard was individually listed with applicable performance designations based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standard areas.

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

As needed throughout the preparation of this report, AHCCCS clarified any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this section of the EQR report.

Using the verified results that AHCCCS obtained from conducting the OR, HSAG organized and aggregated the performance data for each Contractor. HSAG then analyzed the data by performance category (e.g., Quality Management).

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

Scoring Methodology

Each standard area consists of several standards designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS ALTCS contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured in the CYE 2019 OR. Within each standard are specific scoring detail criteria worth defined percentages of the standard's total possible score.

AHCCCS includes the percentages awarded for each scoring detail in the standard's total score. Using the sum of all applicable standard total scores, AHCCCS then develops an overall standard area score. In addition, a standard is scored *Not Applicable (N/A)* if it does not apply to the Contractor and/or no instances exist in which the requirement is applied.

Corrective Action Statements

As part of the AHCCCS methodology, each Contractor receives a report containing review findings. The Contractor has the opportunity to respond to AHCCCS concerning any disagreement related to the findings. AHCCCS reviews and responds to any Contractor disagreements based on review of the

Contractor information, and then revises the report if necessary. AHCCCS issues the final report to the Contractor, describing the findings, scores, and required CAPs.

Contractors must complete a CAP for any standard for which the total score is less than 95 percent. The report, based on the review and the findings, may contain one of the three following statements:

- *The Contractor must* …. This statement indicates a critical noncompliant area that must be corrected as soon as possible to comply with the AHCCCS contract.
- *The Contractor should* …. This statement indicates a noncompliant area that must be corrected to comply with the AHCCCS contract but is not critical to the day-to-day operation of the Contractor.
- *The Contractor should consider* …. This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.

Appendix B. Validation of Performance Measure Methodology and Additional Results

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

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1-5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 2019 annual report.

Conducting the Review

HSAG calculates and reports rates on AHCCCS' behalf for a variety of Contractor-specific and statewide aggregate performance measures to address different quality initiatives. HSAG calculated the measure rates for CYE 2018.

Using the results and statistical analysis of Contractors' performance measure rates, HSAG organized, aggregated, and analyzed the performance data. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services provided to AHCCCS members for CYE 2018.

Objectives for Conducting the Review

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS conducted the following activities:

- Provided key information about AHCCCS-selected performance measures to each Contractor.
- Collected Contractor data for use in calculating performance measure rates.

Methodology for Conducting the Review

For the CYE 2018 review period (i.e., measurement year ending September 30, 2018), AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each State-selected measure.
- Contracted with HSAG to calculate Contractor-specific performance rates and statewide aggregate rates for all Contractors for each measure.
- Reported Contractor performance results by individual Contractor and a statewide aggregate.
- Compared Contractor performance rates with MPS defined by the AHCCCS' contract, if available.

CAPs, key components of the AHCCCS Quality Strategy, are used as foundational elements to improve performance measure rates that fall below the contractual MPS. During CYE 2019, AHCCCS required Contractors to propose and implement CAPs for CYE 2017 performance measures that did not meet the MPS. The Contractors then submitted CAP proposals. Once a CAP proposal was approved by AHCCCS and implemented, the Contractors were required to provide CAP updates as required by AHCCCS.

HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Adult Core Set, and CMS Child Core Set. The Contractors' performance rates were calculated for AHCCCS-selected measures using administrative data collected from the automated managed care data system known as the Prepaid Medical Management Information System (PMMIS). The administrative methodology used for data collection in the current measurement period differed slightly from the methodology used for the previous measurement period (e.g., identification of paid claims, continuous enrollment, and removal of linked members in enrollment files). NCQA and CMS update their respective methodologies annually to add new codes to better identify the eligible populations and/or services being measured or to delete codes retired from standardized coding sets used by providers.

HSAG analyzed Contractor-specific and statewide aggregate performance results for each measure to determine if performance rates met or exceeded each corresponding AHCCCS MPS. Relative rate changes and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether that change was significant.

Using the performance rates that HSAG calculated on AHCCCS' behalf, HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance related to providing quality, timely, and accessible care and services to AHCCCS members. (See Table B-1 for the assignment of performance measures with an MPS to the Quality, Timeliness, and Access areas.) When applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Table B-1—Assignment of Performance Measures With an MPS to the Quality, Timeliness, and Access Areas

Performance Measure	Quality	Timeliness	Access
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Annual Dental Visits			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Pediatric Health			
Adolescent Well-Care Visits	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Preventive Screening			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Utilization			
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	N/A	N/A	N/A
Plan All-Cause Readmissions	✓		
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓

N/A indicates Not Applicable.

Performance Measures Results—ALTCS E/PD Contractors

The following tables include performance measure results for the ALTCS E/PD Contractors. The tables display the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2018 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Banner University Family Care-Long Term Care (BUFC-LTC)

Table B-2—CYE 2017 and CYE 2018 Performance Measure Results—BUFC-LTC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	—	33.3%	—	—	85.0%
30-Day Follow-Up	—	61.5%	—	—	95.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer					
*Total**	—	23.2%	—	—	—
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	—	62.6	—	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	—	245.8	—	—	—
Mental Health Utilization					
Any Service—Total	—	22.6%	—	—	—
Plan All-Cause Readmissions[2]					
*Total**	—	15.4%	—	—	17.0%

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made.
— Indicates that the CYE 2017 rate was not displayed because the plan was not an ALTCS E/PD Contractor in CYE 2017 and that a comparison of performance between CYE 2017 and CYE 2018 was not possible, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Mercy Care Plan-Long Term Care (MC-LTC)

Table B-3—CYE 2017 and CYE 2018 Performance Measure Results—MC-LTC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	29.3%	28.9%	-1.4%	P=0.953	85.0%
30-Day Follow-Up	50.0%	48.5%	-3.0%	P=0.852	95.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	22.8%	—	—	—
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	72.9	68.2	-6.6%	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	268.0	306.9	14.5%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	23.1%	—	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	21.0%	—	—	17.0%

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

UnitedHealthcare Community Plan-Long Term Care (UHCCP-LTC)

Table B-4—CYE 2017 and CYE 2018 Performance Measure Results—UHCCP-LTC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	31.2%	45.5%	45.8%	P=0.113	85.0%
30-Day Follow-Up	54.1%	52.7%	-2.6%	P=0.882	95.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	17.6%	—	—	—
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	58.2	77.6	33.3%	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	110.2	279.6	153.7%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	23.1%	—	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	15.4%	—	—	17.0%

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

ALTCS E/PD Contractors Aggregate

Table B-5—CYE 2017 and CYE 2018 Performance Measure Results—ALTCS E/PD Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	30.3%	34.6%	14.2%	P=0.415	85.0%
30-Day Follow-Up	51.0%	52.4%	2.7%	P=0.810	95.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	21.3%	—	—	—
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	66.7	69.9	4.8%	—	80.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	194.4	284.4	46.3%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	22.9%	—	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	18.7%	—	—	17.0%

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] Due to changes in the technical specifications for this measure, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Performance Measures Results—DES/DDD

Table B-6—CYE 2017 and CYE 2018 Performance Measure Results—DES/DDD

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	85.8%	87.3%	1.8%	**P<0.001**
Annual Dental Visits				
2–20 Years	56.5%	56.9%	0.7%	P=0.444
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.2%	100.0%	4.0%	P=0.238
25 Months–6 Years	89.2%	87.4%	-2.0%	**P=0.030**
7–11 Years	92.1%	92.2%	0.1%	P=0.918
12–19 Years	89.6%	89.8%	0.2%	P=0.677
Medication Management				
Use of Opioids at High Dosage in Persons Without Cancer[2,3]				
*Total**	—	8.9%	—	—
Pediatric Health				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.4%	45.8%	5.5%	**P=0.001**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.4%	55.2%	3.4%	P=0.154
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	45.9%	45.1%	-1.7%	P=0.698
Cervical Cancer Screening				
Cervical Cancer Screening	16.6%	16.3%	-1.8%	P=0.711
Utilization				
Ambulatory Care (per 1,000 Member Months)				
*ED Visits—Total**	39.1	44.0	12.8%	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total[2†]				
Days per 1,000 Member Months (Total Inpatient)—Total	43.4	61.5	41.8%	—
Plan All-Cause Readmissions[4]				
*Total**	—	13.1%	—	11.0%

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*

[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
[2] An MPS had not been established for this measure.
[3] Due to changes in the technical specifications for this measure, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[4] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes or a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Appendix C. Validation of Performance Improvement Project Methodology

Performance Improvement Project Design

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

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

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

Data Collection Methodology

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

Measurement of Significant Improvement

AHCCCS expects Contractors to implement interventions to meet a benchmark level of performance for any PIP. AHCCCS defines this benchmark level in advance for all AHCCCS-mandated PIPs. The Contractors must initiate interventions that result in significant improvement, sustained over time, in their performance for the quality indicators being measured. AHCCCS requires that improvement be evidenced in repeated measurements of the quality indicators specified for each PIP undertaken by the Contractors.

AHCCCS determines a Contractor has demonstrated significant improvement when the Contractor:

- Meets or exceeds the AHCCCS overall average for the baseline measurement, if its baseline rate was below the average and the increase is statistically significant;
- Demonstrates a statistically significant increase, if its baseline rate was at or above the AHCCCS overall average for the baseline measurement; or
- Demonstrates the highest-performing (benchmark) plan in any remeasurement and maintains or improves its rate in a successive measurement.

AHCCCS determines a Contractor has demonstrated sustained improvement when the Contractor:

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

Performance Improvement Project Time Frames

AHCCCS-mandated PIPs begin on a date that corresponds with a contract year. Baseline data for the PIP are collected and analyzed at the beginning of the PIP. Depending on the PIP topic, AHCCCS may provide baseline data by Contractor and include additional data by age, race, sex, ethnicity, and/or geographic area to assist Contractors in refining interventions. During the first year of the PIP, AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

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

AHCCCS will conduct annual measurements to evaluate Contractor performance and may conduct interim measurements, depending on the resources required, to collect and analyze data. Contractors must include internal annual measurements/rates and results, used as the basis for analysis (both quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions.

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

Appendix D. Network Adequacy Validation Methodology and Detailed Results

HSAG used data supplied by AHCCCS to calculate the number and percent of ALTCS E/PD beneficiaries within a defined time or distance from 12 types of AHCCCS-defined providers. As Table D-1 describes, these time/distance standards vary by provider type and county, and some standards may not apply to every Contractor.

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

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

1. Applies only to Maricopa and Pima counties.
2. Applies only to ALTCS E/PD Contractors.

Data Sources

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

1. Prepaid Medical Management Information System (PMMIS) provider data—data files maintained by AHCCCS that list all AHCCCS-registered providers and their corresponding addresses.
2. AHCCCS beneficiary data—a data file compiled by AHCCCS from the PMMIS and Client Assessment and Tracking System (CATS) data.
   a. PMMIS data elements include the addresses and pertinent demographic information for AHCCCS beneficiaries.[D-1]
   b. CATS data elements identify AHCCCS beneficiaries that live in their own home, for calculation of the Nursing Facility time/distance standard applicable to the ALTCS E/PD line of business.
3. Provider Affiliation Transmission (PAT) file—a data file listing each Contractor's contracted providers.
4. AHCCCS Contractor Operations Manual Policy 436 (ACOM 436) submission—a Microsoft (MS) Excel workbook with a tab listing the quarterly results for compliance with county-level time/distance standards.

Table D-2 shows the effective dates for the data files supplied to HSAG in each quarter.

Table D-2: Effective Dates for AHCCCS-Supplied Network Adequacy Data by Quarter and Data Type

Data Source	Quarter One	Quarter Two	Quarter Three
Measurement Period	October 1, 2018– December 31, 2018	January 1, 2019– March 31, 2019	April 1, 2019– June 30, 2019
PMMIS Providers	Data as of January 16, 2019	Data as of April 24, 2019	Data as of July 17, 2019
AHCCCS Beneficiaries	Active Enrollment as of January 1, 2019	Active Enrollment as of April 1, 2019	Active Enrollment as of July 1, 2019
Contractor-Specific PAT Providers	Submitted to AHCCCS in January 2019	Submitted to AHCCCS in April 2019	Submitted to AHCCCS in July 2019
Contractor-Specific ACOM 436 Submissions	Submitted to AHCCCS in January 2019	Submitted to AHCCCS in April 2019	Submitted to AHCCCS in July 2019

[D-1] Prior to conducting analyses, HSAG assigned beneficiaries to counties consistent with AHCCCS' ACOM 436 requirements, including county reassignments for beneficiaries residing in the following AHCCCS-specific ZIP codes, updated May 2019: beneficiaries residing in ZIP codes 85120, 85140, 85142, 85143, and 85190 are assigned to Maricopa County; beneficiaries residing in ZIP code 85135 are assigned to Gila County; and beneficiaries residing in ZIP codes 85542, 85192, and 85550 are assigned to Graham County.

Study Indicators

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

1. **Time/Distance Calculation**: HSAG's calculation of results for all applicable AHCCCS-established time/distance standards by Contractor, line of business, and county, using beneficiary and PAT data.
   - Study indicators show the percent of beneficiaries assigned by AHCCCS to the specified county, with access to any provider serving the line of business within the time/distance standard.
2. **Time/Distance Validation**: Validation of each Contractor's compliance with the time/distance standards, based on HSAG's time/distance calculation results from #1 above.
   - Study indicators validate each Contractor's reported compliance with each time/distance standard applicable to the line of business and county.
     - A score of "*met*" indicates that HSAG's time/distance results show a percentage of beneficiaries at or above the time/distance standard.
     - A score of "*not met*" indicates that HSAG's time/distance results show a percentage of beneficiaries below the time/distance standard.
     - The value "*NA*" identifies standards not applicable to the line of business and/or geography.
     - The value "*NR*" identifies standards for which no beneficiaries met the network requirement denominator for the line of business and geography; therefore, HSAG calculated no corresponding time/distance result.
     - An asterisk (*) identifies standards with fewer than five beneficiaries included in HSAG's time/distance calculation results.
   - Study indicators also consider the degree to which HSAG's time/distance results align with the time/distance values reported in each Contractor's ACOM 436 submission.
     - Shaded cells in the Findings tables identify notable differences between each Contractor's ACOM 436 time/distance calculation results and HSAG's results.
3. **Provider Saturation Analysis**: HSAG's assessment of the degree to which each Contractor's provider network reflects available AHCCCS-contracted providers.
   - Study indicators include the number of AHCCCS-contracted providers not reflected in each Contractor's quarterly PAT file for each applicable time/distance standard scored as *"not met."*

Analytic Process

HSAG used the Quest Analytics Suite software, version 2019.1 (Quest) to geocode the PAT and PMMIS addresses for beneficiaries and providers, assigning each address to an exact geographic location (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized beneficiary and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files.

HSAG assembled the geocoded beneficiary (PMMIS) and provider (PAT) addresses into datasets that were used with Quest to calculate the percentage of beneficiaries meeting the time/distance standards described in Table D-1. Quarterly county-specific time/distance calculations were conducted separately for each line of business and excluded less than 1 percent of beneficiaries and providers with addresses that could not be geocoded or were geocoded to non-neighboring states. HSAG's time/distance calculations considered the driving time/distance between a beneficiary and the nearest provider (i.e., the time or distance for the beneficiary to reach the provider using established roadways). Driving time calculations assumed 30 miles per hour (MPH) for Maricopa and Pima counties and 55 MPH for all other counties.

To assess the validity of each ALTCS E/PD Contractor's quarterly ACOM 436 submission, HSAG compared the time/distance results calculated from the PMMIS and PAT data against the quarterly ACOM 436 time/distance results submitted to AHCCCS by each ALTCS E/PD Contractor.

Quarterly analyses reflect the following measurement periods:

- Quarter One: October 1, 2018–December 31, 2018
- Quarter Two: January 1, 2019–March 31, 2019
- Quarter Three: April 1, 2019–June 30, 2019

AHCCCS does not define the software or process by which each ALTCS E/PD Contractor calculates the quarterly ACOM 436 time/distance results. As described above, HSAG uses Quest to calculate time/distance results based on driving distances, and additional discrepancies may result from the Contractors' use of different versions of Quest. Table D-3 describes each ALTCS E/PD Contractor's self-reported methods for calculating the ACOM 436 results, as of January 2019.

Table D-3—AHCCCS Contractors' ACOM 436 Calculation Methods

Contractor	ACOM 436 Calculation Method
BUFC-LTC	Uses Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).
MC-LTC	Uses Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).
UHCCP-LTC	Uses GeoNetworks and Quest to calculate time/distance results based on straight-line distances (i.e., not driving distances).

AHCCCS beneficiaries may seek care from network providers practicing outside of the beneficiary's county of residence. As such, HSAG considered all applicable providers within a line of business when calculating time/distance results.

The tables below present quarterly ALTCS E/PD validation findings, with one results table for each of the following counties by region:

- Central Region: Gila, Maricopa, Pinal

- North Region: Apache, Coconino, Mohave, Navajo, Yavapai
- South Region: Cochise, Graham,[D-2] Greenlee, La Paz, Pima, Santa Cruz, Yuma

Each county-specific table summarizes quarterly validation results containing the percent of beneficiaries meeting each time/distance standard by quarter and ALTCS E/PD Contractor, with color-coding to identify whether the time/distance standard was *"met"* or *"not met."* The value, "NA," is shown for time/distance standards that do not apply to the county or ALTCS E/PD line of business. The value, "NR," is shown for time/distance standards in which no beneficiaries met the network requirement denominator for the ALTCS E/PD line of business and county; therefore, HSAG calculated no corresponding time/distance result.

[D-2] Graham County includes the 85542, 85192, and 85550 ZIP codes representing the San Carlos Tribal area; these ZIP codes are physically located in Gila or Pinal County.

Central Region: Gila, Maricopa, and Pinal Counties

Table D-4—ALTCS E/PD Time/Distance Validation Results for Gila County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC			MC-LTC			UHCCP-LTC		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	NR	NR	NR
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	NR	NR	NR
Dentist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	NR	NR	NR
Hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	NR	NR	NR

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

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

NA indicates results are not applicable to the county.

Table D-5—ALTCS E/PD Time/Distance Validation Results for Maricopa County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC			MC-LTC			UHCCP-LTC		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	98.2	98.0	97.7	98.2	98.2	98.2	95.6	99.7	99.7
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	97.4	97.3	96.7	95.2	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	99.3	99.4	99.1	99.5	99.5	99.4	98.9	99.2	98.9
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	99.2	99.2	99.2	98.1	100.0	99.2
Hospital	99.8	99.8	99.8	100.0	100.0	100.0	99.9	99.9	99.8
Nursing Facility *(Only ALTCS E/PD Contractors)*	99.7	99.7	99.7	99.9	99.9	99.8	99.6	99.6	99.7
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.8	99.8	99.8	99.6	99.6	99.6	99.4	99.5	99.6
PCP, Adult	99.9	99.9	99.9	99.8	99.8	99.8	100.0	99.9	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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

Table D-6—ALTCS E/PD Time/Distance Validation Results for Pinal County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC			MC-LTC			UHCCP-LTC		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

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

Table D-7—ALTCS E/PD Time/Distance Validation Results for Apache County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	97.6	98.8	98.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	97.6	98.8	98.8
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	96.5	97.7	97.7
PCP, Adult	98.8	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-8—ALTCS E/PD Time/Distance Validation Results for Coconino County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	93.7	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	98.6
Nursing Facility *(Only ALTCS E/PD Contractors)*	93.3	91.3	90.2
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	96.9	97.2	96.4
PCP, Adult	100.0	100.0	99.5
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-9—ALTCS E/PD Time/Distance Validation Results for Mohave County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	97.7	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	98.9	98.9	98.1
Nursing Facility *(Only ALTCS E/PD Contractors)*	99.8	99.8	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	97.6	97.8	98.0
PCP, Adult	99.4	99.2	98.9
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-10—ALTCS E/PD Time/Distance Validation Results for Navajo County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0

NA indicates results are not applicable to the county.

Table D-11—ALTCS E/PD Time/Distance Validation Results for Yavapai County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	UHCCP-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	99.9	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	99.5	99.5	99.5
PCP, Adult	99.9	99.9	100.0
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

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

Table D-12—ALTCS E/PD Time/Distance Validation Results for Cochise County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	99.8	99.8	99.8
PCP, Adult	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-13—ALTCS E/PD Time/Distance Validation Results for Graham County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-14—ALTCS E/PD Time/Distance Validation Results for Greenlee County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	NR	NR	NR
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	NR	NR	NR
Dentist, Pediatric	NR	NR	NR
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0
PCP, Pediatric	NR	NR	NR

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

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

NA indicates results are not applicable to the county.

Table D-15—ALTCS E/PD Time/Distance Validation Results for La Paz County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	93.1	94.6	94.1
PCP, Adult	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-16—ALTCS E/PD Time/Distance Validation Results for Pima County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC			MC-LTC		
	Q1	Q2	Q3	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	98.1	98.5	98.4	99.0	99.0	99.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	96.4	96.6	96.3	95.8	95.7	92.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	92.6	92.3	92.3	98.2	98.2	98.1
Cardiologist, Adult	99.7	99.7	99.7	99.8	99.8	99.8
Cardiologist, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0	97.3	97.2	94.6
Hospital	99.6	99.7	99.7	99.9	99.9	99.9
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	99.5	99.8	99.8	99.8
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.3	99.3	99.2	99.6	99.6	99.5
PCP, Adult	100.0	100.0	100.0	99.9	99.9	99.9
PCP, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

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

Table D-17—ALTCS E/PD Time/Distance Validation Results for Santa Cruz County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	100.0	100.0	100.0
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0
PCP, Adult	100.0	100.0	100.0
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Table D-18—ALTCS E/PD Time/Distance Validation Results for Yuma County—Percent of Beneficiaries Meeting Minimum Network Requirements

Minimum Network Requirement	BUFC-LTC		
	Q1	Q2	Q3
Behavioral Health Outpatient and Integrated Clinic, Adult	99.8	99.8	99.8
Behavioral Health Outpatient and Integrated Clinic, Pediatric	100.0	100.0	100.0
Behavioral Health Residential Facility *(Only Maricopa and Pima Counties)*	NA	NA	NA
Cardiologist, Adult	100.0	100.0	100.0
Cardiologist, Pediatric	100.0	100.0	100.0
Dentist, Pediatric	100.0	100.0	100.0
Hospital	100.0	100.0	100.0
Nursing Facility *(Only ALTCS E/PD Contractors)*	100.0	100.0	100.0
Obstetrics/Gynecology (OB/GYN)	100.0	100.0	100.0
Pharmacy	99.8	99.8	99.8
PCP, Adult	99.8	99.8	99.8
PCP, Pediatric	100.0	100.0	100.0

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

NA indicates results are not applicable to the county.

Appendix E. CYE 2019 Network Adequacy Validation Report

2019 AHCCCS NETWORK ADEQUACY REPORT

PREPARED BY

DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS

CONTENTS

Purpose

This report outlines the processes the Arizona Health Care Cost Containment System (AHCCCS) uses to ensure contracted Managed Care Organizations (health plans) and state agencies maintain adequate networks to serve Medicaid beneficiaries in Arizona.

The report is designed to address the requirements outlined as mandatory External Quality Review (EQR) activities under 42 CFR 438.358(b)(1)(iv), state monitoring of the availability and accessibility of services through network adequacy standards under 42 CFR 438.66(b)(11), and Arizona's review of the health plans' assurances of adequate capacity of services under 42 CFR 438.207(d).

In this report, AHCCCS describes its program, requirements for contracted health plans and authorized state agencies, the reporting used to ensure network adequacy, how the validity and accuracy of this reporting is ensured, and other work used to ensure Arizonan's have reasonable access to Medicaid services.

Based upon this program and the documentation, AHCCCS assures the Center for Medicare and Medicaid Services (CMS) that its contracted health plans meet the state's requirements for the availability of services as set forth in 42 CFR 438.68 and 438.206.

Program Description

Arizona currently operates under an 1115 Waiver, extended by CMS on September 30, 2016. The extension was approved for a five-year period from October 1, 2016 to September 30, 2021.

AHCCCS administers a wide variety of covered services through its Medicaid program. These services include acute care services, behavioral health services covering general mental health as well as crisis services, services for members determined to have a Serious Mental Illness (SMI), children in the state's foster care program, and long term care and support services for the state's aging and/or physically disabled population, including individuals with developmental disabilities.

For most members[1], services are administered through contracts with health plans, including contracts with two Arizona state agencies.

- ***AHCCCS Complete Care (ACC) Contractors*** provide integrated care addressing the physical and behavioral health needs for the majority of Title XIX/XXI eligible children and adults. AHCCCS contracts with seven ACC Contractors: Arizona Complete Health-Complete Care Plan, Banner University Family Care, Care1st Health Plan, Magellan Complete Care, Mercy Care, Health Choice of Arizona, and UnitedHealthcare Community Plan. Each ACC Contractor is assigned to serve one or more of three county-based Geographic Service Areas (GSAs).

- ***Regional Behavioral Health Authority (RBHA) Contractors*** provide integrated physical and behavioral health services to eligible members determined to have a Serious Mental Illness as well as comprehensive behavioral health services to individuals enrolled in CMDP, as outlined below. RBHA Contractors are also responsible for the provision of crisis services to all individuals, including but not limited to, crisis telephone services, mobile crisis teams and crisis stabilization services. AHCCCS contracts with three RBHA Contractors: Arizona Complete Health-Complete Care Plan, Mercy Care and Health Choice of Arizona. Each RBHA Contractor is assigned to serve one of three county-based GSAs.

- ***Arizona Long Term Care System Elderly and Physically Disabled (ALTCS E/PD) Contractors*** provide long term services and supports and acute physical and behavioral health services to eligible members who are Elderly and/or have a Physical Disability. AHCCCS Contracts with three ALTCS E/PD Contractors: Banner University Family Care, Mercy Care and UnitedHealthcare Community Plan. Each ALTCS E/PD Contractor is assigned to serve one or more three county-based GSAs.

- ***Arizona Long Term Care System Arizona Department of Economic Security/Division of Developmental Disabilities (ALTCS/DDD)*** is a contracted Arizona state agency responsible for providing long term services and supports and acute physical and behavioral health services to

[1] Arizona American Indian members meeting specific criteria may receive services through an MCO, or may choose to receive services through the state-administered fee for service program

eligible members with Intellectual and/or Developmental Disabilities as outlined under Arizona state law. The ALTCS/DDD Contractor directly contracts with providers for long term care services and supports statewide, and subcontracts with two health plans who administer acute physical and behavioral health services to ALTCS/DDD members statewide.

- ***Department of Child Safety/Comprehensive Medical and Dental Program (CMDP)*** is a contracted Arizona state agency responsible for providing physical health services for children in the custody of the Department of Child Safety (DCS) as outlined under Arizona state law. Current Arizona law allows CMDP members to see any AHCCCS registered provider.

AHCCCS provides oversight of health plans through contracts, policies, and guidance documents.

AHCCCS Contracts are available on the AHCCCS website at the following link: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html

The AHCCCS Contractor Operations Manual (ACOM) provides information to health plans on their operational responsibilities and requirements under the AHCCCS program. The AHCCCS Medical Policy Manual (AMPM) provides information to health plans and providers regarding the services covered within the AHCCCS program. Both Policy Manuals are available on the AHCCCS website at the following link: https://www.azahcccs.gov/Resources/GuidesManualsPolicies/.

In addition, AHCCCS has developed several guidance documents that exist outside of these policies. The primary guidance document related to network adequacy is the AHCCCS Provider Affiliation Transmission (PAT) Manual, found at the Guides, Manuals and Policies page linked above.

Health plans demonstrate compliance with program requirements through the submission of required deliverables. These deliverables are identified in a table within each contract under a section called "Contractor Chart of Deliverables". The chart defines each deliverable submission requirements, including due date and any associated policy and checklist.

If, as a result of AHCCCS' review of the deliverable, or if for any other reason a health plan fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose and Administrative Action. Administrative Actions may include the issuance of any or all of the following: Notice of Concern, Notice to Cure, a mandated Corrective Action Plan, or financial sanction. AHCCCS also publishes issued Administrative Actions on its website at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/AdministrativeActions/

Deliverables Demonstrating Network Adequacy

In order to demonstrate network adequacy, AHCCCS health plans submit a number of deliverables as outlined below:

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

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

- A formal attestation of the health plan's network adequacy,
- An evaluation of the previous contract year's network plan,
- A description of the current status of the network by service type,
- A description of the health plan's process for evaluating its network adequacy,
- An evaluation of the previous year's compliance with AHCCCS network standards
- A review of services provided by out of network providers, and
- A description of the health plan's approach to community-based providers.

AHCCCS performs a cross agency review by subject matter experts who review the Network Plans and provide feedback on areas within their areas of expertise. The feedback is collected and the Network Plan is either accepted or rejected, requiring resubmission until the Network Plan is accepted.

A key goal of the AHCCCS 2019 review process was to ensure the Network Plans balanced a descriptive outline of health plan's network management processes with planning for the coming year. As a result, many Network Plans were required to be resubmitted to formally address planning priorities for the coming year, along with measurable goals to determine the Network Plan's effectiveness.

The Provider Affiliation Transmission (PAT) File – The PAT file is a quarterly electronic submission outlining each health plan's contracted provider network. The Pat file is used as a source of validating health plan compliance with minimum network requirements, to support review of material change submissions, and to assist in the research of network issues.

Minimum Network Requirements Verification – Each quarter, health plans[2] are required to submit a completed Minimum Network Requirement Verification Report (Verification Report). The requirements for this report are outlined in ACOM Policy 436. In the Verification Report health plans describe their compliance with minimum network requirements, including time and distance requirements (*See Attachment C ACOM 436 Verification Report*). These requirements identify thirteen provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards specific to all health plans, as well as some standards specific to RBHA and ALTCS E/PD health plans. Moreover, some standards are measured against specific member populations and the standards vary by county. These standards are identified in Table 1, below:

Table 1 - AHCCCS Minimum Time and Distance Standards

Provider Type	Beneficiary Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
1. Behavioral Health Outpatient and Integrated Clinic, Adult	Beneficiaries aged 18 years and older	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 60 miles
2. Behavioral Health Outpatient and Integrated Clinic, Pediatric	Beneficiaries younger than 18 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 60 miles
3. Behavioral Health Residential Facility *(Applies to Maricopa and Pima Counties Only)*	All beneficiaries	90 percent of beneficiaries within 15 minutes or 10 miles	Not Applicable
4. Cardiologist, Adult	Beneficiaries aged 21 years and older	90 percent of beneficiaries within 30 minutes or 20 miles	90 percent of beneficiaries within 75 minutes or 60 miles
5. Cardiologist, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 60 minutes or 45 miles	90 percent of beneficiaries within 110 minutes or 100 miles
6. Crisis Stabilization Facility *(Applies to RBHAs only)*	All beneficiaries	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 45 miles
7. Dentist, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles
8. Hospital	All beneficiaries	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 95 minutes or 85 miles
9. Nursing Facility *(Applies to ALTCS E/PD Plans Only)*	All beneficiaries currently residing in their own home	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 95 minutes or 85 miles
10. Obstetrics/Gynecology (OB/GYN)	Female beneficiaries aged 15 to 45 years	90 percent of beneficiaries within 45 minutes or 30 miles	90 percent of beneficiaries within 90 minutes or 75 miles
11. Pharmacy	All beneficiaries	90 percent of beneficiaries within 12 minutes or 8 miles	90 percent of beneficiaries within 40 minutes or 30 miles

[2] CMDP is exempted from this requirement as state law also allows members enrolled in CMDP to see any AHCCCS registered provider. This lack of a defined provider network prohibited this kind of network analysis for CMDP.

Provider Type	Beneficiary Population	Network Standard Maricopa and Pima Counties	Network Standard All Other Arizona Counties
12. PCP, Adult	Beneficiaries aged 21 years and older	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles
13. PCP, Pediatric	Beneficiaries younger than 21 years	90 percent of beneficiaries within 15 minutes or 10 miles	90 percent of beneficiaries within 40 minutes or 30 miles

AHCCCS validates the Verification Report submissions by conducting an independent time and distance analysis of the health plan's compliance. This analysis is completed through a contract with Health Services Advisory Group (HSAG). Each quarter, AHCCCS provides HSAG with each health plan's Verification Report submission, the health plan's PAT file, the health plan's enrolled membership and a file of all AHCCCS registered providers. For each health plan, HSAG produces a report comparing the Verification Report submissions with its validation.

The first validation report was generated using Quarter 1, 2019 data. In the early stage of this process, AHCCCS wanted to ensure any discrepancies found were not the result of different methods, or errors in reporting. As a result, AHCCCS provided information to assist the health plan plans research and address any identified discrepancies. AHCCCS provided the following information to the health plans:

- The health plan's quarterly report completed by HSAG
- The list of the providers sent to HSAG for the analysis
- The list of addresses rejected by HSAG's address matching software as not compliant with United State Postal Service standards

AHCCCS provided this information to the health plans with the expectation that they research the discrepancies, and identify and correct any reporting issues for future submissions.

After completion of the individual quarterly reports, HSAG also generated an annual validation report which is attached with this Network Adequacy Report (*See Attachment A HSAG Validation Report).*

After review of HSAG's validation, AHCCCS identified a number of areas where health plans appear to struggle to meet the minimum network requirements. For example, the validation of both ACC contractors serving Apache County shows difficulty in meeting the time and distance requirements for Outpatient and Integrated Clinics, Pediatric Dentists, and Pharmacies. While, as previously indicated, AHCCCS is working in the initial stages to ensure the discrepancies are not the result of differences in methodology and data, AHCCCS has also been working with the health plans to identify out of network providers to address any identified network gaps. Further, Banner University Family Care's ALTCS E/PD plan was out of compliance with seven of assisted living standards in ACOM Policy 436. AHCCCS required them to address these gaps, and Banner University Family Care has come into compliance with 3 of them, and is pursuing additional contracts to address the others.

The process of reviewing and validating the health plans' progress towards compliance with minimum network requirements is underscoring the relative lack of providers in some of Arizona's more rural counties. ACOM Policy 436 does include an exception process for health plans to request an exception from any minimum network standard that cannot be met after all efforts are exhausted. AHCCCS will review certain criteria to determine if an exception will be allowed, these criteria include but are not limited to; the number of providers available in the area, provider willingness to contract with a health plan, the availability of IHS/638 facilities[3] to serve the American Indian population, and the availability of alternate service delivery mechanisms. Plans are then required to monitor member access to the services covered by the exception while the exception is in place. In 2019 there were no exemptions in place.

In addition to time and distance standards, AHCCCS has established a number of other minimum network requirements that define network access under this policy.

- ALTCS E/PD and ALTCS/DDD health plans report compliance with requirements for long term care facilities in specific areas of any county served. For example, an ALTCS E/PD health plan serving Coconino County must have one assisted living facility in Page and five additional facilities within the county boundary.
- All health plans report compliance with network requirements related to Multi-Specialty Interdisciplinary Clinics (MSICs).
- RBHA health plans report compliance with Mobile Behavioral Health Crisis Team response time requirements.

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

Each quarter health plans submit the Appointment Availability report outlining their method for monitoring their provider network against appointment standards, as well as a matrix specifying audited provider compliance with standards (*See Attachment D ACOM 417 Template*). Provider compliance for PCPs, specialists and dentists is reported separately for new and established members, where a new member would be one who has not received services from the physician within the previous three years.

[3] American Indian members are able to receive services from any IHS/638 facility regardless of contracted status with a health plan.

While AHCCCS has not established specific compliance percentages for meeting appointment availability standards, health plan performance is closely monitored and trended over time. AHCCCS addresses any significant changes in provider availability directly with the health plan when needed. Further, in their Network Plan, health plans must compare their performance in these standards to the previous year, and if there was a decrease in available appointments conduct an analysis of the sufficiency of their network.

Material Changes to the Provider Network – AHCCCS has established reporting requirements for when a significant change is made to a health plan's provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires health plans to evaluate changes made to their provider network for materiality. A material change to provider network is defined as any change in the composition of or payments to the health plan's provider network that would cause or is likely to cause more than five percent of its members in a GSA to change where they receive services, or any change impacting fewer than five percent of members but 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 health plan identifies a material change to provider network, it submits an assessment of the impact of the change, how the health plan will transition members, a communication plan regarding the change, and how the health plan will monitor the impact of the change after transition (*See Attachment E ACOM 439 Material Change Checklist*). After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status of transitioning members. In 2019, AHCCCS approved four Material changes from contracted health plans.

Provider Changes Due to Rates Reporting – Health plans must also identify when a provider leaves, or reduces services due to rates, regardless of whether the change is a material impact on the provider network. Specifically, ACOM Policy 415 includes and attachment where plans report the name, type, whether the provider is a PCP, the region served, and number of members assigned of any provider leaving the network, or reducing or diminishing their scope of services due to sufficiency of rates (*See Attachment F ACOM 415 Rates Template*). The health plan must also conduct an analysis to determine if the loss is a material change and requires more in-depth reporting under ACOM Policy 439.

AHCCCS uses this information to inform its rate setting, access to care reporting to CMS, and also evaluate the impact on provider networks of Arizona Statutory changes, such as the passage of a new minimum wage law impacting the salaries of health care workers.

Gap in Critical Services Reporting – AHCCCS has established reporting requirements for gaps in the provision of specific Home and Community Based (HCBS) services provided to ALTCS E/PD and ALTCS/DDD members. Under ACOM Policy 413, each quarter these health plans must report their 'gap hours', or the number of hours of scheduled Attendant Care, Personal Care, Homemaker and Respite care services that were not delivered to members without being replaced by another paid caregiver (*See Attachment G ACOM 413 Gap Reporting Template*). Plans also report the percent of gap hours compared to total authorized hours for these services. In 2019, AHCCCS health plans reported less than .05% of authorized hours were gap hours.

This reporting was instituted as a part of a settlement agreement for a class action lawsuit. While the lawsuit has since been dismissed, AHCCCS retains this report and continues to monitor it as a measure of member access to HCBS services deemed critical under the lawsuit. Starting in 2019, AHCCCS has been exploring replacing this reporting with an automated method through its planned Electronic Visit Verification program.

In addition to monitoring health plan network adequacy, AHCCCS has been required to produce various network reports to the Arizona State Legislature. In 2019, this consisted of a report on the number of Behavioral Health Residential Facility and Supportive Housing beds available to members determined to have a Serious Mental Illness.